STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 3/8/21 through 3/11/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CYOP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was originally conducted 3/8/21 to 3/11/21. Event ID# CYOP11. Following a Centers for Medicare and Medicaid Services' review, the recertification and complaint investigation survey conducted from 3/8/21 to 3/11/21 was re-opened and continued from 9/14/21 through 9/20/21. Event ID# CYOP11. The statement of deficiencies was amended and the severity for citations F686 and F842 was increased. Additional citations were found during the course of the re-investigation at F580, F585, F656, and F689. 11 of the 18 complaint allegations were substantiated resulting in deficiencies. The Statement of Deficiencies was amended on 10/1/21. The number of substantiated allegations changed from 2 to 11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		4/8/21

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

Electronically Signed | 03/26/2021

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interviews, the facility failed to promote dignity by failing to provide privacy cover	F 550	F550 Address how corrective action will be	

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F 550	Continued From page 2 for the urinary drainage bag for 1 of 2 sampled residents with an indwelling urinary catheter (Resident # 10) and failed to knock on resident's doors or to ask permission to enter on resident's room for 3 of 3 residents observed for privacy (Residents # 1, #10 & # 3). Findings included: 1a. Resident # 10 was admitted to the facility on 9/12/17 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 12/21/20 indicated that Resident #10's cognition was intact, and she has an indwelling urinary catheter. Resident #10 was observed in bed on 3/8/21 at 9:30 AM and at 1:30 PM. She has an indwelling urinary catheter and the drainage bag was not covered. The catheter bag was facing the door and was visible to her roommate. When interviewed, Resident #10 stated that she would feel much better with the drainage bag being covered so her urine would not be seen by others. On 3/8/21 at 1:31 PM, Nurse Aide (NA) # 4 was interviewed. She stated that she was assigned to Resident #10. NA #4 observed the urinary drainage bag and stated that she didn't notice that it was not covered. NA #4 replied that she would get a drainage bag cover and would cover it right away. She reported that it was the NAs and nurse responsibility to make sure urinary drainage bag always has a privacy cover. On 3/8/21 at 1:32 PM, Nurse # 2 was interviewed. She stated that she was assigned to Resident #10. She reported that nurses and NAs were	F 550	accomplished for those residents found to have been affected by the deficient practice; The licensed nurse replaced the privacy bag for resident #10 on 3/10/21. Residents number 1, 10 and 3 were notified by the Director Of Nursing on 3/12/21 of the education that would be provided to staff. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; A 100% audit of all residents with a catheter was completed by the Director Of Nursing on 3/22/21 and there were no other residents identified to be affected by not having a dignity bag at that time. Any resident with an indwelling catheter has the potential to be affected by the deficient practice. The facility has ordered the catheter bags with the built-in privacy cover and disposed of the drainage bags without the covers. Resident #10 was identified as having been impacted by the deficient practice when staff failed to knock on her door and announce themselves prior to entering her room. No other residents were identified as being impacted yet all facility residents have the potential to be affected by the deficient practice. Resident #10 was informed that staff would be educated on resident rights including her right to privacy and the requirement to knock on her door and announce themselves prior to entering her room.. Address what measures will be put into	

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F 550	Continued From page 3 responsible for ensuring urinary drainage bag was covered. Nurse #2 further stated that she didn't notice that the urinary drainage bag was not covered when she administered her medications this morning. On 3/10/21 at 3:55 PM, the Director of Nursing (DON) was interviewed. She stated that she expected urinary drainage bag to be covered at all times for dignity purposes. She added that the facility has a blue colored drainage bag which she expected the staff to use to ensure the contents of the bag was not visible to the public. 1b. Resident # 10 was admitted to the facility on 9/12/17 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 12/21/20 indicated that Resident #10's cognition was intact. On 3/10/21 at 8:18 AM, Housekeeper #1 was observed to enter Resident #10's room without knocking on the door or asking permission to enter. On 3/10/21 at 8:20 AM, Resident #10 was interviewed. She stated that she would like the staff to knock on her door before entering her room. She added that some staff did knock but others did not. On 3/10/21 at 8:19 AM, Housekeeper #1 was interviewed. She stated that she knocked when the doors were closed but she did not have to knock when the doors were open. On 3/11/21 at 3:55 PM, the Director of Nursing (DON) was interviewed. She stated that she	F 550	place or systemic changes made to ensure that the deficient practice will not recur; Central supply ordered bags with built in privacy bags and the facility disposed of the old drainage bags on 3/12/21. Every new admission or readmission from the hospital that has a catheter in place, will have the catheter bag exchanged to the current system with built in privacy bags. The Assistant Director of Nursing provided education to the nursing staff regarding Residents Right to dignity. The systemic change for resident rights included re-educating staff about resident's rights and the exercise of those rights. On 3/19/21 the Assistant Director of Nursing and the Human Resource Director provided an educational in-service on residents rights to dignity and privacy. The right to dignity focused on providing residents with catheters a fig leaf drainage bag with a build in privacy flap. The education on residents rights to privacy focused on knocking on a resident□s door, announcing oneself prior to entering a residents room. Any staff not present for education will be educated prior to returning to work. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing/ Assistant Director of Nurses will audit all new admissions with catheters and any resident with a new order for a catheter to	

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F 550	Continued From page 4 expected all staff to knock on doors or to ask permission before entering a resident's room. The DON added that no matter if the door was open or closed, staff were expected to knock. Attempted to call the Housekeeping Director but was unsuccessful. 2. Resident #1 was admitted to the facility on 8/9/19 with multiple diagnoses including Congestive Heart Failure (CHF) and Atrial Fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated that Resident #1 had moderate cognitive impairment. On 3/10/21 at 8:12 AM, Housekeeper #1 was observed to enter Resident #1's room without knocking on the door or asking permission to enter. On 3/10/21 at 8:13 AM, Resident #1 was interviewed. He stated that he would appreciate staff knocking so he would know who was entering his room. He added that he wished the staff would always knock, even the door was open or closed. On 3/10/21 at 8:19 AM, Housekeeper #1 was interviewed. She stated that she knocked when the doors were closed but she did not have to knock when the doors were open. On 3/11/21 at 3:55 PM, the Director of Nursing (DON) was interviewed. She stated that she expected all staff to knock on doors or to ask permission before entering a resident's room. The DON added that no matter if the door was open or closed, staff were expected to knock.	F 550	ensure that the appropriate drainage bag has been applied five times per week for four weeks then weekly for two months. The Environmental services director, Social Worker, Human Resource Director, Medical records director and Activity Director will monitor the halls five times weekly for four week and then weekly for two months to ensure that staff are knocking and announcing themselves prior to entering the room. The Social Worker will interview 5 alert and oriented residents weekly for 4 weeks and then 10 monthly for two months to validate that employees are knocking and announcing themselves prior to entering rooms. The _Director of Nursing and Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and Director of Nursing will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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F 550	Continued From page 5 Attempted to call the Housekeeping Director but was unsuccessful. 3. Resident # 3 was admitted to the facility on 11/20/20 with multiple diagnoses including schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated 2/25/21 indicated that Resident #3 had severe cognitive impairment. On 3/10/21 at 8:10 AM, Housekeeper #1 was observed to enter Resident #3's room without knocking on the door or asking permission to enter. On 3/10/21 at 8:19 AM, Housekeeper #1 was interviewed. She stated that she knocked when the doors were closed but she did not have to knock when the doors were open. On 3/11/21 at 3:55 PM, the Director of Nursing (DON) was interviewed. She stated that she expected all staff to knock on doors or to ask permission before entering a resident's room. The DON added that no matter if the door was open or closed, staff were expected to knock. Attempted to call the Housekeeping Director but was unsuccessful.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		9/20/21

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F 561	Continued From page 6 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to provide showers according to resident's preference for 1 (Resident #43) of 1 residents reviewed for activities of daily living (ADLs). The findings included: Resident #43 was admitted on 12/12/18 with a diagnosis for Cerebral Vascular Accident (CVA). Resident #43's quarterly Minimum Data Set (MDS) dated 1/18/21 indicated Resident #43 was cognitively intact, exhibited rejection of care behaviors and required total assistance with	F 561	F561 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #43 had a shower on 3/9/21. The Director of Nursing was made aware that resident # 43 had a shower on 3/6/21 which was not her scheduled shower days as well. In review of resident□s record it was noted by staff that the resident had showers on the following dates: January 1,6,8,12,15,19,22,25,& 29 and in February	

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F 561	Continued From page 7 bathing. Resident #43 was care planned for activities of daily living (ADLs) self-care performance deficit, behavior symptoms such as refusal of care, hallucinating/paranoia, and yelling out and care planned for making false statements toward staff (states staff does not come into room during shift). The care plan was revised on 2/8/21. Review of Resident #43's Physician orders for January 20201 to March 2021 indicated she was scheduled for her showers on Tuesday's and Friday's on first shift. Review of Resident #43's Medication Administration Records (MAR) from 1/1/21 to 3/10/21 indicated the nurses documented she received her showers every Tuesday and Friday on first shift. Review of the nursing assistant's ADL charting from 2/9/21 to 3/10/21 indicated she received a shower on 2/9/21, 2/23/21, 2/26/21, 3/1/21 and 3/5/21. Review of a grievance dated 3/2/21 read Resident #43 reported she was not getting her showers. The grievance read that Resident #43 understood it was a lot of work but she wanted to feel fresh. The grievance read that Resident #43 last received a shower and washed her hair on 2/27/21. In an observations and interview on 3/8/21 at 10:51 AM, Resident #43 was in bed. Her hair appeared disheveled. She was absent of odors and there was no evidence of lack of incontinence care. Resident #43 stated she was	F 561	on 2,5,9,12,16,19 and 23. Resident #43 refused a shower on 2/26/21. Resident #43 will receive showers per preference on Tuesdays and Fridays day shift (between 7a-3pm). The Director of Nursing spoke with the resident on 3/12/21 and discussed her preference for showers. The resident stated she was okay with her current schedule for showers. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a 100% audit was done by the Director of Nursing on 3/12/21 for all alert and oriented residents currently in house regarding their shower preference and their care plans and kardexes were updated to reflect their preferred schedule. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The nursing department staff were educated on 3/19/21 by The Director of Nursing regarding the shower preference and completing a shower sheet for each resident who is offered a shower. This education will be added to the orientation process for new nursing department hires. Any nursing department staff not present for the education will be educated prior to returning to work. The facility initiated shower sheets on 3/5/21 prior to the survey process. The	

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F 561	Continued From page 8 getting bed baths but she was not getting her showers according to her schedule and preference. She stated she understood that the staff were really busy but she had not been getting her showers at scheduled since sometime in January 2021. In an observation and interview on 3/10/21 at 8:20 AM, Resident #43 was in bed. She stated she got a shower and had her hair washed yesterday. She appeared clean and her hair had been washed. In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated she was not aware of any shower refusals by Resident #43. In an interview on 3/10/21 at 11:00 AM, Unit Manager (UM)# 1 stated he was not aware of any ADL refusals by Resident #43. In an interview on 3/10/21 at 11:15 AM, Nursing Assistant (NA) #1 stated Resident #43 does not refuse ADL assistance. She stated both shower rooms on the skilled hall and rehabilitation hall were out of order. If a resident was due a shower, they had to take the resident to the other side of the facility. NA #1 stated recently the aides started completing shower sheets to give to the floor nurse and the nurse checked something off in the computer. She stated when completing shower sheets, she was really completing bed baths. In an interview on 3/10/21 at 11:50 AM. NA #2 stated she was not aware of any ADL refusals. In an interview on 3/10/21 at 12:24 PM, NA #3 stated the previous company used shower sheets	F 561	Certified Nursing Assistants (CNAs) are to fill out the shower sheets every time a resident is offered a shower and then turn that into the nurse to verify that the resident has had a shower or has refused a shower. The nurse then turns these shower sheets into the Director of Nursing. These shower sheets will be utilized for all residents and monitored to verified that showers are being given per resident preference. If the resident refuses a shower the nurse is to document that in the resident□s chart. All new admission that are Alert and oriented will have their shower preference discussed at admission and that preference will be added to their care plan and Kardex. Any resident without preference will be assigned showers 2 times per week and well as daily bed baths. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of nursing/Administrative nurse will interview 5 alert and oriented resident weekly for 4 weeks and then 10 monthly for two months to ensure that showers are given per their preference The Director of Nursing will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Director of Nursing and Administrator will review the plan during the monthly	

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F 561	Continued From page 9 but the new company did not want the aides using shower sheets. NA #3 stated the facility restarted using the shower sheets about a week ago. She stated she was not aware of any shower refusal by Resident #43. She stated the shower room on the skilled hall was not working last week. She stated it was not draining but it was fixed by maintenance last week. She stated the shower room on the rehabilitation hall was still out of order due to the tile floor and ongoing renovations. In an interview on 3/10/21 at 12:30 PM, the Maintenance Director stated he was made aware that the skilled hall shower room was draining slow so he unclogged drain last week. He stated staff had been able to use the skilled hall shower room since last week. The Maintenance Director stated because of the remodeling on the rehabilitation hall, the tile was removed from the hall and caused staff difficulty wheeling residents into the shower room safely. He stated the rehabilitation hall shower room should be in working order next week. In an email correspondence on 3/11/21 at 10:30 AM, the Director of Nursing (DON) indicated the facility reinstituted the shower sheets at the beginning of March because it was the expectation of Corporate that the use of the shower sheets was a way to validate that showers were given since the nurses may not always witness the shower. Aides filled out the shower sheets and gave them to the nurse to validated the shower were done or refused. In another email correspondence dated 3/11/21 at 12:11 PM, the DON indicated that it was expectation that staff provide Resident #43's	F 561	QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed: 4/8/21	

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F 561	Continued From page 10 showers as scheduled and per her preference. She stated the staff were providing her showers as scheduled and preferred but Resident #43 tended to refuse a shower and then request on her shower on a non- scheduled day. She stated the staff obliged her due to her multiple refusals. The DON indicated the staff gave her showers when she requested one so that the facility could ensure she was getting her showers.	F 561		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		10/11/21

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and Physician Assistant interviews, the facility failed to notify the physician of newly identified pressure ulcers resulting in a delay in obtaining treatment orders for two separate instances. This was for 1 of 4 residents reviewed for pressure ulcers (Resident #85). The findings included: Resident #85 was admitted to the facility on 11/25/20 with multiple diagnoses that included dementia, atrial fibrillation, coronary artery disease and muscle weakness. He was diagnosed with COVID-19 on 12/1/20.	F 580	F 580 At the time of survey the facility did not have a treatment nurse. The Director of Nursing was receiving the communication/reviewing the documentation for skin issues. On 3/16/21 a new treatment nurse was in place. The resident affected by the deficient practice #85 was sent to the hospital on 2/11/21 due to respiratory distress and did not return to the facility. Address how the facility will identify other	

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F 580	Continued From page 12 The admission Minimum Data Set (MDS) assessment dated 12/1/20 indicated Resident #85 had severe cognitive impairment. He required extensive assistance from staff for bed mobility and toileting, was incontinent of bowel and bladder, and was at risk for pressure ulcers. The assessment further revealed he had no pressure ulcers or other skin conditions, but a pressure reducing device was present to the bed. A nursing progress note dated 1/28/21 indicated Resident #85 was found to have open areas to the right and left heel with mild drainage and the size of a quarter. The wound nurse was notified, the areas were cleansed, and a dry dressing was placed over both areas. Resident #85's spouse was notified of the wounds. There was no indication the physician or physician's assistant (PA) were made aware. Resident #85's physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2021 were reviewed and there was no order or treatment documented for the right or left heel pressure ulcers. A physician's assistant (PA) progress note for 2/3/21 was reviewed and indicated Resident #85 was seen for new wounds to his bilateral heel. There was no pain at rest and minimal discomfort was present with the assessment of the wounds. There had been no unexpected weight change, there was no edema to the right or left leg and his skin was warm and dry. The left heel was described as 2.4 cm in length and 2 cm in width with 100% slough and unstageable pressure ulcer. The right heel was described as 4 cm in length and 3 cm in width with non-blanchable	F 580	residents having the potential to be affected by the same deficient practice; All current facility residents are at risk to be affected. A 100% audit of all current residents was completed on 2/25/21 by the Director Of Nursing and there were no other resident noted to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing/Assistant Director of Nursing completed education on 2/26/21 for the licensed nurses and nursing assistants, regarding the wound protocol. Nursing staff were not permitted to work until the education had been received. When a resident is admitted, readmitted or if a skin injury is identified, the licensed will assess the resident□s skin and notify the physician to obtain treatment orders. The licensed nurse will complete weekly skin assessments in Point Click Care (PCC) electronic medical record on current facility residents and notify physician and residents or their Responsible Party (RP) regarding any new skin issues and initiate treatment orders. The licensed nurse will document the injury in the wound communication book as well as the medical record and will complete a Braden risk assessment. The nursing assistants will complete a shower sheet that will be used to identify any areas to the resident□s skin. These sheets will be turned into the license nurse who will initiate the protocol and	

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F 580	Continued From page 13 erythema (skin redness that does not turn white when pressed) and was classified as deep tissue pressure injury. A nursing progress note dated 2/5/21 indicated Resident #85 was found to have two small open areas to his buttocks. The first was centrally located on the sacrum and the second smaller one was on the buttock. No drainage was present, or pain expressed by Resident #85. Both areas were cleansed, dry dressings applied, and the wound care nurse was notified. There was no indication that the physician or PA were notified of the new skin breakdown. Resident #85 was transferred to the Emergency Room on 2/11/21 due to respiratory distress. He did not return to the facility. A phone interview was conducted with Nurse #3 on 3/11/21 at 11:00 AM, who was assigned to Resident #85 on 1/28/21. She explained on 1/28/21 the newly found pressure areas to both heels and reported this to the former wound care nurse as well as notified Resident #85's family member. On 3/10/21 at 3:26 PM, an interview occurred with Nurse #4 who was assigned to Resident #85 on 2/5/21. Nurse #4 stated when he observed the open areas on Resident #85's buttocks there were 2 small, superficial openings. He recalled alerting the former wound care nurse to the new pressure areas, as well as Resident #85's spouse. Another interview was completed with Nurse #4 on 9/14/21 at 4:10 PM and recalled when he identified skin breakdown to Resident #85's buttocks area he notified the former wound care nurse as well as Resident #85's spouse. He	F 580	then place these sheets in the wound communication book for follow up by the wound nurse. He wound nurse will monitor the communication book daily during the work week and will complete a follow up assessment of wounds that are identified. The wound nurse will review the treatment orders with the physician. The wound nurse will completed the wound evaluation assessment in PCC weekly and update the wound log at that time. The wound nurse along with the Interdisciplinary Team (IDT) will review wounds weekly and will make suggestions/changes as needed to promote wound healing. The Registered Dietician will be updated weekly by the DON/wound nurse on the condition of current wounds and any new wounds identified. The wound nurse/MDS will update the resident□s care plan. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON/ADON will review and compare shower sheets, skin assessments and progress notes 5 times per week for 4 weeks and then 3 times per week for 2 months to validate that treatment order are in place, the Physician and RP have been notified and the wound documentation is complete. The _Director of Nurses will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.	

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F 580	Continued From page 14 further stated at that time the former wound care nurse would have been responsible for notifying the physician or PA. The Director of Nursing (DON) was interviewed by phone on 3/11/21 at 12:07 PM and stated she was aware Resident #85 had pressure areas to his heels and buttocks. She further stated at the time, the staff nurses informed the wound care nurse of the wounds when they were identified, and she would have been responsible for notifying the physician or PA. The DON further stated she expected the nurse who identified the open area to obtain a treatment order by following the facility's wound protocol or calling the physician. The Medical Director was interviewed via phone on 9/14/21 at 1:21 PM and was familiar with Resident #85 and stated the facility staff had notified himself or the facility PA when Resident #85 developed skin breakdown. Although, he was unaware the notification was not when the wounds were first observed on 1/28/21 and 2/5/21. The Medical Director stated he expected to be notified when areas of skin concerns were first identified either by the staff nurse or wound care nurse. A phone interview was conducted with the former wound care nurse on 9/15/21 at 2:00 PM who left her employment at the facility in March 2021. She was able to recall Resident #85 and stated she remembered the floor nurse telling her about his heel wounds and instructed the nurse how to dress the wounds until she could get there to look at them on 1/28/21. She went onto say notified the facility PA on the date of the initial wound evaluation (2/2/21) and requested the facility PA	F 580	The Director of Nurse/ Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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F 580	Continued From page 15	F 580		

to assess the wounds the following day. The former wound care nurse recalled being informed by the floor nurse when Resident #85 developed breakdown to his buttocks area on 2/5/21, recalled assessing those wounds a few days later (2/8/21) and notified the facility PA/physician of the new areas on the same day as the assessment. The former wound care nurse acknowledged the facility PA or physician should have been notified on the day the wounds were first identified.

On 9/15/21 at 2:38 PM, a phone interview was held with the facility PA who was able to recall Resident #85. She reviewed her notes and stated she was notified by the former wound care nurse on 2/2/21 regarding Resident #85's wounds to both heels and assessed them the following day. She stated the facility staff had notified herself or the Medical Director when Resident #85 developed skin breakdown, however, she was unaware the notification was not when the wounds were first observed on 1/28/21 and 2/5/21. The facility PA stated it was her expectation for either herself or the Medical Director to be notified when areas of skin concerns were first identified by the staff nurse or wound care nurse.

