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	345006	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL NURSING & REHABILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 6/21/21 through 6/24/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DCPS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 6/21/21 through 6/24/21. Event ID #DCPS11. 22 of the 58 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to determine whether the self-administration of medications was clinically appropriate for 2 of 2 sample residents (Resident #79 and Resident #78) who were observed to have medications at bedside. The findings included: 1. Resident #79 was admitted to the facility on 2/12/21 with a diagnosis of heart disease. A quarterly Minimum Data Set assessment dated 5/21/21 revealed Resident #79 had moderately impaired cognition.	F 554	F554 □ Resident Self-Adm Meds 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Nystatin Powder for both residents #79 and #78 was removed from the bedside of both residents by the charge nurse on 6/23/21. The charge nurse for these residents was educated on 6/23/21 by Staff Development Coordinator the intent of F554, including that resident are not	7/22/21

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

Electronically Signed | 07/19/2021

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F 554	Continued From page 1 On 6/21/21 at 3:06 PM, a small bottle Nyamyc (nystatin topical powder) was observed on Resident #79 ' s bedside. Resident #79 stated she had a rash under her breast. She stated she didn ' t know how often the medication was used. A physician ' s order dated 6/16/21 for Nystatin 100,000 unit/gram powder apply powder under both breasts twice daily for yeast for 10 days. The physician ' s order did not state the medication could be left at the bedside. A comprehensive medical record review completed 6/21/21 did not include an assessment to self-administer medications was completed for Resident #79. An interview was conducted with Medication Aide #4 on 6/21/21 at 3:10 PM revealed Resident #79 should not have the nystatin powder at bedside. She added she did not know how it got there . On 06/24/21 at 9:25 AM, an interview was conducted with the facility's Director of Nursing (DON). The DON stated "that is not okay" when told about the nystatin powder left at the bedside. The DON added if a resident is to self-administer their medications, a self-administer medication assessment would be completed and it would need to be added to the care plan. 2. Resident #78 was admitted to the facility on 5/14/21. His cumulative diagnoses included a history of bacteremia with ongoing antibiotic treatment. The resident ' s admission Minimum Data Set	F 554	allowed to keep medications at their bedside unless there is a completed self-administration assessment completed, medication is secured in a locked box, and this is a request of the resident. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility Interdisciplinary (IDT) Team, (Activities, Social Services, Admissions, Business Office, Medical Records, and Nursing Administrative Nurses) completed observation rounds checking each current resident□s room to ensure there were no other medications being stored at their bedside or room. Any other medications at bed side were removed. These rounds were completed on 7/12/21. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A list of any residents deemed clinically appropriate to self-administer medication has been placed in a binder at each nursing station to indicate who is appropriate to have medications at their bedside. Staff development Coordinator will educate License Nurses, medication aides and med techs on F554 with emphasis on the importance not leaving	

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F 554	Continued From page 2 (MDS) dated 5/21/21 revealed the resident had intact cognitive skills for daily decision making. He was assessed as requiring extensive assistance from staff for all of his Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating. Resident #78's comprehensive care plan included the following areas of focus, in part: --Activities of Daily Living (Initiated on 6/11/21): Resident requires assistance for eating, mobility, transfers, dressing, grooming, toileting, and bathing related to impaired mobility, muscle weakness, and unsteadiness on feet. --Vision (Initiated on 6/11/21): Resident has impaired vision, able to see large print. Further review of the resident's care plan revealed it did not address the resident's self-administration of medications. A review of Resident #78's current physician orders revealed a medication order was received on 6/19/21 for nystatin powder (a prescription antifungal medication) to be applied to the affected area twice daily until healed. No notes in the MD order indicated the resident may apply the medicated powder himself. Further review of the resident's medical record revealed no assessments were completed for the self-administration of medications. An observation and interview were conducted with Resident #78 on 6/22/21 at 9:08 AM. The resident was awake, alert, and lying in his bed. A container of nystatin topical powder was observed to be placed within the resident's reach on the nightstand next to his bed. Upon questioning, Resident #78 reported the powder was used to treat a rash he had on the area of his groin. The	F 554	medications at bedside of any resident not deemed clinically appropriate to self-administer medications. Any nursing staff licensed, med techs and medication aide will receive this training prior to their next scheduled shift. New employees will receive this training during their orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or designee will audit 20 residents per week X 4 weeks, 15 residents per week X 4 weeks, and 10 residents per week x 4 weeks to ensure no medications are left at the bedside. Audits will be conducted on weekends and all shifts. The Director of Nursing (DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 554	Continued From page 3	F 554		

resident stated he applied the powder to his groin once daily. Upon further inquiry, the resident reiterated he applied the powder himself one time a day.

An observation was conducted on 6/23/21 at 3:32 PM of the resident's room from the hallway. There was no response heard upon knocking on the door to the room. Resident #78 did not appear to be in the room. The nystatin powder container was observed from the doorway to be placed on the nightstand next to the resident's bed.

An observation was conducted on 6/24/21 at 8:30 AM as Resident #78 was eating his breakfast while in bed. The container of nystatin topical powder was observed to be placed within the resident's reach on the nightstand next to his bed at that time.

An interview was conducted on 6/24/21 at 8:32 PM with Nurse Aide (NA) #1. During the interview, the NA reported she applied a topical treatment (an over-the-counter skin protectant) to Resident #78's skin after incontinence episodes. When asked, NA #1 reported she did not apply any other topical treatments to the resident's skin.

An interview was conducted on 6/24/21 at 9:25 AM with the facility's Director of Nursing (DON). During the interview, the DON was informed of the observations and interview with Resident #78 with regards to the nystatin powder. Concern was expressed with regards to the resident's report that he applied this nystatin powder once daily (versus twice daily as ordered). Additionally, the resident was care planned to have impaired vision and only able to read large print, potentially

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F 554	Continued From page 4 impairing his ability to read instructions on the labeling of the nystatin powder. The DON stated Resident #78 needed to have a self-administration of medication assessment completed. This assessment would ensure he knew what the medication was for, the risks and potential side effects of the medication, how and when to apply the medication, and when to notify the nurse if he had any problems. The DON stated Resident #78 also needed to have a physician's order and to be care planned for the self-administration of medications.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide residents access to turn on and off the overbed lighting as desired for 1 of 5 residents reviewed for unnecessary medications (Resident #14) and 1 of 7 residents reviewed for nutrition (Resident #109). The findings included: 1. Resident #14 was readmitted to the facility on 4/8/21 with diagnoses of, in part, right hip fracture and history of falling. A significant change in status Minimum Data Set	F 558	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The overbed light for both residents #14 and #109 was fixed on 6/30/21 and made accessible for them to turn it on and off, by the Maintenance Director. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Maintenance Director completed	7/22/21

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F 558	Continued From page 5 assessment dated 4/15/21 revealed Resident #14 had impaired cognition and required extensive assistance for bed mobility, transfers, toileting and hygiene. During an interview with Resident #14 on 6/21/21 at 3:16 PM, no attachment was observed to the overbed light and the light was on. The resident stated the chain that was attached to the light came off and he has asked for it to be fixed but it hasn ' t happened yet. The chain was observed located on Resident #14 ' s nightstand. Resident #14 stated when the staff came in at night, they turned on the light and sometimes didn ' t turn it off and it stayed on while he was trying to sleep. He added he was unable to get up on his own to turn it off and would like to have the attachment put back on. An observation on 6/23/21 at 8:10 AM revealed the chain for the overbed light was still observed on the nightstand and the overbed light was observed to be on. A review of the environmental rounds checklists revealed the last rounds completed were conducted on 5/21/21. An interview was conducted on 6/24/21 at 2:51 PM with the Maintenance Director. He stated he conducted weekly environmental rounds himself and the administrative staff also completed rounds on assigned rooms. He starts on the 100 hall, documents it and immediately begins repairs. He stated it usually took a couple of weeks to get the repairs completed depending on the repairs needed. He added he was going o begin working on the 700 hall, where Resident #14 resided, soon.	F 558	observation rounds of each current resident room on 7/12/21 to ensure the overbed light switch was accessible to the resident and working properly. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Observation round sheets completed by administrative staff, (includes, Activities Director, Medical Records, Social Workers, Admissions Director, Business office Manager and Administrative Nurses), will be modified to include whether a resident's overbed light is working appropriately and provides access for resident to turn it on and off. This was modified by administrator on 7/15/21. If there is an issue with a work order and immediate repair is not feasible, facility administrator will be made aware at the daily morning meeting. Maintenance Director along with maintenance assistant were educated on 7/12/21 by Staff Development Coordinator, on the intent of F558, including to ensure that all residents have access to turn their overbed light on and off. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 5 resident rooms will be audited by a member of the administrative team, daily	

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F 558	Continued From page 6 An interview was conducted with Social Worker #1 on 6/24/21 at 3:30 PM. She stated she made room rounds and documented findings on a form that she turned into the Administrator and it included ensuring the lighting in the room was working but, did not include ensuring the resident had overbed lighting attachment. 2. Resident #109 was admitted to the facility on 10/31/17 with diagnosis of, in part, osteoarthritis. A Quarterly Minimum Data Set assessment dated 5/27/21 revealed Resident #109 had moderately impaired cognition and required minimal assistance of one person for bed mobility, transfers, toileting and hygiene. On 6/21/21 at 2:48 PM, an observation revealed Resident #109 did not have an attachment to her overbed lighting which was on. During an interview with Resident #109 on 6/21/21 at 2:48 PM, she stated she would like to be able to turn the light on and off without getting out of bed, but she was unable to. An interview was conducted on 6/24/21 at 2:51 PM with the Maintenance Director. He stated he conducted weekly environmental rounds himself and the administrative staff also completed rounds on assigned rooms. He starts on the 100 hall, documents it and immediately begins repairs. He stated it usually took a couple of weeks to get the repairs completed depending on the repairs needed. He added he was going o begin working on the 700 hall, where Resident #14 resided, soon. An interview was conducted with Social Worker	F 558	Monday – Friday x 4 weeks , weekly X 4 week, and monthly X 1 to ensure adequate compliance with F558 and its content ensuring that all residents have access to their overbed light on and off. Findings will be documented on Ambassador round tool. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 558	Continued From page 7 #1 on 6/24/21 at 3:30 PM. She stated she made room rounds and documented findings on a form that she turned into the Administrator and it included ensuring the lighting in the room was working but, did not include ensuring the resident had overbed lighting attachment.	F 558		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir 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	F 578		7/22/21

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F 578	Continued From page 8 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to document code status in the electronic health record (EHR) for 4 of 7 residents (Resident #100, Resident #95, Resident #616 and Resident #617) who were newly admitted and reviewed for advance directives. Findings included: 1. Resident #100 was admitted to the facility on 5/21/21. She discharged to the hospital on 5/22/21 and re-admitted to the facility on 5/27/21. Cumulative diagnoses included hypertension, chronic kidney disease and tachycardia. The comprehensive Minimum Data Set assessment dated 6/3/21 revealed Resident #100 was cognitively intact. The physician orders were reviewed in the EHR and there was no order that addressed code status for Resident #100. Additionally, statements in the EHR read, "Set CPR (cardio-pulmonary resuscitation) status and CPR/Resuscitation Status requires review." On 6/23/21 at 8:57 AM an interview was	F 578	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The code status for residents #100, #95, #616, and #617 were documented in the resident Electronic Health Record on 6/24/21 by facility Director of Nursing and/or Administrative Nurses. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing (DON) and Administrative Nurses (includes Assistant Director of Nursing, Assistant Director of Nursing, Unit managers, and Staff Development Coordinator) completed an audit of current resident's electronic health record (EHR) to ensure that the Alert Section of the resident record identified resident Code Status and specified if the resident is a Do Not Resuscitate (DNR) or Full Code. The audit was completed on 7/7/21.	

