

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		
(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	E 000			
F 000	An unannounced recertification survey was conducted 11/29/2021 through 12/2/2021. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 16PN11.	F 000			
F 558 SS=D	INITIAL COMMENTS A recertification survey was conducted 11/29/2021 through 12/2/2021. Event ID # 16PN11. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to place the call bell within reach for 1 of 2 residents sampled for accommodation of needs. (Resident # 60) Findings included: Resident #60 was admitted to the facility on 6/29/2015. Her diagnoses included stroke and hemiplegia. The annual Minimum Data Set (MDS) assessment dated 8/14/2021 indicated Resident #60 was relatively cognitively intact with disorganized thoughts and required extensive	F 558	On 11/30/2021, the MDS Coordinator placed Resident #60 call light within reach. On 11/30/2021, the MDS Coordinator completed a 100% audit to ensure that all residents to include resident # 60 call light was within reach. All identified concerns was addressed during the audit by the MDS Coordinator by placing the call light within reach. The audit will be completed by 11/30/2021. On 12/19/2021, the Director of Nursing initiated an in-service with all staff regarding call light placement to ensure all call lights are within reach of the residents. In-service will be completed by	1/11/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/23/2021

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

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F 558	<p>Continued From page 1</p> <p>assistance of one person with all activities of daily living (ADLs) except eating. The MDS assessment further indicated impairments to one side of Resident #60's upper and lower extremities.</p> <p>Resident #60's care plan dated 11/8/2021 included a risk for falls. Interventions included keeping the call light within reach and encouraging Resident #60 to call for assistance before standing.</p> <p>On 11/29/2021 at 10:40 am, Resident #60 was observed sitting in a recliner positioned on the right side of the bed. Resident #60 stated the call bell was used to call the nurse and stated she was unable to reach the call bell, but she did not need the nurse. The wall outlet was observed with a call bell cord connected for Resident #60, but the location of the call bell was not visible.</p> <p>On 11/29/2021 at 4:15 pm Resident #60 was observed sitting in recliner beside the bed with no call bell in reach.</p> <p>On 11/30/2021 at 4:25 pm Resident #60 was observed lying in bed, and the call bell was not observed within reach of Resident #60.</p> <p>On 11/30/2021 at 4:25 pm in an interview with Nurse Aide (NA) #2, she stated Resident #60 was capable of using a call bell and knew staff would come when activated. NA #2 stated the call bell should be within reach of Resident #60 at all times and located Resident #60's call bell on the floor behind Resident #60's recliner positioned beside the bed. NA #2 positioned the call bell across the lower chest area of Resident #60 and stated she was assigned to Resident #60, but</p>	F 558	<p>1/11/2022. All newly hired staff will be in-serviced during orientation in regard to call light placement.</p> <p>The Medical Records Manager or Supply Clerk will audit 10% of all call bells to include resident # 60 to ensure the call bells are within reach of the resident weekly x 4 weeks then monthly x 1 month utilizing a Call Light Audit Tool. All identified areas of concern will be addressed during the audit by ensuring the call light is within reach and the staff will be reeducated by the Unit Manager or Administrative Nurse. The Director of Nursing will review and initial the Call Light Audit Tool weekly x 4 weeks for completion and to ensure all areas of concern have been addressed.</p> <p>The Administrator will forward the Call Light Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Call Light Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</p>		

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F 558	Continued From page 2 another nurse aide had assisted Resident #60 back to bed without placing the call bell within Resident #60's reach.	F 558			
F 583 SS=D	On 11/30/2021 at 4:31 pm in an interview with the Director of Nursing, she stated call bells should be within reach of the residents at all times. Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		1/11/22	

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F 583	<p>Continued From page 3</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and staff interviews, the facility failed to provide personal privacy when assisting with dressing for 1 of 1 resident reviewed for privacy. (Resident # 60)</p> <p>The findings included:</p> <p>Resident #60 was admitted to the facility on 6/29/2015. Her diagnoses included stroke and seizure disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated 8/14/2021 indicated Resident #60 was cognitively intact and required extensive assistance of one person with all activities of daily living (ADLs) except eating.</p> <p>On 12/01/2021 at 11:15 a.m. when walking down the hallway, Resident #56 was observed in a wheelchair in the hallway outside of Resident #60's door, and Resident #60's door was observed opened. Upon arriving at Resident #60's door, NA #1 was observed standing in front of Resident #60 assisting her in dressing. Resident #60's top was pulled up to the mid trunk level, her pants were positioned above her knees on the thighs and the back and left side of the adult brief was visible. NA #1 was observed stopping resident care, walking toward the door to gather a pair of gloves and returning to Resident #60 to continue to assist with dressing the pants while Resident #60 was standing and transferring</p>	F 583	<p>On 12/20/2021, NA # 1 was retrained on providing personal privacy for a resident assisting with dressing by the Unit Manager.</p> <p>On 12/17/2021, 100% audit of all residents to include resident #60 was completed by the administrative LPN to ensure that all residents were provided personal privacy to include closing door and/or pulling the privacy curtain while being provided assistance with dressing. There were no additional identified areas of concern during the audit. The audit will be completed on 12/17/2021.</p> <p>On 12/9/2021, 100% in-service was initiated by the Director of Nursing on with all nurses and nursing assistants regarding providing personal privacy to include providing personal privacy by closing the door and/or pulling the privacy curtain for a resident while assisting with dressing. All newly hired nurses and nursing assistants will be in-serviced by the DON or Unit Manager during orientation in regard to personal privacy. In-service will be completed by 1/11/2022. The Unit Manager or Administrative Nurse will complete 10% observation of activity of daily living (ADL) resident care to include providing personal privacy for residents while assisting with dressing for all residents to include resident # 60</p>		