Another phone interview was completed with Nurse #3 on 9/15/21 at 3:03 PM, who was assigned to Resident #85 on 1/28/21. She explained when she observed the skin changes to Resident #85's heels on 1/28/21, she reported this to the former wound care nurse who provided how to cleanse and dress the wounds as well as the Director of Nursing. Nurse #3 added she notified Resident #85's family of the skin changes, but at that time the former wound care

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F 580	Continued From page 16 nurse notified the physician or PA. The Administrator and current DON were interviewed on 9/16/21 at 1:40 PM and stated it was their expectation for the physician/PA as well as the resident and/or responsible party to be notified the same day a skin issue was observed.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		10/11/21

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F 585	Continued From page 17 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

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F 585	Continued From page 18 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, responsible party (RP) and staff interviews, the facility failed to provide a written grievance response summary and failed to follow the facility policy regarding grievance. This was for 1 of 1 resident reviewed for grievances (Resident #8). The findings included: A review of the undated facility grievance policy read as follows: - All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a	F 585	Address How Corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility retained a copy of the grievance letter that had been mailed to the resident□s responsible party (RP) on August 18,2021. On September 9, 2021 resident□s RP contacted the administrator stating she never received the grievance letter and could she come to the facility to pick up a copy. The Social Worker pulled the grievance packet and made a copy of the original letter and	

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F 585	Continued From page 19 rationale for the response. - Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within 5 working days of receiving the grievance and/or complaint. - The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. a) The Administrator, or his/her designee, will make such reports orally within 5 working days of the filing of the grievance or complaint with the facility. b) A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. Resident #8 was admitted to the facility on 6/25/21 with diagnoses that included a recent traumatic subdural hemorrhage, end stage renal disease on hemodialysis and cognitive communicative deficit. The admission Minimum Data Set (MDS) assessment dated 6/25/21 indicated Resident #8 had moderately impaired cognition. Review of the facility grievance logs indicated a grievance form was initiated on 8/16/21 by Resident #8 regarding missing dentures. The grievance form indicated the grievance was unresolved based on investigation results, dated 8/17/21 and did not indicate whether Resident #8 or the Responsible Party was updated verbally or provided a written response of the grievance resolution. The grievance was signed by the Administrator and dated 8/26/21.	F 585	gave it to the RP. During our survey which began September 14, 2021 the surveyor showed the administrator a copy of the letter that was sent to them by the resident□s RP. The facility also showed the survey team the grievance packet which included the original grievance investigation form, documentation collected during the investigation as well as the facility copy of the grievance letter. On October 12, 2021 another letter regarding this grievances was drafted and sent via certified mail to the residents RP Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit was completed the administrator on September 22, 2021 of all grievances from July to present and no other residents were affected nor have there been other reports of residents or responsible parties not receiving written notification about a grievance. Address what measures will be put into place or systemic changes to ensure the deficient practice will not recur; The Social Worker and External Marketer/Social Worker have been educated on the grievance process by the administrator on 9/22/2021 to include that all grievance letters must be on company letter head, specify the grievance and the resolution and be completed within the required time frame. Additionally, they were educated that written notification is mandatory and must be checked off on the grievance report. How will the facility monitor its performance to make sure that solutions	

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F 585	Continued From page 20 On 9/17/21 at 11:33 AM, a phone interview occurred with the Social Worker (SW) who explained she had been employed for 2 days at the facility when she completed the grievance report for Resident #8. She explained she spoke with the RP for Resident #8 on 8/17/21 and mailed a generic letter regarding the outcome of the grievance but failed to indicate any of this on the grievance form. In addition, the SW stated she failed to send a copy of the grievance report, as she was unaware it was needed. The Administrator was interviewed via phone, on 9/17/21 at 2:30 PM. She reviewed the grievance report for Resident #8 and acknowledged the form was incomplete as to whether the RP was notified both verbally and in writing. The Administrator stated it was her expectation that the Grievance Officer/SW adhered to the regulatory guidelines and should have provided a copy of the written grievance response summary to the RP. A phone interview occurred with the RP for Resident #8 on 9/20/21 at 9:00 AM and confirmed she had not received the written grievance report form via mail or in person as requested.	F 585	are sustained; The administrator will review all grievances monthly and validate that an appropriate grievance letter has been written and that the grievance report reflects that written notification has been sent. Indicate dates when corrective action will be complete; September 22, 2021 The Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Interdisciplinary Team will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Completed action by 9/22/2021	
F 641 SS=E	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 record reviews, observation, and staff and Registered Dietician interviews the facility	F 641	F 641	4/8/21

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F 641	Continued From page 21 failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications (Residents #1, #10, #21, #29, #235), urinary catheter (Resident #14), weight loss (Resident #76), skin condition (Resident #78) and smoking (Resident #1) for 8 of 20 residents reviewed. The findings included: 1) Resident #21 was originally admitted to the facility on 7/5/16 with diagnoses that included a history of a pulmonary embolism (a blood clot) and cerebrovascular disease. A review of the Medication Administration Record (MAR) for Resident #21 from 2/13/21 to 2/19/21 revealed he received Eliquis 5 milligrams (mg) by mouth twice a day for an anticoagulant. The quarterly Minimum Data Set (MDS) assessment dated 2/19/21 indicated Resident #21 had moderately impaired cognition and he was not coded for anticoagulant use. On 3/10/21 at 10:20 AM, an interview occurred with the MDS Nurse #1. She reviewed the 2/19/21 MDS and February 2021 MAR, confirming anticoagulant should have been coded for 7 days. During an interview on 3/10/21 at 4:56 PM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately. 2) Resident #76 was originally admitted to the facility on 4/23/19 with diagnoses that included end stage renal disease on hemodialysis,	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The residents identified as having inaccurately coded assessments had reviews and modifications made to their assessments by Minimum Data Set (MDS) Nurse as follows: 1) The MDS nurse completed a modification of the 2/19/21 MDS assessment for Resident #21 on 3/10/21, to include coding of an anticoagulant. 2) The MDS nurse completed a modification of the 2/9/21 MDS assessment for Resident #76 on 3/10/21, to include coding of weight loss. 3) The MDS nurse completed a modification of the 2/11/21 MDS assessment for Resident #78 on 3/10/21, to remove inaccurate coding of skin condition. 4) a) The MDS nurse completed a modification of the 8/27/20 MDS assessment for Resident #1 on 3/18/21, to include coding that resident did use tobacco during the assessment period. b) The MDS nurse completed a modification of the 2/18/21 MDS assessment for Resident #1 on 3/10/21, to include coding of an anticoagulant. 5) The MDS nurse completed a modification of the 12/21/20 MDS assessment for Resident #10 on 3/10/21, to include coding of an anticoagulant. 6)a) The MDS nurse completed a modification of the 1/8/21 MDS assessment for Resident #29 on 3/10/21,	

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 641	Continued From page 22 dysphagia (difficulty swallowing), diabetes, and schizophrenia. Resident #76's weight data revealed the following weights during the MDS assessment look back period of August 2020 to February 2021, which showed a weight loss. 8/12/20 154.4 pounds (lbs.) 9/9/20 155.5 lbs. 10/22/20 156.2 lbs. 11/18/20 154.1 lbs. 12/15/20 155 lbs. 1/25/21 153.4 lbs. 2/3/21 120.7 lbs. 2/8/21 122.4 lbs. The quarterly MDS assessment dated 2/9/21 indicated Resident #76 was cognitively intact. She was not coded for weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. On 3/10/21 at 2:56 PM, an interview was conducted with the MDS Nurse #1 who stated the Registered Dietician coded the nutritional section of the MDS assessment. She reviewed the Resident #76's weight data and confirmed the MDS should have been coded with a weight loss. During an interview on 3/10/21 at 4:56 PM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately. A phone interview occurred with the Registered Dietician on 3/11/21 at 9:25 AM. She reviewed the MDS assessment dated 2/9/21 and Resident #76's weight data and indicated it should have been coded with a weight loss.	F 641	to remove inaccurate coding of Gradual Dose Reduction (GDR) for an antipsychotic medication. b) The MDS nurse completed a modification of the 2/16/21 MDS assessment for Resident #29 on 3/10/21 to include coding of a GDR for an antipsychotic medication. 7) The MDS nurse completed a modification of the 1/4/21 MDS assessment for Resident #14 on 3/10/21, to remove inaccurate coding of a urinary catheter. 8) The MDS nurse completed a modification of the 2/25/21 MDS assessment for Resident #235 on 3/10/21, to include coding of an anticoagulant. All residents have the potential to be affected by inaccurate coding of assessments in the areas related to; anticoagulants, weight loss, skin condition, smoking, antipsychotic use, GDR and urinary catheter. The MDS nurses completed an audit on 3/19/21 of the last completed MDS assessments for residents receiving anticoagulants, weight loss, skin condition, smoking, antipsychotic medication, GDR of antipsychotics, and indwelling catheter, to validate that assessments were coded accurately. There were three other residents noted to be affected and those MDS were modified on 3/19/21 Address what measures will be put into place or systemic changes made to	

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F 641	Continued From page 23 3) Resident #78 was originally admitted to the facility on 8/24/20 with diagnoses that included diabetes, and end stage renal disease on hemodialysis. A review of the February 2021 Medication Administration Record (MAR) revealed no treatments delivered to Resident #78 for open lesions to the foot, a surgical wound, burns or skin tear. There was not a Treatment Administration Record (TAR) developed for February 2021. Review of a skilled nursing progress note dated 2/5/21 did not reveal any skin condition concerns were present. The most recent quarterly MDS assessment dated 2/11/21 indicated Resident #78 was cognitively intact. She was coded with open lesions to the foot, a surgical wound, burns and skin tear. The area for skin and ulcer treatments had pressure reducing device for bed marked only. A weekly skin assessment dated 2/13/21 revealed Resident #78 had a scab to the left lower leg, bruising to her arms, a dialysis shunt present and dialysis port to the right chest. On 3/10/21 at 2:45 PM, an interview was conducted with MDS Nurse #1 who stated she coded the skin condition section of the MDS dated 2/11/21 in error. During an interview on 3/10/21 at 4:56 PM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately.	F 641	ensure that the deficient practice will not recur; When an MDS assessment is completed, prior to locking, the second MDS nurse will review and validate for accuracy of coding. The MDS assessment is then sent to a MDS scrubber (Scrubber is a software tool utilized for improvement of resident assessment data accuracy) that will identify a potential inaccuracy with coding. The MDS will be corrected as necessary, locked and submitted. The Director of Reimbursement provided education to the MDS nurses on 3/10/21, regarding accuracy of coding according to the RAI manual and validation of accuracy prior to locking and submitting the MDS assessment. Newly hired MDS nurses will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) or the Administrator will audit 5 MDS assessments weekly for 4 weeks, then 10 MDS assessments monthly to validate accuracy of coding related to anticoagulants, weight loss, skin condition, smoking, antipsychotic use, GDR and catheter. The DON and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the	

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F 641	Continued From page 24 4 a. Resident #1 was admitted to the facility on 8/9/19 with multiple diagnoses including Congestive Heart Failure (CHF) and Atrial Fibrillation. The annual Minimum Data Set (MDS) assessment dated 8/27/20 indicated that Resident #1 did not use tobacco during the assessment period. Resident #1 had a smoking assessment completed on 5/28/20 and he was assessed as able to smoke without supervision (unsupervised smoker). The care plan that was initiated on 5/28/20 included a problem that "Resident #1 is a smoker". The nurse's note dated 3/4/21 at 5 PM revealed that Resident # 1 went outside to smoke occasionally. Resident #1 was interviewed on 3/10/21 at 10:58 AM. He stated that he had been smoking since he came to the facility. MDS Nurse # 1 was interviewed on 3/10/21 at 2:50 PM. She stated that the MDS Nurse who completed the annual MDS dated 8/27/20 was no longer employed at the facility. MDS Nurse #1 verified that Resident #1 had used tobacco during the assessment period based on the smoking assessment and the care plan. She added that the annual MDS dated 8/27/20 should have been coded for tobacco use, but it was not.	F 641	discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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The Director of Nursing (DON) was interviewed on 3/10/21 at 3:55 PM. The DON stated that she expected the MDS assessments to be coded accurately. She added that the facility had 2 MDS Nurses and both nurses just started working at the facility few months ago.

4 b. Resident #1 was admitted to the facility on 8/9/19 with multiple diagnoses including Congestive Heart Failure (CHF) and Atrial Fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated that Resident #1 had not received anticoagulant medication during the assessment period.

Resident #1 had a doctor's order for Eliquis 5 milligrams (mgs.) by mouth twice a day for Atrial Fibrillation on 8/10/19.

The February 2021 Medication Administration Records (MARs) revealed that Resident #1 had received Eliquis twice a day during the assessment period.

MDS Nurse #1 was interviewed on 3/10/21 at 2:58 PM. She verified that Resident #1 was on Eliquis and had received Eliquis during the assessment period in February 2021. She stated that she did not know that she had to code Eliquis as anticoagulant medication.

The Director of Nursing (DON) was interviewed on 3/10/21 at 3:55 PM. The DON stated that she expected the MDS assessments to be coded accurately. She added that the facility had 2 MDS Nurses and both nurses just started working at the facility few months ago.

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5. Resident #10 was admitted to the facility on 9/12/17 with multiple diagnoses including Pulmonary Embolism (PE). The quarterly Minimum Data Set (MDS) assessment dated 12/21/20 indicated that Resident #10 did not receive an anticoagulant medication during the assessment period.

Resident #10 had a doctor's order for Eliquis 5 milligrams (mgs.) by mouth twice a day for history of PE.
The December 2020 Medication Administration Records (MARs) revealed that Resident #10 had received Eliquis during the assessment period.

MDS Nurse #1 was interviewed on 3/10/21 at 2:58 PM. She verified that Resident #10 was on Eliquis and had received Eliquis during the assessment period in December 2020. She stated that she did not know that she had to code Eliquis as anticoagulant medication.

The Director of Nursing (DON) was interviewed on 3/10/21 at 3:55 PM. The DON stated that she expected the MDS assessments to be coded accurately. She added that the facility had 2 MDS Nurses and both nurses just started working at the facility few months ago.

6. Resident #29 was admitted to the facility on 11/2/16 with multiple diagnoses that included schizophrenia and dementia without behavioral disturbance.

A physician ' s order dated 4/5/20 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) once daily for Resident #29.

A review of the active physician ' s orders for

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1/8/21 indicated Resident #29 ' s order for Seroquel 50 mg (initiated on 4/5/20) remained an active order.

1a. The quarterly Minimum Data Set (MDS) assessment dated 1/8/21 indicated Resident #29 was rarely/never understood. She was administered routine antipsychotic medication on 7 of 7 days. The medications section of the MDS indicated Resident #29 had a Gradual Dose Reduction (GDR) of antipsychotic medication on 1/15/21. This was 7 days after the 1/8/21 MDS Assessment Reference Date (ARD). The medications section of this MDS for Resident #29 was coded by MDS Nurse #1.

An interview was conducted with MDS Nurse #1 on 3/10/21 at 2:30 PM. The quarterly MDS assessment dated 1/8/21 that indicated Resident #29 had a GDR of her antipsychotic medication on 1/15/21 was reviewed with MDS Nurse #1. She revealed this was an error. She stated that this GDR should not have been included on the 1/8/21 MDS as it occurred after the ARD.

An interview was conducted with the Director of Nursing on 3/10/21 at 4:56 PM. She stated that she expected the MDS to be coded accurately.

1b. A physician ' s order dated 1/15/21 indicated Resident #29 had a GDR of Seroquel decreasing her dose from 50 mg once daily to 25 mg once daily.

The quarterly Minimum Data Set (MDS) assessment dated 2/16/21 indicated Resident #29 ' s cognition was severely impaired. She was administered antipsychotic medication on 7 of 7 days and was noted with no GDR of antipsychotic

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medication. The medications section of this MDS for Resident #29 was coded by MDS Nurse #1.

An interview was conducted with MDS Nurse #1 on 3/10/21 at 2:30 PM. The quarterly MDS assessment dated 2/16/21 that indicated Resident #29 had no GDR of her antipsychotic medication was reviewed with MDS Nurse #1. The physician ' s order dated 1/15/21 that indicated Resident #29 had a GDR of Seroquel was reviewed with MDS Nurse #1. She revealed this was an MDS error. MDS Nurse #1 stated that this 1/15/21 GDR should have been coded on this 2/16/21 MDS assessment for Resident #29.

An interview was conducted with the Director of Nursing on 3/10/21 at 4:56 PM. She stated that she expected the MDS to be coded accurately.

7. Resident #14 was admitted to the facility on 1/31/20 with diagnoses that included diabetes mellites type 2 with diabetic neuropathy.

The annual Minimum Data Set (MDS) assessment dated 1/4/21 indicated Resident #14 ' s cognition was severely impaired (07). He was coded for an indwelling catheter and was also coded for occasional incontinence of bladder. The catheter and incontinence section of the MDS was coded by MDS Nurse #1.

An interview and observation were conducted with Resident #14 on 3/8/21 at 12:35 PM. Resident #14 was observed with no urinary catheter and he stated that he never had a urinary catheter.

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An interview was conducted with Nursing Assistant (NA) #6 on 3/10/21 at 9:05 AM. She stated that she was familiar with Resident #14. She indicated that she worked at the facility since November 2020 and since that time Resident #14 had no urinary catheter.

An interview was conducted with MDS Nurse #1 on 3/10/21 at 2:30 PM. The annual MDS assessment dated 1/4/21 that indicated Resident #14 had a urinary catheter was reviewed with MDS Nurse #1. She revealed this was an error. She stated that she must have clicked the wrong button as Resident #14 had no urinary catheter.

An interview was conducted with the Director of Nursing on 3/10/21 at 4:56 PM. She stated that she expected the MDS to be coded accurately.

8. Resident #235 was admitted on 2/24/21 with a diagnosis of Atrial Fibrillation (A. Fib).

Resident #235's admission orders dated 2/24/21 included an order for Eliquis (anticoagulant) 5 milligrams in the morning and at bedtime for A.Fib.

Review of Resident #235's admission Minimum Data Set (MDS) dated 2/25/21 was not coded for the use of Eliquis (anticoagulant).

An interview was conducted on 3/10/21 at 2:49 PM with MDS Nurse #1. She stated Resident #235's admission MDS should have been coded for the use of an anticoagulant and it was an

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F 641	Continued From page 30 oversight. An interview was conducted on 3/10/21 at 5:00 PM with the Director of Nursing (DON). She stated it was her expectation that Resident #235's admission MDS be accurate and coded for the use of an anticoagulant.	F 641		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		10/11/21

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F 656	Continued From page 31 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for the risk of pressure ulcers for 1 of 4 residents reviewed for pressure ulcers (Resident #85). The findings included: Resident #85 was admitted to the facility on 11/25/20 with multiple diagnoses that included dementia, atrial fibrillation, coronary artery disease and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 12/1/20 indicated Resident #85 had severe cognitive impairment, required extensive assistance from staff for bed mobility and toileting, was incontinent of bowel and bladder, and was at risk for pressure ulcers. The assessment further revealed he had no pressure ulcers or other skin conditions. The pressure ulcer care area assessment (CAA) summary dated 12/14/20 revealed Resident #85 was at risk for pressure ulcer development	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #85 was discharged to the hospital on 2/11/2021 and did not return to the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents are at risk to be affected. The MDS coordinator completed an audit on October 8, 2021 to identify current residents that are at risk for pressure ulcers based off of the Braden Scale assessment , and validate that current residents have a care plan for At risk for pressure ulcers. All current residents identified as high risk, had an At risk care plan in place. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 656	Continued From page 32 related to impaired bed mobility, weakness, and incontinence and would be care planned as such. The care plan for Resident #85 was reviewed and a focus area for pressure ulcers was initiated on 1/28/21 and revised on 2/8/21, that read in part, "actual pressure ulcer development to sacrum and left buttock and bilateral heels. Is at risk for further pressure ulcer development related to impaired bed mobility, weakness and incontinence". There was no original care plan developed for the risk of pressure ulcers as stated in the pressure ulcer CAA summary dated 12/14/20. An interview was completed with MDS Nurse #2 on 9/15/21 at 3:54 PM and indicated it was an oversight not to develop an initial care plan for the risk of pressure ulcers as Resident #85 was incontinent and had decreased mobility. On 9/16/21 at 1:40 PM, an interview occurred with the Administrator and current Director of Nursing. They both stated it was their expectation for the care plan to be comprehensive and patient centered. They both agreed per the CAA summary a risk for pressure ulcer care plan should have been developed as Resident #85 had weakness, incontinence, and decreased mobility.	F 656	The Regional Clinical Director provided education on 9/21/2021, for the MDS nurse regarding implementation of At risk for pressure ulcer care plan for residents that are identified as a high risk, using the Braden Scale assessment. Upon admission, readmission or significant change of condition, the licensed nurse will complete the Braden Assessment. If the resident is identified as an high risk for pressure ulcer, the MDS nurse will initiate an At risk for pressure ulcer care plan. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) and/or Administrator will audit all new admission, readmission and significant change resident care plans weekly for 4 weeks then monthly for 2 months, to validate that if the resident was identified as a high risk for pressure ulcers, that a care plan for At risk for pressure ulcer was initiated. The DON or Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; Completed action by 10/07/2021	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		4/8/21

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F 658	Continued From page 33 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Pharmacy Consultant interview, the facility failed to accurately transcribe physician ' s orders resulting in a duplicate order for PRN (as needed) Ultram (opioid pain medication). This was for 1 of 5 residents (Resident #41) reviewed for unnecessary medications. The findings included: Resident #41 was admitted to the facility on 10/31/18 with multiple diagnoses that included cerebral infarction with hemiparesis (muscle weakness on one side of the body) and hemiplegia (paralysis on one side of the body) A physician ' s order for Resident #41 dated 9/25/19 indicated Ultram (opioid pain medication) 50 milligrams (mg) as needed for pain greater than 5 out of 10. A physician ' s order for Resident #41 dated 6/12/20 indicated Ultram 50 mg as needed for pain greater than 5 out of 10. The previous order for as needed Ultram 50 mg that was initiated on 9/25/19 for Resident #41 remained an active order. The quarterly Minimum Data Set (MDS) assessment dated 1/14/21 indicated Resident #41 ' s cognition was moderately impaired. She	F 658	F658 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The licensed nurse discontinued the duplicate order for resident #41 on 3/10/21. An audit of the medical record showed no evidence that the medication had been given twice at any time. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; A 100 % audit of all current residents was completed on 3/17/21 by the DON and there were no other resident affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Licensed nurses were educated on 3/19/21 on the importance of discontinuing the previous order prior to placing another order into the system. All nurses not present will be educated prior to returning to work. This education will be	

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F 658	Continued From page 34 received PRN (as needed) pain medications, no routine pain medications, and reported pain frequently at a rating of 02 out of 10. Resident #41 was administered opioid medication on 2 of 7 days. A review of pharmacy recommendations from 6/12/20 through 3/8/21 for Resident #41 revealed the Pharmacy Consultant made recommendations on 12/2/20 and 3/3/21 related to the duplicate Ultram 50 mg PRN orders. Both recommendations indicated the Medication Administration Record (MAR) showed 2 active orders for Ultram 50 mg with the same instructions. The Pharmacy Consultant wrote, "Because this is a duplication, please discontinue one of these orders from her MAR". Resident #41 ' s active care plan included the focus area of pain. The interventions included, in part, evaluating the effectiveness of pain interventions, review for compliance, alleviation of symptoms, dosing schedules, resident satisfaction with results, impact on functional ability, and impact on cognition. A review of Resident #41 ' s active physician ' s orders was conducted on 3/8/21 and revealed 2 active orders for Ultram 50 mg PRN with the same instructions for administration. One order was initiated on 9/25/19 and the other order was initiated on 6/12/20. A review of the MARs for Resident #41 from 6/12/20 through 3/8/21 showed no instances of both PRN Ultram 50 mg orders being administered during the same timeframe. An interview was conducted with Nurse #6 on	F 658	added to the orientation process for all newly hired nurses. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nurses/ ADONS will review all orders during the daily clinical meeting to validate no duplicate orders are present. This review and audit will be done five times per week for four weeks and then twice weekly for three months. The Director of Nurses will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Director of Nursing and Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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3/10/21 at 11:30 AM. She reported that she was regularly assigned to Resident #41. Resident #41 ' s active physician ' s orders that revealed 2 active orders for PRN Ultram 50 mg was reviewed with Nurse #6. She revealed she had not noticed this before. She indicated she was going to speak with the Physician ' s Assistant (PA) and would have one of the orders discontinued. Nurse #6 acknowledged that with 2 of the same orders in place, there was a risk that Resident #41 could be administered PRN Ultram 50 mg twice during the same time period.