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F 578	Continued From page 9 completed with Nurse #3. She explained there was a pink colored binder at the nurse's desk that included information on each resident's code status. Nurse #3 reviewed the binder and located Resident #100's code status information which included a Do Not Resuscitate (DNR) form (do not initiate cardio-pulmonary resuscitation should respirations and heartbeat stop), effective 5/21/21 and a Medical Orders for Scope of Treatment (MOST) form that was checked "Do Not Attempt Resuscitation," effective 5/28/21. Nurse #3 said she looked at the binder first when she needed to determine a resident's code status if she worked on the hall and was not on a medication cart. She added if she had a medication cart on her assignment she looked for the code status in the computer in the resident's EHR under the electronic medication administration record (EMAR) tab. Resident #100's EHR was reviewed with Nurse #3 during the interview and code status was not located in the EMAR or in any of the physician orders. During an interview with the Admissions Coordinator (AC) on 6/24/21 at 9:21 AM she stated code status was included in the admissions packet information that was reviewed with residents and/or representatives prior to or upon admission to the facility. Once a resident's code status was determined the AC gave the code status form to the nurse practitioner or physician who signed the paperwork. The code status form was then forwarded to the medical records department who then sent the information to the nursing unit and the order was entered into the EHR. The AC said she thought Resident #100 was admitted on a weekend and was unsure which nurse manager was on duty.	F 578	3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: DON and/or administrative nurses will review the new admissions for the previous day to ensure that all admission paperwork has been completed which includes the CODE status being available in the resident EHR. This audit was completed on 7/22/21. Licensed Nurses, including contracted licensed nurse were educated on intent of F578, including ensuring that all new and current residents have a code status entered the resident EHR. This training was completed by July 22, 2021, by the Staff Development Coordinator. Licensed Nurses not present during this training will not be allowed to work until they have received this training. Newly hired Licensed Nurses or contract licensed Nurse will receive this training during orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Advance Directive CODE status/CPR will be audited for accuracy by Medical Records, weekly X4 weeks, biweekly X4 weeks, and monthly x1 month to ensure current residents have code status and orders in their electronic medical record.	

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F 578	Continued From page 10 Nurse #5 was interviewed on 6/24/21 at 11:14 AM. She said she helped at times with the paperwork for new admissions and verified she was the nurse who entered pre-admission orders on Resident #100. She explained typically a nurse entered orders into the computer before a resident arrived at the facility. The orders were usually medications and once they were entered into the computer they were displayed as "pre-admit status" in the EHR. Once a resident arrived, the admitting nurse then activated those orders. She further stated "ancillary" orders (code status, diet order, therapy orders) weren't added into the EHR until the resident physically arrived at the facility. Nurse #5 said if she was not in the building when a resident arrived then the nurse who accepted the resident was responsible to enter the remainder of the orders, which included code status. Nurse #5 was unable to recall if she was in the building when Resident #100 admitted on 5/27/21. She added if she was in the building she would have entered the code status order into the EHR. An interview with Nurse #4 on 6/23/21 at 5:06 PM revealed the "admission group" received orders for code status and when a resident was admitted the order was entered into the EHR by the admission team. Nurse #4 stated when a resident arrived at the building her responsibility was to activate the orders that were already entered into the system. Nurse #4 recalled she activated the orders on Resident #100 when she arrived at the facility. She was unable to recall if the code status order was already in the computer prior to Resident #100's arrival. She reported there was a binder at the nurse's desk that contained code status information or staff looked at the top of the EMAR for a resident's	F 578	Findings will be documented on Advance Directive Audit tool. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 578	Continued From page 11	F 578		

code status.

On 6/24/21 at 11:58 AM an interview was completed with the Director of Nursing (DON), during which she explained the process for new admissions was as follows: Pre-admission orders were entered into the computer which typically included medications and diet orders. Once a resident arrived at the facility and the pre-admission orders were activated, then staff entered in orders such as code status, laboratory orders, and therapy orders. She added the pre-admission orders only allowed staff to enter certain orders, "mostly medications." The DON said the nurse who was on duty when a resident arrived entered the "ancillary" orders if the unit manager or other administrative nurse was not available. She reported Resident #100 arrived at the facility around 9:00 PM and Nurse #4 should have entered the order for code status.

2. Resident #95 was admitted to the facility on 5/24/2021 with diagnosis that included fracture, diabetes, depression, and hypertension.

The comprehensive Minimum Data Set assessment dated 5/3/2021 revealed Resident #95 was moderately cognitively impaired.

The physician orders were reviewed in the electronic health record (EHR) and there was no order that addressed code status for Resident #95. When Resident #95's EMR was opened, a profile bar appeared at the top of the page and beside Resident #95's photo read "Set CPR (cardio-pulmonary resuscitation) status.

Review of the code status binder at the nurse's station revealed dividers with room numbers.

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After Resident #95's assigned room number the original copy of DNR (Do Not Resuscitate) form was signed and dated 5/24/2021.

On 6/23/2021 at 2:30PM an interview with Nurse #5 revealed on admission any code status paper the resident arrived with was filed in a binder at the nurse's station. The admitting nurse's responsibility included verifying and/or entering resident code status in the EHR. Resident #95's EHR was reviewed with Nurse #5 during the interview and the code status was not located in the EMAR (electronic medical administration record) or in any of the physician orders. Nurse #5 stated the information should be in the EHR and she was not sure why it was not entered.

An interview on 6/24/2021 at 9:07AM with the Admissions Coordinator (AC) revealed the code status was part of the admission package and reviewed with the resident/resident's responsible party prior to or on admission to the facility. After the Physician or Nurse Practitioner signed the code status the original code status paperwork was sent to the nursing unit. The nursing unit was responsible to ensure the code status was entered into the resident's EMR.

An interview conducted on 6/24/2021 at 1:51PM with the Assistant Director of Nursing (ADON) revealed she entered pre-admission orders for residents. The pre-admission orders included a resident's allergies, medications, and advanced directives if available in the admissions package. The floor nurses were responsible to verify and activate the orders when the resident arrived at the facility.

On 6/24/21 at 11:58 AM an interview was

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completed with the Director of Nursing (DON), during which she explained the process for new admissions was as follows: Pre-admission orders were entered into the computer which typically included medications and diet orders. Once a resident arrived at the facility and the pre-admission orders were activated, then staff entered in orders such as code status, laboratory orders, and therapy orders. She added the pre-admission orders only allowed staff to enter certain orders, "mostly medications." The DON stated the code status for residents should be entered into the computer by nursing staff and she is unsure why it was not completed for this resident.

3. Resident #616 was admitted to the facility on 6/11/2021 with diagnosis that included atrial fibrillation, heart disease, and fracture of humor.

The comprehensive Minimum Data Set dated 6/18/2021 revealed Resident #616 was cognitively intact.

The physician orders were reviewed in the electronic health record and there was no order that addressed code status for Resident #616. When Resident #616's EMR was opened, a profile bar appeared at the top of the page and beside Resident #616's photo read "Set CPR (cardio-pulmonary resuscitation) status.

Review of the code status binder at the nurse's station revealed dividers with room numbers. After Resident #616's assigned room number the original Full Code Agreement form was signed and dated 6/11/2021.

On 6/23/2021 at 2:30PM an interview with Nurse

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#5 revealed on admission any code status paper the resident arrived with was filed in a binder at the nurse's station. The admitting nurse's responsibility included verifying and/or entering resident code status in the EHR. Resident #616's EHR was reviewed with Nurse #5 during the interview and the code status was not located in the EMAR or in any of the physician orders. Nurse #5 stated the information should be in the EHR and she was not sure why it was not entered.

On 6/24/2021 at 12:45PM an interview with Nurse #9 revealed axillary orders are entered into a resident's EHR prior to their admission to the facility by the Director of Nursing, Staff Development Coordinator, Unit Manager, or Floor Nurse. The code status was part of the axillary orders and was entered when included in the admission paperwork. Nurse #9 recalled she activated the orders on Resident #616 when she arrived at the facility. She was unable to recall if the code status order was already in the computer prior to Resident #616's arrival.

An interview on 6/24/2021 at 9:07AM with the Admissions Coordinator (AC) revealed the code status was part of the admission package and reviewed with the resident/resident's responsible party prior to or on admission to the facility. After the Physician or Nurse Practitioner signed the code status the original code status paperwork was sent to the nursing unit. The nursing unit was responsible to ensure the code status was entered into the resident's EMR.

An interview conducted on 6/24/2021 at 1:51PM with the Assistant Director of Nursing (ADON) revealed she entered pre-admission orders for

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residents. The pre-admission orders included a resident's allergies, medications, and advanced directives if available in the admissions package. The floor nurses were responsible to verify and activate the orders when the resident arrived at the facility.

On 6/24/21 at 11:58 AM an interview was completed with the Director of Nursing (DON), during which she explained the process for new admissions was as follows: Pre-admission orders were entered into the computer which typically included medications and diet orders. Once a resident arrived at the facility and the pre-admission orders were activated, then staff entered in orders such as code status, laboratory orders, and therapy orders. She added the pre-admission orders only allowed staff to enter certain orders, "mostly medications." The DON stated the code status for residents should be entered into the computer by nursing staff and she is unsure why it was not completed for this resident.

4. Resident #617 was admitted to the facility on 6/18/2021 with diagnosis that included fracture, hypertension, and osteoporosis.

The comprehensive Minimum Data Set had not been completed at the time of investigation.

The physician orders were reviewed in the electronic health record and there was no order that addressed code status for Resident #617. When Resident #617's EMR was opened, a profile bar appeared at the top of the page and beside Resident #617's photo read "Set CPR (cardio-pulmonary resuscitation) status.

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A review at the nurse's station revealed a binder with Resident #617's code status filed behind her room number. The paperwork was titled Full Code Agreement signed by dated 6/17/2021.

On 6/23/2021 at 2:30PM an interview with Nurse #5 revealed on admission any code status paper the resident arrived with was filed in a binder at the nurse's station. The admitting nurse's responsibility included verifying and/or entering resident code status in the EHR. Resident #617's EHR was reviewed with Nurse #5 during the interview and the code status was not located in the EMAR or in any of the physician orders. Nurse #5 stated the information should be in the EHR and she was not sure why it was not entered.

On 6/23/2021 at 2:35PM an interview with Nurse #8 revealed prior to a resident's arrival at the facility, physician orders were entered by a nurse in the resident's EHR under pre-admission status. The floor nurse was responsible to activate the pre-entered physician orders when the resident arrived at the facility. Nurse #8 verbalized on admission resident code status should be verified and entered in the resident's EHR. Nurse #8 recalled she activated the orders on Resident #617 when she arrived at the facility. She was unable to recall if the code status order was already in the computer prior to Resident #167's arrival.

An interview on 6/24/2021 at 9:07AM with the Admissions Coordinator (AC) revealed the code status was part of the admission package and reviewed with the resident/resident's responsible party prior to or on admission to the facility. After the Physician or Nurse Practitioner signed the

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F 578	Continued From page 17 code status the original code status paperwork was sent to the nursing unit. The nursing unit was responsible to ensure the code status was entered into the resident's EMR. An interview conducted on 6/24/2021 at 1:51PM with the Assistant Director of Nursing (ADON) revealed she entered pre-admission orders for residents. The pre-admission orders included a resident's allergies, medications, and advanced directives if available in the admissions package. The floor nurses were responsible to verify and activate the orders when the resident arrived at the facility. On 6/24/21 at 11:58 AM an interview was completed with the Director of Nursing (DON), during which she explained the process for new admissions was as follows: Pre-admission orders were entered into the computer which typically included medications and diet orders. Once a resident arrived at the facility and the pre-admission orders were activated, then staff entered in orders such as code status, laboratory orders, and therapy orders. She added the pre-admission orders only allowed staff to enter certain orders, "mostly medications." The DON stated the code status for residents should be entered into the computer by nursing staff and she is unsure why it was not completed for this resident.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		7/22/21

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F 583	Continued From page 18 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain privacy for 1 of 1 sampled resident (Resident #17) who resided in a semi-private room which had no privacy curtain. Findings included:	F 583	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The privacy curtain for resident #17 was provided on 6/24/21 by the facility maintenance director.	