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F 583	Continued From page 4 Resident #60 to the wheelchair. A male visitor was observed walking by the hallway while NA #1 was assisting Resident #60 with dressing. Resident #60's roommate was not observed in the room during resident care. On 12/01/2021 at 11:23 a.m. in an interview with NA #1, she stated during resident care privacy was provided by pulling the curtain and closing the door. She stated while assisting Resident #60 in dressing, the curtain was not pulled, and the door was not shut. She stated privacy had not been provided because she was going to look for the person who requested to observe Resident #60 transfer from the bed to the chair. On 12/2/2021 at 11:44 a.m. in an interview with the Director of Nursing, she stated when providing resident care, the door should be shut, and the curtains should be drawn to keep the resident not in sight.	F 583	weekly x 4 weeks then monthly x 1 month utilizing the Privacy Audit Tool. This audit is to ensue residents were provided personal privacy to include closing door and/or pulling privacy curtain when being assisted with dressing. Any identified areas of concern will be addressed during the audit by the DON, Unit Manager, or Administrative Nurse to include providing privacy and additional staff re-training. The Director of Nursing will review and initial the Privacy Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Director of Nursing will present the findings of the Privacy Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Privacy Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.		
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	F 585		1/11/22	

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F 585	<p>Continued From page 5 residents, and other concerns regarding their LTC facility stay.</p> <p>§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.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§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:</p> <p>(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;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,</p>	F 585			

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F 585	Continued From page 6 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 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	F 585			

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F 585	<p>Continued From page 7</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff and family interviews, the facility failed to make prompt efforts to resolve a grievance for 1 (Resident #27) of 1 resident reviewed for grievances.</p> <p>Findings included:</p> <p>Resident # 27 was admitted to the facility on 01/29/2021 with diagnoses that included: dementia, hypertensive heart disease with heart failure and unspecified psychosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated 10/08/2021 revealed Resident #27 had severe cognitive impairment and had physical and verbal behaviors that occurred 1 to 3 days and rejection of care behaviors that occurred 1 to 3 days. The assessment also revealed the resident required extensive assistance with bed mobility, transfers, toileting and dressing with one-person physical assist.</p> <p>A review of the facility grievance forms indicated Resident #27's responsible party filed a written grievance on 11/15/2021. The sections of the grievance form revealed the following:</p> <p>Page 1, section "the nature of concern/grievance": an evening NA (nurse aide) was rough with Resident #27 helping her to get undressed. Resident #27's roommate said she told the NA "you don't have to be so rough with her" and Resident #27 talked about being treated</p>	F 585	<p>On 12/1/2021, the Administrator completed a grievance form and initiated an investigation for resident # 27. Grievance investigation was completed, and letter of resolution mailed to the resident representative on 12/17/2021. On 12/10/2021, the facility LPN initiated questionnaires with all alert and oriented residents to include resident #27 roommate in regard to any concerns. This questionnaire is to identify any resident with a concern that the facility is not aware of and been addressed. The Social Worker, Director of Nursing, or Unit Manager will address all concerns identified during the audit to include completing a grievance form, initiating investigation, reporting as indicated per the regulations, and completing a written grievance response. The audit will be completed by 12/10/2021.</p> <p>On 12/23/2021, a 100% audit of all grievances from 11/1/2021-12/17/2021 was initiated by the clinical consultant utilizing the concern audit tool to ensure all grievances were logged, investigated with witness statements as indicated, in-services completed as indicated, written grievance response provided to the resident or resident representative per the Resident Grievance Policy and per Resident Concern and Grievance guidelines. The Administrator will address</p>		

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F 585	<p>Continued From page 8 badly.</p> <p>Page 2, section "Investigation" was not completed.</p> <p>Page 2, "Concern/Grievance Resolution" was not completed.</p> <p>A phone interview with the complainant on 11/29/2021 at 9:39 am revealed she completed the facility's grievance form on 11/15/2021 while attending an in-person care plan meeting with the Social Worker and the Director of Nursing (DON). She stated the grievance form was related to a concern regarding a nursing assistant (NA) being rude, rough, and treating Resident #27 badly while helping the resident get undressed. She stated at the end of the care plan meeting, she gave the completed grievance to the Social Worker who then told her the facility would conduct a complete investigation and follow up with the complainant regarding the results of the investigation and the resolution. The complainant added she learned of the alleged incident while visiting Resident #27 at which time Resident #27's roommate informed her that "about two weeks ago" (date unknown) a NA "jerked" Resident #27 "around" and the roommate relayed to the NA "she didn't have to snatch the resident around like that."</p> <p>An interview with the Social Worker on 12/01/2021 at 10:19 am revealed an in-person care plan meeting was conducted for Resident #27 on November 15, 2021 and attendees were the complainant, the Social Worker and the DON. The Social Worker further stated during the meeting, the complainant expressed concern regarding a staff member being "rude a couple of</p>	F 585	<p>all areas of concern identified during the audit to include completing investigation of grievance, reporting as indicated per the regulations, in-services, obtaining statements, providing written grievance response to the resident/resident representative at the end of the investigation. Audit will be completed by 12/23/2021.</p> <p>On 12/23/2021, the Administrator, Director of Nursing and the Social Worker was in-serviced by the clinical consultant on the Resident Grievance Policy and Guidelines to include the Administrator's responsibility to ensure all concerns are investigated per facility protocol to include HCPI reporting when indicated and the resident or resident representative is provided with a written grievance summary results upon completion of the grievance investigation. All newly hired Administrator, Director of Nursing and the Social Worker will receive in service upon hire by the Director of Nursing or Unit Manager during orientation on Resident Grievance Policy and Guidelines. In Service will be completed by 12/23/2021. 10% audit of resident grievances will be reviewed weekly for 4 weeks, then monthly x 1 month by the Medical Records Manager or Administrative Nurse utilizing the Concern Audit Tool. This audit is to ensure all concerns are investigated per facility protocol to include HCPI reporting when indicated and the resident or resident representative is provided a written grievance summary upon completion of the grievance investigation. The Social Worker, Unit Manager or</p>		

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F 585	<p>Continued From page 9</p> <p>weeks ago" to Resident #27. The Social Worker stated during the care plan meeting on 11/15/2021, a blank grievance form was given to the complainant, which the complainant completed, and returned to the Social Worker at the end of the meeting. The Social Worker stated she thought the completed grievance had been placed in the DON's mailbox or the Unit Manager's mailbox. The Social Worker noted she did not log the grievance on the grievance log because the facility's process was to log the grievance after it had been completed and resolved. She also stated there had not been any follow up information or resolution communicated or mailed to Resident #27's responsible party.</p> <p>An interview with the DON on 12/01/2021 at 10:37 am revealed she remembered a discussion of the grievance among Administrative staff but couldn't remember the date or the specifics of the discussion other than it was about a staff member being "a little rude" to Resident #27 due to an observation made by Resident #27's roommate. The DON stated had not seen the grievance form after giving it to the Administrator.</p> <p>An interview with the Administrator on 12/01/21 10:41 AM revealed she remembered reviewing a grievance that was filed during a during care plan meeting for Resident #27 and remembered specific details about a staff member being rude. She stated she gave the written grievance to the Unit Manager to follow up on, but it had not been returned to her (the Administrator) yet.</p> <p>An interview with the Unit Manager on 12/01/2021 at 10:54 am revealed she remembered talking to the complainant regarding a medication change but never about staff being rude or rough with</p>	F 585	<p>Administrative Nurse will address all concerns identified during the audit to include initiating an investigation, obtaining statements, HCPI reporting when indicated and providing a written grievance summary to the resident representative following completion of investigation. The Administrator will review the Concern Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.</p> <p>The Administrator will forward the results of the Concern Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Concern Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</p>		

