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	345547	A. BUILDING _____ B. WING _____	C 03/17/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A unannounced complaint investigation and recertification Survey was conducted on 3-17-21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #65ZI11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 3-17-21. 9 of 27 complaint allegations were substantiated. Event ID 65ZI11	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview, Nurse Practitioner, Responsible Party, and staff	F 552	***Complete review of resident #75's medications was completed 4/1/21.	4/15/21

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

Electronically Signed | 04/08/2021

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

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F 552	Continued From page 1 interview the facility failed to provide information on resident COVID status per the Responsible Party's request prior to the resident's discharge home. The facility additionally failed to follow-up on a Responsible Party's request to speak to the resident's provider regarding the addition of an antidepressant to his medication regimen. This was evident for 2 of 3 residents reviewed for right to be informed and make treatment decisions (Resident #311 and Resident #75). The findings included: 1. Resident #311 was admitted to the facility on 08/12/20 with diagnoses of chronic hypertension, COVID-19 infection, Alzheimer's disease, and history of cardiovascular accident. A review of Resident #311's admission Minimum Date Set (MDS) dated 08/16/20 revealed Resident #311's cognition was severely impaired, and he was unable to make his needs known to staff. Resident #311 required extensive assistance to total dependence on staff for all his activities of daily living (ADL's). Resident #311 was always incontinent of urinary and bowel. Review of a nursing progress note dated 08/28/20 at 11:24 am revealed a discharge care plan meeting was held with Resident #311's family via telephone conference. The resident was set to discharge home with home health on 8/31/2020 and would require 24/7 assistance at home. Nothing in the note discussed the health condition and or Resident #311's status as it related to COVID-19. Review of a physician's order dated 08/28/20 revealed Resident #311 was to be discharged	F 552	***To ensure no other residents were affected, the Staff Development Coordinators conducted an education and was completed by the with nurses and social work regarding the residents right to be informed and make treatment decisions specifically to discharge instruction and information provided for medication changes on 4/5/21. ***In an attempt to ensure this deficient practice does not recur, weekly audits will be conducted of 5 residents each week for 4 weeks, then 5 residents monthly for 2 months by the Director of Nursing and/or Nurse Manager, from a random sampling of residents to ensure proper discharge instruction and information is provided on medication changes. *** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly times 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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home with home health services including PT, OT, ST, and home health aide.

A review of the discharge summary written by the Nurse Practitioner (NP) dated 09/01/20 revealed Resident #311 was seen today for discharge. The resident was admitted to the facility after hospitalization from 07/29/20 through 08/12/20 after presenting with malaise post-fall. COVID-19 test was positive in emergency room. The discharge summary note stated the PT note indicated the resident needed moderate assist with transfer to wheelchair and he was able to self-propel in the wheelchair. PT was unsuccessful in being able to advance the patient's ambulation. The resident would need to continue to work with PT and OT at discharge. Resident #311 was medically stable for discharge at this time with appropriate support system arranged for him at home with family.

During an interview with Family member (FM) on 03/09/21 at 8:30 am she indicated Resident #311 was discharged home on 09/01/20 and no one discussed Resident #311's condition related to any signs/symptoms of COVID-19. The FM indicated Nurse #11 told the family he was still on the COVID-19 positive unit, however Nurse #11 indicated she had no knowledge if Resident #311 had been retested for the virus. The FM also indicated she asked the Social Worker (SW) #1 on Monday about Resident #311's COVID status. She added no one at the facility would give her any information about Resident #311's status as it related to COVID-19. The FM also indicated that during Resident #311's stay at the facility the only calls she received from the facility was the night Resident #311 had a fall and on 08/28/20 to discharge Resident #311. The FM indicated that

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she called the SW and the Nurses on the unit, but no one would answer her questions about Resident #311 COVID-19 status.

During an interview with SW #1 on 03/10/21 at 9:00 am she denied the family of Resident #311 had inquired about his status related to COVID-19. The SW indicated the facility communicated with all the residents and/or resident's responsible party about the resident's status as it related to COVID-19. She explained the facility used robocall and individual phone calls to communicate with the families regarding COVID-19 status.

During an interview with the Administrator on 03/10/21 at 9:30 am he indicated he had no knowledge of Resident #311's family not receiving any information from the facility regarding the status of the resident's COVID-19 status upon discharge. The Administrator stated he was aware Resident #311 was discharged home from the positive COVID-19 unit.

An interview was conducted with Nursing Assistant (NA) #21 on 03/14/21 at 2pm, she stated she had worked with Resident #311 on the COVID-19 hall during his stay at the facility. NA #21 stated the resident needed assistance with all his ADL's during his stay at the facility. She stated she was his NA the day he was discharged from the facility. NA #21 indicated the FM asked about Resident #311's condition and status due to being positive for COVID-19. NA #21 indicated Resident #311 was on the COVID-19 unit and she had to use full Personal Protective equipment (PPE) during care and treatment of Resident #311. NA #21 indicated she could not report to any resident's family about if they were still

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positive and/or if he had been retested for COVID-19 before being discharge home.

An interview with Nurse #11 on 03/14/21 at 3:00 pm, indicated she worked on the unit with Resident #311 and discharged him. Nurse #11 stated she remembered this discharge because the family was upset about having to wait while they got the resident ready and out to their car. Nurse #11 indicated she was the only nurse on the COVID-19 unit that day and she had to complete her medication pass before completing the discharge for Resident #311. Nurse #11 indicated once we were outside with the family, she had no problem with the family. She stated she apologized to them for the wait and instructed the family on Resident #311's medication and what appointments he had if any. Nurse #11 indicated to the family she did not have or provide any information to the FM concerning Resident #311's COVID-19 status when he was discharged.

2, Resident #75 was admitted to the facility on 1/7/19 and diagnoses included dementia with behavioral disturbance, congestive heart failure and chronic kidney disease.