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F 583	Continued From page 19 Resident #17 was admitted to the facility on 12/29/15 with the diagnoses which included: a neurological disease with involuntary movement and contracture of multiple sites. Review of the quarterly minimum data set dated 4/6/21 indicated Resident #17 had short- and long-term memory problems. Review of the care plan dated 6/21/21 revealed Resident #17 required assistance for all activities of daily living related to a neurological disease with involuntary movement. Interventions included the staff assisted the resident in dressing appropriately for season/comfort. During an observation on 6/21/21 at 3:11 p.m., Resident #17 was lying in a low bed, near the opened door. The resident was observed constantly moving and changing positions causing the bed linen to slide down his body exposing his adult brief and shirtless, upper body. The resident's roommate was not in the room during this observation. On 6/24/21 at 9:13 a.m., Resident #17 was observed sitting upright in bed as NA#7 (nursing assistant) assisted him with his breakfast. The resident was not wearing a shirt and was only wearing an adult brief. The resident's roommate (who was wearing day clothes) was sitting on his bed which was located next to the window and directly across from the foot of Resident #17's bed. The mini blinds on the window were open. There was no privacy curtain or a tract for a privacy curtain in the room. During a second observation on 6/24/21 at 9:20 a.m., Resident #17 was lying on his bed, on top of	F 583	2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Maintenance director completed observation rounds of current resident rooms on 6/24/21 to ensure that each resident room contained a cubical curtain. No other room was found to be out of compliance. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Maintenance Director along with other administrative staff (includes, Activities Director, Medical Records, Social Workers, Admissions Director, Business office Manager and Unit Managers, and Director of Nursing) were educated on 7/12/21 by Staff Development Coordinator intent of F583, including the importance of ensuring that all Residents who reside in semi-private rooms possess a privacy curtain. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Observation rounds of 5 resident rooms will be completed, by the Interdisciplinary (IDT) Team (includes social workers, business office managers, activities director, unit managers, MDS, medical records and Admissions Director) daily,	

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F 583	Continued From page 20 the bed linen. NA#7 was no longer in the room or in the hallway. The resident's roommate was sitting on his bed located next to the window and directly across from the foot of Resident #17's bed. The window's miniblinds were open. Resident #17 was and not wearing any clothes. There appeared to be a square piece of cloth or part of an adult brief covering the front area below the resident's abdomen; but his left hip, both legs, and chest were visible. During an observation and interview on 6/24/21 at 9:22 a.m., Medication Aide #1 was administering medications to residents to rooms past Resident #17's room. She revealed she administered Resident #17's medications to him before the breakfast meal while he was in bed and he was wearing a shirt, but his legs were covered by bed linen. During an interview on 6/24/21 at 10:03 a.m., the Administrator revealed he was not aware there was no privacy curtain and there was no divider to separate each of the residents of the room from exposure. He stated that as the result of this observation of Resident #17 exposure, he directed the maintenance supervisor to immediately apply a privacy curtain tract and privacy curtain in Resident #17's room. The Administrator stated "my expectation is that there is a privacy curtain to maintain privacy for each resident residing in a semi-private room with a roommate" During an interview on 6/24/21 at 11:04 a.m., NA#7 revealed that after assisting Resident #17 with his breakfast, she removed his shirt because she was going to start his ADL (activities of daily living) care; then she left the room to obtain a	F 583	Mon-Fri, x 4 weeks, and monthly x1 month to ensure residents rooms have a cubical curtain present to provide privacy. Findings will be documented on observation rounds form & discussed at the facility Morning Meeting. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 583	Continued From page 21 clean top sheet for the resident's bed. NA#7 stated that after breakfast, she noticed there was no privacy curtain in the resident's room but did not report the observation. She explained that once she exited Resident #17's room to obtain the clean linen, another nursing assistant requested her assistance in repositioning a different resident in bed. NA#7 insisted that when she left Resident #17's room he was wearing his adult brief and the brief remained in place when she returned to the resident's room. She indicated Resident #17 did have a condition of uncontrollable body movement. NA#7 acknowledged the window's mini blinds were open in Resident #17's room but stated there was no one outside of the window. During an interview on 6/24/21 at 11:32 a.m., Medication Aide #1 revealed immediately following her earlier interview, she went to Resident #17's room. She stated she observed the resident in his bed, but his adult brief was detached exposing his hip. She stated that Resident #17's roommate was also in the room and the window blinds were open. Medication Aide #1 revealed that after obtaining a top sheet from the linen cart on the hall, she covered Resident #17 with the sheet before leaving the room to locate NA#7 to provide care for the resident.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		7/22/21

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F 584	Continued From page 22 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interview, the facility failed to replace a cracked door guard (in place to protect the doors to the	F 584	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 584	Continued From page 23 rooms) in a resident room (Room 711) for 1 of 20 resident rooms on the 700 hall. The findings included: An observation during a facility tour on 6/21/21 at 10:00 AM revealed a large section of the wall across from the bathroom in Room 711 was chipped exposing sheetrock. The wall was observed from the hallway with the door to Room 711 open. The door guard to Room 711 was observed to be soiled and cracked, with sharp edges exposed. An interview was conducted with the resident residing in Room 711 on 6/24/21 at 4:05 PM. He stated he moved into the room about 2 weeks ago from another room in the facility and the wall and the door were in the same condition when he moved in. He added it didn ' t bother him, but it needed to be fixed and if it was his house, it would have already been fixed. An interview was conducted with the Admissions Director on 6/24/21 at 2:30 PM. She stated housekeeping and maintenance get a list of new admissions daily, so they know to get the rooms ready. She stated for room changes within the facility, the social workers handled those. A review of environmental rounds revealed Room 711 was checked and signed as completed on 3/26/21. The last weekly round was documented on 5/21/21. An interview was conducted with the Maintenance Director on 6/24/21 at 2:51 PM. He stated he does weekly environmental rounds and starts working on things that need to be repaired right	F 584	practice: No resident was named. The cracked door guard for the resident residing in room 711 was replaced on 6/24/21 by maintenance director. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Maintenance Director completed observation rounds on 7/12/21, to identify any other resident room doors who may have had a cracked door guards that may have a cracked door guard 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Environmental observation rounds will be completed daily, M-F, by the facility maintenance director and/or assistant maintenance director to ensure that any noted repairs are identified, and repairs noted are completed timely, by facility maintenance department or an outside vendor is contacted for timely repairs. Maintenance Director and maintenance assistant were educated on 7/12/21 by Staff Development Coordinator on the intent of F584, including ensuring that all cracked door guards must be repaired or replaced if not in working condition. If there is an issue with a work order and	

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F 584	Continued From page 24 away. The Maintenance Director added he would get to the 700 hall soon. Regarding the door guard that was dirty and cracked, the Maintenance Director stated he was aware that there were several door guards that needed to be replaced. He stated he got a quote for getting them all replaced facility wide in June 2020 but haven ' t replaced them yet.	F 584	immediate repair is not feasible, facility Administrator will be made aware by the Maintenance director immediately. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Observation rounds of 5 resident rooms will be completed, daily by maintenance director and/or Assistant Maintenance Director, weekly X 4 weeks, biweekly X4 weeks, and monthly x 1 to ensure that resident rooms door guard is in good condition. The Facility Administrator and/or Maintenance director will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of: 1) Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #48); 2) Vision/use of corrective lenses for 1 of 2 residents reviewed for the self-administration of medications (Resident #78);	F 641	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: MDS Nurse completed a review of Resident #48's medical record and MDS on 6/25/21, to review current PASRR	7/22/21

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and, 3) Medications and assistance for Activities of Daily Living (ADLs) for 1 of 5 residents reviewed for unnecessary medications (Resident #14).

The findings included:

1. Resident #48 was admitted to the facility on 8/22/19 with a cumulative diagnoses which included schizophrenia, mood and delusional disorders.

A review of Resident #48's State Preadmission Screening and Resident Review (PASRR) Level II Determination Notification dated 5/18/15 revealed the resident's PASRR number ended with the letter "B," which was indicative of a PASRR Level II determination. Determination of a PASRR Level II resident is made by an in-depth evaluation. Results of the evaluation are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care.

Resident #48's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 10/22/20. Section A (Identification Information) of the MDS revealed the resident was considered by the State Level II PASRR process to have a serious mental illness and/or intellectual disability. However, the PASRR Level II condition(s) related to intellectual or developmental disabilities was not coded.

An interview was conducted on 6/23/21 at 2:20 PM with Social Worker (SW) #1. At that time, SW #1 confirmed Resident #48 was determined to have PASRR Level II status on 5/18/15.

Level II status with condition, related to intellectual or developmental disabilities. MDS Nurse made modification and completed transmission of Resident #48's MDS on 6/25/21.

MDS Nurse completed review of Resident #78's medical record and MDS, to review current vision status. MDS Nurse made modifications and completed transmission on 7/19/21.

MDS Nurse completed a review of Resident #78's medical record and current MDS, to review status of aiding with meals. MDS Nurse made modifications and completed transmission of Resident #14's MDS on 6/25/21.

MDS Nurse #1 is no longer working at this facility.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Social Workers and MDS completed an audit, on 7/14/21 of current residents with a Level 2 PASRR to ensure that their MDS was marked with the correct condition, related to intellectual or development disabilities.

RN Unit manager and MDS Nurse have identified current residents who have vision assistance (i.e. wears contact lenses and/glasses) and who need assistance with meals to ensure that

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F 641	Continued From page 26 An interview was conducted on 6/23/21 at 2:27 PM with MDS Nurse #1. Upon request, the nurse reviewed Section A of the Resident #48's annual MDS assessment dated 10/22/20. MDS Nurse #1 reported although the resident was coded as having a PASRR Level II determination, neither a condition code nor "none of the above" were checked in this section. When asked if either a condition code or "none of the above" should have checked in this section, MDS Nurse #1 stated it should have been. An interview was conducted on 6/24/21 at 9:36 AM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the failure to code the PASRR on Resident #48's MDS for conditions related to intellectual or developmental disabilities was discussed. Upon inquiry, the DON stated her expectation was for staff to know exactly how the section on PASRR (related to conditions) needed to be completed. 2. Resident #78 was initially admitted to the facility on 4/3/21 from a hospital. His cumulative diagnosis included Type 2 diabetes. The resident' s admission Minimum Data Set (MDS) dated 4/10/21 reported he had impaired vision and was able to see large print, but not regular print in newspapers/books. He wore corrective lenses. Resident #78 was discharged on 4/18/21 and re-admitted to the facility on 5/14/21. A review of Resident #78's MDS dated 5/21/21 revealed he had adequate vision and was able to see fine detail, including regular print in	F 641	current residents MDS is accurately coded. Any modifications identified will be corrected and transmitted by 7/22/21. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The IDT Team, DON, and/or administrative nurses will review random current resident MDS daily, M-F, at the facility Clinical Meeting, to ensure accuracy of MDS. The MDS Nurse will select a random MDS, to be reviewed at the Clinical Meeting. The results of this audit will be documented on the MDS Audit tool. MDS staff have been educated on by Regional MDS Consultant on F641 and its content, with emphasis on ensuring that residents who possess Level 2 PASARR have indicating condition, current vision and assistance with meals coded accurately. Education was completed on 7/19/21. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The director of nursing and/or administrative nurses will review an MDS assessment daily (M-F) X4 weeks, monthly X3 months, and quarterly	

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newspapers/books. No corrective lenses were reported.

The resident's comprehensive care plan included an area of focus related to vision (initiated on 6/11/21). The care plan indicated Resident #78 had impaired vision with the ability to see large print.

An interview was conducted on 6/23/21 at 2:05 PM with MDS Nurse #1. Upon request, the MDS nurse reviewed Resident #78's admission MDS dated 4/10/21 and the MDS assessment dated 5/21/21. She confirmed the 4/10/21 MDS indicated the resident had impaired vision while the 5/21/21 MDS reported his vision as adequate. MDS nurse #1 also confirmed Resident #78's care plan included a care area related to his impaired vision. During a follow-up interview conducted on 6/23/21 at 2:45 PM, MDS Nurse #1 reported Resident #78's 5/21/21 admission MDS should have been coded to indicate the resident had impaired vision and corrective lenses.

An interview was conducted on 6/24/21 at 9:36 AM with the facility's Director of Nursing (DON). During the interview, concerns regarding the failure to accurately code Resident #78's MDS in the area of vision was discussed. The DON stated she would expect staff to communicate with the resident and/or family to ensure accurate information was obtained about a resident's vision.

3. Resident #14 was readmitted to the facility on 4/8/21 with a diagnosis of depression.

A significant change in status Minimum Data Set

thereafter to ensure accurate coding.