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NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD DUNN, NC 28334		
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F 585	Continued From page 10 Resident #27. The Unit Manager stated she had no knowledge of a written grievance for regarding Resident #27 and stated she didn't ordinarily handle grievances. An additional interview with the Administrator on 12/02/2021 at 10:23 am revealed the grievance should have been followed up on and resolved as quickly as possible. She also noted there had been no progress related to the grievance as it had not been investigated or resolved and there had been no communication to Resident #27's responsible party since the grievance was filed on 11/15/2021.	F 585			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/11/22	

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F 609	<p>Continued From page 11</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and family and staff interviews, the facility failed to submit a 2 hour and a 5-day report to the State Survey Agency and failed to investigate an allegation of mistreatment by a staff member due to being "rough" while providing care to 1 of 1 resident reviewed, Resident #27.</p> <p>The findings included:</p> <p>Resident # 27 was admitted to the facility on 01/29/2021 with diagnoses that included: dementia, hypertensive heart disease with heart failure and unspecified psychosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated 10/08/2021 revealed Resident #27 had severe cognitive impairment and had physical and verbal behaviors that occurred 1 to 3 days and rejection of care behaviors that occurred 1 to 3 days. The assessment also revealed the resident required extensive assistance with bed mobility, transfers, toileting and dressing with one-person physical assist.</p> <p>A review of the facility's reportable incidents from 09/01/2021 - 11/30/2021 revealed no reportable investigations were completed for Resident #27.</p> <p>A review of the facility grievance forms indicated</p>	F 609	<p>On 12/2/2021, the Administrator submitted an Initial Allegation 2 Hour Report to the Health Care Personal Registry regarding Resident # 27 allegation of abuse and initiated investigation.</p> <p>On 12/7/2021, the Administrator submitted the Investigation Summary 5 Day Report to the Health Care Personnel Registry regarding Resident # 27 allegation of abuse.</p> <p>On 12/23/2021 the clinical consultant initiated a 100% audit of all grievances from 11/15/21-12/17/21 utilizing the Concerns Audit Tool to ensure all that all allegations of abuse to include being roughly handled were timely reported and investigated to the Health Care Personnel Registry per the regulations. The administrator or director of nursing will address all concerns identified during the audit to include submitting the Initial Allegation 2 Hour Report and completing investigation as well as submitting the Investigation Summary 5 Day Report to Health Care Personnel Registry. Audit will be completed by 12/23/2021.</p> <p>On 12/1/2021, the RN Facility Consultant initiated an in-service with the Administrator and Director of Nursing</p>		

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F 609	<p>Continued From page 12</p> <p>Resident #27's responsible party filed a written grievance on 11/15/2021. The sections of the grievance form revealed the following:</p> <p>Page 1, section "the nature of concern/grievance": an evening NA was rough with Resident #27 helping her to get undressed. Resident #27's roommate said she told the NA "you don't have to be so rough with her" and Resident #27 talked about being treated badly.</p> <p>A phone interview with Resident #27's family member on 11/29/2021 at 9:39 am revealed she completed the facility's grievance form on 11/15/2021 while attending an in-person care plan meeting with the Social Worker and the Director of Nursing (DON). She stated the grievance form was related to a concern regarding a nursing assistant (NA) being rude, rough, and treating Resident #27 badly while helping the resident get undressed. She stated at the end of the care plan meeting, she gave the completed grievance to the Social Worker who then told her the facility would conduct a complete investigation. Resident #27's family member added she learned of the alleged incident while visiting Resident #27 at which time Resident #27's roommate informed her that "about two weeks ago" (date unknown) a NA "jerked" Resident #27 "around" and the roommate relayed to the NA "she didn't have to snatch the resident around like that."</p> <p>An interview with Resident 27's alert and oriented roommate on 12/01/2021 at 4:39 pm revealed she remembered the alleged incident but could not recall the exact date or the name of the staff member involved as the facility had a lot of "agency" workers and she saw new faces daily. She also revealed she had not been asked about</p>	F 609	<p>regarding reporting and investigating allegations timely to the Health Care Personal Registry by submitting an Initial Allegation Report and completing an Investigative Report per the regulations. In-service will be completed by 12/1/2021. All newly hired Administrators and Directors of Nursing will be in-serviced by the RN Facility Consultant during orientation in regards to reporting and investigating all allegations and timely submission of Initial Allegation and Investigative Reports to Health Care Personal Registry.</p> <p>On 12/21/2021 the Administrator initiated an in-service with the Administrative Nurses, Social Workers, Admissions director, Therapy Director, Housekeeping Supervisor, and Dietary Manger regarding reporting all grievances that include allegations to include residents being handled roughly immediately to the Administrator or Director of Nursing. In-service will be completed by 12/24/2021. All newly hired Administrative Nurses (List out), Social Workers will be in-serviced by the Administrator or DON during orientation in regards to reporting all grievances to include allegations to the Administrator or Director of Nursing. 10% audit of all grievances will be reviewed to include resident # 27 by the Medical Records Manager or Administrative Nurse weekly x 4 weeks then monthly x 1 month utilizing the Concerns Audit Tool. This audit is to ensure all allegations to include abuse, were reported timely to the Director of Nursing, Administrator and that all</p>		