A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. Resident #41 ' s active physician ' s orders that revealed 2 active orders for PRN Ultram 50 mg was reviewed with the Pharmacy Consultant. The Pharmacy Consultant stated that she made 2 recommendations to discontinue one of these PRN Ultram 50 mg orders, but her recommendations had not been responded to. She reported that having a duplicate order in place created a risk for Resident #41 being administered both PRN Ultram 50 mg orders during the same time period.

An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. Resident #41 ' s active physician ' s orders that revealed 2 active orders for PRN Ultram 50 mg was reviewed with the DON. The DON stated that one of these PRN Ultram 50 mg orders should have been discontinued. She explained that she recalled this being discussed in a morning meeting with Unit Manager #1 and Unit Manager #2 when the Pharmacy Consultant wrote the 12/2/20 recommendation and she thought one of the orders was discontinued at that time. The

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F 658	Continued From page 36 DON revealed that having a duplicate order in place created a risk for Resident #41 being administered both PRN Ultram orders during the same time period. She stated that one of the orders for PRN Ultram 50 mg for Resident #41 would be discontinued.	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and wound physician interviews, the facility failed to obtain a treatment order when pressure ulcers were first identified for 1 of 4 residents reviewed for pressure ulcers (Resident #85). The findings included: Resident #85 was admitted to the facility on 11/25/20 with multiple diagnoses that included dementia, atrial fibrillation, coronary artery disease and muscle weakness. He was diagnosed with COVID-19 on 12/1/20.	F 686	F 686 At the time of survey the facility did not have a treatment nurse. The Director of Nursing was receiving the communication/reviewing the documentation for skin issues. On 3/16/21 a new treatment nurse was in place. The resident affected by the deficient practice #85 was sent to the hospital on 2/11/21 due to respiratory distress and did not return to the facility.	10/11/21

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F 686	Continued From page 37 The November 2020 physician orders included to perform a weekly skin assessment every Monday on day shift. A facility Admission Nursing Assessment on 11/25/20 indicated Resident #85 had intact skin but numerous bruises to his upper extremities. Review of the facility's weekly skin assessment form dated 11/25/20 indicated there were no skin issues noted at the time of admission. The weekly skin assessment form for 11/30/20 revealed there were no skin issues noted. The admission Minimum Data Set (MDS) assessment dated 12/1/20 indicated Resident #85 had severe cognitive impairment. He required extensive assistance from staff for bed mobility and toileting, was incontinent of bowel and bladder, and was at risk for pressure ulcers. The assessment further revealed he had no pressure ulcers or other skin conditions, but a pressure reducing device was present to the bed. The pressure ulcer care area assessment (CAA) summary dated 12/14/20 revealed Resident #85 was at risk for pressure ulcer development related to impaired bed mobility, weakness, and incontinence and would be care planned as such. Review of the Physical Therapy discharge summary dated 12/24/20 indicated Resident #85 was using protective boots to reduce the risk of pressure ulcers due to his decreased mobility status. The weekly skin assessment report on 12/28/20	F 686	Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All current facility residents are at risk to be affected. A 100% audit of all current residents was completed on 2/25/21 by the Director Of Nursing and there were no other resident noted to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing/Assistant Director of Nursing completed education on 2/26/21 for the licensed nurses and nursing assistants, regarding the wound protocol. Nursing staff were not permitted to work until the education had been received. When a resident is admitted, readmitted or if a skin injury is identified, the licensed will assess the resident□s skin and notify the physician to obtain treatment orders. The licensed nurse will complete weekly skin assessments in Point Click Care (PCC) electronic medical record on current facility residents and notify physician and residents or their Responsible Party (RP) regarding any new skin issues and initiate treatment orders. The licensed nurse will document the injury in the wound communication book as well as the medical record and will complete a Braden risk assessment. The nursing assistants will complete a shower sheet that will be used to identify	

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F 686	Continued From page 38 indicated there were no skin abnormalities found. Review of the weekly skin assessment form for 1/11/21 stated there were no skin abnormalities noted. The weekly skin assessment form dated 1/25/21 revealed no new skin conditions were found. A nursing progress note dated 1/28/21 indicated Resident #85 was found to have open areas to the right and left heel with clear drainage and the size of a quarter. The wound nurse was notified, the areas were cleansed, and a dry dressing was placed over both areas. Resident #85's spouse was notified of the wounds. The care plan for Resident #85 was reviewed and a focus area for pressure ulcers was initiated on 1/28/21 and revised on 2/8/21, that read in part, "actual pressure ulcer development to sacrum and left buttock and bilateral heels. Is at risk for further pressure ulcer development related to impaired bed mobility, weakness and incontinence". The interventions included: - Administer treatments as ordered and monitor for effectiveness. - Assess/record/monitor wound healing weekly and as needed. - Monitor nutritional status. Serve diet as ordered, monitor intake and record. - Alternating pressure mattress to bed due to noncompliance with turning and repositioning was initiated on 2/8/21. Resident #85's physician orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2021 were reviewed and there was no order or	F 686	any areas to the resident□s skin. These sheets will be turned into the license nurse who will initiate the protocol and then place these sheets in the wound communication book for follow up by the wound nurse. He wound nurse will monitor the communication book daily during the work week and will complete a follow up assessment of wounds that are identified. The wound nurse will review the treatment orders with the physician. The wound nurse will completed the wound evaluation assessment in PCC weekly and update the wound log at that time. The wound nurse along with the Interdisciplinary Team (IDT) will review wounds weekly and will make suggestions/changes as needed to promote wound healing. The Registered Dietician will be updated weekly by the DON/wound nurse on the condition of current wounds and any new wounds identified. The wound nurse/MDS will update the resident□s care plan. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON/ADON will review and compare shower sheets, skin assessments and progress notes 5 times per week for 4 weeks and then 3 times per week for 2 months to validate that treatment order are in place, the Physician and RP have been notified and the wound documentation is complete. The _Director of Nurses will review the	

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F 686	Continued From page 39 treatment documented for the right or left heel pressure ulcers. A review of the weekly skin assessment dated 2/1/21 indicated no new skin conditions were noted and Resident #85 had previously identified skin abnormalities. A review of the facility's wound evaluation flowsheet dated 2/2/21 indicated the following: - Right heel unstageable pressure ulcer acquired in the facility on 1/28/21, measured 4 centimeters (cm) in length, 3 cm in width, 90% necrotic tissue (non-viable tissue due to reduced blood supply and could look like dry leathery tissue or moist and stringy. Colors range from yellow, tan, brown or black), scant serosanguinous drainage (drainage that is pale red or pink), and no odor. - Left heel unstageable pressure ulcer acquired in the facility 1/28/21, measured 2.4 cm in length, 2 cm in width, 50% slough (yellow/white material in the wound bed), 50% granulation (appearance of red, bumpy tissue in the wound bed as it heals), scant serosanguinous drainage, and no odor. The form indicated the doctor and family were notified, and a treatment order of calcium alginate with silver (a dressing that aides in prevention of infection, absorbs drainage and promotes rapid healing) and protective boots was obtained. A review of the physician orders, and TAR, revealed the following orders: - An order dated 2/2/21 to cleanse the right and left heel with wound cleanser, pat dry, apply calcium alginate with silver to the wound bed, cover with a thick dressing and secure with a dressing wrap every day and as needed. - An order dated 2/3/21 for a wound consult for unstageable wounds to bilateral heels.	F 686	audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Director of Nurse/ Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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A physician's assistant (PA) progress note for 2/3/21 was reviewed and indicated Resident #85 was seen for new wounds to his bilateral heel. There was no pain at rest and minimal discomfort was present with the assessment of the wounds. There had been no unexpected weight change, there was no edema to the right or left leg and his skin was warm and dry. The left heel was described as 2.4 cm in length and 2 cm in width with 100% slough and unstageable pressure ulcer. The right heel was described as 4 cm in length and 3 cm in width with non-blanchable erythema (skin redness that does not turn white when pressed) and was classified as deep tissue pressure injury.

A nursing progress note dated 2/5/21 indicated Resident #85 was found to have two small open areas to his buttocks. The first was centrally located on the sacrum and the second smaller one was on the buttock. No drainage was present, or pain expressed by Resident #85. Both areas were cleansed, dry dressings applied, and the wound care nurse was notified.

A review of the facility's wound evaluation flowsheet dated 2/8/21 indicated the following:
- Sacral pressure ulcer acquired in facility on 2/5/21, measured 4 cm in width, 1 cm in length and 0.1 cm in depth, 100% granulation, and moderate serosanguinous drainage.
- Right buttock pressure ulcer acquired in facility on 2/5/21, measured 2 cm in width, 1 cm in length and 0.1 cm in depth, 100% granulation, moderate serosanguinous drainage, and no odor.
The form indicated the doctor and family were notified, and a treatment order of a dry protective dressing was obtained for the buttock wounds. In

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addition, the wound evaluation flowsheet described the left and right heel wounds as follows:
- Right heel pressure ulcer measured 4 cm in length and 2.5 cm in width. The area was specified as unstageable with 100% slough to the area, and serosanguinous drainage. The wound care order was unchanged.
- Left heel pressure ulcer measured 2.5 cm in length and 2 cm in width. The area was described as unstageable with 100% eschar (dry, dead tissue that adheres to the wound bed and has a spongy or leather-like appearance) and serosanguinous drainage present. The wound care order was unchanged.

A nursing progress note dated 2/8/21 by the former wound care nurse stated a dry dressing was applied to the sacrum and buttock until the wound could be further assessed by the wound care physician.

The 2/9/21 VOHRA (a physician wound management group) wound care progress notes were reviewed and indicated Resident #85 was seen as an initial wound evaluation due to multiple wounds. The progress note stated Resident #85 was 5'8 and weighed 220.1 pounds (lbs.). There was no edema present and pedal pulses were present to both his left and right tibial area. Protective boots were present to both feet and a pressure reducing mattress was on the bed. He was noted to have heart disease, decreased mobility, dementia, and a fair oral intake. The wounds were described as follows:
- The left heel wound had been present for approximately 12 days and was unstageable due to noninfected necrosis, measured 4.1 cm in length and 3 cm in width, with moderate

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serosanguinous drainage.
- The right heel was approximately 12 days in duration, measured 4.5cm in length and 2.9 cm in width. Sharp's debridement was performed (performed by a skilled practitioner using surgical instruments such as a scalpel, scissors, and forceps. This type of debridement promotes wound healing by removing dead tissue).
- Sacrum wound was classified as a healing stage 3 with greater than 4 days duration. It measured 5.7 cm in length, 1.3 cm in width and 0.1cm in depth. Sharp's debridement was performed.
- The right buttock wound was classified as a Stage 3 with greater than 4 days duration. Measurements were 1.5 cm in length, 0.9 cm in width and 0.1 cm in depth with light serous drainage.

A review of the physician orders, and TAR, indicated there was no order or treatment documented to the sacral pressure ulcer prior to 2/10/21. After 2/10/21 the following orders were present on the physician orders and TAR:
- An order dated 2/10/21 to cleanse the sacral and left buttock wounds with normal saline, pat dry, apply Hydrogel (used to facilitate autolytic debridement and can help to maintain wound healing) to the wound bed and cover with dry dressing every day and as needed.
- An order dated 2/10/21 to cleanse the left and right heel with normal saline and pat dry. Apply Santyl ointment (removes dead tissue from wounds so they can start to heal) and cover with a dry dressing every day.

Resident #85 was transferred to the Emergency Room on 2/11/21 due to respiratory distress. He did not return to the facility.

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A review of the Emergency Room record dated 2/11/21 indicated Resident #85 was a well-developed and chronically ill-appearing person. His skin was not pale and there was no redness or rashes present. Both heels were wrapped in gauze with a protective garment in place to the right heel. A stage 2 pressure ulcer was present to the sacral area.

The hospital History and Physical summary dated 2/11/21 stated Resident #85 had superficial sacral and bilateral heel ulcers with no signs of infection. A wound care consult was made.

A hospital wound consult note dated 2/12/21 revealed Resident #85 was assessed with a Stage 3 pressure ulcer to his sacrum and unstageable pressure areas to both heels. There was clinical evidence of arterial insufficiency with nonpalpable pedal pulses. Resident #85 presented to the hospital with protective boots to his feet. It was noted Resident #85 carried a history of dementia and was difficult to differentiate pain to wounds versus just generalized discomfort or dementia related response to activity and repositioning. The wound were described as follows:
- An unstageable pressure area was present to the right heel and measured 7 cm in length and 2.5 cm in width with no odor, redness, or signs of infection.
- An unstageable pressure area was present to the left heel and measured 3.5 cm in length and 3 cm width with no odor, redness, or signs of infection.
- A stage 3 pressure ulcer was present to the sacrum with multiple open areas within areas of deep tissue injury and measured 1 cm in length

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and 1 cm in width.

The hospital discharge summary on 2/21/21 indicated Resident #85 had a stage 3 sacral ulcer and unstageable bilateral heel ulcers. He was seen in consultation by the Wound Care team who recommended a gel treatment for autolytic debridement and was noted to have moderate protein-calorie malnutrition.

A phone interview was conducted with Nurse #3 on 3/11/21 at 11:00 AM, who was assigned to Resident #85 on 1/28/21. She explained on 1/28/21 she assessed pink areas to both heels that were free from drainage, reported this to the former wound care nurse, cleansed the areas and applied a dry dressing.
On 3/10/21 at 3:26 PM, an interview occurred with Nurse #4 who was assigned to Resident #85 on 2/5/21. Nurse #4 stated when he observed the open areas on Resident #85's buttocks there were 2 small, superficial openings. He recalled alerting the former wound care nurse to the new pressure areas, cleansing, and applying a dry dressing to the sacral and buttock pressure areas. Nurse #4 stated he notified the physician and obtained orders for the wound care but was unable to state why there was no treatment orders documented for the sacral and buttock wounds until 2/10/21.

The Director of Nursing (DON) was interviewed by phone on 3/11/21 at 12:07 PM and stated she was aware Resident #85 had pressure areas to his heels and buttocks. She further stated at the time, the staff nurses informed the wound care nurse of the wounds when they were identified. She stated the former wound care nurse failed to obtain and place the orders for treatments on the

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F 686	Continued From page 45	F 686		

MAR or TAR when the wounds were first identified. The DON further stated she expected the nurse who identified the open area to obtain a treatment order by following the facility's wound protocol or calling the physician.

On 9/14/21 at 12:13 PM, a phone interview occurred with the VOHRA wound physician. She verified assessing Resident #85's pressure wounds on 2/9/21. She stated the right buttock wound was small in size and the sacrum pressure ulcer was described as a cluster wound. At the time of her assessment there was 5% necrosis to the sacral wound, 20% necrosis to the right heel wound and both areas were Sharp's debrided. The physician explained the left heel was 100% necrotic with moderate drainage. She chose to use an enzymatic ointment to debride the area with hopes of possibly Sharp's debriding in the future. She wasn't sure if the necrotic areas were eschar or just leathery skin and stated it was her clinical judgment to not use a Sharp's debridement to the left heel on the day of the assessment. The physician continued to say it was possible for necrosis to develop in a short amount of time to Resident #85's heels due to his clinical decline, poor nutrition and possible shuffling his feet despite dressings and protective boots in place. The shuffling action causes friction to the area creating a risk for further breakdown to include necrosis. The physician further added there were many different types of debridement and not all areas of necrosis were treated the same way. At the time of her assessment the right buttock wound did not need any type of debridement.

The Medical Director was interviewed via phone on 9/14/21 at 1:21 PM and was familiar with

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Resident #85. He recalled the facility PA assessed Resident #85's heel wounds shortly after they were observed and was aware the nursing staff and former wound care nurse failed to transcribe wound care orders in a timely manner. He could not say if this directly resulted in the deterioration of Resident #85's wounds and stated Resident #85's wound could have progressed rather quickly due to his decline in medical status, decline in mobility, poor appetite and possible shuffling his feet when in bed.

A phone interview was conducted with the former wound care nurse on 9/15/21 at 2:00 PM who left her employment at the facility in March 2021. She was able to recall Resident #85 and stated she remembered the floor nurse telling her about his heel wounds and instructed the nurse how to dress the wounds until she could get there to look at them on 1/28/21 but failed to ensure wound care orders were present. She assessed the heel wounds on 2/2/21 and could not recall any large dark areas present and there was minimal drainage present. A dry dressing was in place to both heels, protective booties were on his feet and she requested the facility PA to assess the wounds the following day. The former wound care nurse recalled being informed by the floor nurse when Resident #85 developed breakdown to his buttock area on 2/5/21 and stated she forgot to ensure treatment orders were in place. She recalled assessing the wounds on 2/8/21 and remembered the areas to be small in size with minimal drainage and he was on the list to be seen by the wound care provider the following day.

On 9/15/21 at 2:38 PM, a phone interview was held with the facility PA who was able to recall

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Resident #85. She reviewed her notes and stated she was notified by the former wound care nurse on 2/2/21 regarding Resident #85's wounds to both heels. She assessed the areas on 2/3/21 which had clean dry dressings in place. She recalled his heels were dark red in color, open areas, and small amount of drainage. There were no black areas, but one heel was darker than the other and was difficult to stage. The facility PA stated she could not recall any concerns with pain, but it wouldn't have been uncommon for Resident #85 to make a noise, move around or have facial changes when she was assessing his wounds due to his dementia. The facility PA added she had no concerns for pain during Resident #85's stay at the facility.

Another phone interview was completed with Nurse #3 on 9/15/21 at 3:03 PM, who was assigned to Resident #85 on 1/28/21. She explained on 1/28/21 she assessed pink areas to both heels and reported this to the former wound care nurse. She went on to say the former wound care nurse advised her to cleanse the areas and applied a dry dressing. Nurse #3 stated she didn't write the treatment order as she felt the former wound care nurse would be responsible for assessing Resident #85's wounds and obtain orders afterwards. Nurse #3 denied Resident #85 complaining of pain during his stay at the facility.

The Administrator and current DON were interviewed on 9/16/21 at 1:40 PM and stated it was their expectation for nurse who any skin issue, to obtain a treatment order by following the facility's wound protocol or calling the physician. The wound care nurse would be notified as well.

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F 689	Continued From page 48	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement a fall intervention for a resident who sustained a fall with the staff present. This was for 1 (Resident #5) of 3 residents reviewed for accidents. The findings included: Resident #5 was admitted on 5/18/21 with cumulative diagnoses of Cerebral Vascular Accident and right hemiplegia. Resident #5's quarterly Minimum Data Set (MDS) dated 7/17/21 indicated she had severe cognitive impairment and rejection of care behaviors. She was coded to extensive assistance of two staff with bed mobility, impairment to one upper and one lower extremity. She was also coded for one fall with no injury. Resident #5 was care planned for a risk of falls on 5/27/21. Her care plan was revised on 7/30/21 for an actual fall and interventions included bilateral grab bars for turning and repositioning in bed. Review of Resident #5's medical record indicated	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #5 was reassessed by the Interdisciplinary Team on 9/20/21, regarding interventions related to a staff assisted fall on 6/21/2021. It was determined that grab bars would not be appropriate for the resident at that time. The staff were following residents care plan regarding turning and repositioning by using 2 staff members. The incident that occurred was an isolated incident and staff responded appropriately. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that have sustained a fall have the potential to be affected. The Director of Nursing (DON) completed an audit on 9/22/2021 of current facility residents that has sustained a fall from July-September, to validate that an investigation was completed and	10/11/21

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F 689	Continued From page 49 she sustained an assisted fall on 6/21/21. There were no injuries. Nursing Assistant (NA #5 and NA #7) rolled Resident #5 over in the bed to provide incontinence care and Resident #5 continued rolling to the edge of the bed into NA #5's arms who tried to prevent the fall. NA #5 assisted Resident #5 to the floor. Review of Resident #5's Interdisciplinary Team (IDT) Post Fall Investigation/Summary dated 6/21/21 read orders had been obtained for bilateral grab bars. The investigation was completed and signed by the previous Director of Nursing (DON). Review of Resident #5's cumulative Physician orders did not include any orders for garb bars and no side rail assessment had been completed since admission (5/18/21) which determined no need for side rails as enablers. An observation of Resident #5 was conducted on 9/14/21 at 12:50 PM. She was sitting up in her wheelchair having lunch. There were no observed grab bars on her bed. She was unable to recall anything about the fall on 6/21/21. A telephone interview was conducted with NA #5 on 9/15/21 at 1:50 PM. NA #5 stated she was assisting NA #7 with her last rounds before the end of her shift. NA #5 stated NA #7 raised the bed to ease in her incontinence care. NA #5 stated that NA #7 rolled Resident #5 over onto her right side while she was on the other side of the bed with her hand on Resident #5. She stated Resident #5 lifted her left leg and threw it over the right side of the bed. She stated it happened so fast that when she threw her left leg over the right side of the bed, it caused Resident #5's lower body to slip off the bed. NA #5 stated she	F 689	interventions were initiated. No residents were identified with missing interventions. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; When an incident occurs, the licensed nurse will initially implement an intervention to promote safety for the resident. The IDT will investigate the incident and validate that the intervention was initiated and remains appropriate. The MDS nurse or licensed nurse will update the care plan with the intervention that was initiated. The Regional Clinical Director completed education on 9/21/2021, for the DON, ADON and unit manager regarding incident investigation and implementation of interventions. The DON, ADON and unit manager completed education on 10/07/2021 for the nursing staff regarding implementation of interventions following an incident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator will audit incident investigation and intervention implementation for residents with falls, weekly for 4 weeks then monthly for 2 months, to validate that an investigation was completed for each incident and interventions were implemented as recommended by the IDT team. The Administrator will review the audits monthly to identify patterns and trends and will adjust the plan as necessary to	

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F 689	Continued From page 50 attempted to prevent her from falling but she was unable. NA #5 stated her thought process was to prevent Resident #5 from hitting her upper body or head on the floor. NA #5 stated NA #7 ran to get Nurse #5 who assessed Resident #5 for injuries. She stated at no time did she or NA #7 leave Resident #5's bedside while they were rolling her in preparation for incontinence care. NA #5 stated she did not know what intervention was put in place for Resident #5, but she had never seen grab bars on her bed. NA #5 stated it would probably help Resident #5 with rolling and repositioning. A telephone interview was conducted on 9/15/21 at 1:55 PM with NA #7. She stated she was assigned Resident #5 on 6/21/21, the day of fall. She stated she was near the end of her shift when NA #5 came in a little early and assisted her with her last incontinence rounds before her shift ended. NA #7 stated she raised the bed and pulled Resident #5 by her under pad closer to her then rolled her onto her right side. She stated NA #5 was on the other side of the bed with her hand on Resident #5 when Resident #5 threw her left leg over and off the bed which resulted in her lower body sliding off the bed onto the floor. NA #7 stated NA #5 had hold of Resident #5's upper body and tried to stop the fall but she was unable to because of Resident #5's size. She stated NA #5 eased Resident #5's upper body to the floor and she went and got Nurse #5 to assess Resident #5 for injuries. There were no injuries. She stated Resident #5 had a habit of trying to help the staff by making things easier with rolling and repositioning. NA #7 stated she had never observed grab bars on Resident #5's bed but agreed that one on her right side would be helpful for repositioning.	F 689	maintain compliance. The Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Date completed:10/07/2021 _____	

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A telephone interview was conducted on 9/15/21 at 7:35 PM with Nurse #5. She stated she recalled Resident #5's fall because it was unusual because 2 staff members were present when she fell. She stated there were no injuries and verified the information regarding the circumstances of the fall as conveyed during the survey. Nurse #5 stated a grab bar was not a bad idea, but she thought that other interventions would have been tried first.