Facility Administrator and/or DON will create a summary of these audits and present at the facility's monthly QAPI meeting to ensure continued compliance

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F 641	Continued From page 28 (MDS) assessment dated 4/15/21 revealed Resident #14 received an antipsychotic all 7 days of the look back period, but the assessment further indicated in the antipsychotic review section Resident #14 did not receive antipsychotic medications. The MDS also revealed Resident #14 required minimal assistance of 2 people for meals. A physician ' s order dated 4/8/21 read, "Seroquel 25 milligrams one tablet by mouth at bedtime. The Medication Administration Record (MAR) for April 2021 revealed Resident #14 received Seroquel 25 milligrams at 9:00 PM from 4/9/21 to 4/15/21. An observation on 6/21/21 at 12:15 PM revealed Resident #14 was eating breakfast independently. Resident #14 stated he was able to feed himself. An interview was conducted with MDS Nurse #1. She stated Resident #14 did receive an antipsychotic during the assessments look back period so the MDS should have indicated that in the antipsychotic medication review section. MDS Nurse #1 also stated Resident #14 did not require the assistance of two people to eat and that section on the MDS was miscoded.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		7/22/21

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F 657	Continued From page 29 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, resident, facility and rehabilitation staff interviews, and medical record reviews, the facility failed to review and revise a resident's care plan to accurately reflect the assistance required to safely transfer 1 of 10 residents reviewed for accidents (Resident #48). The findings included: Resident #48 was admitted to the facility on 8/22/19. Her cumulative diagnoses included fibromyalgia (a disorder characterized by widespread muscle pain and tenderness) and a history of falls. Resident #48's most recent quarterly Minimum Data Set (MDS) assessment dated 4/21/21	F 657	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The care plan was modified by MDS nurse on 6/24/21 to accurately reflect the assistance required for resident #48 for safe transfer. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current Census as of 7/12/21 was reviewed by Administrative Nurses to ensure that their care plan accurately	

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revealed the resident had intact cognitive skills for daily decision making. Resident #48 was reported as requiring extensive assistance with one person physical assist for all of her Activities of Daily Living (ADLs), with the exception of needing supervision only for eating.

The resident's plan of care revealed the area of focus related to ADLs included: Requires a mechanical lift for all transfers (start date 3/22/21).

A review of the Daily Care Guide for Resident #48 revealed the safety devices and appliances utilized for this resident included a sit-to-stand lift (a device designed to help patients who lack the specific strength or muscle control to rise to a standing position and assist with transfers). A Daily Care Guide is a tool available to Nurse's Aides (NAs) via an electronic Kiosk used to communicate the care and assistance required for an individual resident.

A review of Resident #48's Rehabilitation Records revealed she recently received Physical Therapy (PT) from 3/18/21 - 4/7/21; 5/16/21 - 5/20/21; and 6/1/21 - (ongoing).

An observation and interview were conducted on 6/23/21 at 8:30 AM with Resident #48. When asked how she usually transferred from the bed to a wheelchair and then back to bed, the resident reported she used her walker to steady herself as she stood up from the bed. She stated one staff person would be present to place the wheelchair close by so she could turn and get into it. Resident #48 reported she did the same when transferring from her wheelchair to the bed. When asked if any type of a lift had been used for

reflected the assistance required for residents to safely transfer. Audit will be completed by 7/22/21, MDS Nurse and Rehab Director.

3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
During morning clinical meetings, MDS nurse will identify any resident who has a current assessment that indicates a significant change. MDS nurse will identify

Residents who have had a change in transfer status and indicate change on resident's care plan.

MDS Nurse will be Inservice by regional MDS consultant on F657 and its content with emphasis on the importance of ensuring that any changes in resident's transfer status is accurately reflected on resident's care plan. Education was completed on 7/19/21.

4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

5 resident care plans will be reviewed at random by unit managers, weekly X4, monthly X3 and quarterly thereafter to ensure adequate compliance. Findings will be documented on care plan audit tool.

The DON and/or Administrative Nurses will complete a summary of the audit

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her in the past, the resident stated, "No." She reported a Hoyer lift (a total mechanical lift) was used only to obtain her weight.

An interview was conducted on 6/24/21 at 11:07 AM with the Rehab Director and Physical Therapy Assistant (PTA) #1. PTA #1 was identified as a staff member who was currently providing therapy treatments with Resident #48. PTA #1 reported he did not think the resident had experienced a big change in condition or need in ADL assistance required over the last several months (other than the time around her hospitalization in May 2021).

An interview was conducted on 6/24/21 at 11:27 AM with Nurse Aide (NA) #2. NA #2 was assigned to care for Resident #48 and reported this was her usual assignment. When asked what assistance the resident required for transfers, the NA stated the resident would stand and pivot with one staff member present; no equipment (lift) was used. Upon request, the NA reviewed the information provided by the electronic Kiosk regarding transfers for Resident #48. NA #2 confirmed the Kiosk indicated the resident used a sit-to-stand lift. When told Resident #48's care plan indicated a "mechanical lift" was required for the resident's transfers, the NA reported she would interpret "mechanical lift" to mean a Hoyer lift should be used. NA #2 stated as long as she has known Resident #48 to reside at the facility, she has transferred by standing and pivoting on her own with no mechanical device used.

An observation was made 6/24/21 at 11:45 AM as Physical Therapist (PT) #1, PTA #1, and the Rehab Director went to Resident #48's room to assess what was required for her safe transfer

results and present at the facility monthly QAPI meeting to ensure continued compliance.

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F 657	Continued From page 32 from surface to surface. The resident was observed to be able to stand and pivot with assistance as she transferred from her bed to the wheelchair, and then back to the bed. During the transfer, the PTA stood behind the locked wheelchair while the PT was positioned in front of the resident as she appeared to use a walker for support and stabilization. An interview was conducted on 6/24/21 at 11:51 AM with PT #1. During the interview, the PT reported from her observation and assessment of Resident #48's transfer, she felt nursing staff could safely transfer the resident as she stood and pivoted with 1 person physical assist. No mechanical device(s) were needed. An interview was conducted on 6/24/21 at 2:42 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings related to Resident #48. During the interview, the discrepancies between the resident's care plan, care guide, and past/current practices used for transferring the resident were discussed. The DON and Administrator agreed each of these components and means of communicating the resident's care and need for assistance should be consistent with one another.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 677	1.Address how corrective action will be	7/22/21

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and staff interviews the facility failed to assure incontinence care needs were met for three (Resident # 59, # 33 and # 28) of seven residents reviewed for activities of daily living (ADL) assistance.

1.Record review revealed Resident #59 was admitted to the facility on 2/12/2020 with diagnosis that included hemiplegia, lack of coordination, abnormalities of the gait and mobility, cerebral palsy and anxiety.

A review of the Resident's Minimum Data Set (MDS) assessment, dated 4/27/2021, coded Resident #59 to be cognitively intact, required extensive assistance of one staff member with bed mobility, toilet use and personal hygiene and was occasionally incontinent of bowel and bladder.

A review of Resident # 59's care plan revealed focused areas for incontinence of bowel and bladder and assistance with ADL care. Interventions included assist with ADL's as needed and assist with brace application used for mobility and support.

A review of the facility grievance log revealed Resident # 59 filed a concern on 3/2/2021 and 3/24/2021 that a third shift nursing assistant (NA) was not willing to assist her with necessary steps to get out of the bed and to the bathroom. The concern was reviewed by the previous Director of Nursing (DON) and the action taken included education to third shift NA's to provide ADL care for Resident #59.

An interview was conducted with Resident # 59 on 6/21/2021 at 3:56 PM and she revealed that

accomplished for those residents found to have been affected by the deficient practice:

Residents #59, #33, and #28 were provided incontinence care by their Certified Nursing Assistant on 6/24/21.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Director of Nursing DON and/or Administrative Nurses (includes Assistant Director of Nursing, Assistant Director of Nursing, Unit Managers, and Staff Development Coordinator) completed an observation round to identify current residents that are dependent and in need of receiving incontinent care. The intent of the audit was also to ensure that residents were cared for timely. The audit was completed on 6/24/21.

3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 7/19/21, Director of Nursing and/or Administrative Nurses will provide License Nurses, Certified Nursing Aide, Medication Aides, Medication Tech, and contract nurse staffing with the list of current residents that are dependent on receiving incontinent care.

Staff development Coordinator will educate License Nurses, Certified Nursing

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F 677	Continued From page 34 for the past several months she had concerns because third shift would occasionally leave her in the bed for first shift to get up and not provide incontinent care as needed. She added that she had informed administration including the current DON. She stated the same morning the staff did not get her up on third shift or change her brief that was wet with urine. She said this occurred the previous week on June 17th and June 18th. The Resident revealed she had informed staff during care plan meetings she desired to get out of bed from 5:00 AM to 6:00 AM to go to the bathroom to change her brief and cleanse. A. An interview was conducted with NA # 04 on 6/24/2021 at 6:53 AM. The NA revealed that she was the caregiver for Resident # 59 on June 17th, third shift, and was the only NA for three halls. She stated she did not provide incontinence care or assist Resident # 59 to get out of bed on the morning of June 18th, because there was not enough staff. B. An interview was conducted with Nurse #06 on 6/24/2021 at 6:48 AM and she revealed she was working on Friday night, 6/18/2021 and there were two NA's on the unit 2 assignment (500, 600 and 700 hall) and one NA on the unit 1 assignment (200, 300 and 400 hall). She revealed that during the morning rounds one NA from unit 2 had to assist the unit 1 NA and left only one NA for half of the rounds. She added that due to staffing, Resident # 59 was not assisted to get out of bed. C. An interview was conducted on 6/24/2021 at 6:32 AM with NA # 04 and NA # 05 and they stated they had completed their morning rounds on their assigned halls. They added that the 700	F 677	Aide, Medication Aides, Medication Tech and contract nursing staff on 7/19/21 on the importance of providing incontinent care in a timely manner and rounds are to be made on the dependent residents throughout their shift attending certified nursing aide. Any nursing staff licensed, unlicensed, or contract, will receive this training prior to their next scheduled shift. New employees will receive this training during their orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or Administrative Nurse will complete, random observations rounds, to include varies shifts and weekends of 20 residents daily x 4 weeks, then weekly for 4 weeks, to ensure incontinence care is being provided timely. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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hall was one of their assigned halls.

An observation was conducted on 6/24/2021 at 6:44 AM of Resident # 59 lying in bed.

An interview and observation was conducted on 6/24/2021 at 6:45 with Resident # 59 and she revealed she was told the staff could not get her out of bed this morning because they did not have enough staff. She added that she had not received incontinence care this morning and raised her blanket to reveal a saturated brief and a strong urine odor. Resident # 59 stated this made her feel like her needs were not important.

An interview was conducted with NA # 04, that worked third shift, on 6/24/2021 at 6:53 AM. The NA revealed that Resident # 59 had not received incontinence care on 6/24/2021 due to not having enough staff to complete all the care. She revealed the last round for Resident # 59 was prior to her falling asleep, sometime before midnight.

An interview was conducted with the DON on 6/24/2021 at 11:30 AM and she revealed Resident # 59 had expressed a preference to get out of bed by 6 AM and she had educated third shift staff to provide assistance with ADL's as needed and to get the Resident out of bed between 5:00 AM and 6:00 AM. She added that she placed these instructions on the assignment sheet for the hall nurse and demonstrated the assignment sheet. She revealed it was her expectation that staff contact her or another on call administrative staff member if they do not have adequate staffing to complete the ADL care a resident required. She added that she expects ADL care and incontinence care to be provided.

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2. Resident # 33 was admitted to the facility on 4/29/2019 with diagnosis that included dementia, chronic obstructive pulmonary disease, muscle weakness and anxiety.

A review of the most recent MDS, dated 4/13/2021, assessed Resident # 33 had moderate cognitive impairment with no behaviors and required extensive assistance of one staff member for bed mobility, toileting, and personal hygiene. She was coded to be frequently incontinent of bowel and bladder.

A review of the care plan revealed Resident # 33 had focused areas for required assistance for all ADL's and urinary incontinence with interventions that included assistance as needed for ADL's, perineal cleansing as needed and assist to bathroom or commode as needed.

An interview was conducted on 6/24/2021 at 6:32 AM with NA # 04 and NA # 05 and they stated they had completed their morning rounds on their assigned halls. They added that the 700 hall was one of their assigned halls.

An observation was conducted on 6/24/2021 at 6:34 AM of Resident # 33 with the Resident lying in bed. Her gown was observed removed from her body and only attached around the neck, draped over the side of the bed. Her oxygen tubing was observed lying in the floor. The room had a strong urine odor. The Resident was covered by only a corner of the blanket and the call bell was clipped to another corner at the foot of the bed. Resident # 33 then raised the corner of her blanket, stated she was wet and cold and needed help getting cleaned. The brief was

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observed saturated with urine, the bed sheet and gown were wet and the incontinence pad beneath the resident was wet. A saturated brief was also observed on a bedside table.