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F 609	<p>Continued From page 13</p> <p>the alleged incident by any facility employee, including the Social Worker, DON or Administrator. She added she had not seen the worker who was involved "lately."</p> <p>An interview with the Social Worker on 12/01/2021 at 10:19 am revealed she thought the completed grievance had been placed in the DON's mailbox or the Unit Manager's mailbox.</p> <p>An interview with the DON on 12/01/2021 at 10:37 am revealed she remembered a discussion of the grievance among Administrative staff but couldn't remember the date or the specifics of the discussion other than it was about a staff member being "a little rude" to Resident #27 due to an observation made by Resident #27's roommate. The DON stated after reading the grievance form, she gave it to the Administrator. Stated further she did not think being rude to a resident would be considered abuse and an investigation regarding this allegation had not been completed</p> <p>An interview with the Administrator on 12/01/21 10:41 AM revealed she remembered reviewing a grievance that was filed during a during care plan meeting for Resident #27 and remembered specific details about a staff member being rude. She stated she gave the written grievance to the Unit Manager to follow up on, but it had not been returned to her (the Administrator) yet. She stated after reading the grievance form, she didn't get the impression the grievance was interpreted as "harmful" behavior, including being rude to a resident, and as a result, she did not report the allegation to the State Survey Agency.</p> <p>An interview with the Unit Manager on 12/01/2021 at 10:54 am revealed she had no knowledge of a written grievance for regarding Resident # 27 and</p>	F 609	<p>allegations are reporting and investigated timely to the Health Care Personal Registry by submitting an Initial Allegation Report and completing an Investigative Report per the regulations. The Administrator or Director of Nursing will complete the Initial Allegation report, investigate, and submit the Investigative report to the Health Care Personal Registry for any identified areas of concerns during the audits. The Administrator or Director of Nursing will review and initial the Concerns Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.</p> <p>The Administrator will present the findings of the Concerns Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Concerns Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.</p>		

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F 609	Continued From page 14 stated she doesn't ordinarily handle grievances. An additional interview with the Administrator on 12/02/2021 at 10:23 am revealed she initially questioned the grievance as an allegation of abuse, but trusted the DON's judgement, therefore, did not complete a full investigation regarding the alleged allegation for Resident #27. She also stated being "rough" or "rude" with a resident would be considered abuse and a full investigation should have been completed.	F 609			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 657		1/11/22	

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F 657	<p>Continued From page 15</p> <p>team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, and resident, responsible party, and staff interviews, the facility failed to conduct and document quarterly care plan meetings and failed to invite the resident to the care plan meetings for 1 of 1 resident reviewed for care planning (Resident #44).</p> <p>Findings included:</p> <p>Resident #44 was admitted to the facility on 12/09/2019, and her diagnoses included Atrial Fibrillation, Diabetes and Depression.</p> <p>A review of Resident #44's care plan initiated on 12/10/2019 revealed it had been reviewed quarterly and most recently on 10/27/2021.</p> <p>A review of Resident #44's medical record revealed on 12/19/2019 a care plan meeting had been held, and Resident #44 and her Responsible Party had attended. Resident #44's medical record further revealed five care plan meeting invitations, with the last one dated 4/6/2021, had been sent to the Responsible Party. No further documentation that care plan meetings had been conducted was observed.</p> <p>A Significant Change in Status Minimum Data Set assessment dated 7/07/2021 indicated Resident #44 was cognitively intact, and her assistance level in activities of daily living improved in areas of bed mobility, transfers, dressing, and eating.</p> <p>On 11/29/2021 at 12:03 p.m. during an interview</p>	F 657	<p>On 12/2/2021, the Social Worker scheduled care plan meeting for resident # 44.</p> <p>On 12/2/2021 the Social Worker mailed a care plan invitation to the resident representative for resident # 44.</p> <p>On 12/13/2021, the Social Worker completed a 100% audit of all care plans completed from 11/1/2021-12/13/2021. This audit is to ensure the resident representative was invited to attend scheduled care plan meetings with documentation in the clinical record. All identified areas of concern will be addressed during the audit by the Social Worker. The Social Worker will review care plan by phone, mail a copy of the care plan and/or reschedule care plan meeting to include mailing care plan invitation for any resident/ resident representative not invited to care plan meeting with documentation in the clinical record. Audit will be completed by 12/13/2021.</p> <p>On 12/9/2021, the Administrator initiated an in-service with the Social Workers, Director of Nursing and Minimum Data Set nurses in regards to Comprehensive Care Plans to include quarterly care plan meetings. Education emphasis on written invitation of resident and/or resident representative with documentation of invitation mailed and response of resident and/or resident representative in the</p>		

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F 657	<p>Continued From page 16</p> <p>with Resident #44, she stated she recalled attending a care plan meeting after deciding to stay in the facility. She stated she nor her family had attended another care planning meeting since that time.</p> <p>On 11/30/2021 at 3:30 p.m. during an interview with the Social Worker, she stated care plan meetings were conducted every three months and documented in the social worker progress notes. She stated coherent residents and the responsible party were invited. After reviewing Resident #44's medical record, she stated she was unable to locate information that care plan meetings had been held.</p> <p>On 11/30/2021 at 8:40 p.m. during an interview with the Responsible Party, she stated she could not recall Resident #44 or herself attending a care plan meeting. She stated she did recall receiving one invitation to a care plan meeting this past year, but she was not able to attend.</p> <p>On 12/02/2021 at 9:01 a.m. during an interview with the Administrator, she stated care plan meetings were to be held quarterly or after a significant change in the resident. She further stated the social worker documented care plan meetings in the residents' record, and Resident #44 should have been invited and involved in her care plan meetings.</p>	F 657	<p>electronic record. All newly hired Social Workers, Director of Nursing and Minimum Data Set nurses will be in-serviced during orientation in regards to Comprehensive Care Plans. In-service will be completed by 12/10/2021.</p> <p>On 12/9/2021, the Administrator initiated an in-service with the Social Workers, Director of Nursing and Minimum Data Set nurses in regards to conducting and documenting quarterly care plan meetings in the clinical record. All newly hired Social Workers, Director of Nursing and Minimum Data Set nurses will be in-serviced during orientation in regards to conducting and documenting care plan meetings. In-service will be completed by 12/10/2021.</p> <p>The Administrative Nurse or MDS Nurse will review progress notes for all resident care plan to include resident #44 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure the Social Worker scheduled, mailed a written invitation to the resident and/or resident representative for all care plan meetings and conducted care plan meetings with documentation in the clinical record. The Social Worker or DON will address all concerns identified during the audit to include conducting care plan meeting over the phone, mailing a copy of the care plan or re-scheduling care plan meeting if indicated and education of staff. The Administrator and/or DON will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.</p>		