An interview was conducted on 9/15/21 at 2:25 PM with the Administrator. She stated the previous DON left her position recently and that she was responsible for the fall investigations and the implementation of interventions. The Administrator stated the IDT met daily and all falls from the previous day were reviewed in the meeting. She stated it was at that time that new interventions are implemented, the investigation was completed, and the care plan revised.

An observation on 9/15/21 at 2:55 PM, revealed Resident #5 sitting up in the bed. There were no grab bars on the bed.

An interview was conducted on 9/15/21 at 4:00 PM with MDS Nurse #2. She confirmed at all falls were reviewed daily for interventions and the care plan was revised at that time. MDS Nurse #2 confirmed that the previous DON revised Resident #5's care plan for bilateral grab bars. She further stated normally, therapy completed an evaluation before any side rails or grab bars were added to a bed. She stated it appeared that the previous DON added the grab bars to the care plan, but nobody bothered to follow through with a side rail assessment or implementation.

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F 689	Continued From page 52 An interview was conducted on 9/16/21 at 12:55 PM with the Interim Rehabilitation Manager (RM). She stated during the IDT meetings, each fall was reviewed and discussed. If there were any therapy needs identified, therapy first completed a therapy screening and if therapy was needed, the Physician was contacted to obtain therapy orders. The RM stated the nurses determined who needed side rails or grab bars on admission. The RM stated the facility did not use any side rails and only a small number of residents used a grab bar as an enabler. Attempts to contact the previous DON were unsuccessful. Messages were left without a return call. An interview was conducted on 9/16/21 at 1:40 PM with the Interim DON and Administrator. They stated it was their expectation that all falls were investigated thoroughly and any needed intervention to prevent Resident #5 from rolling off the bed would be implemented.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		4/8/21

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F 690	Continued From page 53 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to have physician ' s orders for the use of a urinary catheter, for urinary catheter care, and for the discontinuation of a urinary catheter for 1 of 3 residents reviewed for urinary catheters (Resident #40). The findings included: Resident #40 was admitted to the facility on 11/14/19 and most recently readmitted on 1/7/21 with multiple diagnoses that included Alzheimer ' s Disease.	F 690	F 690 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 40 has an order that was written on 1/26/21 for PRN catherization every 8 hours if no voiding. Resident #40 has not required continuous catheter use. Address how the facility will identify other residents having the potential to be	

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F 690	Continued From page 54 A review of the nursing admission/readmission assessment dated 1/7/21 completed by Nurse #8 indicated Resident #40 had an indwelling urinary catheter. A nursing note dated 1/7/21 completed by Nurse #8 indicated Resident #40 had an indwelling urinary catheter in place. The significant change Minimum Data Set (MDS) assessment dated 1/13/21 indicated Resident #40 ' s cognition was severely impaired and she had indwelling urinary catheter. The Urinary Incontinence Care Area Assessment (CAA) related to the 1/13/21 significant change MDS assessment indicated Resident #40 had an indwelling urinary catheter in place for urinary elimination. An observation of Resident #40 was conducted on 3/10/21 at 9:00 AM. She was observed with no indwelling urinary catheter in place. A review of Resident #40 ' s medical record from 1/7/21 through 3/10/21 revealed no physician ' s orders for the use of an indwelling urinary catheter, the care/treatment of the urinary catheter, and no discontinuation order for the urinary catheter. An interview was conducted with NA #6 on 3/10/21 at 9:05 AM. She stated that Resident #40 had an indwelling urinary catheter when she was readmitted from the hospital in January 2021, but the catheter had since been removed. She was unable to recall when the indwelling urinary catheter was removed. She reported that	F 690	affected by the same deficient practice; Current facility residents with indwelling urinary catheter are at risk of the alleged deficient practice of failing to have a physicians order to support the use of an indwelling urinary catheter. The Director of Nursing (DON) and/or Assistant Director of Nursing/ADON completed an audit on 3/22/21, of current facility residents with indwelling urinary catheter, to validate that there is a physicians order to support the use of the catheter. There were no other residents affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and ADON completed education on 3/19/21, for the licensed nurses regarding obtaining orders and transcribing orders into the resident electronic medical record whenever a resident requires an indwelling urinary catheter. When a resident is admitted/readmitted or has a change in condition that requires use of an indwelling urinary catheter, the nurse must obtain an order for the catheter and the order must be input into the electronic medical record that includes the size of the catheter and balloon size, the reason/diagnosis for use, when to change the catheter and care of catheter. New admissions and physicians orders will be reviewed daily at the clinical meeting.	

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F 690	Continued From page 55 she was certain urinary catheter care was provided daily and as needed for Resident #40 when the urinary catheter was in use. An interview was conducted with Nurse #6 on 3/10/21 at 11:30 AM. She indicated that she was regularly assigned to Resident #40. She confirmed NA #6 ' s interview that Resident #40 had an indwelling urinary catheter when she was readmitted from the hospital in January 2021, but the catheter had since been removed. Nurse #6 was asked when the indwelling urinary catheter was removed and she indicated she needed to review the medical record. Resident #40 ' s medical record that included no physician ' s orders for the use of the indwelling urinary catheter, no urinary catheter care/treatment orders, and no discontinuation order for the urinary catheter was reviewed with Nurse #6. Nurse #6 confirmed there were no physician ' s orders related to Resident #40 ' s indwelling urinary catheter that she had when she was readmitted from the hospital on 1/7/21. Nurse #6 revealed that because there were no physician orders related to this indwelling urinary catheter she was unable to tell the exact date of when it was discontinued. She stated that to the best of her recollection Resident #40 ' s indwelling urinary catheter was removed sometime in January 2021. She was asked who was responsible for entering admission/readmission orders and she indicated this was normally done by the nurse who completed the admission/readmission. Nurse #6 reported that she was certain catheter care was completed as required even though the physician ' s orders were not in the medical record. A phone interview was attempted with Nurse #8	F 690	Newly hired licensed nurses will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON will audit/observe new admissions/readmissions and residents identified with a change of condition 5 x week for 4 weeks then weekly for 2 months to determine if the resident has an indwelling urinary catheter and will validate that a physicians order has been obtained and input into the residents electronic medical record. The DON and/or ADON will review the audits for patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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F 690	Continued From page 56 on 3/11/21 at 10:00 AM. She was unable to be reached. An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:30 PM. The DON indicated that Resident #40 was readmitted to the facility from the hospital on 1/7/21 with an indwelling urinary catheter. She verified that there were no physician ' s orders in Resident #40 ' s medical record related to this indwelling urinary catheter. The DON reported that she reviewed Resident #40 ' s nursing notes and based on the notes the indwelling urinary catheter was removed in the latter half of January 2021. She reported that the nurse who completed the readmission (Nurse #8) should have entered the physician ' s orders for the urinary catheter when Resident #40 was readmitted on 1/7/21 and the nurse on duty at the time of the urinary catheter ' s removal should have then discontinued these orders. The DON stated that it was her expectation for a physician ' s order to be in place for the use of a urinary catheter, for the care/treatment of the urinary catheter, and for the discontinuation of the urinary catheter.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		4/8/21

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F 695	Continued From page 57 by: Based on observations, staff and resident interviews and record review, the facility failed to administer oxygen as ordered for 3 (Resident #69, Resident #43, and Resident #82) of 3 residents reviewed for respiratory care. The findings included 1. Resident #69 was admitted on 1/26/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Resident #69's admission Minimum Data Set (MDS) dated 1/31/21 indicated cognitive status was not assessed and she exhibited no behaviors. She was coded for extensive assistance with bed mobility and non-ambulatory. Resident #69 was care planned for altered respiratory status due to COPD. There was mention of the need for oxygen. Review of a nursing note dated 2/18/21 read Resident #69 was short of breath with an oxygen saturation of 78% on room air. Oxygen via nasal cannula (NC) at 3 liters was administered and increased to 4 liters to increase saturation. Once Resident #69 calmed down, the oxygen was decreased to 3 liters. The Physician was notified. Review of a Physician order dated 2/24/21 read Resident #69 was ordered oxygen at 2 liters via NC continuously for COPD. In an observation and interview, Resident #69 was deemed alert and oriented. Her oxygen concentrator was running a 3.5 liters via NC. Resident #69 did not appear short of breath and stated she thought her oxygen should be running	F 695	F 695 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) On 3/10/21, the licensed nurse adjusted the oxygen rate to 2 liters per minute according to the physicians order for Resident #69. 2) On 3/10/21, the licensed nurse adjusted the oxygen rate to 2 liters per minute according to the physicians order for Resident # 43. 3) On 3/10/21, the licensed nurse obtained a physicians order for continuous oxygen at 2 liters per minute for Resident # 82 and set the rate to 2 liters minute. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that receive oxygen is at risk for the alleged deficient practice of failing to administer oxygen as ordered. The DON, ADON and licensed nurses completed an audit on 3/22/21, of current facility residents with oxygen to validate that oxygen was administered according to the physician orders. All residents identified were receiving oxygen as ordered. Address what measures will be put into place or systemic changes made to	

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F 695	Continued From page 58 at 4 liters. She stated she wore her oxygen at all times. Observation on 3/8/21 at 2:28 PM, revealed Resident #69's oxygen concentrator was running at 3.5 liters via NC. Review of a nursing note dated 3/8/21 at 5:43 PM read Resident #69 was alert and oriented with oxygen running at 2 liters via NC. Review of a nursing note dated 3/9/21 at 6:37 AM read Resident #69 was alert and oriented and her oxygen was running continuously at 2 liters via NC. In an observation and interview on 3/10/21 at 8:15 AM, Resident #69's oxygen concentrator was running at 3.5 liters. She stated she required her oxygen at all times and staff checked her oxygen saturation levels and she felt everything was good because they never adjusted her oxygen rate. In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated Resident #69 was very compliant and was not known to self-adjust her oxygen concentrator. In an interview on 3/10/21 at 11:00 AM, Unit Manager (UM) #1 stated Resident #69 was very anxious at times and very complaint with wearing her oxygen. He stated Resident #69 had not been observed self-adjusting her oxygen concentrator. In an interview on 3/10/21 at 11:15 AM, Nursing Assistant (NA) #1 stated does not refuse or remove her oxygen. She stated she had never observed Resident #69 attempting to adjust her oxygen concentrator.	F 695	ensure that the deficient practice will not recur; The DON and ADON completed education on 3/19/21, for nursing staff regarding following physician orders for administration of oxygen. Newly hired nursing staff will be educated during new hire orientation. When an order is obtained for oxygen the licensed nurse will implement the order and will place a sticker on the concentrator to indicate the amount of oxygen flow for the resident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or ADON will observe 10 residents weekly for 4 weeks then 20 residents monthly to validate that oxygen is administered as ordered. The DON or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or the ADON will review the plan during the monthly QAPI and will continue the audits at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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In an observation on 3/10/21 at 11:45 AM, Resident #69's oxygen concentrator was running at 3.5 liters via NC.

In an observation on 3/10/21 at 1:34 PM, Resident #69's oxygen concentrator was running at 3.5 liters via NC.

In an observation on 3/10/21 at 3:20 PM, Resident #69's oxygen concentrator was running at 3.5 liters via NC.

In an interview on 3/10/21 at 4:00 PM, NA #5 stated she had not observed Resident #69 attempting to adjust her oxygen concentrator and did not believe she would because she was very compliant.

In an observation on 3/10/21 at 4:10 PM, Resident #69's oxygen concentrator was running at 3.5 liters via NC.

In an interview on 3/10/21 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #69's oxygen be administered as ordered at 2 liters continuously via NC.

2. Resident #43 was admitted on 12/12/18 with a diagnosis of Cerebral Vascular Accident.

Review of Resident #43's Physician orders included an order dated 2/19/20 for oxygen at 2 liters via nasal cannula (NC) continuously.

Resident #43's quarterly Minimum Data Set (MDS) dated 1/18/21 indicated she was

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cognitively intact, exhibited rejection of care behaviors and coded for the use of oxygen.

Resident #43's revised care plan dated 2/8/21 read she was at risk for respiratory distress due to sleep apnea. Oxygen was not included in any interventions.

Review of a nursing note dated 2/17/21 read Resident #43 was alert and oriented and on continuous oxygen at 2 liters.

In an observation and interview on 3/8/21 at 10:51 AM, Resident #43's oxygen concentrator was running at 3 liters. She stated she wore her oxygen at all times.

In an observation on 3/10/21 at 8:20 AM, Resident #43's oxygen concentrator was running at 3 liters. Resident #43 stated she had not observed staff adjusting her oxygen rate but stated they checked her saturation rate consistently.

In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated Resident #43 was on continuous oxygen at 2 liters via NC and she was not able to self-adjust her oxygen.

In an interview on 3/10/21 at 11:00 AM, Unit Manager (UM) #1 stated Resident #43 was physically unable to self-adjusted her oxygen concentrator.

In an interview on 3/10/21 at 11:15 AM, Nursing Assistant (NA) #1 stated Resident #43 could not adjust her oxygen concentrator.

In an interview on 3/10/21 at 11:50 AM, NA #1

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F 695	Continued From page 61	F 695		

stated Resident #43 could not adjust her oxygen concentrator.

In an observation on 3/10/21 at 12:20 PM, Resident #43's oxygen concentrator was running at 3 liters.

In an interview on 3/10/21 at 12:24 PM, NA #3 stated Resident #43 could not self-adjust her oxygen concentrator.

In an observation on 3/10/21 at 2:30 PM, Resident #43's oxygen concentrator was running at 3 liters.

In an interview on 3/10/21 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #43's oxygen be administered as ordered at 2 liters continuously via NC.

3. Resident #82 was admitted on 2/10/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

Review of Resident #82 Physician orders included an order dated 2/10/21 for oxygen at 2 liters via nasal cannula (NC) at bedtime for COPD.

Resident #82's admission Minimum data Set (MDS) dated 2/17/21 indicated he was cognitively intact and exhibited no behaviors. He was coded for oxygen.

Resident #82 was revised care plan dated 2/24/21 for altered respiratory status due to COPD. Interventions included oxygen via NC at 2

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liters.

Review of a nursing note dated 3/4/21 at 1:41 PM read Resident #82 was lying in bed with his oxygen running at 2 liters via NC.

In an observation and interview on 3/8/21 at 11:12 AM, Resident #82 was lying in bed wearing his oxygen NC with his oxygen concentrator running at 5 liters. He stated he required oxygen due to his COPD. He stated he was unsure what rate his oxygen was running.

In an observation on 3/8/21 at 2:30 PM, Resident #82's oxygen concentrator was running at 5 liters.

In an observation on 3/10/21 at 8:50 AM, Resident #82's oxygen concentrator was running at 2 liters per NC. He stated he did not notice if anyone adjusted his oxygen concentrator.

In an interview on 3/10/21 at 11:00 AM, Unit Manager (UM) #1 stated Resident #82 was physically unable to self-adjust his oxygen concentrator. UM #1 confirmed he worked the medication cart on 3/8/21 and did not notice Resident #82's oxygen running at 5 liters. He stated someone must have adjusted it. He also stated he also did not notice the order that Resident #82 oxygen was only ordered for at night. UM #1 stated Resident #82 had experienced a rapid decline and wanted to wear his oxygen at all times. He stated he would clarify Resident #82's oxygen orders with the Medical Director.

In an interview on 3/10/21 at 11:15 AM, Nursing Assistant (NA) #1 stated #82 Resident could not adjust her oxygen concentrator.

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F 695	Continued From page 63 In an interview on 3/10/21 at 11:50 AM, NA #2 stated Resident #82 could not adjust his oxygen concentrator. In an interview on 3/10/21 at 12:50 PM, UM #1 stated he spoke with the Medical Director and received orders for Resident #82 to wear his oxygen at 2 liters via NC continuously. In an interview on 3/10/21 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #82's oxygen be administered as ordered.	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		4/8/21

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F 756	Continued From page 64 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with staff, Pharmacy Consultant, and Medical Director, the Pharmacy Consultant failed to identify and address the facility ' s need to assess residents on antipsychotic medication for abnormal involuntary movement disorders (Residents #3, #18, #29, #31, #41, and #43), the facility ' s need to identify target behavioral symptoms and to monitor those symptoms (Residents #18 and #43), the facility ' s need to ensure PRN (as needed) psychotropic medications were time limited in duration (Resident #40), and the facility ' s need to evaluate residents on psychotropic medications for gradual dose reductions (Residents #18 and #43). In addition, the facility failed to act upon recommendations made by the Pharmacy Consultant (Residents #3, #41, and #66). This was for 8 of 10 residents whose medications were reviewed.	F 756	F 756 A total of 6 Abnormal Involuntary Movement Scale (AIMS) assessments were not up to date and a total of 9 residents that did not have target behaviors identified at the time of survey. For those residents found to have been affected by the deficient practice of not receiving drug regimen reviews/reports of irregularities related to the Abnormal Involuntary Movement Scale (AIMS) and the Gradual Dose Reductions (GDR) were updated as follows: 1-Resident #29□s antipsychotic medication was discontinued on 2/27/21, so therefore an AIMS assessment is not required at this time. 2- a) The licensed nurse completed an	

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F 756	Continued From page 65 The findings included: 1. Resident #29 was admitted to the facility on 11/2/16 with multiple diagnoses that included schizophrenia and dementia without behavioral disturbance. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 12/1/19 for Resident #29 with a score of 0 (no involuntary movements identified). A physician ' s order dated 4/5/20 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) once daily for Resident #29. The quarterly Minimum Data Set (MDS) assessment dated 1/8/21 indicated Resident #29 was rarely/never understood. She was assessed with no behavioral symptoms, but had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician ' s order dated 1/15/21 indicated Resident #29 had a GDR of Seroquel decreasing the dose from 50 mg once daily to 25 mg once daily. The quarterly MDS assessment dated 2/16/21 indicated Resident #29 ' s cognition was severely impaired. She had no behavioral symptoms, but she had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician ' s order dated 2/27/21 indicated Resident #29 ' s Seroquel was discontinued.	F 756	AIMS assessment for Resident #41 on 3/10/21. b) The licensed nurse discontinued the duplicate Ultram order on 3/10/21. 3- The licensed nurse received a physician order on 3/10/21, to discontinue the Ativan order for Resident #40. 4-The physician declined to initiate a GDR of Resident #18□s antidepressant at this time, due to residents current health condition. The behavior monitor was updated on 3/19/21, to monitor for signs of depression. 5- The licensed nurse completed an AIMS for Resident #43 on 3/10/21. The Behavior monitor was updated to include target behaviors on 3/21/21. The physician declined to initiate a GDR at this time due to risks verses benefit related to the residents diagnosis. 6- The licensed nurse received an order from the physician on 3/25/21, to include a hold for Sotalol when pulse rate is less than 50 for Resident #66. 7- a) The licensed nurse completed an AIMS for Resident #3 on 3/10/21. b) Sertraline and Hydroxyzine had diagnosis included with the original order for Resident #3 but was not pullng over to the electronic medication administration record (EMAR). The licensed nurse updated the orders on 3/25/21 and the diagnosis are showing on the Resident #3□s EMAR. 8- The licensed nurse completed an AIMS for Resident #31 on 3/10/21. Address how the facility will identify other	

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F 756	Continued From page 66 A review of the Medication Administration Records (MARs) from 12/2/19 through 2/27/21 indicated Resident #29 was administered Seroquel daily as ordered. A review of the hard copy and Electronic Medical Record (EMR) from 1/1/20 through 3/8/21 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #29 since 12/1/19. There was no evidence in Resident #29 ' s medical record of the Pharmacy Consultant identifying and addressing that an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #29 since 12/1/19. An observation was conducted of Resident #29 on 3/8/21 at 12:30 PM. There were no involuntary movements observed. An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. She stated that the facility ' s normal process was to complete AIMS assessments on admission and then every 6 months thereafter for residents on antipsychotic medication. The assessments were completed in the EMR under the assessment section. She indicated the AIMS assessments were completed by the admission nurse on admission and then by the floor nurses every 6 months with coinciding dates of the MDS assessments. The DON explained that the MDS Nurses (MDS Nurse #1 and MDS Nurse #2) put out a calendar of MDS assessments that were due each month and this was used to inform the floor nurses of when an AIMS assessment was	F 756	residents having the potential to be affected by the same deficient practice; All facility residents have the potential to be affected by the alleged deficient practice of failure to assess residents on antipsychotic medication for abnormal involuntary movement disorders, identify target behaviors and monitor those symptoms, ensure PRN psychotropic medications are time limited in duration, evaluate residents on psychotropic medications for gradual dose reduction and act upon pharmacy recommendations. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit on 3/10/21, of current facility residents with orders for antipsychotic medications to validate that an AIMS had been completed within the last 6 months. All AIMS were up to date by 3/10/21. A total of 6 AIMS and 0 GRDs were identified from the audits conducted on 3/9/21 and 3/10/21. On 3/21/21, the DON and ADON completed updating behavior monitors to include target behaviors for residents that receive psychoactive medications. 9 residents were identified as not having target behaviors. On 3/10/21, the DON and ADON completed an audit of PRN psychoactive medications to assure there are stop dates and reassessment of use. 3 residents were identified that did not have stop dates for orders. On 3/9/21, the pharmacist completed an audit of current facility residents that	

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due. The most recent AIMS assessment for Resident #29 dated 12/1/19 was reviewed with the DON. The DON confirmed there were no AIMS assessments completed after 12/1/19 for Resident #29. She revealed she was not aware of this issue of AIMS assessments not being completed every 6 months. She indicated there may be a problem with the facility ' s protocol for completion of AIMS assessments as Resident #29 should have had 2 AIMS assessments completed since 12/1/19. The DON stated that she would have expected the Pharmacy Consultant to identify and address the need for AIMS assessments to be completed every 6 months for residents on antipsychotic medication.