An interview was conducted on 6/24/2021 at 6:55 AM with Nurse # 06, NA # 04 and NA # 05 in Resident # 33's room. NA # 04 and NA # 05 revealed they did not provide incontinent care for Resident # 33 and began to provide care during the interview. They both stated the Resident was wet and required a linen change and a brief change. NA # 05 added that the Resident did not receive care because there was not enough staff to complete all the assignment.

An interview was conducted with the DON on 6/24/2021 at 11:30 AM and she revealed she had educated third shift staff to aid with ADL's as needed. The DON revealed that the facility had hired several NA's since she began a few weeks prior and were aware of the need for NA's. She added it was her expectation that staff contact her or another on call administrative staff member if they do not have adequate staffing to complete the ADL care a resident required. She added that she expected ADL care and incontinence care to be provided.

3. Resident # 28 was admitted to the facility on 10/25/2020 with diagnosis that included abnormalities of gait and mobility, respiratory failure, and heart failure.

A review of Resident # 28's most recent MDS, dated 5/06/2021, revealed the Resident was cognitively intact, required extensive assistance of two staff members for bed mobility and extensive assistance of one staff member for

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F 677	Continued From page 38 transfers, personal hygiene and toileting. She was coded to be occasionally incontinent of bowel and bladder. A review of the care plan revealed a focused area for ADL assistance was revised on 2/26/2021. Interventions included assist Resident # 28 with incontinence care or toileting as needed. An interview was conducted with Resident # 28 on 6/22/2021 at 1:15 PM and she revealed on third shift, 6/18/2021 she waited 1 hour and 15 minutes to be changed from a wet brief. She indicated she knew the time because she had a cell phone by her bed. She stated the NA on the shift reported the wait was due to not having enough staff. She added that when she was first admitted, the third shift NA's made rounds at regular intervals and had not occurred for several months. Resident # 28 revealed not receiving assistance with changing her brief makes her feel angry and concerned for other residents that cannot speak up for themselves. An interview was conducted with NA # 04 on 6/24/2021 at 6:53 AM. The NA revealed that she was the caregiver for Resident # 28 on June 17th, third shift, and was the only NA for three halls. She stated she did not provide incontinence care or assist Resident # 28 on the morning of June 18th, because there was not enough staff.	F 677		
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-	F 686		7/22/21

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F 686	Continued From page 39 (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 observation, record review, Resident and staff interviews, the facility failed to provide physician recommended repositioning for 1 of 2 residents (Resident # 92) reviewed for pressure ulcers. The findings included: Resident # 92 was admitted to the facility on 6/3/2020 with diagnosis that included monoplegia of an upper limb, muscle weakness, Diabetes Mellitus Type II and Multiple Sclerosis. A review of the Minimum Data Set (MDS) dated 5/27/2021, revealed the Resident had minimal cognitive impairment, required extensive assistance of one staff member with bed mobility, transfers and personal hygiene. She was coded to have one Stage III pressure ulcer that required pressure ulcer care. A review of the care plan dated, for Resident # 92, revealed a focused area identified on 2/19/2021 for A pressure ulcer to her sacrum with risk for further skin breakdown related to impaired mobility and urinary incontinence. The interventions included provide pressure reducing	F 686	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Upon notification, resident #92 was repositioned by attending certified nursing assistant on 6/23/24. 2)Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of current of residents was performed on 7/12/21 by Administrative Nurses to identify any residents that are dependent upon staff turning and repositioning. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A list of resident’s who require frequent positioning will be placed in a binder at each nursing station by Unit manager to	

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F 686	Continued From page 40 surfaces on bed, utilize the blue water physicians services to evaluate and treat every week (wound care specialist), perform wound care as ordered, and reposition routinely and as needed. A review of the wound care documentation for Resident # 92 on 5/12/2021 written by the wound care PA included a review of the order to cleanse the sacral wound with normal saline, apply medihoney dressing, cover with a dry dressing daily and continue to use the low air loss mattress, reposition frequently and offload the wound. A review of the previous 90 days of wound care notes from the wound care PA all stated recommendations to reposition frequently and offload the wound. An interview occurred with Resident # 92 on 6/21/2021 at 10:11 AM and she revealed she should have a pillow to keep her off of her bottom because she has a sore there and today the staff had not placed the pillow behind her back after they helped her clean up. She stated she had been on her back all night. She added that she is unable to reposition herself due to her weakness in her arm and the shape of the mattress. An observation occurred of Resident #92 on 6/21/2021 at 10:12 AM and she was observed on a pressure relieving air mattress with high wings on the side, lying on her back without a positioning device to keep her on her side. An observation occurred of Resident # 92 on 6/23/2021 at 10:34 AM and she was observed to be positioned on her back without a pillow for offloading and positioning. An observation occurred of Resident # 92 on 6/23/2021 at 12:22 PM and she was observed to	F 686	ensure that all staff who are providing care to respective residents, know those residents who are in need of frequent turning and repositioning. All nursing staff, including licensed, unlicensed, and contract nurse staff, will be educated on this new system by staff development Coordinator, on 7/22/26, as well as on the intent of F686, with emphasis on the importance of ensuring that frequent repositioning is provided as care planned for residents with pressure ulcers. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Administrative staff (includes Activities Director, Medical Records, Business Office Manager, Admissions Director, Social Workers, and Maintenance Director), will audit 10 residents 3 x weekly x 4 weeks, weekly x 4 weeks, biweekly x 4 weeks to ensure frequent repositioning of resident. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 686	Continued From page 41 be positioned on her back without a pillow for repositioning. An observation was conducted on 6/24/2021 at 6:32 AM and Observed Resident # 92 lying in bed, positioned on her back with no pillow for repositioning or offloading. An observation was conducted on 6/24/2021 at 10:15 AM of Resident # 92 lying in bed, positioned on her back with no pillow for repositioning or offloading. An interview was conducted on 6/14/2021 at 10:17 with Nursing Assistant (NA) # 6 and she revealed she was the assigned NA for Resident # 92. She added that she had the assignment four days a week. She revealed Resident # 92 required every 2 hour repositioning with pillow support due to a pressure ulcer on her bottom. She added that the Resident had been on her back since breakfast because she had to be on her back for eating and would be turned to a side when she gave her bath 11:00 AM. She denied turning the Resident yet this morning. An interview was conducted with the Director of Nursing (DON) on 6/24/2021 at 11:30 AM and she revealed it was her expectation that a resident with a pressure ulcer receive frequent repositioning and that the wound care PA recommendations be followed.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		7/22/21

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F 692	Continued From page 42 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, dietician and staff interviews, the facility failed to provide nutritional supplements (fortified cereal and 206 cookie) as recommended by the Registered Dietician for 1 of 7 residents (Resident #109) reviewed for nutrition. The findings included: Resident #109 was admitted to the facility on 10/31/17 with diagnoses of, in part, heart disease, depression and dementia. A quarterly Minimum Data Set assessment dated 5/27/21 revealed Resident #109 had severely impaired cognition, required set up assistance only with meals and did not have weight loss. A care plan indicated Resident #109 was at risk	F 692	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Fortified cereal and 206 cookie was added to resident #109's meal tray on 6/25/21, by dietary manager. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Dietary recommendations for the past 30 days were reviewed by DON and/or Administrative Nurses on 7/16/21 to ensure that all recommendations were on the resident's tray card.	

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F 692	Continued From page 43 for nutritional decline related to medical history of congestive heart failure, kidney disease and hyperlipidemia and a history of weight loss and history of variable intakes of meals and snacks. The goal read, "Will remain free from signs and symptoms of dehydration x 90 days, will consume 50-75% of most meals and supplements and no significant weight changes x 90 days. Interventions included: encourage good nutritional intake and provide supplemental nutritional support, provide fortified foods for added caloric intake. During a meal observation on 6/22/21 at 8:42 PM, Resident #109 ' s tray card for breakfast indicated fortified cereal and 206 cookie. Observed on Resident #109 ' s tray was a bowl of grits, a biscuit and bacon, juice and a health shake. Resident #109 had consumed approximately 25% of the breakfast. An observation on 6/23/21 at 7:55 AM revealed Resident #109 did not receive fortified cereal or a 206 cookie on her breakfast tray and had consumed less then 25% of the meal. On 6/23/21 at 8:55 AM, an interview was conducted with the Dietician. She was unaware if fortified cereal or 206 cookies had to be physician ordered. She stated there was a note in Resident #109 ' s chart that was written by a previous dietician in July 2020 for fortified cereal and a September 2020 note that indicated the 206 cookie was recently ordered. She stated Resident #109 should be receiving a 206 cookie and fortified cereal on her breakfast tray. She added she entered the supplements into the tray card system and also sent a list of her recommendations to the Administrator, Director of	F 692	3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Supplement recommendations will be reviewed during the daily clinical meeting by the DON and/or Administrative Nurses to ensure that dietary has received the supplement recommendations. The Dietary Manager will add any recommendations for supplements to the resident tray card and review the addition or deletion with the dietary staff, to ensure dietary staff is aware of the dietary supplement to be place on resident meal tray. Dietary Manager and staff (includes cooks, aides, and assistant manager) were educated on F692, including ensuring that dietary supplements are added to the resident meal tray, on 7/15/21 by the facility administrator. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 5 random resident trays will be reviewed during meal times (to include breakfast,lunch, and/or dinner) by Dietician/designees, weekly X4, monthlyX3 and quarterly thereafter to ensure adequate compliance with F692. Findings will be documented on meal audit tool.	

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F 692	Continued From page 44 Nursing and the Corporate Nurse Consultant. She does this so the facility can be aware of who she sees on her visits and what her recommendations are. On 6/24/21 at 2:14 PM, an interview was conducted with the Director of Nursing (DON). She stated she initiated a new process since she started at the facility on 6/8/21 because she did not know what the facility was doing prior. She added the recommendations should have come to the nursing department so they could monitor the resident was receiving the supplements.	F 692	The Facility Administrator will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		7/22/21

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F 725	Continued From page 45 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to allocate sufficient nursing staff to provide residents with incontinence care as care planned for 3 of 7 residents reviewed for the provision of activities of daily living (ADL) care (Resident # 59, # 33 and #28). The findings included: This tag is cross referenced to tag F677. F677: Based on observations, record review, resident and staff interviews the facility failed to assure incontinence care needs were met for three (Resident # 59, # 33 and # 28) of seven residents reviewed for activities of daily living (ADL) assistance. An interview was conducted on 6/24/2021 at 06:48 AM with Nurse #6 and she revealed that she was assigned the 200, 300, 400 (Unit 1) and 500, 600 and 700 (unit 2) hall, with 108 residents, as well as the assisted living areas of the facility. She stated she was not scheduled to work on the date of 6/23/2021 - 6/24/2021 night shift and the facility had contacted her because they had no one else to work the shift due to staff calling in for their assigned shift. She said there should be two nurses working, one on Unit 1 and one on Unit 2. She added the previous Friday, she worked with only one nursing assistant (NA) on unit 1 and two NA's on unit 2 and normally there should be two	F 725	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #59, #33, and #28 were provided incontinence care by their Certified Nursing Assistant on 6/24/21. 2)Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 6/24/21, Staffing schedule were reviewed for the remainder of the week by Director of Nursing and Staff Development Coordinator to ensure adequate nursing coverage throughout all shifts. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility Administrator and the Director of Nursing, Staff Development Coordinator and Administrative Nurses will have a Daily Labor Meeting, starting 7/19/21. This meeting will be held to review current/upcoming nursing schedule, to include staffing levels for	