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F 657	Continued From page 17	F 657			
F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide nail care to 1 of 2 residents reviewed who were dependent on staff for assistance with activities of daily living. (Resident #18)</p> <p>Findings included:</p> <p>Resident #18 was admitted to the facility on 3/3/2021. Her diagnoses included Non-Alzheimer's Dementia and Depression.</p> <p>The significant change Minimum Data Set (MDS) assessment dated 3/15/2021 indicated Resident #18 was severely mentally impaired and required total assistance with personal hygiene and bathing.</p>	F 677	<p>The Director of Nursing will forward the Care Plan Audit Tool to the Quality Assurance and Performance Improvement (QA) Committee monthly for 2 months. The QA Committee will meet monthly for 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.</p> <p>On 12/2/2021, the nurse provided nail care to including cutting nails to resident # 18. On 12/2/2021, a 100% audit of all residents fingernails was completed by the MDS coordinator to ensure all residents were provided nail care per resident preference. The MDS coordinator or hall nurse provided nail care for all identified concerns during the audit. On 12/9/2021, the Director of Nursing initiated 100% in service with all nurses and nursing assistants regarding nail care to include cleaning and cutting nails. In-services will be completed by 1/11/2022. All newly hired nurses and nursing assistants will be in-serviced by the Director of Nursing or Unit Manager</p>	1/11/22	

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F 677	<p>Continued From page 18</p> <p>Nursing documentation revealed Resident #18's fingernails were trimmed on 9/4/2021.</p> <p>Resident #18's care plan dated 9/10/2021 revealed she needed assistance with activities of daily living (ADLs), and interventions included providing total care for washing and drying face, skin, nails and hands.</p> <p>On 11/29/2021 at 11:18 a.m. Resident #18's fingernails were observed curved and extended beyond the fingertips. Broken and chipped nail polish was observed to the right fingernails.</p> <p>On 12/2/2021 at 10:11 a.m. NA #1 had completed Resident #18's morning bath and personal care. Resident #18's fingernails were observed clean, but not cut. The left and right fingernails were three fourths inches in length. NA #1 stated she cleaned the nails with morning care, and the nurse was responsible for cutting the nails. Na #1 stated she had cut Resident #18's fingernails prior to the Thanksgiving holiday, and the fingernails were overdue to be cut.</p> <p>On 12/2/2021 at 10:18 a.m. in an interview with Nurse #1, she stated fingernails were cut every two weeks and nail care was documented in the nursing notes. She stated Resident #18 received nail care daily because her nails get dirty from digging, and Resident #18's fingernails needed to be cut.</p> <p>On 12/2/2021 at 10:29 a.m. in an interview with the Director of Nursing, she stated nail care was conducted by the nurse aide or nurse, and fingernails should be cut when nursing staff observe the fingernails long in length.</p>	F 677	<p>during orientation in regards to nail care. 10% observation of resident care to include nail care for all residents to include resident #18 will be completed by the Supply Coordinator (medication aide), Administrative Nurse or Unit Manager weekly x 4 weeks then monthly x 1 month utilizing a Resident Care Audit Tool. This audit is to ensue residents were provided nail care to including cutting nails. Any identified areas of concern will be addressed by the Supply Coordinator, Administrative Nurse or Unit Manager to include providing nail care and staff retraining. The Director of Nursing will review and initial the Resident Care Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed.</p> <p>The Administrator will present the findings of the Resident Care Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Resident Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.</p>		

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F 690 F 690 SS=D	Continued From page 19 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 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:	F 690 F 690		1/11/22	

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F 690	<p>Continued From page 20</p> <p>Based on staff interviews and record review, the facility failed to provide an anchor device to prevent tension on catheter tubing for one of one resident reviewed for catheters (Resident #75).</p> <p>Findings included:</p> <p>A review of medical records revealed Resident #75 was admitted 12/02/2020 with diagnoses including Lewy Body dementia, pulmonary emboli (blood clots in the lungs), and urinary retention.</p> <p>The Significant Change Minimum Data Set (MDS) dated 7/15/2021 noted an indwelling catheter in place.</p> <p>The care plan dated 4/27/2021 noted an indwelling catheter present due to urinary retention. The interventions included: Ensure that drainage tubing is secure with anchoring device, i.e., leg strap, to prevent tension or accidental removal.</p> <p>On 11/29/2021 at 4:15 PM, in Resident #75 's room, Nursing Assistant (NA) #3 removed the bed linen to view the leg strap for the catheter. There was no anchoring device in place. The NA stated he would tell the nurse and she would put a strap on.</p> <p>On 11/30/2021 at 3:23 PM the anchor strap was observed to be in place.</p> <p>On 11/30/2021 at 4:05 PM Nurse #4 was interviewed and stated the anchor strap was in place. Nurse #4 stated when residents are admitted, the admission assessment would be done and if there was no anchor strap in place, the nurse would be responsible to apply one.</p>	F 690	<p>On 11/30/2021, the assigned hall nurse secured the catheter with an anchoring device to prevent tension on catheter tubing for resident # 75.</p> <p>On 11/30/2021, a 100% audit was initiated of all residents with indwelling urinary catheters and/or suprapubic catheters by the Minimum Data Set Nurse utilizing a resident census to ensure that the indwelling urinary catheters and/or suprapubic catheters were secured with an anchoring device to prevent tension on the catheter tubing. Any identified areas of concerns will be addressed during the audit to include securing the indwelling urinary catheters and/or suprapubic catheter tubing with an anchoring device to prevent tension on catheter tubing. Audit completed on 11/30/2021.</p> <p>On 12/9/2021, 100 % in-service was initiated by the Director of Nursing with all nurses and nursing assistants in regards to: securing the indwelling urinary catheters and/or suprapubic catheter tubing with an anchoring device to prevent tension on catheter tubing. In service will be completed 1/11/2022. All newly hired nurses and nursing assistants will be in-serviced by the Director of Nursing or Unit Manager during orientation in regards to securing indwelling catheter tubing with anchor devices to prevent tension on catheter tubing.</p> <p>10% of all residents requiring an indwelling urinary catheter and/or a suprapubic catheter to include resident # 75 will be audit by the Minimum Data Set Nurse or Administrative Nurse utilizing a Catheter Audit Tool weekly x 4 weeks and</p>		