A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated that her expectation for the completion of AIMS assessments was on initiation of an antipsychotic medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessments for antipsychotic medications due to the potential side effects of the medications. Resident #29 ' s most recent AIMS completed on 12/1/19 was reviewed with the Pharmacy Consultant. Resident #29 ' s physician ' s orders and MARs that indicated she received Seroquel daily from 12/1/19 through 2/27/21 were reviewed with the Pharmacy Consultant. She revealed she had not identified that an AIMS assessment was not completed since 12/1/19 for Resident #29. The Pharmacy Consultant explained that she began working with the facility in May of 2020 and had been doing remote reviews until January 2021. She revealed that she thought the AIMS assessments were in the hard chart so she was unaware that she could have reviewed the AIMS

receive psychotropic medications and made recommendations for 3 residents to have a gradual dose reduction.
On 3/25/21, the DON completed pharmacy recommendations that were received for February and March 2021.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
When a resident has a physician order for an antipsychotic medication, the licensed nurse will complete an AIMS assessment. The assessment will be updated at least every 6 months and will be tracked and schedules by Minimum Data Set (MDS) Nurse. The licensed nurse will implement a behavior monitor in the electronic medical record to include resident targeted behaviors and side effect monitoring every shift.
When a PRN psychoactive medication is ordered, the order will include a 14 day time limit, and the physician will reassess for continued use.
The pharmacist will complete monthly audits of resident medication and will make recommendations to the physician regarding gradual dosage reduction. The pharmacist will validate monthly if a GDR was completed and if not, will follow up with the DON and physician to assure proper documentation is completed to support.
When the DON receives the Pharmacy recommendations monthly, she will provide copies to the physician and

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F 756	Continued From page 68 assessments when completing her remote monthly medication regimen reviews in 2020. The Pharmacy Consultant was asked if she had began completing a review for AIMS assessments for residents on antipsychotic medications when she started to coming to the facility in person in January 2021 for her monthly medication regimen reviews. She revealed that she also had not completed a review for AIMS assessments during her in person monthly medication regimen reviews in 2021. The Pharmacy Consultant acknowledged that her expectation would have been for an AIMS assessment to be completed a minimum of every 6 months for Resident #29 due to her extended use of the antipsychotic medication Seroquel. She also acknowledged that a recommendation should have been to alert the facility that an AIMS assessment needed to be completed for Resident #29. 2a. Resident #41 was admitted to the facility on 10/31/18 with diagnoses that included schizophrenia. A physician ' s order dated 4/10/19 for Aripiprazole (antipsychotic medication) 15 milligrams (mg) once daily in the morning. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for 1/28/20 for Resident #41 with a score of 1.0. The quarterly Minimum Data Set (MDS) assessment dated 1/14/21 indicated Resident #41 ' s cognition was moderately impaired. She was assessed with no behavioral symptoms, but had rejected care on 1 to 3 days during the MDS	F 756	nurses for follow up of recommendations. A copy of the recommendations will be kept in a folder and the DON will monitor and validate follow through of recommendations within 30 days of receipt of recommendations. The Regional Director of Clinical Services provided education to the DON on 3/10/21, regarding drug regimen review, psychoactive med monitoring, behavior and side effect monitoring, GDR process, time limit for psychoactive medications and process for pharmacy recommendation follow through. The DON provided education to the physician on 3/25/21, regarding drug regimen review, psychoactive med monitoring, behavior and side effect monitoring, and process/documentation regarding gradual dose reductions of psychoactive medication and time limit for psychoactive medications. The Pharmacy manager provided education on 3/24/21, for the pharmacist regarding regulations related to AIM□s monitoring, GDR process and documentation requirements, time limit for PRN psychoactive medications and follow up for recommendations that are given to the facility. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON will monitor 5 x week for 4 weeks then weekly for 2 months, residents with new orders for	

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F 756	Continued From page 69 review period. Resident #41 was administered routine antipsychotic medication on 7 of 7 days. A review of Resident #41 ' s current physician ' s orders on 3/8/21 indicated the 4/10/19 order for Aripiprazole 15 mg remained an active order. A review of the Medication Administration Records (MARs) from 1/29/20 through 3/8/21 indicated Resident #41 was administered Aripiprazole daily as ordered. A review of the hard copy and Electronic Medical Record (EMR) from 1/29/20 through 3/8/21 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #41 since 1/28/20. There was no evidence in Resident #41 ' s medical record of the Pharmacy Consultant identifying and addressing that an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #41 since 1/28/20. An observation was conducted on Resident #41 on 3/10/21 at 11:45 AM. There were no involuntary movements observed. An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. She stated that the facility ' s normal process was to complete AIMS assessments on admission and then every 6 months thereafter for residents on antipsychotic medication. The assessments were completed in the EMR under the assessment section. She indicated the AIMS assessments were completed by the admission nurse on admission and then by the floor nurses every 6	F 756	psychoactive medications to assure AIMs has been completed when medication initiated , Behavior monitor with target behavior and side effect monitoring initiated, PRN psychoactive medication has a stop date of 14 days. The Administrator will audit completion of pharmacy recommendations monthly for 3 months, to validate that pharmacy recommendations, to include GDR□s, have been completed within 30 days of receipt of recommendations. The Administrator and DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and DON will review the plan during monthly QAPI and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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months with coinciding dates of the MDS assessments. The DON explained that the MDS Nurses (MDS Nurse #1 and MDS Nurse #2) put out a calendar of MDS assessments that were due each month and this was used to inform the floor nurses of when an AIMS assessment was due. The most recent AIMS assessment for Resident #41 dated 1/28/20 was reviewed with the DON. The DON confirmed there were no AIMS assessments completed after 1/28/20 for Resident #41. She revealed she was not aware of this issue of AIMS assessments not being completed every 6 months. She indicated there may be a problem with the facility ' s protocol for completion of AIMS assessments as Resident #41 should have had 2 AIMS assessments completed since 1/28/20. The DON stated that she would have expected the Pharmacy Consultant to identify and address the need for AIMS assessments to be completed every 6 months for residents on antipsychotic medication.

A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated that her expectation for the completion of AIMS assessments was on initiation of an antipsychotic medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessments for antipsychotic medications due to the potential side effects of the medications. Resident #41 ' s most recent AIMS completed on 1/28/20 was reviewed with the Pharmacy Consultant. Resident #41 ' s physician ' s orders and MARs that indicated she received Aripiprazole daily from 1/28/20 through 3/9/21 were reviewed with the Pharmacy Consultant. She revealed she had not identified that an AIMS assessment was not completed since 1/28/20 for

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Resident #41. The Pharmacy Consultant explained that she began working with the facility in May of 2020 and had been doing remote reviews until January 2021. She revealed that she thought the AIMS assessments were in the hard chart so she was unaware that she could have reviewed the AIMS assessments when completing her remote monthly medication regimen reviews in 2020. The Pharmacy Consultant was asked if she had begun completing a review for AIMS assessments for residents on antipsychotic medications when she started coming to the facility in person in January 2021 for her monthly medication regimen reviews. She revealed that she also had not completed a review for AIMS assessments during her in person monthly medication regimen reviews in 2021. The Pharmacy Consultant acknowledged that her expectation would have been for an AIMS assessment to be completed a minimum of every 6 months for Resident #41 due to her extended use of the antipsychotic medication Aripiprazole. She also acknowledged that a recommendation should have been made to alert the facility that an AIMS assessment needed to be completed for Resident #41.

2b. Resident #41 was admitted to the facility on 10/31/18 with multiple diagnoses that included cerebral infarction with hemiparesis (muscle weakness on one side of the body) and hemiplegia (paralysis on one side of the body)

A physician ' s order for Resident #41 dated 9/25/19 indicated Ultram (opioid pain medication) 50 milligrams (mg) as needed for pain greater than 5 out of 10.

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A physician ' s order for Resident #41 dated 6/12/20 indicated Ultram 50 mg as needed for pain greater than 5 out of 10. The previous order for as need Ultram that was initiated on 9/25/19 for Resident #41 remained an active order.

A pharmacy recommendation for Resident #41 dated 12/2/20 completed by the Pharmacy Consultant indicated the Medication Administration Record (MAR) showed 2 active orders for Ultram 50 mg with the same instructions. The Pharmacy Consultant wrote, "Because this is a duplication, please discontinue one of these orders from her MAR". There was no indication this pharmacy recommendation dated 12/2/20 for Resident #41 had been responded to by the facility.

The quarterly Minimum Data Set (MDS) assessment dated 1/14/21 indicated Resident #41 ' s cognition was moderately impaired. She received PRN (as needed) pain medications, no routine pain medications, and reported pain frequently at a rating of 02 out of 10. Resident #41 was administered opioid medication on 2 of 7 days.

A pharmacy recommendation for Resident #41 dated 3/3/21 completed by the Pharmacy Consultant indicated a repeat recommendation from 12/2/20. The Pharmacy Consultant reported a duplicate order of Ultram 50 mg was present on the MAR and she requested one of the orders be discontinued. There was no indication this pharmacy recommendation dated 3/3/21 had been responded to.

A review of Resident #41 ' s active physician ' s

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orders was conducted on 3/9/21 and revealed 2 active orders for Ultram (opioid pain medication) 50 milligrams (mg) PRN (as needed) with same directions for administration. One order was initiated on 9/25/19 and the other order was initiated on 6/12/20.

An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. She stated that she received the pharmacy recommendations from the Pharmacy Consultant by email. She indicated that recommendations related to nursing were reviewed within the week during the morning meetings that were conducted Monday through Friday with herself, Unit Manager (UM) #1, and UM #2. The DON reported that the recommendations were normally responded to and/or acted upon during the morning meeting and/or after the meeting during that same day. The pharmacy recommendations for Resident #41 dated 12/2/20 and the repeat recommendation dated 3/3/21 related to a duplicate order for Ultram 50 mg PRN were reviewed the with DON. Resident #41 ' s active physician ' s orders that revealed the duplicate Ultram 50 mg PRN order was still in place was reviewed with the DON. She revealed that she recalled reviewing the 12/2/20 pharmacy recommendation and discussing with UM #1 and UM #2 and determining that one of the orders for PRN Ultram 50 mg needed to be discontinued. She reported that Resident #41 was on UM #2 ' s unit so she most likely would have been the person who was supposed to discontinue one of the Ultram 50 mg PRN orders for Resident #41. The DON stated that the 3/3/21 pharmacy recommendation had not yet been reviewed. She reported that she expected all pharmacy recommendation to be responded to and/or acted

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upon by the time of the Pharmacy Consultant ' s next monthly medication regimen review.

An interview was conducted with UM #2 on 3/10/21 at 1:20 PM. The pharmacy recommendations for Resident #41 dated 12/2/20 and the repeat recommendation dated 3/3/21 related to a duplicate order for Ultram 50 mg PRN were reviewed with UM #2. Resident #41 ' s active physician ' s orders that revealed the duplicate Ultram 50 mg PRN order was still in place was reviewed with UM #2. UM #2 stated that she could recall any pharmacy recommendations related to a duplicate order for PRN Ultram for Resident #41.

A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She indicated that she expected her recommendations to be responded to and/or acted upon by the time of her next monthly regimen review. The pharmacy recommendations for Resident #41 dated 12/2/20 and the repeat recommendation dated 3/3/21 related to a duplicate order for Ultram 50 mg PRN were reviewed with the Pharmacy Consultant. She indicated that during her most recent review on 3/3/21 she realized her previous recommendation from 12/2/20 to discontinue one of Resident #41 ' s orders for Ultram 50 mg PRN had not been responded to or acted upon. She stated that this was why she repeated the recommendation.

3. Resident #40 was admitted to the facility on 11/14/19 and most recently readmitted on 1/7/21 with multiple diagnoses that included Alzheimer '

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s Disease.

A physician ' s order for Resident #40 dated 1/8/21 indicated she was admitted to hospice care.

A physician ' s order for Resident #40 dated 1/8/21 indicated Ativan (antianxiety medication) 0.5 milligram (mg) every 1 hour as needed (PRN). This PRN Ativan physician ' s order had no stop date.

The significant change Minimum Data Set (MDS) assessment dated 1/13/21 indicated Resident #40 ' s cognition was severely impaired. She was noted with a prognosis of less than 6 months and was on hospice. Resident #40 had received no antianxiety medication during the MDS review period.

Pharmacy consultant medication regimen reviews dated 2/1/21 and 3/8/21 for Resident #40 were completed by the Pharmacy Consultant. There were no recommendations made related to Resident #40 ' s PRN Ativan (initiated on 1/8/21) that was prescribed with no stop date.

The March 2021 active physician ' s orders for Resident #40 were reviewed on 3/9/21 and revealed the 1/8/21 PRN Ativan physician ' s order continued to be active.

A review of the Medication Administration Records (MARs) from 1/8/21 through 3/9/21 for Resident #40 indicated no PRN Ativan had been administered.

A phone interview was conducted with the Medical Director on 3/10/21 at 3:45 PM. He

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stated he was aware that physician ' s orders for PRN Ativan and other PRN psychotropic medications were required to be time limited in duration for all residents including those on hospice. The PRN Ativan order for Resident #40 initiated on 1/8/21 that included no stop date was reviewed with the Medical Director. He revealed that not including a stop date was an error. He indicated he had been ensuring all PRN psychotropic medications were prescribed with a time limited duration in accordance with the regulations.

A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated she was aware that physician ' s orders for PRN Ativan and other PRN psychotropic medications were required to be time limited in duration for all residents including those on hospice. The PRN Ativan physician ' s order dated 1/8/21 that continued to be active for Resident #40 was reviewed with the Pharmacy Consultant. The medication regimen reviews dated 2/1/21 and 3/8/21 that included no recommendations related to the PRN Ativan for Resident #40 were reviewed with the Pharmacy Consultant. She revealed that she missed this order when she completed her February and March 2021 reviews. She indicated she should have written a recommendation to discontinue the order for PRN Ativan for Resident #40 due to the order having no stop date.

An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. The DON stated she was aware of the regulation that required all PRN psychotropic medications to be time limited in duration, but she had not realized this regulation applied to residents on hospice.

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She reported that she expected the Pharmacy Consultant to identify any issues such as this and to write a recommendation to bring it the nursing staff and physician ' s attention.

4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression.

Review of Resident #18's Physician order dated 4/4/19 read Cymbalta (antidepressant) delayed release particles 30 milligrams every afternoon for depression.

Review of Resident #18's Physician order dated 4/15/19 read monitor for behaviors and indicated yes or no. If behaviors present please document in the medical record every shift.

Resident #18's Minimum Data Set dated 1/15/21 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of an antidepressant.

Resident #18's revised care plan dated 2/8/21 read she was at risk for behaviors related to a history of depression. Resident #18's revised care plan dated 2/14/21 also indicated she was at risk for adverse effects related antidepressant medication for depression.

Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #18 indicated the following:
4/23/20-no recommendations
5/12/20-recommendation completed regarding the need for lab work
6/10/20-recommendation completed regarding

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the continued use of an anti-inflammatory
7/8/20-no recommendation
8/4/2020- recommendation completed regarding the need for lab work
9/1/20-no recommendation
10/2/20-no recommendation
11/2/20-no recommendation
12/2/20-recommendation for a gradual dose reduction (GDR) of Melatonin (hormone)
1/6/21-no recommendation
2/5/21- recommendation completed regarding the need for lab work
3/8/21-no recommendation

Review of Resident 18's nursing notes from 1/1/21 to 3/8/21 did not include any documentation of behaviors.

Review of Resident #18's medication administration records (MARs) from 1/1/21 to present indicated she received her Cymbalta as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff were to monitor.

Review of Resident #18's psychiatric telehealth notes indicated the following:
10/13/20-In good spirits, denies depression and reported a stable mood. Staff reported no concerns. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.
11/13/20-Conversational, appeared at baseline and endorsed a stable mood. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.

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In an observation and interview on 03/08/21 at 2:17 PM, Resident #18 was residing on the isolation unit for testing COVID-19 positive again. She appeared in good spirits and engaging. She reported no feelings of sadness, isolation, or boredom. She stated she enjoyed being in a room but herself so she could have some privacy.

In an interview on 3/8/21 at 2:30 PM, Nurse #7 stated Resident #18 was in good spirits and exhibited no signs of depression. Nurse #7 stated he had not observed any evidence of sadness such as crying or worry. He stated the nurses documented yes or no to her behaviors on every shift. Nurse #7 stated there was no specific behaviors identified for the staff to look for but assumed it would be crying, withdrawal, loss of appetite or lack of attention to personal hygiene.

In an interview on 3/10/21 at 1:00 PM, Unit Manager (UM) #1 stated all residents on psychotropics should have identified target behaviors for the staff to look for specific to each resident. He stated when an order was put in the electronic medical record, there was no place to add specific target behaviors but rather the program populated a generic order to observe for behaviors. UM #1 stated there should be targeted behaviors listed for Resident #18 so the staff knew what to look for. He stated Resident #18 has had a difficult 6 months because she was normally a very social person before COVID. He stated she had been in isolation twice for COVID-19.

In an interview on 3/10/21 at 1:20 PM, the Director of Nursing (DON) stated the Consultant Pharmacist completed her medication reviews remotely and would email her a pharmacy report

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and recommendations each month. Once she received the report and recommendations, she printed a copy for the Medical Director to address. There was a folder for the Medical Director at each nurse's station. The DON stated the Medical Director came to the facility several times per week. He went through the folder and wrote orders if needed and responded to the recommendations then put the recommendation back in a folder for filing. The DON stated if the Medical Director did not agree with a recommendation, he would write the rationale on the recommendation and put it back in the folder to be filed. The DON stated she expected the Consultant Pharmacist to make recommendations for the Medical Director regarding gradual dose reductions (GDRs) and missing targeted behaviors. She stated any nursing recommendations were addressed in the morning meetings.

In a telephone interview on 3/10/21 at 3:20 PM, the Consultant Pharmacist stated she started at the facility in May 2020. She stated she noted during Resident #18's May 2020 medication review that a GDR had not been done since April 2019 for Resident #18's prescribed Cymbalta. She stated since she was new to the facility in 2020 and due to COVID-19, she planned to address the Cymbalta during her April 2021 visit. The Consultant Pharmacist confirmed that a GDR for an antidepressant should be attempted twice in the first year and then annually thereafter. She stated she was unaware of the need for targeted behaviors with the use of psychotropics but knew the facility looked for adverse side effects.

In a telephone interview on 3/10/21 at 3:45 PM, the Medical Director stated he handled all the

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GDRs personally unless the medication was an antipsychotic. He stated Resident #18 has had a difficult year because she tested COVID-19 positive twice and has had to isolate twice. The Medical Director stated he would not recommend a GDR on her antidepressant until things normalize. He stated he expected targeted behaviors to be identified so the staff knew what behaviors to look for and document.

In an interview on 3/10/21 at 5:00 PM, the DON stated it was her expectation that the Consultant Pharmacist identify the lack of targeted behavior documentation and identify the need for a recommendation regarding a GDR of Resident #18's antidepressant unless contraindicated with documented rationale.

In a telephone interview on 3/11/21 at 1:40 PM, the Psychiatric Nurse Practitioner stated she has not received any GDR recommendations from the Consultant Pharmacist regarding Resident #18's prescribed Cymbalta. She stated the facility informed her that the Medical Director preferred to address all recommended GDRs. She stated there should be specific documentation as to why a GDR was contraindicated and the behaviors monitoring by the facility was too vague and needed to be specific to Resident #18.

5. Resident #43 was admitted on 12/12/18 with cumulative diagnoses for Cerebral Vascular Accident (CVA), Schizophrenia and Bipolar Disorder.

Review of Resident #43's Physician orders included an order dated 4/15/19 for Seroquel (antipsychotic) Extended Release 24 hour 50

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milligrams at bedtime for Paranoid Schizophrenia. Also included was an order dated 2/5/20 for staff to monitor and indicate yes or no if behaviors occurred on every shift. If yes, please record behaviors and non-pharmacological interventions in the medical record.

Resident #43's quarterly Minimum Data Set (MDS) dated 1/18/21 indicated Resident #43 was cognitively intact and exhibited rejection of care behaviors. She was coded for the use of an antipsychotic.

Resident #43's revised care plan dated 2/8/21 read she was at risk for adverse effects related to the use of antipsychotic medications for Schizophrenia and Bipolar Disorder. Interventions included the completion of an Abnormal Involuntary Movement Scale (AIMS) assessment to be completed according to facility policy.

Review of Resident #43's medical record indicated the last AIMS completed was on 1/29/20.

Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #43 indicated the following:
4/23/20-no recommendations
5/12/20-no recommendations
6/10/20- recommended pain monitoring and discontinuation of Singular
7/8/20-no recommendations
8/3/20-no recommendations
9/1/20-no recommendations
10/5/20-no recommendations
11/2/20-no recommendations
12/2/20-no recommendations
1/6/21-no recommendations

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F 756	Continued From page 83 2/1/21-no recommendations 3/8/21-no recommendations Review of Resident #43's psychiatry telehealth notes indicated the following: 4/20/20-GDR not recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. 6/3/20-Pleasant and friendly-no delusional thoughts, hallucinations, and mania. Staff report none. Current regime recommended. No medication adjustment recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. 9/11/20-Reported no privacy, stressful, wanting friends to talk too-reported isolation and lonely making symptoms worse. Staff report occasional emotions, gets upset easily-no new recommendations due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. 10/9/20- Reported improvements in mood and coping. GDR would result in risk of decompensation. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. 2/26/21-No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. Review of Resident #43's nursing notes from 1/1/21 to present included nursing notes regarding the refusal to wear foot protectors on 1/18/21 and a refusal of lab work on 3/2/21.	F 756		

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Review of Resident #43's medication administration records (MARs) from 1/1/21 to present indicated she received her Seroquel as ordered and no behaviors exhibited. The MAR did not list any targeted behaviors for staff were to monitor.