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F 725	Continued From page 46 on both units at a minimum. She explained that medication aides (MA's) and nurses help the NA's with the assignment and this allows for ADL care to be completed through most of the shift but during a morning medication pass, the nurse must assist the MA's with insulin and other areas that are outside of their scope of practice. She added that the MA's would be completing a medication pass and the responsibilities of the role take them away from the NA's. She stated that the Nurses and MA ability to assist had been explained to her as rationale for only three NA's in the building. She clarified that on the shift, the previous week, Friday night June 18th, One NA from Unit 2 had to leave to assist Unit 1 with rounds. This left Unit 2 with only one NA during the last rounds. She stated the staffing did not allow for all ADL's to be completed and some ADL care was delegated to the first shift that followed. This included not getting residents out of bed that had been care planned to be assisted prior to first shift arriving. An interview was conducted with NA # 4 on 6/24/2021 at 6:53 AM and she revealed she was the only third shift NA working on unit 2 on 6/17/2021, during the morning rounds for third shift. She stated that working by herself for three halls caused her to not be able to complete ADL care for all residents on the morning round. An interview was conducted on 6/24/2021 at 11:30 AM with the DON and she confirmed that only one nurse had worked, for coverage, for Unit 1 and Unit 2 on the night of 6/23/2021 - 6/24/2021. She added that staffing coverage had been an ongoing focused area since she had been hired a few weeks prior. She revealed nursing assistants and nurses had been hired and were undergoing orientation and training.	F 725	week, agency usage/needs, and recruiting activity. Staffing Coordinator Director of Nursing have been re-educated on F725, and ensuring and its content with emphasis on the importance of allocating sufficient nursing staff to provide incontinence care as care planned. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Daily Labor will continue to be had among the Director of Nursing, Assistant Director of Nursing, Unit managers, Staff development Coordinator, and Staffing Coordinator daily(M-F) X10, weekly X3, and monthly X2 to ensure adequate compliance with F756 ensuring that adequate staff is allocated to provide incontinence care. The facility Administrator and/or Staff Development Coordinator will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 725	Continued From page 47 She added that she had received concerns regarding ADL care not provided by third shift and had provided education and instructions to provide the ADL care on the hall nurse assignment sheet. She stated it was her expectation that ADL care be provided to all residents as needed and if there was not enough staff to provide the needed care, that the nursing team would contact the DON or another administration staff member to request back up support .	F 725		
F 756 SS=D	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	F 756		7/22/21

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F 756	Continued From page 48 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 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 reviews and interviews with the facility staff and consultant pharmacist, the facility failed to retain the pharmacy's New Admission Reviews in the resident's medical record or within the facility so the records were readily available for 1 of 5 residents reviewed for unnecessary medications (Resident #56). The findings included: Resident #56 was admitted to the facility on 11/24/18 with re-entry from a hospital on 2/1/21. Her cumulative diagnoses included anxiety disorder, depression, and gastroesophageal reflux disease (GERD). Resident #56 was sent out to the hospital on 1/29/21 with re-entry to the facility on 2/1/21. The resident's medication orders dated 2/1/21 included, in part: 40 milligrams (mg) pantoprazole (a medication used to treat GERD) Delayed Release (DR) to be given as one tablet by mouth twice a day; 20 mg famotidine (a	F 756	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The new admission review for resident #56 was obtained from pharmacy and scanned into resident's 'electronic medical record on 6/25/21. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents admitted to facility within the past 30 days was reviewed on 7/16/21 by Director of Nursing and/or Administrative Nurse to ensure all new admission reviews were entered into resident's electronic medical record. 3.Address what measures will be put into place or systemic changes made to	

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F 756	Continued From page 49 medication used to decrease gastric acid secretions) to be given as one tablet by mouth twice a day; and 1 gram (gm) sucralfate (a medication which may be used to treat irritation/inflammation of the esophagus) to be given as one tablet by mouth four times a day. Resident #56's electronic medical record included a Pharmacy Note authored by the facility's consultant pharmacist and dated 2/7/21. The note read as follows: "Pharmacy: New admission review to be completed and forwarded from (name of contracted pharmacy) for placement on resident ' s chart." However, Resident #56's electronic medical record did not include the New Admission Review. Resident #56 was sent out to the hospital on 2/16/21 with return to the facility on 2/20/21. The resident's medication orders dated 2/20/21 included, in part: 7.5 mg buspirone (an antianxiety medication) to be given as one tablet by mouth twice a day; and, 0.5 mg clonazepam (an antianxiety medication) to be given as ½ tablet by mouth twice a day. Resident #56's electronic medical record did not include a Pharmacy Note to indicate a New Admission Review was completed for this resident. Upon further review, the resident's electronic medical record also did not include a New Admission Review corresponding to her re-entry to the facility on 2/20/21. Resident #56 was sent out to the hospital on 3/3/21 with re-entry to the facility on 3/7/21. Resident #56's electronic medical record included	F 756	ensure that the deficient practice will not recur: The new admission review from the pharmacy will now be given to the admissions nurses to ensure that it is scanned into the resident's Echart on the within 72 hrs of admission. Regional Clinical Nurse will educate the Administrative Nurses on 7/16/21, (includes Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator and Admissions Nurse on F756 with emphasis on ensuring that all new admissions reviews are readily available. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Morning clinical meeting has been modified as of 7/12/21 to include the new admission review conducted by Administrative Nurses (includes Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit managers) to ensure that all new admission reviews are readily available. Findings will be documented and clinical check list. Checklist will be reviewed weekly X4, monthly X3, and quarterly thereafter to ensure adequate compliance. The Director of Nursing and/or Administrative Nurses will complete a	

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F 756	Continued From page 50 a Pharmacy Note authored by the facility's consultant pharmacist and dated 3/8/21. The note read as follows: "Pharmacy: New admission review to be completed and forwarded from (name of contracted pharmacy) for placement on resident's chart." However, Resident #56's electronic medical record did not include the New Admission Review. Resident #56 was sent out to the hospital on 4/9/21 with return to the facility on 4/14/21. The resident's medication orders dated 4/14/21 included, in part: 40 mg pantoprazole DR to be given as one tablet by mouth twice a day; 1 gm sucralfate to be given as one tablet by mouth four times a day; and, 500 mg cephalexin (an antibiotic) to be given as one capsule by mouth every 12 hours. Resident #56 ' s electronic medical record included a Pharmacy Note dated 4/16/21. The note read as follows: "Pharmacy: New admission review to be completed and forwarded from (name of contracted pharmacy) for placement on resident's chart." However, Resident #56's electronic medical record did not include the New Admission Review. Resident #56's most recent Minimum Data Set (MDS) was a significant change assessment dated 4/24/21. The MDS assessment revealed Resident #56 had intact cognitive skills for daily decision making. The medication section of the resident's MDS indicated her medications included administration of an antianxiety and antibiotic medication on 7 out of 7 days during the look back period.	F 756	summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 756	Continued From page 51	F 756		

Upon request, the facility provided six (6) pharmacist recommendations for Resident #56 on 6/24/21. The documents provided by the facility did not include the New Admission Reviews referenced in Resident #56's Pharmacy Notes dated 2/7/21, 3/8/21, or 4/16/21.

Upon further request, the facility provided a copy of Resident #56's New Admission Reviews (dated 2/2/21, 2/23/21, 3/9/21, and 4/15/21) on 6/24/21 at 1:15 PM. These reviews included the following pharmacy recommendations.
--On 2/2/21, the review indicated two issues needed to be addressed:
1) Please clarify the following duplicate therapy: pantoprazole and famotidine; and,
2) Other: Administer sucralfate 2 hours after and 4 hours before other meds to reduce potential of adversely affecting absorption.
At the bottom of the New Admission Review, the following statement was written in bold print and capital letters: "Please place with the consultant pharmacist's review in the resident's medical record."
--On 2/23/21, the review indicated two issues needed to be addressed:
1) Resident was admitted on a medication requiring a DISCUS or an AIMS (tests used to identify and assess the severity of tardive dyskinesia). Please ensure one is completed and placed on the chart.
2) Please clarify the following duplicate therapy: clonazepam and buspirone.
At the bottom of the New Admission Review, the following statement was written in bold print and capital letters: "Please place with the consultant pharmacist's review in the resident's medical record."
--On 3/9/21, the review indicated no medication

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F 756	Continued From page 52	F 756		

irregularities were noted upon initial review. At the bottom of the New Admission Review, the following statement was written in bold print and capital letters: "Please place with the consultant pharmacist's review in the resident's medical record."
--On 4/15/21, the review indicated two issues needed to be addressed:
1) Please clarify the following duplicate therapy: sucralfate and pantoprazole; and,
2) Other: Need stop date for cephalexin.
At the bottom of the New Admission Review, the following statement was written in bold print and capital letters: "Please place with the consultant pharmacist's review in the resident's medical record."

An interview was conducted on 6/24/21 at 1:20 PM with the facility's Director of Nursing (DON). During the interview, the DON reported Resident #56's New Admission Reviews (dated 2/2/21, 2/23/21, 3/9/21, and 4/15/21) had to be obtained from the pharmacy because the facility could not locate these within the facility. When asked where she would expect these reviews to be located, the DON reported going forward she would like to have them scanned into the resident's electronic medical record. In addition, the DON stated she would like to keep a duplicate copy in her office so they would be readily accessible.

A telephone interview was conducted on 6/21/21 at 1:46 PM with the facility's consultant pharmacist. Upon inquiry, the pharmacist reported New Admission Reviews were conducted by the dispensing, clinical pharmacists who were pharmacy-based. She stated these reviews were kept at the pharmacy but would also

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F 756	Continued From page 53 have been emailed to the facility. The pharmacist reported the transition team at the facility either may not have had access to the pharmacy New Admission Reviews or known how to access them.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		7/22/21

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F 758	Continued From page 54 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, interview with the physician (MD) and record review, the facility failed to ensure a physician's order for an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents (Resident #108) reviewed for unnecessary medications. Findings included: Resident #108 was admitted to the facility on 6/26/19. Her cumulative diagnoses included anxiety disorder, depression and non-Alzheimer's dementia. A physician's order dated 5/6/21 in the electronic health record read alprazolam (an anti-anxiety medication), 0.5 milligrams (mg) twice a day for fourteen days PRN. A telephone physician's order dated 5/14/21	F 758	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An order with a time duration was provided on 6/24/21 for resident #108 by the attending physician and director of nursing. 2)Address how the facility will identify other residents having the potential to be affected by the same deficient practice. A review of all prn psychotropic medications was performed on 7/16/21 by Director of Nursing to ensure that there was a time duration for all drugs. If time duration was beyond the 14 day, then a rational was obtained, from the resident attending physician.	

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F 758	Continued From page 55	F 758		

stated, "May continue alprazolam 0.5mg, give one tablet by mouth twice a day as needed (anxiety)." The medication order did not indicate the intended duration of the PRN order or include a stop date.

The quarterly Minimum Data Set assessment dated 6/5/21 revealed Resident #108 was cognitively intact. In the mood interview section, the resident endorsed that she felt down, felt tired or had little energy and felt bad about herself 7-11 days of the 14 day look back period. She received an anti-anxiety medication 4 out of 7 days of the look back period.

Resident #108's Medication Administration Record for June 2021 was reviewed and revealed ten doses of PRN alprazolam were documented as administered through 6/17/21.

The pharmacy's Nursing Summary Report dated 6/23/21 was provided by the Director of Nursing (DON) on 6/24/21 at 4:27 PM. The consultant pharmacist reviewed Resident #108's medications on 6/9/21 and requested the Provider consider a four month stop date of the PRN alprazolam. On 6/23/21 the PRN alprazolam order was clarified and a stop date was written for four months from the telephone order dated 5/14/21.

On 6/24/21 at 10:00 AM an interview was completed with Resident #108. She shared she asked staff for alprazolam when she felt anxious and nervous and said the medication helped calm her nerves.

During interviews with Nurse #1 on 6/23/21 at 2:41 PM and 6/24/21 at 3:33 PM she said she

3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Daily clinical checklist reviewed by administrative nurses (includes Director of Nursing, Assistant Director of Nursing, Unit managers, treatment nurse and staff development coordinator,) has been modified to include the review of PRN psychotropic physician orders from the day prior, and determine whether a stop date or clarification order is needed for a newly added medication.

Administrative nurses were educated by regional clinical nurse on F758 and its content with emphasis on ensuring that every prn psychotropic has an order that indicates a time duration. If it does not, clarification must be made with physician. Education was provided on 7//19/21.

4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

All new orders will be reviewed daily (M-F) in the morning meeting by nurse administrative staff to ensure any prescribed prn psychotropics, have a time duration of 14-days. If beyond 14-day time duration, nurse managers will obtain a proper rational. Findings will be documented on the clinical check list.