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F 690	Continued From page 21 The Director of Nursing (DON) was interviewed on 12/1/2021 at 12:40 PM, and stated the facility was out of leg straps. The DON indicated she expected the facility to keep leg straps for catheter tubing in stock. On 12/2/2021 at 4:34 PM, the facility Administrator was interviewed and stated she was aware there were no catheter tubing anchor straps and the straps had been ordered.	F 690	monthly x 1 month to ensure that the indwelling urinary catheter and/or suprapubic catheter are secured with an anchoring device to prevent tension. All identified areas of concerns will be addressed by the Minimum Data Set Nurse or Administrative Nurse during the audit by placing an anchoring device on the catheter tubing to prevent tension. The Director of Nursing will review and sign the Catheter Audit Tool weekly x 4 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed. The Director of Nursing will forward the results of the Catheter Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months to review the Catheter Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		1/11/22	

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F 727	<p>Continued From page 22</p> <p>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to maintain Registered Nurse (RN) coverage for 8 hours per day, seven days per week, for three of the sixty days reviewed for RN coverage (10/13/2021, 11/6/2021 and 11/7/2021).</p> <p>Findings included:</p> <p>On 12/2/2021 a review of posted staffing for October and November 2021 revealed no Registered Nurse (RN) coverage on 10/13/2021 and on 11/6 and 11/7/2021.</p> <p>The facility Administrator was interviewed on 12/2/2021 at 4:29 PM and stated "We are onboarding as much RN staff as possible and recruiting. We are usually covered, but sometimes, with call outs and such, we get stuck."</p>	F 727	<p>On 12/3/2021, the Administrator reviewed the upcoming staffing schedule for December 1-31 to ensure the facility had eight hours of registered nursing coverage per the regulations.</p> <p>On 12/23/2021 the Facility Consultant initiated an in-service with the Administrator and Director of Nursing in regards to Medicare Guideline on Register Nurse Coverage. This in-service emphasis on the requirement of 8 hours of consecutive registered nursing Coverage on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and to ensure the facilities ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. In-service will be completed by 12/23/2021.</p> <p>Beginning 12/13/2021, The Administrator and/or Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to ensure the clinical staff are on duty to meets the needs of the residents to include eight (8) consecutive hours of registered nursing coverage.</p> <p>The Director of Nursing, Administrative Nurse and/or Administrator will review staffing schedule daily x 4 weeks then monthly x 1 month utilizing the Sufficient RN Coverage Audit Tool to ensure the facility had 8 consecutive RN coverage</p>		

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F 727	Continued From page 23	F 727	per the Medicare Guideline to provide nursing care to all residents in accordance with resident care plans. The Director of Nursing, Administrative Nurse and/or administrative staff on Duty will address all concerns identified to include but not limited to notification of the Administrator and obtaining required nursing coverage. The Administrator will review the Sufficient RN Coverage Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will forward the results of Sufficient RN Coverage Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Sufficient RN Coverage Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		1/11/22	

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F 758	<p>Continued From page 24</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§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;</p> <p>§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;</p> <p>§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 in the clinical record; and</p> <p>§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.</p> <p>§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 and staff, pharmacists and physician interviews, the facility failed to have</p>	F 758	<p>On 12/1/2021, the RN obtained an order to discontinue Haloperidol from the</p>		

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F 758	<p>Continued From page 25</p> <p>a clinical indication for use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #63)</p> <p>Findings included:</p> <p>Resident #63 was admitted to the facility on 11/2/2021. Her diagnoses included diabetes, atrial fibrillation and unspecified dementia without behavioral disturbances.</p> <p>The admission Minimum Data Set (MDS) assessment dated 11/8/2021 indicated Resident #63 was moderately mentally impaired and exhibited wandering behaviors and behavioral symptoms not directed toward others. The MDS further indicated a diagnosis of Non-Alzheimer's Dementia, Resident #63 received antipsychotics for two days on a routine basis, and a gradual dose reduction for the antipsychotic medication was attempted on 11/4/2021.</p> <p>A review of the physician's orders revealed on 11/2/2021 Resident #63 was ordered Haloperidol, an antipsychotic medication, one milligram by mouth in the evening for dementia and chronic back pain.</p> <p>The Pharmacy Admission Drug Review by Pharmacist #3 dated 11/3/2021 revealed Haloperidol was lacking an indication for the medication.</p> <p>An email by Pharmacist #1 dated 11/3/2021 to Nurse #5 revealed the diagnosis for Haloperidol was listed as dementia and back pain. She requested the nursing staff clarify if Haloperidol was being given for back pain and requested the nursing staff to ask the physician to evaluate for possible dose reduction and the necessity of the</p>	F 758	<p>physician for resident # 63. A new order was written and transcribed to the Electronic Medical Record (EMAR).</p> <p>On 12/20/2021, the pharmacy consultant completed a 100% audit of psychotropic medications. This audit was to ensure that all psychotropic medications for all residents to include resident # 63 have a clinical indication/diagnosis for use by the attending physician or prescribing practitioner with documentation in the clinical record. The unit manager or director of nursing will address all identified areas of concern identified during the audit to include notification of the attending physician or prescribing practitioner for further orders to include clinical indication of use.</p> <p>On 12/9/2021, the Director of Nursing initiated a 100% in-service with all nurses in regards to Psychoactive Medication clinical indication of use. Emphasis was placed all psychoactive medications having a clinical indication/diagnosis for use by the attending physician or prescribing practitioner with documentation in the clinical record. In-service will be completed 1/11/2022. All newly hired nurses will be in-serviced by the Director of Nursing or Unit Manager during orientation in regards to clinical indication/diagnosis with use of psychoactive medications.</p> <p>10% audit of all residents to include resident # 63 physician orders for psychotropic medications will be reviewed</p>		