In an observations and interview on 3/8/21 at 10:51 AM, Resident #43 was in bed. She appeared pleasant, cooperative, and engaging. There was no evidence of psychosis. She reported her only concern was regarding her showers.

In an observation and interview on 3/10/21 at 8:20 AM, Resident #43 was in bed. She appeared pleasant, cooperative, and engaging. There was no evidence of psychosis She stated she got a shower and had her hair washed yesterday.

In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated the MAR did not specify any target behaviors to document in the medical record but Resident #43 exhibited agitation, short temper and verbal behaviors. Nurse #1 stated she was unsure who completed the AIMS assessment but assumed it was the MDS Nurses or the Unit Managers (UM).

In an interview on 3/10/21 at 11:53 AM, the Director of Nursing (DON) confirmed Resident #43 medical record did not identify targeted behaviors. She stated it was an issues with the electronic medical record when entering any order for psychotropics and the facility was actively working to fix it.

In an interview on 3/10/21 at 1:00 PM, UM #1 stated the floor nurses completed Resident #43's

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AIMS every 6 months. He stated the previous MDS Nurse would give him a list of MDS assessments due and would indicate if an AIMS needed to be completed and that the previous MDS Nurse left sometime in December 2020. He stated the current MDS Nurse's did not specify it on the list. He stated the old electronic medical record set up would let staff know when an AIMS was due. UM #1 stated the medical record should specify targeted behaviors for Resident #43 regarding the use of an antipsychotic. He stated when an order for any psychotropics was entered into the electronic medical record, a generic template populated for only yes or no responses. UM #1 stated an AIMS, target behaviors for the use of an antipsychotic and documentation regarding the need to evaluate the need for a GDR unless it was contraindicated.

In an interview on 3/10/21 at 1:20 PM, the DON stated the Consultant Pharmacist completed her medication reviews remotely and would email her a pharmacy report and recommendations each month. Once she received the report and recommendations, she printed a copy for the Medical Director to address. There was a folder for the Medical Director at each nurse's station. The DON stated the Medical Director came to the facility several times per week and he went through the folder and wrote orders if needed and responded to the recommendations then put the recommendation back in a folder for filing. The DON stated if the Medical Director did not agree with a recommendation, he would write the rationale on the recommendation and put it back in the folder to be filed. The DON stated she expected the Consultant Pharmacist to make recommendations for the Medical Director regarding gradual dose reductions (GDRs),

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missing targeted behaviors and the need for an AIMS assessment. She stated any nursing recommendations were addressed in the morning meetings. The DON stated the AIMS protocol was on admission and every 6 months thereafter. The admitting nurse did the baseline AIMS on admission and then the MDS Nurses put out a list of MDS assessments due and the nurses on the floor completed the AIMS. She said the system does not have any automatic prompt to alert the nurses that an AIMS was due. The DON stated she was unaware that Resident #43's last AIMS assessment was completed on 1/29/20 and was unaware that the AIMS assessments were not being done. The DON stated it was her expectation that the Consultant Pharmacist identified the need for an AIMS assessment on Resident #43, identified the need for a GDR in Seroquel been addressed and identified Resident #43 targeted behaviors for the use of an antipsychotic.

In an interview on 3/10/21 at 2:28 PM, MDS Nurse #2 stated she and MDS Nurse #1 completed no tasks related to the AIMS assessments. She reported that each month a calendar with all of the MDS assessments was given to the UM's.

In an interview on 3/10/21 at 2:30 PM, MDS Nurse #1 confirmed MDS Nurse #2's interview that indicated they were not involved with the AIMS assessments and that the monthly calendar they gave to the UM's did not included any information on what AIMS assessments were due.

In a telephone interview on 3/10/21 at 3:20 PM, the Consultant Pharmacist stated she started at

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the facility in May 2020. She stated the expectation of an AIMS assessment on admission and every 6 months thereafter. She stated she did not review Resident #43' medical record for the need of an AIMS assessment and was not aware where the AIMS were documented in the electronic medical record. The Consultant Pharmacist stated she started at the facility in May 2020 and noted no GDR on Seroquel had been addressed since 4/2019. She stated she had planned to address Resident #43's Seroquel in April 2021. She stated she was unaware of the need for targeted behaviors with the use of psychotropics but knew the facility looked for adverse side effects.

In a telephone interview on 3/10/21 at 3:45 PM, the Medical Director stated he handled all the GDRs personally unless the medication was an antipsychotic then he differed to Psychiatry. He stated Resident #43 experienced auditory, visual hallucinations and was known to often yell out and talk to people who weren't there. The Medical Director stated he had not received any recommendations regarding Resident #43's Seroquel, the need for an AIMS or the need for identification of specific targeted behaviors.

In an interview on 3/10/21 at 5:00 PM, the DON stated it was her expectation that the Consultant Pharmacist identify the lack of targeted behavior documentation, identify the need for a recommendation regarding a GDR of Resident #43's antipsychotic unless contraindicated with documented rationale and the need for an AIMS every 6 months. She stated there was a problem with the facility's protocol for completing the AIMS.

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In a telephone interview on 3/11/21 at 1:40 PM, the Psychiatric Nurse Practitioner stated she has not received any GDR recommendations from the Consultant Pharmacist regarding Resident #43' prescribed Seroquel. She stated the facility informed her that the Medical Director preferred to address all recommended GDRs and it was her understanding that a GDR could not be attempted due to Resident #43's diagnosis of Schizophrenia. She stated the Consultant Pharmacist should have identified the need for specific documentation as to why a GDR was contraindicated, the need for an AIMS assessment and identified that the behavior monitoring by the facility was too vague and needed to be specific to Resident #43.

6. Resident # 66 was admitted to the facility on 10/9/20 with multiple diagnoses including Hypertension and atrial fibrillation.

Resident # 66 had a doctor's order dated 2/21/21 for Sotalol (used to treat heart rhythm problems) 40 milligrams (mgs.) daily for atrial fibrillation.

Review of Resident #66's pulse rate revealed that they were frequently below 50's. The following were Resident #66's pulse rate recorded on the electronic vital signs and/or progress notes:

12/7/20 at 3:36 AM - 46 per minute
12/24/20 at 12:06 AM - 48 per minute
1/25/21 at 2:36 PM- 48 per minute
2/1/21 at 7:30 AM - 44 per minute
2/3/21 at 7:30 AM - 44 per minute and at 7:59 PM - 49 per minute
2/13/21 at 7:34 AM and 9:24 AM - 46 per minute

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and at 7:46 PM - 46 per minute
2/19/21 at 7:30 AM and 7:48 PM - 45 per minute
3/8/21 at 5:58 PM - 43 per minute

On 1/7/21, the Pharmacy Consultant had conducted a drug regimen review on Resident #66 and had recommended to add a hold order for pulse readings with Sotalol since the pulse has been in the low 50's frequently.

Resident #66 doctor's order and Medication Administration Records (MARs) for February and March 2021 were reviewed. There was no hold order for pulse readings with Sotalol.

On 3/10/21 at 1:20 PM, the Director of Nursing (DON) was interviewed. She stated that the Pharmacy Consultant was completing the drug regimen review remotely until this month (March 2021). The Consultant was sending the recommendations via email. The DON added that once she received the recommendations, she printed them out and placed them in the folder for the doctor to address. The DON further explained that the doctor comes to the building several times a week and he went through the folder and responded to the recommendations. After he responded to the recommendations, he placed the forms back in the folder at each nurse's station for filing. The DON reported that during the COVID outbreak in December 2020, the doctor was not coming to the facility. She placed the folder in the office at the lobby and the doctor or his Physician Assistant (PA) would pick them up and brought them back off the week after.

On 3/10/21 at 3:25 PM, the Pharmacy Consultant was interviewed. The Consultant stated that she

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had been doing her monthly drug regimen reviews remotely in 2020 and just started coming to the facility in January 2021. She indicated that she expected the facility to respond to her recommendation within 30 days. She added that when she started coming to the facility, she had not seen any of her recommendations in the resident's medical records.

On 3/10/21 at 3:45 PM, the Physician was interviewed. The Physician stated that the pharmacist's recommendation forms were placed in his stack at each nurse's station. He picked them up and addressed them on Saturdays and brought them back the following week. He placed them in the DON's office or Unit Manager's office. The Physician added that he had responded to the recommendations that he had received and if there were recommendations that were not addressed, he never received them.

On 3/10/21 at 3:55 PM, a follow up interview was conducted with the DON. The DON verified that the Pharmacy Consultant had a recommendation for Resident #66 to have hold order for the Sotalol in January 2021. She stated that she didn't know what happened to the recommendation form, but she verified that it was not addressed. The DON added that she knew it was an issue, so she already had a plan of correction. She would print two copies of the pharmacist recommendation, 1 copy for the doctor and 1 copy for herself, that way she could verify if the recommendations were addressed or not.

7a. Resident # 3 was admitted to the facility on 11/20/20 with multiple diagnoses including

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schizophrenia. The quarterly Minimum data Set (MDS) assessment dated 2/25/21 indicated that Resident #3 had severe cognitive impairment and he had received an antipsychotic drug during the assessment period.

Resident #3 had a doctor's order dated 11/21/20 for Risperdal (an antipsychotic drug) 0.5 milligrams (mgs.) by mouth daily for bipolar disorder and on 1/27/21 for Risperdal 1 mgs at bedtime for schizophrenia.

Review of Resident #3's medical records revealed that the Abnormal Involuntary Movement Scale (AIMS) test or Dyskinesia Identification System Condensed User Scale (DISCUS) was not completed since admission to monitor for the psychotropic drug adverse reaction.

On 3/10/21 at 1:20 PM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the Pharmacy Consultant to make recommendation for the AIMS test to be completed.

On 3/10/21 at 3:25 PM, the Pharmacy Consultant was interviewed. The Consultant stated that she had been doing her monthly drug regimen reviews remotely in 2020 and just started coming to the facility in January 2021. She indicated that residents on antipsychotic drug should have AIMS test or DISCUS completed on admission (baseline) and then at least every 6 months. She reported that AIMS tests were documented in the hard copy chart so she could not see the completed AIMS test when she was reviewing the records remotely. When she was informed that the AIMS test were actually in the electronic medical records, she explained that every facility

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had the AIMS test/DISCUS documented in different places and for some reason she thought they were documented in the hard copy chart. The Consultant reported that she had not been reviewing for the need of AIMS test since she started coming to the facility, but she would start to review them next month.

On 3/10/21 at 3:55 PM, a follow up interview was conducted with the DON. The DON stated that residents on antipsychotic drug should have an AIMS test or DISCUS completed on admission and then every 6 months. She verified that Resident #3 did not have an AIMS test nor DISCUS completed on admission. She explained that the MDS Nurses were supposed to notify the floor nurses when AIMS test was due and the admission Nurse was supposed to complete an AIMS test on admission for residents on antipsychotic drug.

7b. Resident # 3 was admitted to the facility on 11/20/20 with multiple diagnoses including schizophrenia. The quarterly Minimum data Set (MDS) assessment dated 2/25/21 indicated that Resident #3 had severe cognitive impairment and he had received an antidepressant drug during the assessment period.

Resident #3 had a doctor's order dated 11/21/20 for Sertraline 50 milligrams (mgs) by mouth daily and on 11/20/20 for Hydroxyzine 25 mgs 1 tablet by mouth every 6 hours as needed.

Resident #3's drug regimen was reviewed by the Pharmacy Consultant on 1/7/21 and the Consultant had recommendation. She was asking to have appropriate diagnosis for the use

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of Sertraline and Hydroxyzine.

Review of Resident #3's medical records revealed that the Sertraline and the Hydroxyzine did not have appropriate diagnosis for its use.

On 3/10/21 at 1:20 PM, the Director of Nursing (DON) was interviewed. She stated that the Pharmacy Consultant was completing the drug regimen review remotely until this month (March 2021). The Consultant was sending the recommendations via email. The DON added that once she received the recommendations, she printed them out and placed them in the folder for the doctor to address. The DON further explained that the doctor comes to the building several times a week and he went through the folder and responded to the recommendations. After he responded to the recommendations, he placed the forms back in the folder at each nurse's station for filing. The DON reported that during the COVID outbreak in December 2020, the doctor was not coming to the facility. She placed the folder in the office at the lobby and the doctor or his Physician Assistant (PA) would pick them up and brought them back off the week after.

On 3/10/21 at 3:25 PM, the Pharmacy Consultant was interviewed. The Consultant stated that she had been doing her monthly drug regimen reviews remotely in 2020 and just started coming to the facility in January 2021. She indicated that she expected the facility to respond to her recommendation within 30 days. She added that when she started coming to the facility, she had not seen any of her recommendations in the resident's medical records.

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On 3/10/21 at 3:45 PM, the Physician was interviewed. The Physician stated that the pharmacist's recommendation forms were placed in his stack at each nurse's station. He picked them up and addressed them on Saturdays and brought them back the following week. He placed them in the DON's office or Unit Manager's office. The Physician added that he had responded to the recommendations that he had received and if there were recommendations that were not addressed, he never received them.

On 3/10/21 at 3:55 PM, a follow up interview was conducted with the DON. The DON verified that the Pharmacy Consultant had a recommendation for Resident #3 to have a diagnosis for the use of the Sertraline and the Hydroxyzine. She stated that she didn't know what happened to the recommendation form, but she verified that it was not addressed. The DON added that she knew it was an issue, so she already had a plan of correction. She would print two copies of the pharmacist recommendation, 1 copy for the doctor and 1 copy for herself, that way she could verify if the recommendations were addressed or not.

8) Resident #31 was admitted to the facility on 5/22/20 with diagnoses that included vascular dementia with behavior disturbance and schizophrenia.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 5/22/20 for Resident #31.

The quarterly Minimum Data Set (MDS) assessment dated 1/9/21 indicated Resident #31's cognition was severely impaired, and she had received routine antipsychotic medication 7

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of 7 days during the MDS look back period.

A review of the current physician orders on 3/9/21 indicated an order for Risperidone Solution (an antipsychotic medication) 2 milligrams (mg) twice a day, had remained active since Resident #31's admission date of 5/22/20.

A review of the hard copy and electronic medical record from 5/22/20 to 3/10/21 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #31 since 5/22/20.

There was no evidence in Resident #31's medical record of the Pharmacy Consultant identifying and addressing that an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #31 since 5/22/20.

During an interview with the Director of Nursing (DON) on 3/10/21 at 1:20 PM, she stated the facility's normal process was to complete an AIMS assessment on admission and then every 6 months for residents on antipsychotic medications. She indicated the initial AIMS assessment was completed by the admitting nurse at the time of admission and then by the floor nurses every 6 months with coinciding dates of the MDS assessment. The DON further stated the MDS Nurses put out a calendar of MDS assessments due each month and this was used to inform the floor nurses when an AIMS assessment was due.

A phone interview was completed with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated her expectation for the completion of AIMS assessments was on initiation of an antipsychotic

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medication and then every 6 months. The Pharmacy Consultant explained it was important to complete routine AIMS assessments for antipsychotic medications due to the potential side effects the medication could cause. Resident #31's most recent AIMS, completed on 5/22/20, was reviewed with the Pharmacy Consultant as well as the physician's orders and MAR's from 5/22/20 through 3/9/21 that indicated Resident #31 received Risperidone twice a day. She confirmed she had not identified an AIMS assessment had not been completed since 5/22/20 for Resident #31. The Pharmacy Consultant further stated she began working at the facility in May 2020 and had been doing remote reviews until January 2021. She thought the AIMS assessments were in the hard chart so she was unaware she could have reviewed the AIMS assessments when completing her remote monthly medication regimen reviews in 2020. The Pharmacy Consultant further revealed she had not completed a review for AIMS assessments during her in-person monthly medication regimen reviews in 2021 either. The Pharmacy Consultant acknowledged her expectation would have been for an AIMS assessment to be completed a minimum of every 6 months for Resident #31 due to her use of the antipsychotic medication Risperidone. She also acknowledged she should have initiated a recommendation alerting the facility an AIMS assessment was needed for Resident #31.

On 3/10/21 at 4:56 PM, the DON indicated she had reviewed Resident #31's hard copy and electronic medical record and confirmed there was no AIMS assessment completed since 5/22/20. The DON expressed she was not aware of the issue of AIMS assessments not being

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F 756	Continued From page 97 completed every 6 months. She further stated she expected the Pharmacy Consultant to identify and address the need for AIMS assessments to be completed every 6 months for residents on antipsychotic medications.	F 756		
F 758 SS=E	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		4/8/21

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F 758	Continued From page 98 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 record review, observation, and interviews with staff, Pharmacy Consultant, and Medical Director, the facility failed to assess residents on antipsychotic medication for abnormal involuntary movement disorders (Residents #3, #18, #29, #31, #41, and #43), failed to identify target behavioral symptoms and to monitor those symptoms (Residents #18 and #43), failed to evaluate residents on psychotropic medications for gradual dose reductions (Resident #18), and failed to ensure PRN (as needed) psychotropic medications were time limited in duration (Resident #40). This was for 7 of 9 residents whose medications were reviewed. The findings included: 1. Resident #29 was admitted to the facility on 11/2/16 with multiple diagnoses that included schizophrenia and dementia without behavioral disturbance.	F 758	F 758 A total of 6 Abnormal Involuntary Movement Scales (AIMS) were not up to date at the time of survey and a total of 9 residents did not have target behaviors identified at the time of survey. Adjustments were made for those residents found to have been affected by the deficient practice as follows ;1 Resident #29□s antipsychotic medication was discontinued on 2/27/21, so therefore an Abnormal Involuntary Movement Scale (AIMS) assessment is not required at this time. 2- a) The licensed nurse completed an AIMS assessment for Resident #41 on 3/10/21. b) The licensed nurse discontinued the duplicate Ultram order on 3/10/21. 3- The licensed nurse received a	

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F 758	Continued From page 99 An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 12/1/19 for Resident #29 with a score of 0 (no involuntary movements identified). A physician ' s order dated 4/5/20 indicated Seroquel (antipsychotic medication) 50 milligrams (mg) once daily for Resident #29. The quarterly Minimum Data Set (MDS) assessment dated 1/8/21 indicated Resident #29 was rarely/never understood. She was assessed with no behavioral symptoms, but had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician ' s order dated 1/15/21 indicated Resident #29 had a GDR of Seroquel decreasing the dose from 50 mg once daily to 25 mg once daily. The quarterly MDS assessment dated 2/16/21 indicated Resident #29 ' s cognition was severely impaired. She had no behavioral symptoms, but she had rejected care on 1 to 3 days during the MDS review period. Resident #29 was administered routine antipsychotic medication on 7 of 7 days. A physician ' s order dated 2/27/21 indicated Resident #29 ' s Seroquel was discontinued. A review of the Medication Administration Records (MARs) from 12/2/19 through 2/27/21 indicated Resident #29 was administered Seroquel daily as ordered.	F 758	physician order on 3/10/21, to discontinue the Ativan order for Resident #40. 4-The physician did not initiate a Gradual Dose Reduction (GDR) of Resident #18□s antidepressant at this time, due to residents current health condition. The behavior monitor was updated on 3/19/21, to monitor for signs of depression. 5- The licensed nurse completed an AIMS assessment for Resident #43 on 3/10/21. The Behavior monitor was updated to include target behaviors on 3/21/21. The physician did not initiate a GDR at this time, due to risks vs benefit related to the residents diagnosis. 6- a) The licensed nurse completed an AIM assessment for Resident #3 on 3/10/21. b) Sertraline and Hydroxyzine had diagnosis included with the original order for Resident #3 but was not pulling over to the EMAR. The licensed nurse updated the orders on 3/25/21 and the diagnosis are showing on the Resident #3□s EMAR. 8- The licensed nurse completed an AIMs assessment for Resident #31 on 3/10/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the alleged deficient practice of failure to assess residents on antipsychotic medication for abnormal involuntary movement disorders, identify target behaviors and monitor those symptoms, ensure PRN	

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F 758	Continued From page 100 A review of the hard copy and Electronic Medical Record (EMR) from 1/1/20 through 3/8/21 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #29 since 12/1/19. An observation was conducted of Resident #29 on 3/8/21 at 12:30 PM. There were no involuntary movements observed. An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. She stated that the facility ' s normal process was to complete AIMS assessments on admission and then every 6 months thereafter for residents on antipsychotic medication. The assessments were completed in the EMR under the assessment section. She indicated the AIMS assessments were completed by the admission nurse on admission and then by the floor nurses every 6 months with coinciding dates of the MDS assessments. The DON explained that the MDS Nurses (MDS Nurse #1 and MDS Nurse #2) put out a calendar of MDS assessments that were due each month and this was used to inform the floor nurses of when an AIMS assessment was due. The most recent AIMS assessment for Resident #29 dated 12/1/19 was reviewed with the DON. The DON confirmed there were no AIMS assessments completed after 12/1/19 for Resident #29. She revealed she was not aware of this issue of AIMS assessments not being completed every 6 months. She indicated there may be a problem with the facility ' s protocol for completion of AIMS assessments as Resident #29 should have had 2 AIMS assessments completed since 12/1/19. An interview was conducted with MDS Nurse #2	F 758	psychotropic medications are time limited in duration, evaluate residents on psychotropic medications for gradual dose reduction and act upon pharmacy recommendations. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit on 3/10/21, of current facility residents with orders for antipsychotic medications to validate that an AIMs had been completed within the last 6 months. All AIMs assessments were up to date by 3/10/21. On 3/21/21, the DON and ADON completed updating behavior monitors to include target behaviors for residents that receive psychoactive medications. 9 residents were identified as not having target behaviors. On 3/10/21 the DON and ADON completed an audit of PRN psychoactive medications to assure there are stop dates and reassessment of use. 3 residents were identified as not having stop dates. On 3/9/21, the pharmacist completed an audit of current facility residents that receive psychotropic medications and made recommendations for 3 residents to have gradual dose reductions. On 3/25/21, the DON completed pharmacy recommendations that were received for February and March 2021. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 758	Continued From page 101 on 3/10/21 at 2:28 PM. She was asked what protocol they utilized to let staff know when an AIMS assessment was due. She stated that she and MDS Nurse #1 completed no tasks related to the AIMS assessments. She reported that each month a calendar with all of the MDS assessments that were due was given to Unit Manager #1 and Unit Manager #2. MDS Nurse #2 indicated that this calendar had not included any information on what AIMS assessments were due. An interview was conducted with MDS Nurse #1 on 3/10/21 at 2:30 PM. She confirmed MDS Nurse #2 ' s interview that indicated they had no involvement with the AIMS assessments and that the monthly calendar they give to the Unit Managers had not included any information on what AIMS assessments were due. A phone interview was conducted with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated that her expectation for the completion of AIMS assessments was on initiation of an antipsychotic medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessments for antipsychotic medications due to the potential side effects of the medications. During a follow up interview with the DON on 3/10/21 at 3:55 PM she revealed that the MDS Nurses were unaware that they were responsible for notifying the floor nurses when AIMS assessments were due. She indicated it was her expectation that AIMS assessments be completed for all residents on antipsychotic medications on admission and every 6 months thereafter. She further indicated that she	F 758	When a resident has a physician order for an antipsychotic medication, the licensed nurse will complete an AIMs assessment. Physicians orders and including new admissions will be reviewed daily at morning clinical meeting The assessment will be updated at least every 6 months with Minimum Data Set (MDS) Nurse tracking and scheduling AIMS. The licensed nurse will implement a behavior monitor in the electronic medical record to include resident targeted behaviors and side effect monitoring every shift. When a PRN psychoactive medication is ordered, the order will include a 14 day time limit, and the physician will reassess for continued use. The pharmacist will complete monthly audits of resident medication and will make recommendations to the physician regarding gradual dosage reduction. The pharmacist will validate monthly if a GDR was completed and if not, will follow up with the DON and physician to assure proper documentation is completed to support. When the DON receives the Pharmacy recommendations monthly, she will provide copies to the physician and nurses for follow up of recommendations. A copy of the recommendations will be kept in a folder and the DON will monitor and validate follow through of recommendations within 30 days of receipt of recommendations. The Regional Director of Clinical Services provided education to the DON on	

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F 758	Continued From page 102 expected the MDS Nurses to notify the floor nurses when the AIMS assessments were due and the floor nurses were then to complete an AIMS assessment in the EMR. 2. Resident #41 was admitted to the facility on 10/31/18 with diagnoses that included schizophrenia. A physician ' s order dated 4/10/19 for Aripiprazole (antipsychotic medication) 15 milligrams (mg) once daily in the morning. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 1/28/20 for Resident #41 with a score of 1.0. The quarterly Minimum Data Set (MDS) assessment dated 1/14/21 indicated Resident #41 ' s cognition was moderately impaired. She was assessed with no behavioral symptoms, but had rejected care on 1 to 3 days during the MDS review period. Resident #41 was administered routine antipsychotic medication on 7 of 7 days. A review of Resident #41 ' s current physician ' s orders on 3/8/21 indicated the 4/10/19 order for Aripiprazole 15 mg remained an active order. A review of the Medication Administration Records (MARs) from 1/29/20 through 3/8/21 indicated Resident #41 was administered Aripiprazole daily as ordered. A review of the hard copy and Electronic Medical Record (EMR) from 1/29/20 through 3/8/21 revealed an AIMS assessment or any other	F 758	3/10/21, regarding drug regimen review, psychoactive med monitoring, behavior and side effect monitoring, GDR process, time limit for psychoactive medications and process for pharmacy recommendation follow through. The DON provided education to the physician on 3/25/21, regarding drug regimen review, psychoactive med monitoring, behavior and side effect monitoring, and process/documentation regarding gradual dose reductions of psychoactive medication and time limit for psychoactive medications. The Pharmacy manager provided education on 3/24/21, for the pharmacist regarding regulations related to AIM□s monitoring, GDR process and documentation requirements, time limit for PRN psychoactive medications and follow up for recommendations that are given to the facility. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON will monitor 5 x week for 4 weeks then weekly for 2 months, residents with new orders for psychoactive medications to assure AIMs has been completed when medication initiated , Behavior monitor with target behavior and side effect monitoring initiated, PRN psychoactive medication has a stop date of 14 days. The Administrator will audit completion of pharmacy recommendations monthly for 3	

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F 758	Continued From page 103 involuntary movement assessment had not been completed for Resident #41 since 1/28/20. An observation was conducted on Resident #41 on 3/10/21 at 11:45 AM. There were no involuntary movements observed. An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. She stated that the facility ' s normal process was to complete AIMS assessments on admission and then every 6 months thereafter for residents on antipsychotic medication. The assessments were completed in the EMR under the assessment section. She indicated the AIMS assessments were completed by the admission nurse on admission and then by the floor nurses every 6 months with coinciding dates of the MDS assessments. The DON explained that the MDS Nurses (MDS Nurse #1 and MDS Nurse #2) put out a calendar of MDS assessments that were due each month and this was used to inform the floor nurses of when an AIMS assessment was due. The most recent AIMS assessment for Resident #41 dated 1/28/20 was reviewed with the DON. The DON confirmed there were no AIMS assessments completed after 1/28/20 for Resident #41. She revealed she was not aware of this issue of AIMS assessments not being completed every 6 months. She indicated there may be a problem with the facility ' s protocol for completion of AIMS assessments as Resident #41 should have had 2 AIMS assessments completed since 1/28/20. An interview was conducted with MDS Nurse #2 on 3/10/21 at 2:28 PM. She was asked what protocol they utilized to let staff know when an AIMS assessment was due. She stated that she	F 758	months, to validate that pharmacy recommendations, to include GDR□s, have been completed within 30 days of receipt of recommendations. The Administrator and DON will review the audits to identify patterns/trends and will adjust the plan to maintain compliance. The Administrator and DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 4/8/21	

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and MDS Nurse #1 completed no tasks related to the AIMS assessments. She reported that each month a calendar with all of the MDS assessments that were due was given to Unit Manager #1 and Unit Manager #2. MDS Nurse #2 indicated that this calendar had not included any information on what AIMS assessments were due.

An interview was conducted with MDS Nurse #1 on 3/10/21 at 2:30 PM. She confirmed MDS Nurse #2 ' s interview that indicated they had no involvement with the AIMS assessments and that the monthly calendar they give to the Unit Managers had not included any information on what AIMS assessments were due.

During a follow up interview with the DON on 3/10/21 at 3:55 PM she revealed that the MDS Nurses were unaware that they were responsible for notifying the floor nurses when AIMS assessments were due. She indicated it was her expectation that AIMS assessments be completed for all residents on antipsychotic medications on admission and every 6 months thereafter. She further indicated that she expected the MDS Nurses to notify the floor nurses when the AIMS assessments were due and the floor nurses were then to complete an AIMS assessment in the EMR.

3. Resident #40 was admitted to the facility on 11/14/19 and most recently readmitted on 1/7/21 with multiple diagnoses that included Alzheimer ' s Disease.

A physician ' s order for Resident #40 dated

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1/8/21 indicated she was admitted to hospice care.

A physician ' s order for Resident #40 dated 1/8/21 indicated Ativan (antianxiety medication) 0.5 milligram (mg) every 1 hour as needed (PRN). This PRN Ativan physician ' s order had no stop date. This order was entered into the Electronic Medical Record (EMR) by Nurse #6.

The significant change Minimum Data Set (MDS) assessment dated 1/13/21 indicated Resident #40 ' s cognition was severely impaired. She was noted with a prognosis of less than 6 months and was on hospice. Resident #40 had received no antianxiety medication during the MDS review period.

The March 2021 active physician ' s orders for Resident #40 were reviewed on 3/9/21 and revealed the 1/8/21 PRN Ativan physician ' s order continued to be active.

A review of the Medication Administration Records (MARs) from 1/8/21 through 3/9/21 for Resident #40 indicated no PRN Ativan had been administered.

An interview was conducted with Nurse #6 on 3/10/21 at 11:30 AM. The PRN Ativan order for Resident #40 initiated on 1/8/21 with no stop date that was entered into the EMR by Nurse #6 was reviewed. She was asked if she was aware of the regulations related to PRN psychotropic medications being time limited in duration. She revealed that she was not aware that this regulation related to PRN psychotropic medications applied to antianxiety medication.

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An interview was conducted with the Director of Nursing (DON) on 3/10/21 at 1:20 PM. The DON stated she was aware of the regulation that required all PRN psychotropic medications to be time limited in duration, but she had not realized this regulation applied to residents on hospice. She reported that it was her expectation for the regulations to be followed.

A phone interview was conducted with the Medical Director on 3/10/21 at 3:45 PM. He stated he was aware that physician ' s orders for PRN Ativan and other PRN psychotropic medications were required to be time limited in duration for all residents including those on hospice. The PRN Ativan order for Resident #40 initiated on 1/8/21 that included no stop date was reviewed with the Medical Director. He revealed that not including a stop date was an error. He indicated he had been ensuring all PRN psychotropic medications were prescribed with a time limited duration in accordance with the regulations.

4. Resident #18 was admitted on 4/2/18 with a diagnosis of depression.

Review of Resident #18's Physician order dated 4/4/19 read Cymbalta (antidepressant) delayed release particles 30 milligrams every afternoon for depression.

Review of Resident #18's Physician order dated 4/15/19 read monitor for behaviors and indicated yes or no. If behaviors present, please document in the medical record every shift. The order did not include any targeted behaviors for staff to be monitoring.

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Resident #18's Minimum Data Set dated 1/15/21 indicated she was cognitively intact and exhibited no behaviors. She was coded for the use of an antidepressant.

Resident #18's revised care plan dated 2/8/21 read she was at risk for behaviors related to a history of depression. Resident #18's revised care plan dated 2/14/21 also indicated she was s at risk for adverse effects related antidepressant medication for depression.

Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #18 indicated the following:
4/23/20-no recommendations
5/12/20-recommendation completed regarding the need for lab work
6/10/20-recommendation completed regarding the continued use of an anti-inflammatory
7/8/20-no recommendation
8/4/2020- recommendation completed regarding the need for lab work
9/1/20-no recommendation
10/2/20-no recommendation
11/2/20-no recommendation
12/2/20-recommendation for a gradual dose reduction (GDR) of Melatonin (hormone)
1/6/21-no recommendation
2/5/21- recommendation completed regarding the need for lab work
3/8/21-no recommendation

Review of Resident 18's nursing notes from 1/1/21 to present did not include any documentation of behaviors.

Review of Resident #18's medication

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administration records (MARs) from 1/1/21 to present indicated she received her Cymbalta as ordered and no behaviors exhibited. The MAR did not list any targeted behaviors for staff were to monitor.

Review of Resident #18's psychiatric telehealth notes indicated the following:
10/13/20-In good spirits, denies depression and reported a stable mood. Staff reported no concerns. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.
11/13/20-Conversational, appeared at baseline and endorsed a stable mood. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.

In an observation and interview on 03/08/21 at 2:17 PM, Resident #18 appeared in good spirits and engaging. She reported no feelings of sadness, isolation, or boredom. She stated she enjoyed being in a room but herself so she could have some privacy.

In an interview on 3/8/21 at 2:30 PM, Nurse #7 stated Resident #18 was in good spirits and exhibited no signs of depression. He stated she enjoyed having a room to herself while in isolation. Nurse #7 stated he had not observed any evidence of sadness such as crying or worry. He stated the nurses documented yes or no for her behaviors on every shift. Nurse #7 stated there was no specific behaviors identified for the staff to look for but assumed it would be crying, withdrawal, loss of appetite or lack of attention to personal hygiene.

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In an interview on 3/10/21 at 11:53 AM, the Director of Nursing (DON) confirmed Resident #18's medical record did not identify targeted behaviors. She stated it was an issue with the electronic medical record when entering any order for psychotropics and the facility was actively working to fix it.

In an interview on 3/10/21 at 1:00 PM, Unit Manager (UM) #1 stated all residents on psychotropics should have identified target behaviors for the staff to look for specific to each resident. He stated when an order was put in the electronic medical record, there was no place to add specific target behaviors but rather the program populated a generic order to observe for behaviors. UM #1 stated there should be targeted behaviors listed for Resident #18, so the staff knew what to look for. He stated Resident #18 has had a difficult 6 months because she was normally a very social person before COVID. He stated she had been in isolation twice for COVID-19.

In an interview on 3/10/21 at 1:20 PM, the DON stated the Consultant Pharmacist completed her medication reviews remotely and would email her a pharmacy report each month. Once she received the report and recommendations, she printed a copy for the Medical Director to address. There was a folder for the Medical Director at each nurse's station. The DON stated the Medical Director came to the facility several times per week. He went through the folders and wrote orders if needed and responded to the recommendations then put the recommendation back in a folder for filing. The DON stated if the Medical Director did not agree with a

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recommendation, he would write the rationale on the recommendation and put it back in the folder to be filed. The DON stated she expected the facility identified the need for a GDR and missing targeted behaviors. She stated any nursing recommendations were addressed in the morning meetings.

In an interview on 3/10/21 at 2:28 PM, MDS Nurse #2 stated she and MDS Nurse #1 completed no tasks related to the AIMS assessments. She reported that each month a calendar with all the MDS assessments was given to the UM's.

In an interview on 3/10/21 at 2:30 PM, MDS Nurse #1 confirmed MDS Nurse #2's interview that indicated they were not involved with the AIMS assessments and that the monthly calendar they gave to the UM's did not included any information on what AIMS assessments were due.

In a telephone interview on 3/10/21 at 3:20 PM, the Consultant Pharmacist stated she started at the facility in May 2020. She stated she noted during Resident #18's May 2020 medication review that a GDR had not been done since April 2019 on Resident #18's prescribed Cymbalta. She stated since she was new to the facility in 2020 and due to COVID-19, she planned to address the Cymbalta during her April 2021 visit. The Consultant Pharmacist confirmed that a GDR for an antidepressant should be attempted twice in the first year and then annually thereafter. She stated she was unaware of the need for targeted behaviors with the use of psychotropics but knew the facility looked for adverse side effects.

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In a telephone interview on 3/10/21 at 3:45 PM, the Medical Director stated he handled all the GDRs personally unless the medication was an antipsychotic. He stated Resident #18 has had a difficult year because she tested COVID-19 positive twice and has had to isolate twice. The Medical Director stated he would not recommend a GDR on her antidepressant until things normalize. He stated he expected targeted behaviors to be identified so the staff knew what behaviors to look for and document.

In an interview on 3/10/21 at 5:00 PM, the DON stated it was her expectation that the facility identified the lack of targeted behavior documentation and identify the need for a recommendation regarding a GDR of Resident #18's antidepressant unless contraindicated with documented rationale.

In a telephone interview on 3/11/21 at 1:40 PM, the Psychiatric Nurse Practitioner stated she has not received any GDR recommendations from the facility regarding Resident #18's prescribed Cymbalta. She stated the facility informed her that the Medical Director preferred to address all recommended GDRs. She stated there should be specific documentation as to why a GDR was contraindicated and the behaviors monitoring by the facility was too vague and needed to be specific to Resident #18.

5. Resident #43 was admitted on 12/12/18 with cumulative diagnoses for Cerebral Vascular Accident (CVA), Schizophrenia and Bipolar Disorder.

Review of Resident #43's Physician orders

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included an order dated 4/15/19 for Seroquel Extended Release 24 hour 50 milligrams at bedtime for Paranoid Schizophrenia. Also included was an order dated 2/5/20 for staff to monitor and indicate yes or no if behaviors occurred on every shift. If yes, please record behaviors and non-pharmacological interventions in the medical record.

Resident #43's quarterly Minimum Data Set (MDS) dated 1/18/21 indicated Resident #43 was cognitively intact and exhibited rejection of care behaviors. She was coded for the use of an antipsychotic.

Resident #43's revised care plan dated 2/8/21 read she was at risk for adverse effects related to the use of antipsychotic medications for Schizophrenia and Bipolar Disorder. Interventions included the completion of an Abnormal Involuntary Movement Scale (AIMS) assessment to be completed according to facility policy.

Review of Resident #43's medical record indicated the last AIMS completed was on 1/29/20.

Review of the Consultant Pharmacist monthly telehealth medication review notes for Resident #43 indicated the following:
4/23/20-no recommendations
5/12/20-no recommendations
6/10/20- recommended pain monitoring and discontinuation of Singular
7/8/20-no recommendations
8/3/20-no recommendations
9/1/20-no recommendations
10/5/20-no recommendations
11/2/20-no recommendations

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12/2/20-no recommendations
1/6/21-no recommendations
2/1/21-no recommendations
3/8/21-no recommendations

Review of Resident #43's psychiatry telehealth notes indicated the following:
4/20/20-GDR not recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.
6/3/20-Pleasant and friendly-no delusional thoughts, hallucinations, and mania. Staff report none. Current regime recommended. No medication adjustment recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.
9/11/20-Reported no privacy, stressful, wanting friends to talk too-reported isolation and lonely making symptoms worse. Staff report occasional emotions, gets upset easily-no new recommendations due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications. Reported improvements in mood and coping. GDR would result in risk of decompensation. No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.
2/26/21-No GDR recommended due to risk of decompensation. Benefits outweigh risk and no clinical indication for any GDR of psychiatric medications.

Review of Resident #43's nursing notes from 1/1/21 to present included nursing notes regarding the refusal to wear foot protectors on 1/18/21 and a refusal of lab work on 3/2/21.

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Review of Resident #43's medication administration records (MARs) from 1/1/21 to present indicated she received her Seroquel as ordered and no behaviors exhibited. The MAR did not list any targeted behaviors for staff were to monitor.

In an observations and interview on 3/8/21 at 10:51 AM, Resident #43 was in bed. She appeared pleasant, cooperative, and engaging. There was no evidence of psychosis. She reported her only concern was regarding her showers.

In an observation and interview on 3/10/21 at 8:20 AM, Resident #43 was again in bed. She appeared pleasant, cooperative, and engaging. There was no evidence of psychosis. She stated she was feeling fine and reported no concerns.

In an interview on 3/10/21 at 8:30 AM, Nurse #1 stated the MAR did not specify any target behaviors to document in the medical record but Resident #43 exhibited agitation, short temper and verbal behaviors. Nurse #1 stated it was her understanding that the MDS Nurse or the Unit Managers completed the AIMs assessments.

In an interview on 3/10/21 at 11:53 AM, the Director of Nursing (DON) confirmed Resident #43 medical record did not identify targeted behaviors. She stated it was an issue with the electronic medical record when entering any order for psychotropics and the facility was actively working to fix it.

In an interview on 3/10/21 at 1:00 PM, UM #1 stated either floor nurses completed Resident

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#43's AIMS every 6 months. He stated the previous MDS Nurse would give the UM's a list of MDS assessments due and if an AIMS needed to be completed and that the previous MDS Nurse left in December 2020. He stated the current MDS Nurses did not specify it on the list. He stated the old electronic medical record set up would let staff know when an AIMS was due. UM #1 stated the medical record should specify targeted behaviors for Resident #43 to support the use of an antipsychotic. He stated when an order for any psychotropics was entered into the electronic medical record, a generic template populates for only yes or no responses. UM #1 stated an AIMS, target behaviors for the use of an antipsychotic and documentation regarding the need to evaluate the need for a GDR unless it was contraindicated.

In an interview on 3/10/21 at 2:28 PM, MDS Nurse #2 stated she and MDS Nurse #1 completed no tasks related to the AIMS assessments. She reported that each month a calendar with all the MDS assessments was given to the UM's.

In an interview on 3/10/21 at 2:30 PM, MDS Nurse #1 confirmed MDS Nurse #2's interview that indicated they were not involved with the AIMS assessments and that the monthly calendar they gave to the UM's did not included any information on what AIMS assessments were due.

In an interview on 3/10/21 at 1:20 PM, the Director of Nursing (DON) stated the Consultant Pharmacist completed her medication reviews remotely and would email her a pharmacy report each month. Once she received the report and

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recommendations, she printed a copy for the Medical Director to address. There was a folder for the Medical Director at each nurse's station. The DON stated the Medical Director came to the facility several times per week. He went through the folders and wrote orders if needed and responded to the recommendations then put the recommendation back in a folder for filing. The DON stated if the Medical Director did not agree with a recommendation, he would write the rationale on the recommendation and put it back in the folder to be filed. The DON stated she expected the Consultant Pharmacist to make recommendations for the Medical Director regarding gradual dose reductions (GDRs), missing targeted behaviors and need for an AIMS. She stated any nursing recommendations were addressed in the morning meetings. The DON stated the AIMS protocol was on admission and every 6 months thereafter. The admitted nurse did the baseline AIMS on admission and then the MDS Nurse put out a list of MDS assessments due and the nurses on the unit completed the AIMS. She said the system does not have any automatic prompts to alert the nurses that an AIMS is due. The DON stated she was unaware that Resident #43's last AIMS assessment was completed on 1/29/20 and was unaware that the AIMS were not being done. The DON stated it was her expectation that the facility identified the need for an AIMS assessment on Resident #43, identified the need for a GDR in Seroquel been addressed and identified Resident #43 targeted behaviors for the use of an antipsychotic.

In a telephone interview on 3/10/21 at 3:20 PM, the Consultant Pharmacist stated she started at the facility in May 2020. She stated the

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expectation of an AIMS assessment on admission and every 6 months thereafter. She stated she did not review Resident #43' medical record for the need of an AIMS assessment and was not aware where the AIMS were documented in the electronic medical record. The Consultant Pharmacist stated she started at the facility in May 2020 and noted no GDR on Seroquel had been addressed since 4/2019. She stated she had planned to address Resident #43's Seroquel in April 2021. She stated she was unaware of the need for targeted behaviors with the use of psychotropics but knew the facility looked for adverse side effects.

In a telephone interview on 3/10/21 at 3:45 PM, the Medical Director stated he handled all the GDRs personally unless the medication was an antipsychotic then he differed to Psychiatry. He stated Resident #43 experienced auditory, visual hallucinations and was known to often yell out and talk to people who weren't there. The Medical Director stated he had not received any recommendations from the facility regarding Resident #43's Seroquel, the need for an AIMS or the need for identification of specific targeted behaviors.

In an interview on 3/10/21 at 5:00 PM, the DON stated it was her expectation that the facility identified the lack of targeted behavior documentation, identify the need for a recommendation regarding a GDR of Resident #43's antipsychotic unless contraindicated with documented rationale and the need for an AIMS every 6 months. She stated there was a problem with the facility's protocol for completing the AIMS.

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In a telephone interview on 3/11/21 at 1:40 PM, the Psychiatric Nurse Practitioner stated she has not received any GDR recommendations from the facility regarding Resident #43' prescribed Seroquel. She stated the facility informed her that the Medical Director preferred to address all recommended GDRs and it was her understanding that a GDR could not be attempted due to Resident #43's diagnosis of Schizophrenia. She stated the facility should have identified the need for specific documentation as to why a GDR was contraindicated, the need for an AIMS assessment and identified that the behavior monitoring by the facility was too vague and needed to be specific to Resident #43.