A quarterly minimum data set (MDS) dated 2/4/21 for Resident #75 identified his cognition was moderately impaired, had not experienced any behaviors during the look-back period and received an anti-anxiety medication for 7 days during the look back period.

A care plan with a revision date of 3/10/21 for Resident #75 stated he was at risk for adverse

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consequences related to receiving psychotropic medication related to anxiety.

Review of the physician ' s orders for Resident #75 identified an order for Zoloft (an antidepressant) 50 milligrams (mg) for depression dated 2/21/21.

A phone interview was conducted on 3/9/21 at 10:49 am with Resident #75 ' s responsible party (RP). She stated the family had a care plan meeting over the phone with the facility on 2/22/21 and were informed the resident had been started on an antidepressant medication. The RP explained they had requested the facility to provide them with the contact information for the provider who had ordered the antidepressant so they could speak to them about the addition of the medication. She stated the facility refused to give them the providers contact information.

Review of a progress note for Resident #75 dated 2/22/21 written by Social Worker (SW) #1 stated in part a care plan meeting was held via phone with the resident ' s family. The residents plan of care, medications, code status were reviewed, and questions / concerns were addressed.

Review of a care plan conference summary dated 2/22/21 completed by SW #1 stated in part medications were reviewed with Resident #75 ' s family and they would like to speak with psych services.

An interview on 3/11/21 at 12:15 pm with SW #1 revealed the facility had recently had a care plan meeting with Resident #75 ' s family over the phone. She stated she did not recall the family requesting any specific information regarding the

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F 552	Continued From page 6 addition of an antidepressant or that they requested the providers contact information. SW #1 stated the resident did have some behaviors of hollering out, but she did not feel they had worsened recently. She added she did not know why the resident had been started on the antidepressant, but she would find out. SW #1 also stated she did not think the resident was being seen by psych services. A follow-up interview on 3/11/21 at 2:20 pm with SW #1 revealed the resident had been seen by the psych Nurse Practitioner (NP) and they had ordered the antidepressant for Resident #75. A phone interview was conducted with the psych NP on 3/15/21 at 10:30 am. She stated she was familiar with Resident #75 and had been providing psych services for him. She explained the staff had reported the resident had low mood and outburst type behaviors and she had started the resident on an antidepressant several weeks ago. The NP stated she had not been notified by the facility that Resident #75 ' s family wanted to speak to her about his medications and she would follow-up on this. An interview on 3/16/21 at 10:50 am with the Administrator revealed he was not aware Resident #75 ' s family had requested the contact information for the psych NP to discuss his medications. He stated he expected the SW would have provided this to the family or would have notified the ps	F 552		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		4/15/21

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Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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F 623	Continued From page 9 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, family, and staff interviews, the facility failed to notify the resident's responsible party of the resident's discharge in writing for 1 of 3 residents reviewed for discharge (Resident #311) who were discharged from the facility to home. The findings included: Resident #311 was admitted to the facility on 08/12/20 with diagnoses of COVID-19 infection, Alzheimer's disease, and history of cardiovascular accident. A review of Resident #311's admission Minimum Date Set (MDS) dated 08/16/20 revealed the resident's cognition was severely impaired, and he was unable to make his needs known to staff. Resident #311 required extensive assistance to total dependence on staff for all his activities of daily living (ADL's). Resident #311 was always incontinent of bowel and bladder. Section Q (return to community) was not selected and	F 623	***Education was provided by the DON to the social workers regarding notification to the resident's responsible party of the resident's discharge in writing 4/8/21. ***To ensure no other residents were affected, facility will conduct audit of prior discharges within last 30 days by 4/15/21 and conduct audits thereafter as stated below. ***Ongoing monitoring will consist of the Administrator conducting an audit of 5 discharged residents weekly for proper notification in writing to resident's responsible party times 4 weeks, then of 2 residents for proper notification of discharge weekly for 4 weeks, then 2 residents monthly for 1 month. ****** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the	

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indicated that neither resident nor family participated in the assessment. The MDS indicated the resident was to remain in the facility; answered yes for the discharge plan and that no referrals were needed.

A review of Resident #311's care plan dated 08/16/20 revealed there was no discharge care plan for the resident.

Review of a progress note, written by the Social Worker (SW) dated 08/28/20 at 11:24 am revealed a discharge care plan meeting was held with Resident #311's family via telephone conference. The resident was set to discharge home with home health on 8/31/2020 and would require 24/7 assistance at home. The resident was still having concerns with chewing and staying alert while eating. The resident required maximum 2-person assist with ADL care and would be sent home with home health, physical therapy (PT), occupational therapy (OT), speech therapy (ST), a home health aide (HHA) and durable medical equipment (DME) will be updated by therapy.

Review of a physician's order dated 08/28/20 revealed Resident #311 was to be discharged home with home health services including PT, OT, ST, and home health aide.

A review of the discharge summary written by the Nurse Practitioner (NP) dated 09/01/20 revealed Resident #311 was seen today for discharge. The resident was admitted to the facility after hospitalization from 07/29/20 through 08/12/20 after presenting with malaise post-fall. COVID-19 test was positive in emergency room. The discharge summary note stated the PT note

interventions to determine if continued auditing is necessary to maintain compliance.

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indicated the resident needed moderate assist with transfer to wheelchair and he was able to self-propel in the wheelchair. PT was unsuccessful in being able to advance the patient's ambulation. The resident would need to continue to work with PT and OT at discharge. Resident #311 was medically stable for discharge at this time with appropriate support system arranged for him at home with family.

A review of the discharge summary from PT dated 09/01/20 indicated that Resident #311 was not able to be complete therapy and recommend 24-hour care at home with home health and support family/caregiver.

A review of the discharge summary from OT dated 09/01/20 indicated that Resident #311 would be discharged home with family. Resident #311 still needed max assistance with all his ADL's. OT was recommended at discharge with home health services.

Review of a progress note, written by the SW dated 09/03/20 (identified as a late entry) stated in part. Resident #311's discharge care plan meeting was held on 8/28/20 with the resident's family and discharge was set for 8/31/20. The family was given discharge options during this time, After the meeting the resident was set up with DME including a wheelchair, bedside commode, and hospital bed. The family was also informed the resident would require a medical transport home and this information was provided as well. The SW informed the family all discharge information would be available on day of discharge. The SW called family back to find out what day to set for discharge and informed the family again that co pays would begin. The family

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stated she still had not scheduled transportation and wasn't sure if family could pick him up on 9/1/20. The SW informed the family the facility business office would possibly call to collect 30 days of copayment upfront or family could provide the Medicaid information to business office. The family had previously stated the resident had Medicaid. The family called back to provide the Medicaid number, but did not set a discharge date. The family indicated they would call back to let us know about discharge plans. Admissions and SW informed the family on 8/31/20 and 9/1/20 that administrative staff leave the facility at 5:00 pm. The family stated the resident's primary care physician informed her the resident could stay at our facility for 2 months and would not have co pays. The family had been informed at their 72-hour meeting, discharge care plan and day of set discharge of co pays which she took note of.

During an interview with a family member (FM) on 03/10/21 at 10:00 am they indicated Resident #311 was discharged home on 09/01/20 and was supposed to have home health services including home health aides, physical, speech and occupational therapy.

During this interview the FM revealed the facility did not give her a discharge letter nor did the FM understand why Resident #311 was being discharged. She also indicated the doctor at the hospital told her Resident #311 would be in the facility for at least 2 months for rehab and short-term services, but the resident was only in the facility from 08/12/20 to 09/01/20. The FM stated the facility informed her if she didn't come and get Resident #311 that APS would be called. The FM indicated she had made several calls to

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the facility to check on the resident and no one would answer the phone. She added she got two phone calls from the facility during his stay: one about a fall on 8/28/20 and about the resident's discharge. The FM indicated the SW informed her of a copayment of $200 beginning on 08/28/20 if she did not come and get him. The FM stated she had told the facility they had no means of providing care and treatment for Resident #311 at home. The FM indicated she had no knowledge of the letter and if we had knowledge of that information, we would have appealed that decision. The FM indicated the SW did not read any letter to her over the phone just told her that Resident #311 needed to be discharged today. The FM stated Resident #311 was very weak at discharge and two people had to help the family place him in the car.

During an interview with the Business Office Manager (BOM) on 03/12/21 at 3:00pm the BOM indicated Resident #311's family did not receive any letter from the facility because he was discharged before his insurance coverage was completed. According to the BOM no letter was completed at the facility for Resident #311's family as the resident had a few more days of coverage left before his letter would be issued.

An interview was conducted with the Administrator on 03/16/21 at 10:30 am who indicated it was the SW's responsible to plan for Resident #311's safe discharge and follow all the federal guidelines for this process. The Administrator indicated he was not aware of the family not receiving the letter and the SW not completing the referral to Home Health until after Resident #311 was discharged. The Administrator stated it was his expectation that

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F 623	Continued From page 14 referrals be made to Home Health services before any resident was discharged. BOM indicated he had few more days left.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655		4/15/21

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F 655	Continued From page 15 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview, the facility failed to develop a base line care plan for a resident who had multiple pressure ulcers for 1 of 3 residents (Resident #214) reviewed for pressure ulcers. Findings included: Resident #214 was admitted to the facility on 7-20-20 with multiple diagnosis that included moderate protein calorie malnutrition and pressure ulcer of left hip, unspecified stage. Resident #214's care plan dated 7-21-20 did not contain goals or interventions for the resident's pressure ulcer. The admission Minimum Data Set (MDS) dated 7-24-20 revealed Resident #214 was moderately cognitively impaired and was coded for four unstageable pressure ulcers. The MDS nurse#4 was interviewed on 3-10-21 at 1:26pm. The MDS nurse confirmed Resident #214 had multiple pressure ulcers upon admission to the facility. She stated she had missed the information on the hospital discharge	F 655	***Resident #214's baseline care plan was immediately updated to accurately reflect resident's pressure ulcers on 3/10/21. ***To ensure no other residents were affected, Minimum Data Set (MDS) Coordinator conducted an 100% audit of all current residents in the facility for up to date base line care plans was completed on 3/29/21. ****Education was completed by Regional Director of Reimbursement with MDS Nurses regarding completion of baseline care plans on 4/6/21. *** 2nd Chair MDS Coordinator will randomly audit for correct documentation on base line care plans for 7 residents weekly times 4 weeks, then randomly audit 5 residents weekly for correct documentation on base line care plans times 4 weeks, then 2 residents for correct documentation on base line care plans times 1 month. ***Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS Coordinator monthly times 3 months. At	

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F 655	Continued From page 16 summary and the facility admission documentation, so she did not add pressure ulcer treatments to Resident #214's base line care plan. During an interview with the facility's medical director on 3-11-21 at 8:15am, the medical director discussed the importance of having a treatment plan for residents and she stated it was improper for the facility not to have a plan of care developed for a residents wounds upon admission. An interview with the Director of Nursing (DON) occurred on 3-11-21 at 2:15pm. The DON stated he could not discuss why a baseline care plan was not developed for Resident #214's pressure ulcers but stated he expected the residents to be care planned according to the resident needs.	F 655	that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
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	F 656		4/15/21

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F 656	Continued From page 17 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an individualized and person-centered care plan that address Resident discharge for 1 of 3 residents (Resident #311) reviewed for discharged. Findings included: Resident #311 was admitted to the facility on 08/12/20 with diagnoses of chronic hypertension, COVID-19 infection, Alzheimer's disease, and history of cardiovascular accident.	F 656	***The MDS nurses and the social workers conducted an 100% audit of all residents in the facility to ensure discharge care plans were in place and accurate on 4/5/21. ***Education was provided to the social workers and MDS nurses by the Regional Reimbursement Manager regarding the need for care plans to accurately reflect the discharge plan for a resident in the comprehensive care plan on 4/6/21. ***MDS Coordinator will randomly audit for discharge care plan for 7 residents	

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F 656	Continued From page 18 A review of Resident #311's admission Minimum Date Set (MDS) dated 08/16/20 revealed Resident #311's cognition was severely impaired, and he was unable to make his needs known to staff. Review of the Participation in Assessment section was not selected and indicated that neither resident nor family participated in the assessment. The MDS further indicated the resident was to remain in the facility. A review of Resident #311's care plan dated 08/16/20 did not include a discharge care plan. During an interview with the MDS Nurse on 03/15/21 at 11:00 am, the MDS Nurse stated that the Social Worker was responsible for developing the discharge care plan. During an interview with the Social Worker (SW) on 03/16/21 at 10:00 am, the SW indicated that Resident #311 was assigned to the former Social Worker, and believed it was an oversight. During an interview with the Administrator on 03/16/21 at 10:30 am, he indicated that it was his expectation for staff to develop a discharge care plan timely.	F 656	weekly times 4 weeks, then randomly audit 5 residents weekly times 4 weeks, then 2 residents monthly times 1 month. *** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the MDS Coordinator monthly times three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		4/15/21

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process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who

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F 660	Continued From page 20 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews with family, facility-staff, Nurse Practitioner, Physician and home health agency staff the facility failed to provide discharge planning process for discharge goals, needs and caregiver support for 1 of 3 residents (Resident #311) reviewed for discharge. The findings included: Resident #311 was admitted to the facility on 08/12/20 with diagnoses of COVID-19 infection, Alzheimer's disease, and history of	F 660	***Education was provided to the social workers regarding the discharge planning process in regards to notification to the resident or his/her responsible party of discharge and the making of necessary referrals for discharge on 4/8/21. ***Administrator will conduct an audit of 5 discharged residents for proper notification and home health services referral times weekly for 4 weeks, then of 2 residents for proper notification of discharge and home health services	

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F 660	Continued From page 21 cardiovascular accident. A review of Resident #311's admission Minimum Date Set (MDS) dated 08/16/20 revealed Resident #1's cognition was severely impaired, and he was unable to make his needs known to staff. Resident #311 required extensive assistance to total dependence on staff for all his activities of daily living (ADL's). Resident #311 was always incontinent of urinary and bowel. Section Q (return to community) was not selected and indicated that neither resident nor family participated in the assessment. The MDS indicated the resident was to remain in the facility; answered yes for the discharge plan and that no referrals were needed. A review of Resident #311's care plan dated 08/16/20 revealed there was no discharge care plan for the resident. Review of a progress note, written by the Social Worker (SW) dated 08/28/20 at 11:24 am revealed a discharge care plan meeting was held with Resident #311's family via telephone conference. The resident was set to discharge home with home health on 8/31/2020 and would require 24/7 assistance at home. The resident was still having concerns with chewing and staying alert while eating. The resident required maximum 2-person assist with ADL care and would be sent home with home health, physical therapy (PT), occupational therapy (OT), speech therapy (ST), a home health aide (HHA) and durable medical equipment (DME) will be updated by therapy. Review of a physician's order dated 08/28/20 revealed Resident #311 to be discharged home	F 660	referral weekly for 4 weeks. *** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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with home health services including PT, OT, ST, and home health aide.

A review of the discharge summary written by the Nurse Practitioner (NP) dated 09/01/20 revealed Resident #311 was seen today for discharge. The resident was admitted to the facility after hospitalization from 07/29/20 through 08/12/20 after presenting with malaise post-fall. COVID-19 test was positive in emergency room. The discharge summary note stated the PT note indicated the resident needed moderate assist with transfer to wheelchair and he was able to self-propel in the wheelchair. PT was unsuccessful in being able to advance the patient's ambulation. The resident would need to continue to work with PT and OT at discharge. Resident #311 was medically stable for discharge at this time with appropriate support system arranged for him at home with family.

A review of the discharge summary from PT dated 09/01/20 indicated that Resident #311 was not able to be complete therapy and recommend 24-hour care at home with home health and support family/caregiver.

A review of the discharge summary from OT dated 09/01/20 indicated that Resident #311 would be discharged home with family. Resident #311 still needed max assistance with all his ADL's. OT was recommended at discharge with home health services.

Review of a progress note, written by the SW dated 09/03/20 (identified as a late entry) stated in part. Resident #311's discharge care plan meeting was held on 8/28/20 with the resident's family and discharge was set for 8/31/20. The

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family was given discharge options during this time. After the meeting the resident was set up with DME including a wheelchair, bedside commode, and hospital bed. The family was also informed that resident would require a medical transport, home and this information was provided as well. The SW informed the family all discharge information would be available on day of discharge. On 08/31/20 the family called the facility and stated they would like to pick up the resident due to medical equipment not being delivered due to rain. The SW confirmed with the medical supply company that equipment was delivered to the family on 8/31/20 and the wheelchair was delivered to facility on 8/28/20. The writer called family back to find out what day to set for discharge and informed the family again that co pays would begin. The family stated she still had not scheduled transportation and wasn't sure if family could pick him up on 9/1/20. The SW informed the family the facility business office would possibly call to collect 30 days of copayment upfront or family could provide the Medicaid information to business office. The family had previously stated the resident had Medicaid. The family called back to provide the Medicaid number, but did not set a discharge date. The family indicated they would call back to let us know about discharge plans. Admissions and SW informed the family on 8/31/20 and 9/1/20 that administrative staff leave the facility at 5:00 pm and she planned to call us before then to confirm discharge plans. No plans were confirmed by end of the day. SW received a call about 7:00 pm on 9/1/20 that the family was at the facility to pick up resident. The family stated the resident primary care physician informed her the resident could stay at our facility for 2 months and would not have co pays. The family had been

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informed at their 72-hour meeting, discharge care plan and day of set discharge of co pays which she took note of. The nurse was able to discharge resident and went over all the discharge paperwork and medications. The nurse also helped place the resident inside the family's van. Writer sent in residents' information to the home health company and reached out to his primary care physician to inform him of discharge and to reach out to family to follow up and continue therapy. The home health company reached out to family with no response. Home health will continue to attempt. Resident has appointment with primary care physician on 9/3/2020 at 8:00AM.
During an interview with the SW on 03/10/21 at 10:30 am, She stated the family was told about the appeal process on 08/28/20 and wanted to discharge Resident #311. She added she had read the letter to the family over the phone during the discharge meeting and the family got upset and indicated they did not want to appeal. The SW indicated she contacted the equipment agency and home health service company for Resident #311 and doctor had also completed the discharge paperwork for Resident #311.

A follow up interview with the SW on 03/11/21 at 1:30 pm revealed she was unsure what day she made the referral for home health services for Resident #311. She was asked to provide the referral that she faxed to the home health agency. The SW provided the referral information and the date of the referral was 9/2/20; the day after the resident was discharged home.

During an interview with a family member (FM) on 03/10/21 at 10:00 am they indicated Resident #311 was discharged home on 09/01/20 and was

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supposed to have home health services including home health aides, physical, speech and occupational therapy. The FM revealed the facility informed them the home health company would contact them within 24 to 48 hours. The FM indicated no one came out to the home until 09/4/20 and Resident #311 never received any home health services only an evaluation. She also indicated the doctor at the hospital indicated that Resident #311 would be in the facility for at least 2 months for rehab and short-term services, but the resident was only in the facility from 08/12/20 to 09/01/20. The FM stated the facility informed her if she didn't come and get Resident #311 that APS would be called. The FM indicated she had made several calls to the facility to check on the resident and no one would answer the phone. She added she got two phone calls from the facility during his stay: one about a fall on 8/28/20 and about the resident's discharge. The FM indicated the SW informed her of a copayment of $200 beginning on 08/28/20 if she did not come and get him. The FM stated that she had told the facility they had no means of providing care and treatment for Resident #311 at home. During this interview with the FM the Surveyor reviewed the letter that the facility indicated had been discussed with the family. The FM indicated she had no knowledge of the letter and if we had knowledge of that information, we would have appealed that decision. FM indicated that the SW did not read any letter to her over the phone just told her that Resident #311 needed to be discharged today. The FM stated Resident #311 was very weak at discharge and two people had to help family place him in the car. Family member indicated that we are not able to provide the care that Resident #311 needed at this time.

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A follow up interview with the FM on 03/11/21 at 9:00 am revealed Resident #311 never got any help from the home health services and indicated the facility did not have everything in place when Resident #311 was discharged home. Home health services were not in place and the FM explained the Home Health PT came and assessed the resident on 09/04/20 but that was the only time any home health visit was received. The FM indicated the facility knew that Resident #311 needed 24-hour care and that family could not provide this.

An interview was conducted with the PT at 11:00 am who indicated the family requested for Resident #311 to be discharged home during the week on 09/01/20, PT stated that the SW indicated them of the family request. The PT indicated Resident #311 needed maximum assistance with all his ADL's and would need to have physical therapy in place at discharge. The PT revealed it would be the facility's responsibility to set up physical therapy services before Resident #311 was discharged and the facility SW would be the person to set up those services for the resident. The PT added Resident #311 was discharged home before his goals were met.

An interview was conducted with the OT on 03/10/21 at 11:15 am, who indicated that Resident #311 needed maximum assistance with his occupational goals. The OT stated Resident #311 needed engagement to continue body movement for improved strength and range of motion. Resident #311 required 2-person maximum assist with his ADL's and 24-care care. The OT also indicated it was the facility's responsibility to set this service up for Resident #311 before discharging he home. Resident #311

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was discharged before any of his goals were met.

An interview with the Physician for Resident #311 on 03/11/21 at 9:30 am revealed she remembered Resident #311 during his admission, and he was admitted with COVID-19. She indicated the nurse practitioner conducted the discharge for Resident #311. She stated she expected the facility would follow up with any recommendation for therapies and services the resident needed before being discharged home.

An interview was conducted with the Home Health Agency representative on 03/11/21 at 10:30 am. The representative stated they received a referral from the facility on 9/2/20 for Resident #311. The representative explained no home health services (PT, OT, ST, or home health aide) were provided to the resident after he was discharged home because he expired on 9/10/29.

Interview with the NP on 03/15/21 at 1:15 pm NP revealed she observed Resident #311 on his day of discharge, and he was up in his wheelchair in his room. She stated the resident was able to answer simple questions. The NP explained her discharge summary was based on other information noted in Resident #311's chart and the notes from PT and OT. The NP indicated she requested Resident #311 be discharged with home health aides, based on what the NAs charted, PT and OT goals and interventions they had put in place for Resident #311. She added the resident needed maximum assistance with all his ADL's. The NP also indicated that it was mainly the SW's job to set up the recommended home health services and medical transport when a resident was discharged. NP indicated she

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F 660	Continued From page 28 have expected the services that Resident #311 was ordered to be in place once he got home. An interview was conducted with the Administrator on 03/16/21 at 10:30 am, Administrator indicated that it was the Social Worker responsible to plan for Resident #311 a safe discharge process and follow all the federal guideline for this process. Administrator indicated that he was not aware of the family not receiving the letter and the SW not completing the referral to Home Health until after Resident #311 was discharge he indicated the expectation was that referrals be made to Home Health services before any resident was discharged.	F 660		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to document and/or provide 3 of 14 pressure ulcer treatments in accordance with a physician's order for 1 of 3	F 686	***Education was provided to nurses by the Staff Development Coordinator and Assistant in regards to completion of all orders and documentation of completion	4/15/21

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F 686	Continued From page 29 residents (Resident #214) reviewed for pressure ulcers. Findings included: Resident #214 was admitted to the facility on 7-20-20 with multiple diagnosis that included moderate protein calorie malnutrition and pressure ulcer of left hip, unspecified stage. Resident #214's care plan dated 7-21-20 did not contain goals or interventions for the resident's pressure ulcer. The admission Minimum Data Set (MDS) dated 7-24-20 revealed Resident #214 was moderately cognitively impaired and was coded for four unstageable pressure ulcers. Review of the admission skin/wound/treatment note dated 7-21-20 revealed Resident #214's left hip pressure ulcer was unstageable and measured 5 centimeters long by 5 centimeters wide. The depth was undetermined as the wound had 100% yellow/brown devitalized necrotic slough. The physician order dated 7-21-20 revealed Resident #214 was to receive treatment to her left hip wound. The treatment was clean area with normal saline, apply skin prep to surrounding wound bed, apply Santyl ointment nickel thick to the wound bed, apply saline moistened foam over the Santyl ointment then cover with a dry dressing. Treatment to be completed daily. Review of Resident #214's Treatment Administration Record (TAR) for July 2020 revealed there was no documentation and/or	F 686	on the EMAR/TAR on 4/5/21. An audit was completed on current residents for compliance on all current treatments on the EMAR/ETAR on 4/6/21. ***Director of Nursing, Unit Managers and/or designees will conduct an audit 5 times a week of the MAR/TAR compliance for 4 weeks, then 3 times a week for 4 weeks, then once a month times 1 month. *** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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treatment provided to Resident #214's left hip pressure ulcer on 7-23-20, 7-25-20 and 7-26-20.

The weekly skin/wound/treatment note dated 7-29-20 was reviewed and revealed no improvement in Resident #214's left hip wound. The documentation revealed the left hip wound measured 4.8 centimeters long and 5 centimeters wide with inability to measure depth. The documentation also revealed the wound remained 100% covered with yellow/brown devitalized necrotic tissue.

During an interview with nurse #1 on 3-10-21 at 2:10pm. Nurse #1 stated he could not remember Resident #214 or if he had worked with Resident #214 on 7-23-20, 7-25-20 or 7-26-20 but then he stated, "the schedule says I did so I guess I did." Nurse #1 explained he did not remember if he provided wound care to Resident #214 on 7-23-20, 7-25-20 and 7-26-20 but acknowledged he would have been the nurse to provide treatment to Resident #214 on those days if there was not a treatment nurse working.

The wound care nurse (nurse #2) was interviewed on 3-11-21 at 7:55am. Nurse #2 acknowledged she was the only treatment nurse working during the time Resident #214 was a resident at the facility. She explained she worked Monday through Friday during the months of July 2020 and August 2020 and that there was not a treatment nurse available to work weekends. Nurse #2 stated the charge nurse for the unit would have been responsible for completing the resident's wound care on the weekends and any day during the week she was not working.

During an interview with the facility's medical

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F 686	Continued From page 31 director on 3-11-21 at 8:15am, the medical director discussed Resident #214's wound to the left hip could have been compromised if the resident was not provided treatments as ordered and she stated she was not aware Resident #214 had missed any wound care treatments. The Director of Nursing (DON) was interviewed on 3-11-21 at 2:15pm. The DON explained he was not working in the facility in July 2020 or August 2020 so he could not discuss what happened but stated he expected staff to provide wound care to the residents per the physician orders.	F 686		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	F 757		4/15/21

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F 757	Continued From page 32 section. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interview the facility failed to assess the residents heart rate prior to administration of a blood pressure medication as ordered by the physician. This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #3). Findings Included: Resident #3 was admitted to the facility on 3/21/18 and diagnoses included hypertension, atrial fibrillation, chronic kidney disease and diabetes. A quarterly minimum data set (MDS) dated 2/21/21 for Resident #3 identified his cognition was intact and he was independent with most of his activities of daily living. Review of the physicians orders for Resident #3 identified an order dated 6/11/20 for Toprol XL (a beta-blocker used to treat hypertension, chest pain and heart failure) 12.5 milligrams (mg) daily; hold for heart rate less than 55 beats per minute (bpm). Review of the medication administration record (MAR) for 3/1/20 through 3/9/20 revealed the Toprol XL was initialed as being administered daily. There was no documentation that Resident #3 ' s heart rate had been assessed prior to administration of the medication. Review of the vital sign report identified Resident #3 ' s vital signs were checked weekly on Tuesdays and his heart rate was documented on	F 757	***Resident #3 electronic medication administration record (EMAR) was immediately updated to include documentation of heart rate prior to administration of Toprol XL on 3/11/21. ***Director of Nursing and admission nurse conducted 100% audit of residents currently in the facility ensuring that medications with parameters (heart rate, blood pressure, etc.) in fact had the parameter documented on 4/5/21. Nurse and med aide education on proper documentation of vital sign parameters as ordered by the physician was completed on 4/5/21 by the Staff Development Coordinator and Assistant. ***Director of Nursing and/or designee will conduct EMAR audit of 5 residents weekly with medication parameters times 4 weeks, then of 2 residents weekly with medication parameters times 4 weeks, then 5 residents once a month times 1 month. *** Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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3/2/21 and 3/9/21.

An interview on 3/11/21 at 11:54 am with Nurse #5 revealed she had administered medications to Resident #3. She acknowledged the MAR stated to check the resident ' s heart rate before giving his Toprol XL, but she was not sure if that was being done. Nurse #5 explained she had been working at the facility for about 3 months and was still getting used to their electronic medical record system. She added typically there would be a space to record the heart rate on the MAR with the medication order, but this order didn ' t have a section to record his heart rate so maybe that was why this was missed. Nurse #5 stated the Nursing Assistants, Med Aides and the Nurses all checked vital signs.

An interview on 3/11/21 at 12:30 pm with the Regional Nurse Consultant stated typically there would be another line under the Toprol XL order for the staff to document the heart rate. She reviewed the March 2020 MAR for Resident #3 and confirmed his heart rate was only documented as being checked on 3/2/20 and 3/9/21. The Nurse Consultant explained it appeared the medication had been administered daily, but she could not confirm that the nurses had checked the resident ' s heart rate prior to administering the medication.

A phone interview was conducted on 3/16/21 at 11:00 am with Resident #3 ' s physician. She stated she expected the nurses to check the resident ' s heart rate prior to administering his Toprol XL. The physician added the heart rate should be documented otherwise there was no way of confirming this had been done.

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F 757	Continued From page 34 A phone interview on 3/16/21 at 10:30 am with the Administrator revealed it appeared Resident #3 had been administered his Toprol XL daily, but there was no evidence his heart rate had been checked prior to administering the medications. He stated he expected the physician ' s orders to be followed.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 761	All medication carts were audited by the	4/15/21

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F 761	Continued From page 35 interview, the facility failed to store an inhalation drug vial according to the manufacturer's specification. The facility failed to label medications and biologicals with an opened date in 4 of 6 medication carts observed. (100 medication cart, 400, 500, and 600 medication cart. Findings included: Review of the manufacturer's specification for Humalog (fast-acting mealtime insulin) and Admelog (short-acting insulin) revealed to discard 28 days after opening. The manufacturer ' s instructions for Ipratropium Bromide 0.55 milligram (mg) and Albuterol Sulfate (drugs used to help control the symptoms of asthma and other lung disease) 3 milliliter (ml) vial indicated the medications should always remain stored in the protective foil pouch and once removed must be used within one week. Review of the Prostat (a protein supplement) bottle instructions read "to discard 3 months after opening." 1. Observation on 3/10/21 at 8:00 AM during the medication pass revealed the 100-unit medication cart had a Humalog multi-vial already open and undated. Nurse #3 attempted to use the multi-vial until an inquiry was made about the opened and undated vial. Nurse #3 stated she did not know when the medication was open. 2. Observation on 3/11/21 at 8:19 AM revealed: 100 medication cart a. Prostat sugar free 30 fluid ounce bottle was open and undated. b. Saline eye drops were open and undated. c. Admelog 3 ml vial was open and undated. d. Clear laxative fiber powder 17.9 grams container was opened and undated. e. Cinnamon 500 milligrams (mg) plus chromium bottle was opened and undated.	F 761	Director of Nursing and Unit Managers for medication open dates and proper medication storage on 4/2/21. Education was completed with nurses and medication aides by Staff Development Coordinator and Assistant regarding labeling of medication containers upon opening and proper storage on 4/5/21. Director of Nursing or designee will complete medication cart audits three times a week for four weeks, then two times a week for four weeks for proper date labeling and medication storage, then once a month times one month. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 761	Continued From page 36 3. Observation on 3/11/21 at 8:37 AM through 9:15 AM on the Magnolia Unit with Nurse #6 revealed: 600 medication cart a. Admelog 3 ml vial was open and undated. b. Clear Laxative container was open and undated. c. Oyster shell with Calcium 500 mg plus Vit D was opened and undated. 400 medication cart a. Prostat sugar free 30 fluid ounce was open and undated. 500 medication cart a. Three (3) vials of Ipratropium Bromide 0.55 mg and Albuterol Sulfate were stored outside of the package and undated. b. Vitamin C 500 mg bottle was opened and undated. c. COQ-10 100 mg bottle was opened and undated. Interview on 3/11/21 at 8:50 AM with Nurse #6 stated staff should date medications when opened. Interview on 3/11/21 at 1:27 PM, with the Director of Nurses stated he did not know the rationale for why the staff did not date medications and solutions when opened. He stated staff should date the medication when opened.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/15/21

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F 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 38 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and physician interview, the facility failed to implement their infection control policies and procedures for personal protective equipment (PPE), hand hygiene and cleaning of reusable resident care equipment when a nurse (Nurse #3) failed to clean resident equipment between usage, doff PPE and perform hand hygiene prior to exiting resident rooms who were on enhanced droplet isolation and a nursing assistant (NA #8) failed to don PPE prior to entering an enhanced droplet isolation room and failed to perform hand hygiene before exiting the resident room for 2 of 2 staff observed working on the facility's new admission quarantine unit (Resident #101, Resident #83 and Resident #216). These failures occurred during a COVID19 pandemic.	F 880	1. Corrective action has been accomplished for the alleged deficient practice – not adhering to proper infection control procedures – specifically for residents on the intake/isolation hall related to enhanced droplet -contact precautions for Residents #101, #83, and #216 on 3/23/21. a. 1:1 Staff education provided immediately by the Regional Clinical Manager/Infection Preventionist (IP) with the staff identified as violating policy/procedure for infection control. Education included when to perform hand hygiene – before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and continuously wearing of PPE while on the isolation unit, proper use of gowns and	

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F 880	Continued From page 39 Findings included: Review of the facility's "Isolation-Categories of Transmission Based Precautions" policy and procedure dated January 2012 revealed in part; in addition to standard precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets. Resident care equipment that is shared should be cleaned and disinfected before use for another resident. The facility will implement a system (signs) to alert staff of the type of precaution the resident needs. Review of the "enhanced droplet isolation" sign revealed staff should don a mask, eye protection, gown and gloves prior to entering an enhanced droplet isolation room. Review of the facility's "Cleaning of non-critical, reusable patient care equipment" policy and procedure dated April 2020 revealed in part; all equipment must be cleaned immediately after use on patients with precautions. Nurse #3 was observed on the facility's new admission quarantine unit during medication pass on 3-10-21 at 8:00am. The nurse entered Resident #101's room with her blood pressure machine and pulse oximeter. Resident #101 had a sign posted on his door for enhanced droplet isolation which required staff to wear a mask, gown, gloves and eye protection when entering the room. When nurse #3 returned, she laid the items on top of her medication cart and proceeded to Resident #83's room, who had a sign posted on her door for enhanced droplet isolation. Nurse #3 retrieved the blood pressure	F 880	cleaning and disinfecting of equipment between uses. 2. Other residents who are on isolation have the potential to be affected by the same alleged deficient practice; therefore, the Regional Clinical Manager/IP has conducted an audit of current residents and no other residents were found to be affected by the deficient practice. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: • Director of Nursing Services (DON)/IP attended and completed SPICE training on 12/16/20 for infection control. • Facility will have Staff Development Coordinator (SDC) assist the DON/IP in conducting all training and surveillance for Infection Control. • SDC began observation/surveillance rounds of staff on 3/18/21 to ensure proper donning and doffing of PPE, hand hygiene, and cleaning equipment between resident use. SDC began competency quizzes to ensure staff can verbalize the company policy as well as demonstrating the use of good PPE utilization and adherence to policy and best practices while providing patient care and while on the isolation/intake unit. • DON and SDC began In-service/reeducation for all staff related to the Centers for Disease Control (CDC), State Guidelines and Company policy and	

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F 880	Continued From page 40 machine and the pulse oximeter from the medication cart and proceeded into Resident #83's room to obtain her vital signs without cleaning the equipment. When Nurse #3 exited Resident #83's room, she did not doff her PPE (gown and gloves) and began touching her computer keyboard and various items on her medication cart. She returned to Resident #83's room to complete her medication pass and exited the room wearing full PPE (gown and gloves) and again began touching her computer and other items on her medication cart. Nurse #3 then doffed her PPE in the hall, throwing away her PPE in the trash bin located inside Resident #83's room and performed hand hygiene. During an interview with Nurse #3 on 3-10-21 at 8:20am, the nurse acknowledged she should have cleaned her blood pressure machine and pulse oximeter prior to using it on Resident #83. The nurse stated, "I just didn't think about it, but I know it could spread the COVID virus if I don't." She also explained she thought it was ok to exit a resident room who was on enhanced droplet isolation with PPE on as long as she had not encountered bodily fluids. Nurse #3 confirmed she had received education on isolation, PPE, hand hygiene and COVID19 in February 2021. Nurse #3 was observed on 3-10-21 at 8:22am to re-enter Resident #83's room to provide an injection. Upon exiting the room, Nurse #3 was observed to be in full PPE including her gloves and touching items on her medication cart. An interview with nurse #3 occurred on 3-10-21 at 8:23am. The nurse explained she did not think she had to remove her PPE or perform hand hygiene because she did not touch the resident.	F 880	expectations related to Infection Prevention and Control. This in-service-reeducation and continued education included: when to perform hand hygiene – before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and continuously wearing of PPE while on the isolation unit, proper use of gowns and cleaning and disinfecting of equipment between uses. Education will be completed by the DON/IP or SDC by 4/15/21 and new employees will receive this education during orientation. • Increased surveillance rounds during Room Round audits 5 times per week to include a weekend day will be completed by DON, SDC, and Department Managers for 1 month; then at least weekly for 3 months to identify any variance from policy with regard to adhering to the policy and procedure for Infection Prevention and Control. • Directed Plan of Correction (DPOC) steps are being implemented by the facility as recommended and will be completed by the DON and the Regional Clinical Manager. Part of this DPOC includes education in the form of the following training/education: o http://youtu.be/t7OH8ORrg - Sparkling Surfaces o http://youtu.be/xmYMUly7qiE - Clean Hands o https://youtu.be/1ZbT1Njv6xA - Closely Monitor Residents	

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F 880	Continued From page 41 Nurse #3 then acknowledged she had touched the resident to provide the injection and should have doffed her PPE and performed hand hygiene before exiting the room. An observation of the facility's new admission quarantine hall occurred on 3-10-21 at 7:35am. Nursing assistant (NA #8) was observed in Resident #216's room, which had an enhanced droplet isolation sign which required staff to wear a gown, gloves, mask and eye protection when entering the room, posted on the door, without donning gloves, gown or eye protection. The NA was observed to be standing over the resident, who was in the bed, having a conversation, then the NA was noted to touch the residents blanket, items on his over the bed table and throw away cups that had been located on the residents over the bed table. NA #8 exited the room without performing hand hygiene and began walking down the hall past the hand sanitizing unit. During an interview with NA #8 on 3-10-21 at 7:38am, the NA acknowledged Resident #216 was on enhanced droplet precautions and she was in his room without full PPE and did not perform hand hygiene before exiting his room. NA #8 stated, "I'm sorry, I am trying to wake up this morning and just did not think about it." She confirmed she had received infection control, hand hygiene and isolation training in February 2021. The facility's medical director was interviewed on 3-11-21 at 8:15am. The medical director stated she was aware infection control had been an issue and that she had been trying to educate staff on hand hygiene, PPE and cleaning surfaces when she was in the building. She also	F 880	o https://youtu.be/7srwrF9MGdw - Keep COVID-19 Out! o https://youtu.be/YYTATw9yav4 - Lessons • Facility held an impromptu Quality Assurance meeting to conduct a Root Cause Analysis on 4/8/21 with the Medical Director, DON/Infection Preventionist, SDC, Regional Operations Manager, the Regional Clinical Manager, Administrator and select members of the QAPI committee. 4. The DON/IP and/or SDC will review data obtained during rounds, analyze the data and report patterns/trends to the QAPI committee every month for 6 months. The QAPI committee and Governing Body will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure continued compliance. Corrective action will be completed on 4/15/21.	

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F 880	Continued From page 42 discussed staff not following infection control practices could put the facility at risk for an outbreak. An interview with the Director of Nursing (DON) occurred on 3-11-21 at 2:15pm. The DON stated staff were aware of infection control practices and that he expected staff to adhere to the facility's policy and procedures for infection control.	F 880		