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F 758	<p>Continued From page 26</p> <p>Haloperidol dose since there was limited psychiatric history.</p> <p>The Medication Regimen Review by Pharmacist #1 dated 11/4/2021 revealed no recommendations to the Physician related to the use of Haloperidol.</p> <p>The physician's orders for Resident #63 revealed Haloperidol was to be discontinued on 11/4/2021.</p> <p>A review of the November 2021 Medication Administration Record (MAR) revealed Resident #63 received Haloperidol one milligram on November 2, 2021 and November 3, 2021 and was discontinued on 11/4/2021.</p> <p>The hospital's discharge summary dated 11/22/2021 revealed Resident #63 was admitted for altered mental status. All sedating medications were held, and Resident #63 returned to her neurological baseline. The discharge medication list for readmission to the facility included Haloperidol one milligram daily and indicated Haloperidol one milligram was last given on 11/20/2021 at the hospital.</p> <p>The physician orders dated 11/22/2021 revealed Haloperidol one milligram by mouth at bedtime was ordered for unspecified dementia without behavioral disturbance and was discontinued on 12/1/2021.</p> <p>The Pharmacy Admission Drug Regimen Review by Pharmacist #2 dated 11/23/2021 revealed no recommendations for the use of Haloperidol.</p> <p>A review of the November 2021 MAR revealed Resident #63 received Haloperidol one milligram</p>	F 758	<p>by the Unit Manager weekly x 4 weeks then monthly x 1 month utilizing a Psychoactive Medication Audit Tool. This audit is to ensure that all psychoactive medications have a clinical indication/diagnosis for use by the attending physician or prescribing practitioner with documentation in the clinical record. The Unit Manager will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit. The Director of Nursing will review and initial the Psychoactive Medication Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.</p> <p>The Director of Nursing will present the findings of the Psychoactive Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Psychoactive Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.</p>		

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F 758	<p>Continued From page 27</p> <p>daily at 8:00p.m. from 11/22/2021 through 11/30/2021.</p> <p>On 12/1/2021 at 1:36 p.m. in an interview with Nurse #2, she stated since her admission on 11/22/2021 Resident #63 had received Haloperidol daily for behavior disturbances and stated Resident #63 exhibited behaviors of confusion and wandering. She stated Haloperidol was ordered for dementia without behavioral disturbances, and the medical record did not reveal the use of other medications to address the behaviors of confusion and wandering. She further stated Resident #63 did not have a diagnosis indicating the use of Haloperidol.</p> <p>On 12/2/2021 at 11:19 a.m. in an interview with Nurse #3, she stated she reviewed Resident #63's medication list when readmitted on 11/22/2021 for antipsychotic medications. She stated she checked for a diagnosis related to the medication, completion of a Dyskinesia Identification System: Condensed User Scale (DISCUS) assessment, an assessment for involuntary skeletal movements associated with the use of antipsychotics and was responsible in placing a referral for the psychiatric nurse to evaluate the residents' medications. Nurse #3 stated there was no order in the medical record for a Psychiatric consult for Resident #63 and the diagnosis, unspecified dementia without behavioral disturbances, was the indication for the use of Haloperidol. Nurse #3 stated she did not review Resident #63's medication list on re-admission with the physician because the physician, who also had hospital privileges, reviewed the medications before the residents were re-admitted to the facility. She further stated Resident #63 continued to exhibit wandering</p>	F 758			

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F 758	<p>Continued From page 28</p> <p>behaviors as the reason Resident #63 continued to receive Haloperidol.</p> <p>On 12/2/2021 at 11:22 a.m. in an interview with the Director of Nursing, she stated antipsychotic medications ordered without a diagnosis should be verified with the physician. She stated the use of Haloperidol for Resident #63 was discussed in an IDT meeting but was unable to recall the exact date. She stated Resident #63 was receiving a low dose of Haloperidol for back pain that was not chemically restraining Resident #63, and the medication was not discontinued because Resident #63 continued to exhibit wandering behaviors. The DON also stated the physician had hospital privileges and reviewed the medications before residents were admitted to the facility.</p> <p>On 12/2/2021 at 2: 44 p.m. in an interview with Pharmacist #1, who conducted the Medication Record Review on 11/4/2021, she stated the nursing staff were concerned Haloperidol may increase Resident #63's risk for falls. She stated she informed Nurse #5 through an email on 11/3/2021 Resident #63 had no diagnosis or psychotic history when admitted to the facility on 11/2/2021 and recommended the nursing staff discuss with the physician the use of Haloperidol for pain since Resident #63 was ordered other pain medications.</p> <p>On 12/2/2021 at 3:12 p.m. in an interview with the Pharmacist #2, she stated she did not request a diagnosis for the use of Haloperidol for Resident #63 because the Pharmacy Admission Drug Review by Pharmacist #3 dated 11/3/2021 had requested an indication. She stated Resident #63 had been on Haloperidol prior to readmission,</p>	F 758			

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F 758	Continued From page 29 and she was not aware the medication had been discontinued, and the medication was continued as ordered on readmission. On 12/2/2021 at 11:54 a.m. in an interview with the Physician, he stated medications were reviewed with the nursing staff unless the resident was admitted from the hospital where he reviewed the medications before the resident ' s discharge from the hospital. The Physician stated he did not see Resident #63's at the hospital or review her medications before discharge. On 12/2/2021 at 5:52 p.m. in a follow up interview with the Physician, he stated there was not a reason why Resident #63 was receiving Haloperidol and should had never been receiving the medication. He stated Resident #63 was ordered Haloperidol by a Psychiatrist prior to her initial admission to the facility.	F 758			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		1/11/22	

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F 880	<p>Continued From page 30</p> <p>reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the</p>	F 880			

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F 880	<p>Continued From page 31</p> <p>corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and the facility's policies "Guidelines on Latest Approach to Personal Protective Equipment (PPE) Use During COVID-19 Pandemic" and "Guidelines for Admission and Readmission during COVID-19 Pandemic", the facility failed to post Enhanced Droplet Isolation signage for 1 of 1 residents (Resident #63) on quarantine for COVID-19, and Nurse #2 failed to remove surgical mask and disinfect face shield after exiting Resident #63's room before entering Resident #67's room located in the general population area. This occurred during a COVID-19 pandemic.</p> <p>Findings included:</p> <p>The facility's policy, "Guidelines for Admission and Readmission during COVID-19 Pandemic" dated 5/10/2021 stated new admissions or readmissions were admitted to the designated admission/readmission quarantine area and placed on contact and droplet precautions with full PPE use by staff.</p> <p>The facility's policy "Guidelines on Latest Approach to PPE Use During COVID-19</p>	F 880	<p>On 11/29/2021 the Director of Nursing posted Enhanced Droplet Isolation Sign on Resident # 63's room.</p> <p>Nurse # 2 was in-serviced on proper donning and doffing personal protective equipment (PPE) for enhanced droplet isolation rooms on the quarantine unit by the Director of Nursing on 12/20/2021.</p> <p>On 12/17/2021, the Administrator completed a 100% audit of all resident rooms that required isolation precautions to ensure that correct isolation precaution signs are posted to include enhanced droplet precautions. The Administrator will address all identified areas of concern during the audit to include posting proper isolation precaution signage.</p> <p>On 12/9/2021 the Director of Nursing initiated an in-service with all nurses and nursing assistants regarding proper isolation precautions to include enhanced droplet isolation signage. The in-service will be completed by 1/11/2022. All newly hired staff will be in-serviced by the Director of Nursing or Unit Manager during orientation in regard to proper handling of soiled linen.</p>		

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F 880	<p>Continued From page 32</p> <p>Pandemic" dated 6/21/2021 stated due to the unknown COVID-19 status of the residents on the quarantine unit a gown, N-95 masks, and protective eye wear was required when entering the quarantine unit and changed when soiled or leaving the quarantine unit. The policy further stated if a staff member working on the quarantine unit moved to the general population unit, all PPE must be removed, and new PPE applied.</p> <p>Resident #63 was admitted on 11/2/2021.</p> <p>Resident #63's immunization record revealed refusal of the COVID-19 vaccinations.</p> <p>Nursing documentation revealed on 11/22/2021 Resident #63 was readmitted to the facility from the hospital.</p> <p>On 11/29/2021 at 9:52 a.m., a pink Enhanced Droplet-Contact Precaution sign was observed posted on Resident #63's door and PPE (gown, gloves, N-95 mask) were observed outside Resident #63's room.</p> <p>On 11/29/2021 at 3:44 p.m. in an interview with the Director of Nursing/acting Infection Preventionist, she stated Resident #63 was placed in quarantine room after readmitted from the hospital. She stated PPE requirements for Resident #63's care was gown, gloves, goggles and face mask. She stated a N-95 was not required because Resident #63 was not known to be COVID positive.</p> <p>On 12/1/2021 at 8:08 a.m., Nurse #2 was observed entering Resident #63's room wearing a surgical mask, face shield, gown and gloves. The</p>	F 880	<p>On 12/9/2021 the Director of Nursing initiated an in-service with all staff regarding PPE to ensure that all staff were wearing appropriate PPE in enhanced droplet isolation rooms to include n-95 mask, gown, gloves as well doffing mask, and performing cleaning of eyewear prior to exiting isolation room. In-service will be 1/11/2022. All newly hired staff will be in-serviced by the Director of Nursing during orientation in regard to PPE with return demonstration.</p> <p>The Unit Manager or Administrative Nurse will observe 20 resident care interactions weekly x 4 weeks and then monthly x 1 month to include all shifts and weekends utilizing the PPE/Signage Audit Tool. This audit is to ensure that all staff ensure that are wearing appropriate PPE in enhanced droplet isolation rooms to include n-95 mask, gown, gloves as well doffing mask, and performing cleaning of eyewear prior to exiting isolation room as well as correct isolation precaution signs are posted.</p> <p>The Unit Manager or Administrative Nurse will address all areas of concern during the audit to include providing staff with the appropriate PPE and ensuring eyewear is cleaned and posting the appropriate isolation signage to include re-training of staff. The Director of Nursing will review the PPE/Signage Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure all areas of concern are addressed.</p> <p>The Director of Nursing will forward the results of the PPE/Signage Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly</p>		

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F 880	<p>Continued From page 33</p> <p>pink Enhanced Droplet-Contact Precaution sign posted on the Resident #63's door listed a surgical mask was required before entering the room.</p> <p>On 12/1/2021 at 8:12 a.m., Nurse #2 was observed removing her gown and gloves prior to exiting Resident #63's room. Nurse #2 continued to wear the surgical mask and face shield and performed hand hygiene at the nurse's station bathroom.</p> <p>On 12/1/2021 at 8:19 a.m., Nurse #2 was observed entering Resident #67's room located in the general population area continuing to wear the surgical mask and face shield worn in Resident #63's room, a quarantined resident. Nurse #2 was stopped as she entered Resident #67's room. In an interview, Nurse #2 stated a gown, gloves, N-95 mask and face shield or goggles was required before entering Resident #63's room. She stated it was not appropriate to wear a surgical face mask in Resident #63's room, but she was in a hurry trying to make sure Resident #63 was not going to fall. She stated the gown, gloves and mask were to be discarded when exiting Resident #63's room and stated she did not change her mask. She stated her assignment consisted on quarantine and general population residents and stated she did not change her mask or disinfect the face shield after exiting Resident #63's room and before entering Resident #67's room. Nurse #2 stated she had received use of PPE education.</p> <p>On 12/1/2021 at 3:00pm in an interview with the Director of Nursing (DON)/acting Infection Preventionist, she stated residents unvaccinated for COVID-19 readmitted from the hospital were</p>	F 880	x 2 month. The QAPI Committee will meet monthly x 2 months and review the PPE/Signage Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 34</p> <p>quarantined on Droplet Precautions. She stated she needed to correct an earlier response to PPE requirements for residents on quarantine and stated based on the company's policy a gown, N-95 mask, gloves and face shield or goggles were required when entering the quarantine room. She stated the gown and gloves were to be removed before exiting Resident 63's room, mask changed outside the door and face shield or goggles wiped clean with a disinfectant. She stated the facility was sharing nursing staff between the quarantine unit and the general population area, and Nurse #2 was to remove PPE, change mask and disinfect the eyewear when exiting Resident #63's room before caring for general population residents. The DON further stated the posted Droplet-Contact Precaution signage posted on Resident #63's door needed to be corrected to state a N-95 mask was required.</p> <p>On 12/2/2021 at 8:30 a.m., Resident #63's door was observed with an Enhanced Droplet Isolation sign indicating the use of a N-95 mask before entering the room.</p> <p>On 12/2/2021 at 4:47 p.m. in an interview with the Administrator, she stated due to the decrease number of quarantine residents in the facility, the nursing staff was shared between the quarantine and general population residents. She stated the nursing staff were to change their PPE (gown, gloves, mask) and disinfect the eyewear when exiting the quarantine area/room before entering the general population residents' rooms.</p>	F 880			