6. Resident # 3 was admitted to the facility on 11/20/20 with multiple diagnoses including schizophrenia. The quarterly Minimum data Set (MDS) assessment dated 2/25/21 indicated that Resident #3 had severe cognitive impairment and he had received an antipsychotic drug during the assessment period.

Resident #3 had a doctor's order dated 11/21/20 for Risperdal (an antipsychotic drug) 0.5 milligrams (mgs.) by mouth daily for bipolar disorder and on 1/27/21 for Risperdal 1 mgs at bedtime for schizophrenia.

Review of Resident #3's medical records revealed that the Abnormal Involuntary Movement Scale (AIMS) test or Dyskinesia Identification System Condensed User Scale (DISCUS) was not completed since admission to monitor for the psychotropic drug adverse reaction.

On 3/10/21 at 1:20 PM, the Director of Nursing (DON) was interviewed. The DON indicated that MDS Nurses were responsible for the AIMS

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test/DISCUS. She indicated that residents on antipsychotic drugs should have AIMS test or DISCUS completed on admission and then every 6 months.

On 3/10/21 at 2:31 PM, MDS Nurse #2 was interviewed. She stated that MDS Nurses were not responsible for completing the AIMS test.

On 3/10/55 at 3:55 PM, a follow up interview was conducted with the DON. The DON stated that residents on antipsychotic drug should have an AIMS test or DISCUS completed on admission and then every 6 months. She verified that Resident #3 did not have an AIMS test nor DISCUS completed on admission. She explained that the MDS Nurses were supposed to notify the floor nurses when AIMS test was due and the admission Nurse was supposed to complete an AIMS test on admission for residents on antipsychotic drug.

7) Resident #31 was admitted to the facility on 5/22/20 with diagnoses that included vascular dementia with behavior disturbance and schizophrenia.

An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 5/22/20 for Resident #31.

The quarterly Minimum Data Set (MDS) assessment dated 1/9/21 indicated Resident #31's cognition was severely impaired, and she had received an antipsychotic medication 7 of 7 days during the MDS look back period.

A review of the current physician orders on 3/9/21 indicated an order for Risperidone Solution (an antipsychotic medication) 2 milligrams (mg) twice

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a day, had remained active since Resident #31's admission date of 5/22/20.

A review of the hard copy and electronic medical record from 5/22/20 to 3/10/21 revealed an AIMS assessment or any other involuntary movement assessment had not been completed for Resident #31 since 5/22/20.

During an interview with the Director of Nursing (DON) on 3/10/21 at 1:20 PM, she stated the facility's normal process was to complete an AIMS assessment on admission and then every 6 months for residents on antipsychotic medications. She indicated the initial AIMS assessment was completed by the admitting nurse at the time of admission and then by the floor nurses every 6 months with coinciding dates of the MDS assessment. The DON further stated the MDS Nurses put out a calendar of MDS assessments due each month and this was used to inform the floor nurses when an AIMS assessment was due. The assessments were completed in the electronic medical record (EMR) under the assessment section.

An interview occurred with MDS Nurse #2 on 3/10/21 at 2:28 PM. She stated she and MDS Nurse #1 completed no tasks related to the AIMS assessments but each month a calendar with all the MDS assessments that were due were given to the Unit Managers. MDS Nurse #2 added the calendar had not included any information on what AIMS assessments were due.

On 3/10/21 at 2:30 PM, an interview was conducted with MDS Nurse #1. She stated she and MDS Nurse #2 had no involvement with the AIMS assessments and the monthly calendar

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F 758	Continued From page 121 provided to the Unit Managers had not included any information on when AIMS assessments were due. A phone interview was completed with the Pharmacy Consultant on 3/10/21 at 3:25 PM. She stated it was her expectation for the completion of AIMS assessments on initiation of an antipsychotic medication and then every 6 months. The Pharmacy Consultant explained it was important to complete routine AIMS assessments for antipsychotic medications due to the potential side effects the medication could cause. On 3/10/21 at 4:56 PM, the DON indicated she had reviewed Resident #31's hard copy and electronic medical record and confirmed there was no AIMS assessment completed since 5/22/20. The DON expressed she was not aware of the issue of AIMS assessments not being completed every 6 months. She further stated the MDS Nurses were unaware they were responsible for notifying the floor nurses when an AIMS assessment was due. The DON stated it was her expectation for AIMS assessments to be completed on admission and every 6 months for residents receiving antipsychotic medications, for the MDS Nurses to notify the floor nurses when an AIMS assessment was due and for the floor nurses to complete the AIMS assessment in the EMR.	F 758		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		4/8/21

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F 803	Continued From page 122 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on review of facility's menu, observation and Registered Dietician (RD), resident and staff interview, the facility failed to serve the menu as planned for 3 of 3 residents observed during dining (Residents # 1, #10 & # 66). The facility also failed to consistently serve the menu as planned for 13 of 13 alert and oriented residents in attendance at the Resident Council meeting (Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55). Findings included: 1. Resident #1 was admitted to the facility on	F 803	F803 Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, # 47, #50, #53, and #55 were identified as being affected by the deficient practice and voiced that the menu specified is not what is served. All residents have the potential to be affected by the deficient practice. On 3/17/21 Ellen Kindred, R.D. educated the Dietary Manager on food ordering, and all dietary personnel including the Dietary Manager on adhering to the posted menu. The Dietary Manager will	

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F 803	Continued From page 123 8/9/19 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated that Resident #1 had moderate cognitive impairment. Resident #1 had a doctor's order for regular diet. Review of the menu for regular diet was conducted. The menu for 3/9/21 (dinner) was grilled chicken breast, roasted red potatoes and buttered cabbage. The menu for 3/10 (lunch) was glazed ham, black eyed peas, and collard greens. Resident #1 was interviewed on 3/10/21 at 10:55 AM. He stated that menu was not followed 50% of the time. Resident #1 stated that the menu for dinner yesterday (3/9/21) listed grilled chicken breast, roasted red potatoes, and buttered cabbage. He reported what was served were coleslaw and looked like "pot pie". On 3/10/21 at 12:34 PM, lunch observation was conducted. Resident #1 was served green beans instead of collard greens that was listed on the menu. 2. Resident 366 was admitted to the facility on 10/9/20 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 2/4/21 indicated that Resident #66's cognition was intact. Resident #66 had a doctor's order for regular diet. Review of the menu for regular diet was conducted. The menu for 3/9/21 (dinner) was grilled chicken breast, roasted red potatoes and buttered cabbage. The menu for 3/10 (lunch)	F 803	review daily the menu for the following day and every Thursday for the weekend to insure that the menu items are available. Should changes need to be made, the Dietary Manger will make sure that substitutions are of equal nutritional value, approved by the Registered Dietician and posted on the substitution list so that the residents are made aware of the changes. Dietary Manager will audit the meal trays to insure they are the same as the posted menu for 5x/week for 4 weeks, then 3x/week for 2 months. The Administrator will review audits weekly. The Dietary Manager will attend the Food Committee Meetings monthly and will interview all resident council members plus 5 additional alert and oriented residents to insure the meal received was the meal specified on the menu. He will conduct these audits every month for 3 months. The Dietary Manager will provide test trays 3x/week to Director of Nursing Services to review menu accuracy on an ongoing basis. The systemic change is the Dietary Manager will not be able to alter the menu without approval from the Registered Dietician The Administrator will review the audits monthly to identify patterns/trends and will adjust the plans necessary to maintain compliance. The Interdisciplinary Team will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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was glazed ham, black eyed peas, and collard greens.

Resident #66 was interviewed on 3/8/21 at 9:39 AM. He stated that most of the time, the menu that was posted was not the menu being served.

On 3/8/21 at 12:25 PM, Resident #66 was observed during lunch. He was served green beans instead of collard greens that was listed on the menu.

3. Resident # 10 was admitted to the facility on 9/12/17 with multiple diagnoses including hypertension. The quarterly Minimum Data Set (MDS) assessment dated 12/21/20 indicated that Resident #10's cognition was intact.

Review of the menu for regular diet was conducted. The menu for 3/9/21 (dinner) was grilled chicken breast, roasted red potatoes and buttered cabbage. The menu for 3/10 (lunch) was glazed ham, black eyed peas, and collard greens.

Resident #10 had a doctor's order for consistent carbohydrate diet.

Resident #10 was interviewed on 3/8/21 at 9:42 AM. She stated that the menu that was posted was not the menu being served. She added that this happened frequently.

On 3/8/21 at 12:25 PM, Resident #10 was observed during lunch. She was served green beans instead of collard greens that was listed on the menu.

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On 3/10/21 at 1:05 PM, Dietary Cook #1 was interviewed. She reported that at times the item on the menu was not available, so she had to substitute it with something. Cook #1 verified that the menu for 3/10/21 for lunch was supposed to be collard greens but since it was not available, she had to substitute it with green beans.

On 3/10/21 at 4:10 PM, Dietary Cook #2 was interviewed. He stated that at times the planned menu was not being followed. He verified that the 3/9/21 dinner menu was supposed to be grilled chicken breast, roasted red potatoes and buttered cabbage. The chicken breast, red potatoes and cabbage were not available, so he had served coleslaw (prepackaged) and chicken pot pie instead.

On 3/10/21 at 4:35 PM, the Dietary Manager (DM) was interviewed. He stated that he was new to the facility and was new as a dietary manager (started in January 2021). The DM indicated that he was aware that residents had complained of menu not being followed. He reported that he was still trying to learn especially in ordering food supplies. He ordered food supplies at least a week ahead but at times they still ran out of items on the menu so, the cook had to substitute it.

On 3/10/21 at 4:45 PM, the Administrator was interviewed. She indicated that she expected the menu to be followed as planned. The Administrator added that the DM was new as dietary manager. She reported that the DM had no previous experience as DM, but he was signed up for the class.

On 3/11/21 at 11:35 AM, the Registered Dietician

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(RD) was interviewed. She stated that she had not been to the facility since March 2020 due to pandemic. She knew that the facility had a new DM and he was still learning. She started coming to the facility today (3/11/21) and would train the new DM. The RD reported that she was made aware of resident's concerns that menu was not being followed. She advised the DM to make sure to order enough food on the menu for regular, renal, and special diet. She added that she expected at times substitution happened but not frequently. The RD stated that the facility might have ran out of food due to the increase in census and this impacted the ordering of food.
4. A review was conducted of grievance forms submitted by the Resident Council from 1/1/21 through 3/9/21. A grievance dated 2/24/21 from the Resident Council indicated, in part, salads were not what was stated on the menu. The grievance indicated the Dietary Manager (DM) and Administrator spoke with the residents related to this concern on 2/24/21 and the grievance was noted to be resolved.

A Resident Council meeting was conducted on 3/10/21 at 11:00 AM. There were 13 alert and oriented residents (Residents #1, #2, #12, #13, #19, #23, #25, #38, #39, #47, #50, #53, and #55) in attendance. The residents spoke about dietary concerns related to the food menu not being followed. The group reported that several days per week the menu that was posted had not matched the food that was served.

On 3/10/21 at 12:15 PM, an observation was conducted of the lunch meal tray for residents on a regular diet. The menu for 3/10/21 (lunch) was glazed ham, black eyed peas, and collard greens. The meal tray observed had green beans in place

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 803	Continued From page 127	F 803		

of collard greens.

On 3/10/21 at 1:05 PM, Dietary Cook #1 was interviewed. She reported that at times the item on the menu was not available, so she had to substitute it with something. Cook #1 verified that the menu for 3/10/21 for lunch was supposed to be collard greens but since it was not available, she had to substitute it with green beans.

On 3/10/21 at 4:10 PM, Dietary Cook #2 was interviewed. He stated that at times the planned menu was not being followed.

On 3/10/21 at 4:35 PM, the DM was interviewed. He stated that he was new to the facility and was new as a dietary manager (started in January 2021). The DM indicated that he was aware that residents had complained of the menu not being followed. He reported that he was still trying to learn, and this learning process included ordering food supplies. He ordered food supplies at least a week ahead but at times they still ran out of items on the menu so, the cook had to substitute it.

On 3/10/21 at 4:45 PM, the Administrator was interviewed. She indicated that she expected the menu to be followed as planned. The Administrator added that the DM was new as dietary manager. She reported that the DM had no previous experience as DM, but he was signed up for the class.

On 3/11/21 at 11:35 AM, the Registered Dietician (RD) was interviewed. She stated that she had not been to the facility since March 2020 due to pandemic. She knew that the facility had a new DM and he was still learning. She started coming to the facility today (3/11/21) and would train the

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F 803	Continued From page 128 new DM. The RD reported that she was made aware of resident's concerns that the menu was not being followed. She advised the DM to make sure to order enough food on the menu for regular, renal, and special diets. She added that she expected that at times a substitution would happen but that it should not happen frequently. The RD stated that the facility might have ran out of food due to the increase in census and this impacted the ordering of food.	F 803		
F 812 SS=D	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 record review, observation and Registered Dietician and staff interview, the facility failed to label and date food items in the container after opening, failed to date thawed	F 812	F812 During the facility annual survey, a surveyor observed on 3/10/21, male dietary staff without a hair net or beard	4/8/21

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F 812	Continued From page 129 nutritional supplements, and failed to wear hair and beard restraints. This is evident in 2 of 2 kitchen observations. Findings included: The facility's policy on food storage dated October 2017 was reviewed. The policy read in part" all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). All perishable prepared food items must be used within 7 days from preparation date". The facility's policy on dress code (undated) was reviewed. The policy read in part" all kitchen employees must wear hair and beard nets". 1. On 3/8/21 at 9:05 AM, initial tour of the kitchen was conducted. The Dietary Manager (DM) was observed to have a full beard. He was not wearing a hair net nor beard guard while in the kitchen. When interviewed, he stated that he normally wears a hair net and a beard guard when in the kitchen. He added that he was new to the facility and new as DM, started in January 2021 and was still learning. On 3/10/21 at 9:35 AM, a follow up kitchen observation was conducted. The DM was again observed not wearing a beard guard. When interviewed, he stated that he had been in and out of the kitchen and he forgot to put on his beard guard. 2. On 3/8/21 at 9:10 AM, walk-in cooler observation was conducted. The following were noted: - A 4-quart container, 1/3 full, unlabeled, and dated 2/26/21. The DM identified it as pudding	F 812	guard and food items without dates or labels. These food items were discarded. No residents were identified as being affected by the deficient practice. All residents have the potential to be affected by the deficient practices. On 3/17/21 Registered Dietician educated all dietary personnel regarding the requirement to wear hair nets and beard guards when in the kitchen and on the facility□s policy and procedure for food storage, labeling and dating. Beard guards/hair nets have been provided for all dietary staff to be worn on duty. The DON will observe that dietary staff are donning hair nets and beard guards 5x/week for 4 weeks; then 3x/week for 4 weeks; then once weekly for 4 weeks. The Dietary Manager will audit the refrigerator/freezer and nourishment rooms for accurate storing, dating and labeling of food to be done 5x/week for 4 weeks; 3x/week for 4 weeks then once weekly for 4 weeks. The Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Interdisciplinary Team will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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F 812	Continued From page 130 and stated that it should have been labeled when opened. The DM verified the pudding as expired and stated that it was good for 7 days after opening. - A 4-quart container - 1/3 full - undated and unlabeled. The DM identified it as apple sauce. And stated that it should have been labeled and dated. The DM indicated that opened food was good for 7 days after opening. -16 cartons of nutritional shakes-thawed and undated. DM stated that the shakes did not need to be dated. The instruction on the carton read "shelf life - 1 year from production date in frozen state. Once thawed, refrigerate for up to 14 days". On 3/10/21 at 4:45 PM, the Administrator was interviewed. The Administrator had provided the facility's policy on food storage and the facility's dress code. She indicated that she expected the DM to follow the facility's policy on food storage and dress code. She added that the DM was new to the facility and new as DM. The DM had no previous experience as DM, but he was signed up for the class. On 3/11/21 at 11:35 AM, the Registered Dietician (RD) was interviewed. She stated that she had not been to the facility since March 2020 due to the pandemic. She knew that the facility had a new DM and he was still learning. She started coming to the facility today (March 11) and would train the new DM. She expected the DM to follow the facility's policy on food storage and dress code.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		10/11/21

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F 842	Continued From page 131 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 132 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for 1 of 4 residents reviewed for pressure ulcers (Resident #85). The findings included: Resident #85 was admitted to the facility on 11/25/20 with multiple diagnoses that included dementia, atrial fibrillation, coronary artery disease and muscle weakness.	F 842	F 842 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #85 was discharge to the hospital on 2/11/2021 and did not return to the facility Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 842	Continued From page 133 Resident #85's physician orders, revealed an order dated 11/25/20 for weekly skin assessments every Monday on day shift (7:00 AM to 3:00 PM). The November 2020 Medication Administration Record (MAR) was reviewed and indicated a weekly skin assessment had been initialed as completed on 11/30/20. A review of Resident #85's electronic medical record revealed weekly skin assessments were completed and documented on 11/25/20 and 11/30/20. The admission Minimum Data Set (MDS) assessment dated 12/1/20 indicated Resident #85 had severe cognitive impairment. He required extensive assistance from staff for bed mobility and toileting, was incontinent of bowel and bladder, and was at risk for pressure ulcers. The assessment further revealed he had no pressure ulcers or other skin conditions present. The December 2020 MAR was reviewed and indicated a weekly skin assessment had been initialed as completed on 12/7/20, 12/14/20, 12/21/20 and 12/28/20. A review of the electronic medical record for Resident #85 revealed weekly skin assessments were completed and documented only on 12/28/20. The January 2021 MAR was reviewed and indicated a weekly skin assessment had been initialed completed on 1/3/21, 1/11/21, 1/18/21 and 1/25/21.	F 842	The Director of Nursing and/or Wound nurse completed an audit on 9/30/21 of current facility residents to validate that a weekly skin assessment was documented on the Weekly Skin Assessment form in the electronic medical record. 9 residents were identified as not having skin assessment documented. All residents have the potential to be affected by the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing, Assistant Director of Nursing and Wound Nurse provided education on 9/30/21-10/01/21 for the licensed nurses, requiring them to document skin integrity on the Weekly Skin Assessment form in the electronic medical record. All new nurses will be educated upon hire. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON or Wound Nurse will randomly select 10 residents weekly for 4 weeks then 20 residents monthly for 2 months, to validate that the skin assessment was documented on the Weekly Skin Assessment form in the electronic medical record. The Wound Nurse will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Wound nurse or DON will review the plan during the monthly QAPI meeting and the audits will continue at the	

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F 842	Continued From page 134 Review of Resident #85's electronic medical record revealed weekly skin assessments were completed and documented on 1/11/21 and 1/25/21. A phone interview occurred with Nurse #3 on 3/11/21 at 11:00 AM who had indicated a skin assessment had been completed on 12/7/20, 12/21/20, 1/4/21 and 1/18/21. She stated she completed the skin assessments as ordered but failed to document the findings of the assessments in the electronic medical record. She denied any skin conditions being present at the time of the assessments. During a phone interview with the Director of Nursing on 3/11/21 at 12:07 PM, she indicated she expected the nursing staff to complete the skin assessment flowsheet in the electronic medical record when they sign off as completed on the MAR.	F 842	discretion of QAPI committee.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain the dish-machine in safe operating condition as evidenced by the high temperature dish-machine wash temperature gauge not working during the 2 of 2 kitchen observations. Findings included:	F 908	F908 The facility failed to maintain the safe operating condition of the dishwasher. No residents were identified to be affected by the deficient practice. All dietary staff were educated on 3/17/21 that all equipment is to be checked for safe working condition and that any equipment malfunctions shall be reported	4/8/21

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F 908	Continued From page 135 During the initial tour of the kitchen on 3/8/21 at 9:05 AM, the staff were observed washing the dishes using the high temperature dish-machine. The dish-machine wash temperature gauge was reading "0" degrees Fahrenheit (F) during the wash cycle. The dish-machine (high temperature) log for March 2021 was reviewed. There was no wash and rinse temperatures recorded for supper from 3/1/21 through 3/9/21. There was no wash temperature recorded for breakfast and lunch from 3/6/21 through 3/9/21. On 3/8/21 at 9:07 AM, Dietary Aide (DA) #1 was interviewed. He stated that the wash temperature gauge had not been working since the weekend (3/6/21). On 3/8/21 at 9:08 AM, the Dietary Manager (DM) was interviewed. He stated that he was aware that the wash temperature gauge was not working since Saturday 3/6/21. He indicated that the dietary aides working in the evening were new and at times forgot to document the wash and rinse temperature on the log. A follow up kitchen observation was conducted on 3/10/21 at 9:35 AM. The staff were observed washing the dishes using the high temperature dish-machine. The dish-machine wash temperature was reading "0" degrees F during the wash cycle. On 3/10/21 at 9:38 AM, the DM was interviewed. He stated that it was his fault, he forgot to inform the Maintenance Director about the dish-machine wash temperature gauge not working. He reported that he just informed the Maintenance	F 908	immediately to the Director of Maintenance. The Director of Maintenance verified on 3/10/21 that the water entering the kitchen is greater than 160 degrees. Dietary Aides will verify that the final rinse temperature exceeds 180 degrees prior to use. If at any point sanitizing does not occur at 180 degrees, dishwasher use will discontinue and manual dishwashing will occur with a chemical sanitizer until the dishwasher can be repaired. All residents have the potential to be affected by the deficient practice. The temperature log will be modified to include that manual dishwashing with use of a chemical sanitizer must be initiated should dishwasher rinse temperatures fall below 180 degrees. The Dietary Manager will audit all essential dietary equipment for proper working condition 5x/week for one month; 3x/week for one month and weekly for one month. Audits will be reviewed weekly by the Administrator and monthly to identify patterns/trends. The plan will be adjusted as necessary to maintain compliance. The IDT will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee. All corrective action to be completed by April 8, 2021	

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F 908	Continued From page 136 Director this morning (3/10/21) and somebody was supposed to come to fix it. On 3/10/21 at 9:50 AM, the Maintenance Director was interviewed. He stated that the DM had informed him this morning (3/10/21) that the dish-machine wash temperature gauge was not working. He went to check it and the wash gauge was reading 0 degrees however when he checked the water temperature, it was reading between 160-165 degrees F. He reported that he already ordered the part and was coming today. On 3/10/21 at 4:45 PM, the Administrator was interviewed. She stated that she expected the DM to inform the Maintenance Director immediately when the dish-machine was not working. The Administrator added that she was not informed until this morning (3/10/21) that the dish-machine was not working.	F 908		