The DON and/or Administrative Nurses

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F 758	Continued From page 56 was familiar with Resident #108 and frequently took care of her. She explained the resident usually requested alprazolam in the morning and again in the evening before she went to sleep to help with her anxious mood. Nurse #1 reported she had contacted Physician #1 on 5/14/21 by telephone and asked if the PRN alprazolam order could be continued. She stated Physician #1 agreed for the order to be continued but had not given her a stop date for the PRN medication. After she spoke with Physician #1 she entered the order information into the computer. Physician #1 was interviewed by telephone on 6/24/21 at 12:43 PM. He was the resident's primary care physician. He said Resident #108 had chronic anxiety and treatment included PRN alprazolam. He shared since the resident's anxiety was chronic he had not added a stop date to the PRN alprazolam. He explained if a resident was at the facility for a short term stay he typically gave a PRN medication for fourteen days then re-evaluated the resident for continued use. Those residents who were at the facility long term and had chronic mood issues, as was Resident #108, he had not placed a duration on the PRN medication because of her need for the medication. Physician #1 said he was aware of the regulation that a stop date or duration needed to be included in PRN psychotropic medication orders and added he depended on the pharmacy consultant's recommendation of when stop dates needed to be added to the order. He expressed Resident #108 was followed by psychiatric services at the facility and said they also provided an evaluation and assessment of the resident. An interview with the DON on 6/24/21 at 4:27 PM revealed she was new to the facility and thought	F 758	will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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F 758	Continued From page 57 facility physicians were aware of the regulation that a duration or stop date needed to be added to PRN psychotropic medication orders. She said Resident #108 was seen by psychiatric services at the facility and "we will make sure they are aware of it and follow the regulation."	F 758		
F 759 SS=E	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; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 26 medication opportunities, resulting in a medication error rate of 15.3% for 3 of 3 residents (Resident #49, Resident #61 and Resident #29) observed during med pass. The findings included: 1. Resident #49 was admitted to the facility on 6/3/21. Her cumulative diagnoses included gastroesophageal reflux disease (GERD) and placement of a gastrostomy tube (a flexible tube surgically placed into the stomach frequently used to allow nutrition, fluids, and/or medications to be put directly into the stomach). On 6/23/21 at 9:23 AM, Medication Aide #2 was observed as she prepared medications for administration to Resident #49. The medications	F 759	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Medication Aide #2 and Medication Aide #3 were re-educated on nursing competencies 6/25/21 by staff development coordinator. 2)Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current licensed nurses, medication aides, and contract licensed nurses were re-educated by Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit Managers on medication pass expectations and completed return demonstration during mock medication	7/22/21

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F 759	Continued From page 58 included one-40 milligram (mg) tablet of Delayed Release (DR) pantoprazole (a medication used for the treatment of GERD). Med Aide #2 was observed as she crushed the pantoprazole DR tablet. On 6/23/21 at 9:30 AM, Med Aide #2 went to get Nurse #3 to administer the prepared medications via gastrostomy tube. When she returned to the med cart, the Med Aide reported she was told Resident #49 "could take her medicines by mouth." Nurse #3 joined Med Aide #2 at the med cart and mixed the crushed medications into a small amount of pudding. At 9:35 AM, Nurse #3 was observed as she administered the medications to the resident. A review of Resident #49's physician orders included a current order for 40 mg pantoprazole DR to be administered as one tablet by mouth once daily for GERD. According to Lexi-Comp, a comprehensive electronic medication database, pantoprazole DR tablets should be swallowed whole; tablets should not be split, crushed, or chewed. An interview was conducted on 6/23/21 at 10:40 AM with Nurse #3. During the interview, the nurse was asked if she would normally crush pantoprazole DR for administration to a resident. She stated, "No." An interview was conducted on 6/23/21 at 10:45 AM with Med Aide #2. During this interview, the Med Aide was asked if she was aware pantoprazole DR should not be crushed for administration. She pulled Resident #49's bubble pack medication card containing pantoprazole DR	F 759	administration. Education and Return Demonstration was completed on 7/22/21. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing and/or designee will educate licensed nurses, medication aides, and contract licensed nursing staff, on 5 rights of medication administration. This training will be completed by July 22, 2021. Any employee not available for this training will not be allowed to work their next scheduled shift without receiving this training. Medication pass audits will be completed for current licensed nurses, medication aids, and contract licensed nurses, by the Staff Development Coordinator to ensure orders are followed as written by Director of Nursing and/or designee. These audits will be completed by July 22, 2021. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A random medication pass audit will be completed for five (5) Licensed Nurses, including contract nursing staff, and medication aides will be monitored by an administrative nurse at weekly X4 weeks, monthly X3 months, and quarterly thereafter to ensure adequate compliance. Findings will be documented on Med Pass Audit form.	

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F 759	Continued From page 59 for review. The instructions on the med card did not specifically say, "do not crush." At that time, the Med Aide stated she was not aware pantoprazole DR should not be crushed. An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for nursing staff to take the time to be sure they were administering the correct medication as ordered and that they knew which medications to crush and not crush. The DON stated she would be sure a "do not crush" list was put on the med carts. 2. Resident #61 was admitted to the facility on 6/17/19 with a cumulative diagnoses which included chronic obstructive pulmonary disease (COPD). On 6/22/21 at 8:45 AM, Medication Aide #3 was observed as she prepared and administered medications to Resident #61. The medications pulled for administration included 200 micrograms (mcg) Arnuity Ellipta inhaler (a steroidal inhaler used for the management of asthma and/or COPD). The resident was observed as inhaled the medication by mouth. Immediately after the resident was finished with the inhaler, the Med Aide administered the resident's oral tablets/capsules with a cup of water to drink after taking the oral medications. Med Aide #3 then exited the room. Upon return to the med cart, Med Aide #3 was asked if she typically provided water and instructions to the resident to rinse and spit out water after using the Arnuity Ellipta. The Med Aide responded by stating instructions to do so were usually written on the medication's label or on the Medication	F 759	DON will complete a summary of these audit results and present on the facility monthly QAPI meeting to ensure continued compliance	

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F 759	Continued From page 60	F 759		

Administration Record (MAR). Upon review of both the medication label and MAR, the Med Aide reported these instructions were not printed on either one. However, the side panel of the manufacturer's box for Arnuity Ellipta specified "rinse mouth after use." After reading the labeling on the inhaler box, Med Aide #3 was observed as she went into the resident's room, gave a cup of water to the resident, and requested she rinse her mouth out with the water.

An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for nursing staff to take the time to be sure they were administering the correct medication and in accordance with the manufacturer's instructions.

3-a) Resident #29 was admitted to the facility on 7/11/18 with a cumulative diagnoses which included age-related osteoporosis.

On 6/23/21 at 8:50 AM, Medication Aide #2 was observed as she prepared and administered medications to Resident #29. The medications administered to the resident on 6/23/21 at 9:11 AM included one tablet containing 600 milligrams (mg) calcium carbonate (a stock medication) given by mouth.

A review of Resident #29's current physician orders revealed her medication orders included 500 mg calcium with 200 units of Vitamin D3 (a combination medication) to be given as one tablet by mouth daily for supplementation.

An interview was conducted on 6/23/21 at 10:45 AM with Med Aide #2. During the interview, the

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Med Aide reviewed Resident #29's Medication Administration Record (MAR). Upon review, the Med Aide confirmed the physician ' s order was for 500 mg calcium with 200 units of Vitamin D3. When she pulled the medication stock bottle observed to be used for the med pass, the Med Aide confirmed she administered one tablet of 600 mg calcium carbonate (which did not contain Vitamin D3) to the resident. Upon further review of the stock meds available on the medication cart, the Med Aide identified a bottle containing 500 mg calcium with 200 units of Vitamin D3 was stored on the med cart and available for administration to Resident #29.

An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for nursing staff to take the time to be sure they were administering the correct medication as ordered.

3-b) Resident #29 was admitted to the facility on 7/11/18 with a cumulative diagnoses which included a history of constipation.

On 6/23/21 at 8:50 AM, Medication Aide #2 was observed as she prepared medications for administration to Resident #29. These medications included one tablet of a combination medication containing 8.6 milligrams (mg) sennosides (a bowel stimulant) / 50 mg docusate (a stool softener) taken from a stock medication bottle stored on the med cart. The medication was administered to Resident #29 on 6/21/21 at 9:11 AM.

A review of Resident #29's current physician orders revealed her medication orders included

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F 759	Continued From page 62 8.6 mg sennosides (not in combination with docusate) to be given as one tablet by mouth daily for constipation. An interview was conducted on 6/23/21 at 10:45 AM with Med Aide #2. During the interview, the Med Aide reviewed Resident #29's Medication Administration Record (MAR). Upon review, the Med Aide confirmed the physician order was written for 8.6 mg sennosides (not a combination medication including sennosides and docusate). The stock bottle used for the med pass was also pulled. Upon review of the label of this stock bottle, Med Aide #2 acknowledged the medication administered to the resident contained 8.6 mg sennosides with 50 mg docusate. Upon further review of the stock meds available on the medication cart, the Med Aide identified a bottle containing 8.6 mg sennosides (as the sole active ingredient) was stored on the med cart and available for administration to Resident #29. An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for nursing staff to take the time to be sure they were administering the correct medication as ordered.	F 759		
F 761 SS=D	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.	F 761		7/22/21

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F 761	Continued From page 63 §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 observations and staff interviews, the facility: 1) Failed to store medications in accordance with the manufacturer's storage instructions in 1 of 3 medication carts and 1 of 2 medication store rooms observed (500/700 Hall Med Cart and Unit 1 Medication Store Room); 2) Failed to date a stored medication with a shortened expiration date in 1 of 2 medication store rooms (Unit 2 Medication Store Room); and, 3) Failed to secure prescription topical medications in a locked compartment for 2 of 2 residents (Resident #78 and Resident #79) who were observed to have medications at bedside. The findings included: 1-a. In the presence of Nurse #2, an observation was made on 6/23/21 at 11:15 AM of the 500/700 Hall Medication Cart. This observation revealed	F 761	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Medication Rooms and Medication Carts (500 and 700 hall) were audited by Unit Manager on 7/16/21 to ensure medications were stored in accordance with manufacturers storage 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit was completed by administrative nurses, on 7/16/21, of all medication carts and medication rooms to ensure medications were labeled, dated,	

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F 761	Continued From page 64 a plastic bag containing three (3) Levemir FlexTouch insulin pens dispensed for Resident #12 were stored on the med cart. One of the insulin pens was noted to be labeled as having been opened on 6/6/21. Two of the Levemir FlexTouch insulin pens were dispensed from the pharmacy on 6/20/21 and were not yet opened; they were not cold or cool to the touch. The plastic bag containing all three of the insulin pens was labeled with large lettering which read, "Refrigerate." A green auxiliary placed on one of the insulin pens read, "Refrigerate until opened." An interview was conducted on 6/23/21 at 11:20 AM with Nurse #2. When the nurse was asked how unopened insulin pens should be stored, she stated, "in the refrigerator." A review of Resident #12's physician orders revealed the resident had a current order for Levemir FlexTouch 100 units per milliliter (ml) to be administered as 24 units injected subcutaneously (under the skin) each night for diabetes. An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported the facility needed to have a plan to frequently check the med carts to be sure they were clean, neat and nothing was expired. She added that checking the med room refrigerators needed to be part of the plan as well as providing staff education on dating medications, in general. 1-b. In the presence of Nurse #3, an observation was made on 6/23/21 at 10:50 AM of the Unit 1	F 761	and stored per manufactured instruction. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Current Licensed Nurses (including contract licensed nurses), Med Aides, and Med Techs were re-educated by staff development coordinator (SDC) on labeling, dating, and storing medications per manufactured instructions. Completed on 7/19/21. Any Licensed Nurse (including contract licensed nurses) and Medication aides who did not receive this training will not be allowed to work until training completed. New employees will receive this training with facility orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrative nurses (includes Director of Nursing, Assistant Director of Nursing, Unit managers, and Staff Development Coordinator) will monitor medication carts and medication rooms 3x weekly x 4 weeks, bi-weekly x 4 weeks, monthly x 1 to ensure medications are labeled, dated, and stored per manufactured instruction. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly	

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F 761	Continued From page 65 Medication Store Room. This observation revealed a 10 milliliter (ml) bottle of 0.6% Systane Balance (a lubricant eye drop containing 0.6% propylene glycol) eye drops dispensed from the pharmacy on 10/18/20 for Resident #89 was stored in the refrigerator. Manufacturer storage instructions printed on the label of the eye drops read in part, "...Store at room temperature." An interview was conducted on 6/23/21 at 10:55 with Nurse #3. When asked if she would expect these eye drops to be stored in the refrigerator, she stated, "No." A review of Resident #89's physician orders revealed the resident had a current order for 0.6% propylene glycol lubricant eye drops to be administered as one drop into each eye four times a day for dry eyes. An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported the facility needed to have a plan to frequently check the med carts to be sure they were clean, neat and nothing was expired. She added that checking the med room refrigerators needed to be part of the plan as well as providing staff education on dating medications, in general. 2. In the presence of Nurse #2, an observation was conducted on 6/23/21 at 10:55 AM of the Unit 2 Medication Store Room. The observation revealed an opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored inside the manufacturer's box in the refrigerator.	F 761	QAPI meeting to ensure continued compliance.	

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Neither the vial nor the manufacturer box was dated as to when the multi-dose vial was opened. The manufacturer's labeling on the box included the following storage instructions in bold print which read, "Discard opened product after 30 days."

An interview was conducted on 6/23/21 at 11:00 AM with Nurse #2 in the presence of Nurse #7. When asked how long the PPD solution could be kept in the refrigerator after being opened, Nurse #2 stated, "I'm thinking 30 days." When asked what should be done with the vial of Tuberculin PPD that was not dated as to when it had been opened, Nurse #7 responded by saying, "Throw it out."

An interview was conducted on 6/23/21 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported the facility needed to have a plan to frequently check the med carts to be sure they were clean, neat and nothing was expired. She added that checking the med room refrigerators needed to be part of the plan as well as providing staff education on dating medications, in general.

3-a. An observation was conducted of Resident #78's room on 6/22/21 at 9:08 AM. A container of nystatin topical powder (a prescription topical antifungal medication) was observed to be placed within the resident's reach on top of the nightstand next to his bed.

A second observation was conducted on 6/23/21 at 3:32 PM of the resident's room from the hallway. A nystatin powder container was

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F 761	Continued From page 67	F 761		

observed from the doorway to be placed on top of the nightstand next to the resident's bed.

A third observation was conducted on 6/24/21 at 8:30 AM. A container of nystatin topical powder was observed to be placed within the resident's reach on top of the nightstand next to his bed.

An interview was conducted on 6/24/21 at 9:25 AM with the facility's Director of Nursing (DON). During the interview, the DON was informed of the observations made of nystatin powder placed on top of Resident #78's nightstand on three consecutive days. In response, the DON stated, "That is not okay." During the interview, the DON stated her expectation was that the nystatin powder would have been kept on the treatment cart and locked up. She further explained if the resident was going to self-administer the medication, the nystatin powder, "Has to be in a lock box and he has to be able to open the lock box."

3-b. On 6/21/21 at 3:06 PM, a small bottle Nyamyc (nystatin topical powder) was observed on Resident #79 ' s bedside. Resident #79 stated she had a rash under her breast. She stated she didn ' t know how often the medication was used.

An interview was conducted with Medication Aide #4 on 6/21/21 at 3:10 PM revealed Resident #79 should not have the nystatin powder at bedside. She added she did not know how it got there.

An interview was conducted with the DON on 6/24/21 at 9:25 AM and she was made aware of the nystatin powder left at the bedside. The DON stated, "that is not okay." The DON stated the

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F 761	Continued From page 68 nystatin powder should be kept locked up on the treatment cart.	F 761		
F 812 SS=F	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 and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not by not labeling and dating resealed food items; by not ensuring the prevention of cross-contamination of dishware during the operation of the dishwashing machine; by not ensuring dishware were stored/stacked clean and dry; by failing to ensure dietary staff were appropriately dressed and wearing hair covering while in the kitchen; by not ensuring the floor and the 2 of 3 handwashing sinks in the kitchen were maintained in good working condition; and, by not	F 812	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was identified. The dietary manager disposed of the unidentifiable roll of meat wrapped in cellophane along with the 2 bags of breaded meat that were not dated or labeled on 6/21/21.	7/22/21

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F 812	Continued From page 69 ensuring the food service equipment were clean and free from debris; by not properly storing food service cleaning supplies; The facility also failed to ensure the food items not provided by the facility were dated and labeled with the residents' names, dates and room numbers when stored in the snack/nourishment refrigerators in 1 of 3 residents' nourishment rooms. These practices had the potential to affect food served to residents. Findings included: 1. During the initial tour of the kitchen with the Dietary Manager (DM) on 6/21/21 at 9:40 a.m., there was an observation of an unidentifiable roll of meat wrapped in cellophane and 2-opened bags of breaded meat that were not dated or labeled in the walk-in freezer. The DM identified the meats as a pork roast and breaded chicken tenders then removed these items from the freezer. 2a. During the initial tour of the kitchen on 6/21/21 at 9:52 a.m., after scraping food debris and placing the dirty dishware into the dishwashing machine, dietary aide #1 was observed moving to the other side of the dishwashing machine, removing racks of clean dishware from the machine then stacking the clean dishware onto the clean storage rack. Dietary aide #1 did not wash her hands. 2b. On 6/21/21 at 10:00 a.m., during the tour of the kitchen, dietary aide #2 was observed cleaning debris from the food preparation tables while wear plastic gloves. Upon completion of this	F 812	Dietary Aide #1 and Dietary aide #2 was educated on the importance of performing proper hand hygiene and infection control with emphasis on the proper use of protective personal equipment (ppe) while working in the kitchen, The male dietary aide and the dietary staff observed wearing a crossbody purse over were in-service by administrator on 6/24/21 on the importance of wearing appropriate attire in kitchen that includes hair nets upon entry to the kitchen and no personal items while working the food preparation line. The bins that were observed stained on 6/21/21 were thoroughly cleaned on 7/22/21. The mop observed in a bucket of dirty, brown colored water were removed and properly hung. The mop water was discarded into kitchen drain. The dustpan observed full of trash was discarded by housekeeping supervisor on 6/21/21. The 2-large handled pans observed on the floor during observations were placed in the dirty dish area by dietary manager to be washed by dietary manager on 6/24/21. The food and dishware observed on the floor beneath meal service tray line/steam table was Also removed by dietary manager on	

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F 812	Continued From page 70 task, dietary aide #2 proceeded to the dishwashing machine and wearing the same plastic gloves, removed clean dishware from the machine and stacked the clean dishware onto the storage rack. 2c. During the meal tray line service observation on 6/24/21 at 12:23 p.m., a male dietary staff was observed without head covering in the kitchen, near the meal service tray line. Another dietary staff was observed wearing a cross-body purse over a zipped sweatshirt while assisting at the meal service tray line. During an interview, the Dietary Manager revealed the facility did not have a uniform policy for its' dietary staff. 3. During an observation of the cleaned dishware storage rack in the kitchen with the Dietary Manager (DM) on 6/21/21 at 10:25 a.m., the following items were stacked wet and/or dirty: 23-small fruit bowls were stacked wet; 7-small fruit bowls were stacked with dried food particles; 7-plastic, sectional plates were stacked wet; and 1-sectional plate containing dried brown debris. As a result of this observation, the DM removed the dirty bowls and plates from the storage rack to be rewashed in the dishwashing machine. 4a. During the initial tour of the kitchen with the Dietary Manager (DM) on 6/21/21 at 9:50 a.m., dirty food service areas and food service equipment were observed. There were 4-plastic bins (containing and labeled thickener, rice, sugar, and flour, respectfully) that were stained with sticky build-up on the lids and along the	F 812	6/24/21. The faucet of 1 of 3 handwashing sinks observed to have a persistent water drip was repaired on 7/22/21 by a local vendor. The unidentified insulin bags located in the nourishment room were removed on 6/24/21 by the facility administrator. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Maintenance, Dietary Manager and facility Administrator completed an observation round of the dietary department to identify any other areas that needed attention to ensure sanitary environment. This observation was completed on 6/30/21. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Kitchen audit checklist has been put in place to ensure sanitary check of the kitchen to indicate the presence of unlabeled and not dated food, proper dress code, sanitary food service equipment, sanitary floors, and that dishware is properly cleaned. Dietary staff was in-service by the administrator on 7/18/21 on F812 and its content with emphasis on the importance	

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F 812	Continued From page 71 sides of the bins. There were 5-plastic cups and several plastic lids scattered on the floor beneath the beverage counter. On 6/21/21 at 10:40 a.m., during an observation of the mop/broom room in the kitchen, there was a mop in a bucket of dirty, brown colored water. Also, there were 2-brooms leaning against the wall with the heads on the floor and a long-handled dustpan full of trash in the mop/broom room. During an interview on 6/21/21 at 10:41 a.m. the DM stated the dietary staff should have emptied the trash from the dustpan, poured the dirty water from the mop bucked into the floor drain, and placed the mop and brooms with the heads upright in the mop/broom room for storage. 4b. During a kitchen observation on 6/24/21 at 12:30 p.m., 2-large pots and 2-large handled pans were observed on the floor beneath the three-compartment sink. There was also food and dishware observed on the floor beneath the meal service tray line/steamtable and the food preparation tables. 5a. During the initial tour of the kitchen on 6/21/21 at 9:40 a.m., the faucet of 1 of 3 handwashing sinks had a persistent water drip when in the off position. The faucet of the three-compartment sink also had a consistent water drip/drizzle when in the off position. During an interview on 6/21/21 at 9:40 a.m., the Dietary Manager (DM) stated that the maintenance department was made aware of the problem with the faucet of the handwashing sink	F 812	of wearing appropriate attire in kitchen that includes hair nets upon entry to the kitchen and no personal items while working the food preparation line. Education also included ensuring that all food service equipment was cleaned before use, ensuring that all food items were labeled and dated, kitchen floor was maintained a good clean condition, labeling and resealing food items, and ensuring that any snacks or foods which properly labeled and dated. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Kitchen audit checklist will be completed by dietary manager or designee daily X10 (M-F), weekly X3 and monthly X1 to ensure adequate compliance. Findings will be presented in facility□s monthly QAPI meeting to determine if any changes need to be made to this plan. The facility Administrator and the Director of Nursing will be responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance	

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F 812	Continued From page 72 approximately two months ago, but the faucet had not been repaired. During interviews on 6/21/21 at 10:02 a.m., the dietary cook stated the faucet of the 3-compartment sink has had the nonstop drizzle for approximately one month. The DM indicated he had also made the maintenance department aware of this problem. 5b. During the kitchen tour on 6/24/21 at 12:58 p.m., 6-broken and loose square floor tiles observed floating in water near the dishwashing machine. During an interview on 6/24/21 at 12:58 p.m., the DM stated he verbally requested the repair of the floor tile approximately two weeks prior but acknowledged he had not followed up with the maintenance department. 6. During an observation of 1 of 3 residents' nourishment rooms with the Administrator on 6/24/21 at 11:01 a.m., there were 2-insulated lunch bags containing food items in the residents' refrigerator. There were no resident's names, room numbers, and dates on the lunch bags or the food items within. The Administrator discarded the lunch bags after the observation. During an interview on 6/24/21 at 1:08 p.m., the Dietary Manager revealed a dietary staff was assigned to restock and organize the refrigerators in the three nourishment rooms, daily.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		7/22/21

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F 814	Continued From page 73 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure the side doors and top lid of 1 of 2 dumpsters remained closed when not in use. Findings included: During the initial tour of the facility on 6/21/21 at 10:55 a.m., two dumpsters were observed enclosed within a wooden fence. The top lid of 1 of 2 of the dumpsters was open. During an interview on 6/21/21 at 10:56 a.m., the Dietary Manager stated the waste management service empties the dumpsters on Mondays, Wednesdays, and Fridays in the early mornings and would sometimes fail to close the top lids of the dumpsters. During an observation on 6/22/21 at 8:46 a.m., one of the side doors and the top lid of 1 of the 2 dumpsters were open. There were bags of trash in the dumpster.	F 814	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Once garbage lid was observed open on 6/23/21, it was immediately closed by administrator. Environmental staff was in-service by Environmental Services Manager on 6/25/21 on the importance of ensuring that the dumpster lid is closed after disposing of trash/debris. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Both Facility Dumpsters were inspected on 7/12/21 by Environmental Services Manager to ensure that the lids remain closed 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A sign has been placed on the inside of the dumpster door by facility administrator to ensure all staff/vendors who dispose of trash or debris in the facility dumpsters to ensure that it is closed before departing dumpster area after disposal.	

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F 814	Continued From page 74	F 814	Environmental and dietary staff were educated by facility administrator on F814 and its content with emphasis on the importance of ensuring that the facility dumpster lid remain closed at all times. Education was provided on 7/19/19. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Environmental rounds will be performed at random by environmental service manager daily X10 (M-F), weekly X3, monthly X3 and quarterly thereafter to ensure that the dumpster is closed at all times. Findings will be documented on environmental round sheet. Findings will be presented in facility's monthly QAPI meeting to determine if any changes need to be made to this plan. The facility Administrator and the Director of Nursing will be responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance	