STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING ______ B. WING ______	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 and complaint investigation survey was conducted on 12/13/21 through 12/16/21 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # RFAF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/13/21 through 12/16/21. Event ID# RFAF11. 5 of the 14 complaint allegations were substantiated resulting in deficiencies (F550, F689, F804 & F 759) On 1/10/22 - 2567 was reposted - tag F801 was deleted and F835 was amended.	F 000		
F 550 SS=E	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 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.	F 550		1/13/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/14/2022

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 550	Continued From page 1 §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 reviews, observations, resident and staff interviews, the facility failed to promote dignity by not providing colostomy care for 2 hours after leakage occurred (Resident # 59), by not providing a privacy cover over a urinary drainage bag (Resident #34) and by not ensuring a resident had a call bell in his room (Resident #6) for 3 of 4 residents reviewed for dignity. In addition, the facility failed to promote a dignified dining experience by using styrofoam plates for 2 of 2 meals observed.	F 550	1. The facility failed to honor resident rights as it relates to catheter privacy bags on catheter for resident #34, colostomy care for resident #59, call lights for resident #6 and #60, serving on Styrofoam trays for residents on 200 hall. Resident # 34 was provided privacy bag for catheter on 12/14/21. Resident #59 was provided colostomy care on 12/15/21. Resident # 6 had call bell placed on 12/14/21 within reach and #60 had call bell placed within reach on 12/16/21.	

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F 550

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The findings included:

1) Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included colostomy status.

The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and required extensive assistance for toileting and personal hygiene tasks. He was coded for an ostomy.

A review of Resident #59's active care plan revealed a focus area initiated 12/2/21, that resident had an alteration in gastrointestinal status related to having a colostomy in place. The interventions read "staff to empty and change colostomy per MD orders or requested".

The December 2021 physician orders included an order, dated 11/19/21, for the colostomy bag to be checked and emptied every shift with replacement as required.

An interview occurred on 12/13/21 at 9:32 AM with Resident #59, who stated at times it was difficult to get staff to care for his ostomy consistently, causing the device to leak onto his clothing and skin. He further stated when he asked for 3rd shift (11:00 PM to 7:00 AM shift) nurses to change the device due to leakage or not adhering to his skin properly, they would not take the time to look at the device and just say they can't keep changing the device or emptying it when it wasn't full.

On 12/15/21 at 8:28 AM, Resident #59 was observed lying flat in his bed with his gown pulled down to waist level, wristwatch in place and dried

F 550

Residents on 200 hall are no longer receiving meals on Styrofoam trays unless medically indicated.

2. All residents have potential to be affected by these deficient practices. The Director of Nursing completed a 100% facility audit on 12/14/2021 to ensure all residents had functioning call bells within reach and documented issues were immediately corrected. Initial audit completed 12/16/2021 by Department Heads to ensure residents did not receive meals on styrofoam plates. No additional residents with Styrofoam plates were identified. Audit completed by Regional Director of Clinical Services on 1/12/21 of all residents with a catheters to ensure privacy bags were in place. Privacy bags were immediately placed for residents identified. Initial audit of residents requiring ostomy care completed by DON on 12/17/2021. All residents continue to receive ostomy care as ordered.

3. Current facility and agency nursing staff were educated by Director of Nursing on facilities policy for Resident Rights to include dignity as it relates to use of privacy bags for residents with catheters, colostomy care as ordered, and call bell accessibility and function, and use of proper dinnerware unless Styrofoam is otherwise ordered by the physician and notification to Administrator with any

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brown substance noted to the gown and bed sheets. He began to explain he was waiting to get cleaned up because his ostomy bag leaked around 6:08 AM that morning and he was still waiting and had once again been told by the 3rd shift nurse that she couldn't keep emptying it.

A phone interview was conducted with Nurse #3 on 12/15/21 at 8:34 AM. She confirmed she had been assigned to care for Resident #59 the night prior and had just left the facility. The nurse went onto say she had not received communication that there was a problem with Resident #59's ostomy bag until she was getting ready to leave the facility between 7:00 AM to 7:30 AM. Nurse #3 continued to state sometimes Resident #59 would ask for it to be changed even when it didn't need to be and that she had told him it didn't need to be changed on a number of occasions. She stated the communication between herself and the Nurse Aide was not good and that was the reason she didn't address the issue early this morning.

On 12/15/21 at 8:47 AM, an interview occurred with Nurse Aide #3 (NA). She had been assigned to care for Resident #59 during the 3rd shift and was asked to stay over to provide personal care to Resident #59 by the Director of Nursing (DON). She explained around 6:00 AM she had entered the resident's room to provide morning care and assist him up for breakfast. She noticed his gown was soiled with brown stains and observed his ostomy had leaked around the stoma causing the adhesive to the ostomy system to come loose from his skin. She went on to say she cleaned around the ostomy site as best as she could and told the nurse the system had leaked and needed to be changed. NA #3 stated she couldn't get

F 550

concerns. Dietary staff educated by the Dietary Manager on proper food plating without use of Styrofoam unless ordered by the physician. Education was completed by 1/13/22. Facility and agency nurses who did not receive initial education will not work until education is complete. Newly hired facility and agency nurses will receive education during orientation. The licensed nurse will be responsible for applying privacy bags for residents with orders for catheters and providing colostomy care as ordered and per plan of care and Kardex throughout their work shift. Dietary staff will only use Styrofoam plates if instructed by the Administrator to do so and the Dietary Manager will ensure appropriate stock and availability of dinnerware.

4. Unit Manager or licensed nurse designee will audit for catheter privacy bags placement, proper colostomy care provided as ordered and call light function and availability, for 3 random residents 3x per week x 2 weeks; weekly x 2 months, and monthly x2 months or until substantial compliance is met. Regional Dietary Manager will audit 5 random test trays per week x 12 weeks or until substantial compliance is met to ensure Styrofoam is not used unless otherwise indicated. Data obtained during the audit process will be analyzed for patterns and trends and reported by the Administrator monthly to Quality Assurance Performance Improvement committee (QAPI). At that time, the QAPI committee will evaluate

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F 550	Continued From page 4 Resident #59 up until the ostomy bag had been changed as it would continue to leak onto his clothing. NA #3 stated the nurse did not attend to Resident #59's ostomy bag, however the DON completed the care close to 8:00 AM. NA #3 stated she was able to get the resident cleaned up, dressed and up for breakfast starting 8:30 AM and added there were times nurses on the 3rd shift would tell Resident #59 they couldn't change his bag without assessing it. NA #3 stated she could empty and rinse out the ostomy bag or let the gas out when needed, but only the nurses could change the system out completely. Resident #59 was interviewed on 12/15/21 at 9:45 AM and stated when the 3rd shift nurses told him his bag or ostomy wafer didn't need to be changed without assessing it, he felt they were not addressing his needs which made him feel angry and sad. An interview occurred with the DON 12/15/21 at 3:00 PM. She explained there was a communication error from the 3rd shift today regarding Resident #59's ostomy care and leakage that occurred. The DON stated when she heard about the issue she went and changed out the ostomy system for him and the 3rd shift aide stayed over and assisted with his care. The DON further stated she would expect personal care to rendered in a timely manner when there was leakage that occurred from an ostomy and Resident #59 should not have had to wait for 2 hours. 2. Resident #34 was admitted to the facility on 11/1/19 with multiple diagnoses including an immune disease that impacts the brain and the spinal cords and paraplegia. The annual	F 550	the effectiveness of the interventions and make changes to the plan as necessary to maintain compliance. 5. Date of compliance: 1/13/2021	

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F 550	Continued From page 5 Minimum Data Set (MDS) assessment dated 10/20/21 indicated that Resident#34's cognition was intact, and she has an indwelling urinary catheter. Resident #34 was observed on 12/13/21 at 11:05 AM and on 12/14/21 at 8:45 AM. She has an indwelling urinary catheter, and the urinary drainage bag (1/3 full of urine) was noted facing the door and was visible to the hallway. The urinary drainage bag was observed with no privacy cover on both observations. When interviewed, she stated that she would rather not say anything. Nurse Aide (NA) #2 was interviewed on 12/14/21 at 8:46 AM. The NA stated that she was assigned to Resident #34. She reported that the facility has 2 catheter drainage bags, one with blue cover and the other one with no cover and the resident can use either of the bags. The NA added that Resident #34's catheter drainage bag has no blue cover in it. The Director of Nurse (DON) was interviewed on 12/14/21 at 8:47 AM. While standing at the doorway of Resident #34's room, she observed the urinary drainage bag of the resident. She stated that a privacy cover was only needed when the resident was outside the room in public. The DON provided additional information on 12/14/21 at 3:40 PM. She stated that she realized that since Resident #34's urinary drainage bag was visible on the hallway, it should have been covered for dignity reason. 3. Resident #6 was admitted on 5/7/09 and readmitted on 9/15/20.	F 550		

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F 550	Continued From page 6	F 550		

The quarterly Minimum Data Set dated 9/15/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for extensive staff assistance for all of his activities of daily living (ADLs.)

Review of Resident #6's revised care plan dated 11/30/21 read he had an behavior problem of not using his call bell when he needed assistance but rather yelled out. The interventions included encouraging Resident #6 to use call bell and to ensure his call bell was within his reach.

An observation was conducted on 12/13/21 at 1:12 PM of Resident #6's room. There was no call bell attached to the wall mount and noted was a plastic plug inserted into the hole where the call bell was to be attached. Resident #6 stated the staff took away his call bell and threw it away but was unable to elaborate of the circumstances or how it made him feel to not have a call bell.

An observation was conducted on 12/14/21 at 8:10 AM. There was no call bell attached to the wall mount and noted was a plastic plug inserted into the hole where the call bell was to be attached.

An interview was conducted on 12/14/21 at 8:10 AM with Nursing Assistant (NA) #3. She stated she worked third shift on 12/14/21 with Resident #6 and he did not use his call bell on her shift and he did not yell out for any staff assistance. NA #3 stated all residents have call bells and should be within reach for dignity.

An interview was conducted on 12/14/21 at 3:50 PM with Medication Aide (MA) #1 She stated

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Resident #6 did not use a call bell but rather yelled out when he wanted something.

An interview was conducted on 12/14/21 at 3:53 PM with NA #6. She stated when Resident #6 needed something, he would just yell. She stated he did not use his call bell.

An observation was conducted on 12/14/21 at 3:55 PM of Resident #6's room along with MA #1 and NA #6. MA #1 observed the white plastic plug in the call bell wall mount. She stated that was put there so his call bell would not alarm continuously and she was not aware that someone had removed Resident #6's call bell from his room. MA #1 stated it was a dignity concern and she would report it immediately to the Director of Nursing (DON). NA #6 stated she was aware Resident #6 did not have a call bell in his room and he had not had a call bell in at least a year. She stated she was uncertain why he did not have a call bell and it was not a dignified way to treat Resident #6. NA #6 stated she had reported it several times in the past to the previous maintenance person and to the DON. She stated when Resident #6 needed something, he would yell out.

An observation and interview was conducted on 12/14/21 at 4:00 PM with the DON. She observed the plastic plug in the call bell wall mount and stated the plastic plug was to prevent the call bell from continuously ringing. The DON was unable to offer an explanation as to why Resident #6 did not have a call bell in his room but she would ensure he was provided a functioning call bell today. She stated it was her expectation that all residents have a call bell in their room and that the call bell remained in reach at all times to

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F 550		F 550		

Continued From page 8
promote dignity.

An observation was conducted on 12/15/21 at 8:48 AM. He had a flat pad call bell attached to his pillow within his reach. He stated they gave him a new call bell yesterday.
4. The morning of 12/13/2021 residents on the 200 hall were observed being served breakfast in Styrofoam containers. The same was observed on the 200 hall during lunch on 12/14/2021.

On 12/14/2021 at 12:03 PM an interview was conducted with the Interim Dietary Manager (IDM). She stated some residents received meals on stryofoam because they did not have enough plates. When asked, she stated she thought the Administrator was aware of the shortage but she could not recall the date or time she had made the Administrator aware. The IDM stated she made the regional director of culinary operations aware of the shortage on 12/13/2021.

An interview was conducted with the director of culinary operations on 12/14/21 at 12:22 PM. He stated he had been in the position for 2 months. He further stated the facility had been without a certified dietary manger for 3-4 months. He stated he was not in the facility every day and was not aware the staff had been serving meals on styrofoam. He stated when he asked the staff about plates, he also found they did not have enough lids or bases. He ordered additional plates, lids, bases, on 12/13/2021 and they were in transit to the facility. When asked why the facility did not have enough plates for each resident, he stated plates that were damaged were taken out of production and the staff had not made him aware of the shortage until 12/13/2021.

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F 558	Continued From page 9	F 558		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to ensure a resident had a call bell in his room (Resident #6) and failed to keep a resident call bell within reach (Resident #60). This was for 2 of 2 residents reviewed for accommodation of needs. The findings included: 1. Resident #6 was admitted on 5/7/09 and readmitted on 9/15/20 with a diagnosis of Cerebral Palsy. The quarterly Minimum Data Set dated 9/15/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for extensive staff assistance for all of his activities of daily living. Review of Resident #6's revised care plan dated 11/30/21 read he had an behavior problem of not using his call bell when he needed assistance but rather yelled out. The interventions included encouraging Resident #6 to use call bell and to ensure his call bell was within his reach. An observation was conducted on 12/13/21 at 1:12 PM of Resident #6's room. There was no call bell attached to the wall mount and noted was a plastic plug inserted into the hole where the call	F 558	1. Resident #6 had a call bell placed in the room on 12/14/2021 and continues to be monitored each shift by nursing for availability and proper function. Resident #60s call bell was placed within reach and secured to bed on 12/16/2021 and continues to be monitored each shift by nursing for availability and proper function. 2. Director of Nursing completed an audit on 12/14/2021 to ensure all current facility residents had properly functioning call bells in place and properly secured within reach. No additional call bells identified as non-functioning. Call bells identified not within reach were immediately secured to bed to ensure resident access and availability. Additional audit completed by Administrator on 1/12/2022 to ensure all current facility residents continue to have properly functioning call bells available within reach and vacant resident rooms have functioning call bells available and ready for potential new resident admissions. Call bells added as appropriate. 3. Administrator will educate all current	1/13/22

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F 558	Continued From page 10 bell was to be attached. Resident #6 stated the staff took away his call bell and threw it away. An observation was conducted on 12/14/21 at 8:10 AM. There was no call bell attached to the wall mount and noted was a plastic plug inserted into the hole where the call bell was to be attached. An interview was conducted on 12/14/21 at 8:10 AM with Nursing Assistant (NA) #3. She stated she worked third shift on 12/14/21 with Resident #6 and he did not use his call bell on her shift and he did not yell out for any staff assistance. An interview was conducted on 12/14/21 at 3:50 PM with Medication Aide (MA) #1 She stated Resident #6 did not use a call bell but rather yelled out when he wanted something. An interview was conducted on 12/14/21 at 3:53 PM with NA #6. She stated when Resident #6 needed something, he would just yell. She stated he did not use his call bell. An observation was conducted on 12/14/21 at 3:55 PM of Resident #6's rooms along with MA #1 and NA #6. MA #1 observed the white plastic plug in the call bell wall mount. She stated that was put there so his call bell would not alarm continuously and stated she was not aware the someone had removed Resident #6's call bell from his room. NA #6 stated she was aware Resident #6 did not have a call bell in his room and he had not had a call bell in at least a year. NA #6 stated she had reported it several times in the past to the previous maintenance person and to the Director of Nursing (DON). She stated when Resident #6 needed something, he would yell out.	F 558	facility and agency staff to ensure call light is present and easily accessible. Staff will be educated to monitor and correct placement of call bells to ensure easy accessibility and to notify maintenance, Director of Nursing, or Administrator if call light is missing or not working. Education will be completed by 1/13/2022. Staff will not be permitted to work without completed education. Newly hired facility and agency staff will receive education during orientation. 4. Unit Manager or designee will audit 3 residents 3x/week x 2wk; weekly x 2 months and monthly x 2 months to ensure that residents have call call bells in place and in reach and proper function. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement committee (QUALITY ASSURANCE PERFORMANCE IMPROVEMENT) monthly by the Administrator. At that time, the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee will evaluate the effectiveness of the interventions and make changes to the plan as necessary to maintain compliance. 5. Date of compliance: 1/13/2022	

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ACCORDIUS HEALTH AT MIDWOOD, LLC	**2727 SHAMROCK DRIVE CHARLOTTE, NC 28205**

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An observation and interview was conducted on 12/14/21 at 4:00 PM with the DON. She observed with plastic plug in the call bell wall mount and stated the plastic plug was to prevent the call bell from continuously ringing. The DON was unable to offer an explanation as to why Resident #6 did not have a call bell in his room but she would ensure he was provided a functioning call bell today. The DON stated all residents should have a functioning call bell within reach at all times.

An observation was conducted on 12/15/21 at 8:48 AM. He had a flat pad call bell attached to his pillow within his reach. He stated they gave him a new call bell yesterday.

2) Resident #60 was admitted to the facility on 11/22/21 with diagnoses that included muscle weakness, anxiety disorder and seizure disorder.

A nursing progress note dated 11/25/21, noted Resident #60 was alert and oriented in 3 areas (person, place, and time).

The admission Minimum Data Set (MDS) assessment dated 11/29/21 indicated Resident #60 had severe cognitive impairment and displayed no behaviors. She required limited assistance with transfers and toileting.

Resident #60's care plan included a focus area, initiated on 12/6/21, for being at high risk for falls. The interventions included to be sure the call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.

F 558 Continued From page 12 F 558

On 12/13/21 at 11:10 AM, an observation occurred of Resident #60 while she was lying in bed. The call light was coiled up under her bed out of reach.

Another observation was made on 12/13/21 at 3:28 PM. Resident #60's call light was observed lying under bed out of reach.

On 12/14/21 at 8:40 AM, Resident #60 was observed lying in her bed and the call light was within reach.

An interview occurred with Nurse Aide #4 (NA) on 12/14/21 at 2:00 PM, who was assigned to care for Resident #60 on the 7:00 AM to 3:00 PM shift. She explained she ensured the call light was within reach of Resident #60, as she was able to use it at times.

On 12/15/21 at 10:41 AM, Resident #60 was observed walking around in her room. The call light was observed draped over the headboard of the bed out of her reach. When resident was asked how she would call for assistance if needed, she grabbed the bed control, looked at it and stated, "that's not it. Guess I would have to yell".

An observation occurred of Resident #60 on 12/15/21 at 2:00 PM. She was working on a paper activity while sitting in her bed. The call light was observed behind the headboard of her bed, out of reach.

On 12/15/21 at 2:45 PM, an interview occurred with NA #5 who was assigned to Resident #60's hall. He was unable to explain why the call light would have been behind her bed and should have

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F 558	Continued From page 13 been within her reach at all times. The Director of Nursing was interviewed on 12/15/21 at 3:00 PM and stated it was her expectation for call lights to be within reach of all residents, despite their cognitive level, at all times. Another observation was made of Resident #60 on 12/16/21 at 8:35 AM. She was observed lying on her bed talking with her roommate. The call light was observed on the back of the bed out of her reach.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		1/13/22

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F 561	Continued From page 14 §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 observations, resident and staff interviews and record review, the facility failed to provide showers and shaving as desired. This was for 1 (Resident #161) of 5 residents reviewed for choices. The findings included: Resident #161 was admitted on 12/3/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). His admission Minimum Data Set (MDS) dated 12/9/21 indicated it was still in progress. Review of Resident #161's baseline care plan dated 12/3/21 indicated he was cognitively intact. The baseline care plan only mentioned his preference for choosing his cloths but the form did not include a question for bathing preferences. An observation and interview was conducted on 12/13/21 at 10:57 AM. Resident #161 was sitting up in bed. He was absent of odors but appeared disheveled. His facial hair was grown out and stated he had not been offered a shower or shave since his admission on 12/3/21. Resident #161 stated prior to his admission, he never had facial hair and he was not aware he had an option of a shower. Review of an undated Shower Schedule indicated	F 561	1. Resident #161 received a shower and shave on 12/14/21 by the nurse aide and will continue to receive showers and shaving per resident preference and as indicated on resident plan of care, Kardex, and master shower schedule. 2. Residents who require assistance with activities of daily living can be affected by the deficient practice. Initial audit of residents completed on 12/16/21 by Director of Nursing to ensure showers and shaving were completed as scheduled and per resident preference. Resident care plan, kardex and master shower schedule updated accordingly and placed at nurse�s station. 3. On 12/23/21 current facility and agency Licensed and Certified Nursing Staff were re-educated by Staff Development Coordinator and Director of Nursing to ensure all residents who require assistance with Activities of Daily Living (shower/bathing, nail care, and facial hair) are provided care to maintain proper grooming and hygiene. Education will be completed by 1/13/2022. Staff will not be permitted to work without completed education. Newly hired facility and agency nurses will be educated upon	

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F 561	Continued From page 15 Resident #161 was scheduled to a shower on Mondays and Thursdays on first shift. There was no documentation indicating any showering or grooming refusals. During an observation on 12/14/21 at 1:35 PM, Resident #161 had a visitor. She indicated they were related. She stated Resident #161's preference for bathing was a shower. Resident #161 confirmed her statement and further stated he did not receive a shower yesterday. Review of the daily schedule for first shift indicated Nursing Assistant (NA) #4 was assigned Resident #161 on 12/13/21. An interview was conducted on 12/14/21 at 2:51 PM with NA #7. She stated she had not worked with Resident #161 before but she was not aware of any refusals of care. An interview was conducted on 12/15/21 at 9:10 AM with NA #1 . She stated she was assigned Resident #161 and his shower days were Monday and Thursday on first shift. She stated the only behavior she had noted was anxiety when he was short of breath. An interview was conducted on 12/15/21 at 10:55 AM with Resident #161. He had been shaven as desired and was very happy about it. He stated he still had not been offered a shower and his family member washed him off daily. Review of the facility activities of daily living (ADL) documentation indicated he received a shower on Saturday 12/11/21 but no other evidence of any showers since admission on 12/3/21.	F 561	hire and annually. The licensed nurse will update care plan, kardex and master shower schedule upon admission and with changes in resident preference. The nurse aide will complete resident showers and shaving per shower schedule and resident kardex and the licensed nurse will monitor electronic Point of Care (POC) documentation for compliance. The Unit Manager will also monitor showers for completion. 4. Beginning 12/23/2021 the Director of Nursing or Designee will audit residents for showers and shaving completion per resident preference against master shower schedule, plan of care and kardex for 5 dependent residents. Audits will be completed 5 times weekly for 4 weeks, then 2 times weekly for 2 months. The results of the audits will be reported by the Director of Nursing and reviewed monthly in Quality Assurance and Performance Improvement Meeting and any changes will be made if necessary to maintain compliance with resident preference. 5. Date Of Compliance- 1/13/2022	

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F 561	Continued From page 16 An interview was conducted on 12/15/21 at 3:00 PM, the Director of Nursing (DON) stated it was her expectation that preferences be honored for bathing and grooming. She stated any ADL refusals should be documented. An interview was conducted on 12/16/21 at 8:47 AM with NA #4. She stated she was assigned Resident #161 on Monday and forgot to offer him a shower. She stated she would offer and provide him a shower today and document if he refuses.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		1/13/22

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F 565	Continued From page 17 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident council interviews, staff interviews and record review, the facility failed to resolve repeated grievances regarding the food voiced during resident council (RC) meetings. The facility also failed to provide evidence for the rationale of unresolved grievances about food. This was for 4 or 4 months reviewed for RC grievances. The findings included: Review of the facility policy titled "Resident and Family Grievances" last revised 10/28/20 read in part as follows: Efforts will be made to resolve all grievances as quickly as possible. The Grievance Officer or designee will provide the resident and/or responsible party a written notification if an extended period is required to conduct a thorough and equitable investigation. The resident will be provided a written summary of the resolution. Review of the RC meeting minutes dated 8/23/21 read the residents would like to have more fried chicken, rice, gravy and less pasta. There was no documented evidence that the previous RC meeting minutes grievances dated 7/16/21 were read or corrected. There was no documented	F 565	1. The facility failed to resolve repeated grievances and provide documented resolution reported in monthly resident council meeting 2. All residents have the potential to be affected by the deficient practice. An ad hoc resident council meeting was held on 1/10/22 to introduce new Regional Dietary Manager and discuss ongoing and unresolved dietary issues. Grievance form was initiated to document specific grievances. Resolution to grievances will be provided to resident council members in next monthly resident council meeting and documented on grievance form. 3. Administrator will educate Interdisciplinary Team members on the proper procedure to address, resolve, and document resident council grievances and concerns and ensure resolutions are communicated to Activities Director. This education was completed by 1/13/22. Activities to maintain a resident council concern log and initiate grievance form as indicated to be shared with	

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F 565	Continued From page 18 evidence that old business was discussed, reviewed or resolved and no list of resident attendees. Review of the RC meeting minutes dated 9/21/21 read little food variety, food not fully cooked, requested more breakfast options (no oatmeal), requested more hamburgers and again requested more fried chicken, rice and gravy. Attached to the minutes was a form titled "Resident Council Concern Follow-Up Form" which included the resident dietary issues discussed during the RC meeting. The form read the action taken was to provide the options of grits and cold cereals and food preferences would be reviewed for all residents by 11/8/21. The RC meeting minutes dated 9/21/21 read the prior RC minutes were read and approved. The RC meeting minutes indicated written responses to the last months RC minutes were to be attached to RC minutes. There were no attachments regarding the dietary concerns from the previous month dated 8/23/21. There were 9 residents in attendance. Review of the RC meeting minutes dated 10/26/21 read concerns about not getting condiments with meals: potato with no butter, not enough ketchup for fries, no sour cream with tacos, no dressing for salad and chicken nuggets with no dipping sauce. Attached to the minutes was a form titled "Resident Council Concern Follow-Up Form" which included the resident dietary issues discussed during the RC meeting. The RC meeting minutes dated 10/26/21 read the prior months RC minutes were read and approved. The RC meeting minutes indicated written responses to the previous months RC minutes were to be attached to RC minutes. There were no attachments regarding the dietary	F 565	Interdisciplinary Team for resolution. Resolution to grievances and other resident council concerns to be resolved by department head responsible and shared with resident council by Activities Director at next monthly meeting. 4. Bimonthly food committee meeting will be held by Regional Dietary Manager to begin on 1/10/22 to ensure resident□s feedback is shared and residents stay informed. Administrator to attend monthly resident council meeting (with invitation) for next 3 months to ensure resident council grievances are documented, communicated, and resolved. Results of monitoring will be reported by the Administrator and reviewed monthly in Quality Assurance and Performance Improvement Meeting and any changes will be made if necessary to maintain compliance with resident council grievances. 5. Date of Compliance 1/13/2022	

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F 565	Continued From page 19 concerns from the previous month dated 9/21/21. There were 6 resident in attendance. Review of the RC meeting minutes dated 11/23/21 read ongoing concerns about the food not being palatable, still serving noodles, carrots, pork and chicken too often. The residents requested more beef. There were no attached concern or grievance forms. The RC meeting minutes dated 11/23/21 read the prior RC minutes were read and approved. The RC meeting minutes indicated written responses to the previous months RC minutes were to be attached to RC minutes. There was no attachments regarding the ongoing dietary concerns from the previous month dated 10/26/21. There were 7 resident in attendance. An observation on 12/14/21 at 12:45 PM revealed Resident #261 was served chicken in a tortilla shell without any condiments. A test tray was provided on 12/14/21 at 1:00 PM. The test tray did not have any condiments for the fish and the food was only slightly warm. A RC meeting was conducted on 12/15/21 at 2:00 PM with 5 resident in attendance. The residents voiced frustration with the facility for not addressing concerns about the food during their RC meetings. They voiced little variety, cold food, no condiments and no fresh fruit for the past 3 months. The RC meeting attendees stated they were served pork a couple times a week, not getting fired chicken , a minimal amount of beef in stew and most meals were served with noodles instead of rice. The attendees stated for some reason the facility was unable to get a dietary manager to stay long enough to get anything	F 565		

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F 565	Continued From page 20 done. Attendees stated the facility had not offered any answers or explanations regarding their ongoing food issues and they had submitted several grievances that were never resolved. An interview was on 12/15/21 at 2:35 PM with the social worker (SW). She stated she was the grievance officer and when a grievance was completed, she logged it and assigned it to the appropriate department. The SW stated she did not log the concern form because they were not considered grievances. She stated all the grievances had to be reviewed and signed by the Administrator. An interview was conducted on 12/16/21 at 12:06 PM with the Administrator. She stated the facility did not typically complete a grievance for RC concerns but rather completed the concern form. She stated the results of voiced concerns from the previous month were read aloud in next meeting. She stated the dietary issues should not be an ongoing problem.	F 565		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid,	F 574		1/13/22

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F 574	Continued From page 21 including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and	F 574		

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F 574	Continued From page 22 Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to identify for emergency contact information for 1 (Resident #161) of 1 resident reviewed for contact information. The findings included: Resident #161 was admitted on 12/3/21. Review of Resident #161's electronic medical record did not include any documented evidence of any emergency contact information. An interview was conducted on 12/15 at 2:35 PM, the Social Worker (SW) verified there was no documentation in Resident #161's electronic medical record identifying his emergency contact information. She stated the facility utilized a corporate referral line and would have requested his FL2 which would have the emergency contact information on it. The FL2 is a form that describes a resident's medical condition and the amount of care they need when placed in a facility.) She was unable to explain why the facility had not	F 574	1. The facility failed to identify emergency contact information for resident #161. Resident #161s emergency contact information was updated in the electronic medical record on 12/14/2021 by facility Social Worker. 2. Newly admitted residents have the potential to be affected by the deficient practice due to contact information having to be obtained. The Regional Director of Clinical Services completed a 100% audit on 12/28/2021 to ensure all current residents had emergency contact information listed in residents electronic medical record. Residents identified with incomplete emergency contact information were updated to reflect accurate, current emergency contact information as preferred and indicated by the resident and/or resident representative. Updated information was obtained by medical record review and/or	

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	345304	A. BUILDING ______ B. WING ______	C 12/16/2021

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F 574	Continued From page 23 identified the missing information. The SW stated Resident #161 was part of the Program of All-inclusive Care for the Elderly (PACE). She stated PACE had oversight of his care and she spoke to a contact at PACE earlier today and requested the contact information but it had not been entered into the electronic medical record yet. An interview was conducted on 12/15/21 at 3:00 PM, the Director of Nursing (DON) stated it was her expectation that Resident #161 have emergency contact information.	F 574	resident/resident representative communication. 3. The following measures that have been put into place to ensure the deficient practice does not recur are as follows; Interdisciplinary Team including Business Office Manager, Social Worker, Director of Nursing, Unit Manager, Activities Director, Medical Records Coordinator, and Admissions Coordinator educated by Administrator on procedure to ensure new admissions have emergency contact information available in the medical record and was completed on 01/10/2022. The procedure will be the admissions coordinator will enter emergency contact information on new admissions and this will be checked during morning clinical meeting and corrections made if needed. 4. The Administrator will audit contact information of new admissions 3 x□s per week x□s 2 weeks, then 2x per week x□s 2 weeks, then weekly x 4 weeks, then monthly x□s 2 months to ensure new admissions have emergency contact information listed in the electronic medical record. The Administrator will report results of audits monthly to Quality Assurance Performance Improvement committee (QAPI). At that time, the QAPI committee will evaluate the effectiveness of the interventions and make changes to the plan as necessary to maintain compliance with resident emergency contact information accurate and available within the medical record.	

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F 574	Continued From page 24	F 574	5. Date of compliance: 1/13/2022	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		1/13/22

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of

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F 623	Continued From page 25	F 623		

this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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F 623	Continued From page 26 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview with the responsible party (RP) and staff, the facility failed to notify the RP in writing of the reason for the discharge to the hospital for 5 of 5 sampled residents reviewed for hospitalizations (Residents #40, #56, #63, #38 & #37). Findings included: 1. Resident #40 was admitted to the facility on 9/21/21. Review of the nurse's note dated 10/16/21 at 8:25 AM revealed that Resident #40's gastrostomy (G) tube was accidentally pulled out and he was discharged to the hospital for	F 623	1. The written notice of transfer and bed hold policy was provided to resident representatives #40, #56, #63, #38, #37 on 1/13/2022 by Administrator. 2. Residents who are transferred to the hospital have the potential to be affected. Administrator audited hospital transfers in the last 30 days to identify other residents affected and provide written notice of transfer and bed hold. This audit and notification were completed on 1/13/2022.	

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F 623	Continued From page 27 reinsertion and was admitted Resident #40 was readmitted back to the facility on 10/22/21. Nurse Unit Manager #2 was interviewed on 10/15/21 at 11:50 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. The RP of Resident #40 was interviewed on 12/15/21 at 1:38 PM. The RP stated that when the resident was discharged to the hospital, the nurse had called to inform him that the resident was sent to the hospital. He added that he had not received a letter notifying him of the reason for hospitalization. The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that she didn't know the regulation to notify the RP in writing the reason for hospitalization. She reported that the nurse notified the RP by calling her/him. 2. Resident #38 was admitted to the facility on 7/16/21. Review of the nurse's note dated 8/26/21 at 5:04 PM revealed that Resident #38 was at the dialysis clinic. The dialysis clinic had called to inform that the resident was sent to the hospital due to a fall. The hospital discharge summary dated 8/30/21 indicated that Resident #38 was sent to the emergency room due to a fall from his wheelchair	F 623	3. Social Services Director, Business Office Manager, current licensed nursing staff, and current agency licensed nursing staff were educated on discharge notification being sent to resident representative on 1/13/2022 by Administrator. Social Services Director, Business Office Manager, current licensed nursing staff, and current agency licensed nursing staff will not be allowed to work until education is completed. Newly hired facility and agency nurses will be educated upon hire and annually. Discharge notification and Bed Hold Notification will be completed on all facility-initiated hospital transfers and sent to resident representative; a copy of notification will be uploaded into Electronic Medical Record. Administrator and Director of Nursing will review facility-initiated transfers during morning meetings to ensure transfer notice and bed hold has been sent. 4. This process will be audited by Administrator weekly times 4 weeks, bi-weekly for 4 weeks, and monthly times 4 months. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meetings and changes will be made to the plan as necessary to maintain compliance with discharge and	

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F 623 Continued From page 28
and the resident was admitted.

Resident #38 was readmitted back to the facility on 8/30/21.

Nurse Unit Manager #2 was interviewed on 10/15/21 at 11:50 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge.

The RP of Resident #38 was interviewed on 12/15/21 at 1:41 PM. The RP stated that when the resident was discharged to the hospital, the nurse had called to inform her that the resident was sent to the hospital. She added that she had not received a letter notifying her of the reason for hospitalization.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that she didn't know the regulation to notify the RP in writing of the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.

3. Resident #37 was admitted to the facility on 8/7/21. Review of the nurse's note dated 11/21/20 at 2:57 PM revealed that Resident #37 was delusional, anxious and was restless. The doctor was notified and ordered to send the resident to the emergency room and was admitted.

Resident #37 was readmitted back to the facility on 11/30/20.

F 623

transfer notifications.

5. Date of compliance: 1/13/2022

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Nurse Unit Manager #2 was interviewed on 10/15/21 at 11:50 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge.

Tried to call the RP of Resident #37 on 12/15/21 at 1:52 PM but was unsuccessful.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that she didn't know the regulation to notify the RP in writing of the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.

4. Resident #56 was originally admitted on 1/16/18 with readmissions on 10/3/21, 11/10/21 and 12/7/21. All readmissions were from the hospital. She was her own Responsible Party (RP) and listed an emergency contact.

The quarterly Minimum Data Set dated 11/15/21 indicated Resident #56 was cognitively intact.

An interview was conducted on 12/15 at 11:50 AM with Unit Nurse Manager #2. She stated that when a resident was discharged to the hospital the RP or family were called to update them that the resident was being sent to the hospital but did not send anything in writing about the reason for transfer.

An interview of conducted on 12/15 at 12:10 PM with the Business Office Manager. She stated it

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was the responsibility of the floor nurse to inform the resident/RP or family the reason the resident was being transferred to the hospital. She stated she was unaware it had to be written.

An interview was conducted on 12/15/21 at 1:54 PM with Resident #56. She stated she was her own RP and she had never received anything in writing regarding the reason for her hospital transfer but she knew the reason. She refused to allow her listed emergency contact to be contacted.

An interview was conducted on 12/15/21 at 2:35 PM with the Social Worker (SW). She stated it was the reasonability of the floor nurses to send the written reason a residents was being transferred to the hospital. She stated she was unaware the reason for a hospital transfer had to be given to the resident/RP or family the in writing.

An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing. She stated she was not aware of the need to provide the resident, RP or family written reason for a hospital transfer.

5. Resident # 63 was admitted to the facility on 10/19/2021 with osteomyelitis of the ankle and foot.

The resident's discharge Minimum Data Set (MDS) dated 11/7/2021 indicated the resident was cognitively intact and return anticipated.

Review of the resident's electronic medical record revealed she was her own RP. She was discharged to the hospital on 11/7/2021 with

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F 623

Continued From page 31

abnormal vital signs.

An interview was conducted on 12/15 at 11:50 AM with Unit Nurse Manager #2. She stated that when a resident was discharged to the hospital the RP or family were called but the facility did not send anything in writing about the reason for transfer.

Attempts to contact resident #63 were not successful.

An interview was conducted with the facility's social worker (SW) on 12/16/21 at 9:52 AM. The SW stated the resident did not return to the facility. She was uncertain of the resident's final disposition. She further stated the resident was admitted for short term rehabilitation and may have discharged home from the hospital. The SW stated it was the responsibility of the floor nurses to send the written reason a resident was being transferred to the hospital. She stated she was unaware the reason for a hospital transfer had to be given to the resident/RP or family the in writing.

An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing. She stated she was not aware of the need to provide the resident, RP or family written reason for a hospital transfer.

F 625 SS=D — Completion date: 1/13/22

Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or

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the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to provide a bed hold notice for 1 (Resident #56) of 5 residents reviewed for hospitalization. This practice had the potential to affect other residents. The findings included:

Resident #56 was originally admitted on 1/16/18 with readmissions on 10/3/21, 11/10/21 and 12/7/21. All readmissions were from the hospital. She was her own Responsible Party (RP) and listed an emergency contact.

The quarterly Minimum Data Set dated 11/15/21

1. The written notice of transfer and bed hold policy was provided to resident representatives #40, #56, #63, #38, #37 on 1/13/2022 by Administrator.

2. Residents who are transferred to the hospital have the potential to be affected. The administrator audited hospital transfers 12/1/2021-1/13/2022 to identify other residents affected and provided written notice of transfer and bed hold to 12 residents that had been sent to the hospital. This audit and notification were

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F 625	Continued From page 33 indicated Resident #56 was cognitively intact. An interview was conducted on 12/15 at 11:50 AM with Unit Nurse Manager #2. She stated the floor nurses did not send the bed hold policy when a resident transferred to the hospital but rather the Business Office Manager called the RP or family. An interview of conducted on 12/15 at 12:10 PM with the Business Office Manager. She stated when a resident was discharged to the hospital, she called the RP or family to see if they wanted to hold the bed. She stated she did not document the call. An interview was conducted on 12/15/21 at 1:54 PM with Resident #56. She stated she was her own RP and she had never received the facility's bed hold policy when she transferred to the hospital. An interview was conducted on 12/15/21 at 2:35 PM with the Social Worker (SW). She stated it was the responsibility of the floor nurses to send the bed hold policy. An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing stated she thought the bed hold policy was included in the documentation sent with the resident to the hospital.	F 625	completed on 1/13/2022 by the Administrator. 3. Social Services Director and Business Office Manager and current licensed nursing staff and current agency licensed nursing staff were educated on discharge notification being sent to resident representative on 1/13/2022 by Administrator. Newly hired facility and agency nurses will be educated upon hire and annually. Social Services Director, Business Office Manager, current licensed nursing staff, and current agency licensed nursing staff will not be allowed to work until education is completed. Discharge notification and Bed Hold Notification will be completed on all facility-initiated hospital transfers and sent to resident representative; a copy of notification will be uploaded into Electronic Medical Record. Administrator and Director of Nursing will review facility-initiated transfers during morning meetings to ensure transfer notice and bed hold has been sent. 4. This process will be audited by Administrator weekly times 4 weeks, bi-weekly for 4 weeks, and monthly times 4 months. The Administrator will report results of audits monthly to Quality Assurance Performance Improvement committee. At that time, the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee will evaluate the effectiveness of the interventions and make changes to the plan as necessary to	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 34	F 625	maintain compliance with bed hold notifications. Date of compliance: 1/13/2022	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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		1/13/22

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(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 in the areas of antipsychotics (Resident #56), ostomy (Resident #21) and pressure ulcer (Resident #34). This was for 3 of 20 residents reviewed for comprehensive care planning. The findings included:

1. Residents #56 was admitted on 1/16/18 with cumulative diagnoses of Schizophrenia.

Review of Resident #56's December 2021 Physician orders included an order dated 10/19/21 for Seroquel (antipsychotic) every night at bed time.

Review of Resident #56's comprehensive care plan last revised 11/4/21 did not include a care plan for the use of an antipsychotic medication.

The quarterly Minimum Data Set (MDS) dated 11/15/21 indicated Resident #56 was cognitively intact and she exhibited no behaviors. The MDS was coded as Resident #56 receiving an antipsychotic for 6 days during the look back

F 656

1. The facility failed to develop a comprehensive care plan for Resident # 56 taking an antipsychotic medication. Care plan updated on 12/16/21 to reflect current antipsychotic medication. Care plan for Resident #21 failed to include ostomy. Care plan updated on 12/14/21 to include ostomy. Resident # 34 care plan reflected 2 out of the 3 pressure ulcers. Resident care plan was updated on 12/16/21 to reflect third pressure ulcer.

2. All residents have the potential to be affected. Initial audit completed by Minimium Data Set Coordinator by 1/13/2022 to ensure residents receiving antipsychotic medications, residents with ostomy, and residents with acquired pressure ulcers to ensure accurate care plan in place. Residents identified with inaccuracies on their care plans were corrected to reflect accurate data.

3. Minimum Data Set Coordinator was reeducated by Regional Minimum Data

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period.

An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing. She stated Resident #56's Seroquel should be included in her comprehensive care plan.

An interview was conducted on 12/16/21 at 9:15 AM with the MDS nurse. She stated Resident #56's Seroquel should have been care planned and that it was an oversight.

2. Resident #21 admitted 9/30/16 with a diagnosis of quadriplegia.

The quarterly Minimum Data Set (MDS) dated 10/3/21 Resident #21 was cognitively intact and she exhibited no behaviors. She was coded for an ostomy for bowel continence.

Review of Resident #21's comprehensive care plan last revised 9/21/21 did not include a care plan for her ostomy.

An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing. She stated Resident #21's ostomy should be included in her comprehensive care plan.

An interview was conducted on 12/16/21 at 9:15 AM with the MDS nurse. She stated Resident #21's ostomy should have been care planned and that it was an oversight.

3. Resident #34 was admitted to the facility on 11/1/19 with multiple diagnoses including paraplegia.

The wound doctor progress note dated 10/18/21

F 656

Set Coordinator on 1/10/2021 on proper procedure for completing comprehensive care plans. New Hires are educated upon hire and annually.

4. Director of Nursing will audit 3 care plans of residents receiving psychotropics, residents with acquired pressure ulcers to ensure all wounds are care planned, and residents with ostomies to ensure proper care plan in place. Audits will be Director of Nursing 5 x weekly for 4 weeks, 2 times weekly x 2 months and then monthly x 2 months or until substantial compliance is met. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee by Administrator monthly. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary.

5. Date of Compliance 1/13/2022

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F 656	Continued From page 37 revealed that Resident #34 had 2 stage IV pressure ulcers on her right and left malleolus and 1 unstageable pressure ulcer on her right buttock. The annual Minimum Data Set (MDS) assessment dated 10/20/21 indicated that Resident#34's cognition was intact, and she had 2 stage IV and 1 unstageable pressure ulcers. The care area assessment (CAA) for pressure ulcer dated 10/20/21 indicated that pressure ulcer CAA triggered secondary to 3 pressure ulcers. She had 2 documented stage IV and one unstageable and would proceed to care plan. Resident #34 was care planned on 10/20/21 for left and right foot pressure ulcers. She did not have a care plan for her right buttock pressure ulcer. The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that the care plan for the unstageable right buttock pressure ulcer for Resident #34 was missed by the MDS Nurse. The MDS Nurse was interviewed on 12/16/21 at 9:25 AM. The MDS Nurse reviewed Resident #34's care plan and stated that she was not aware that there was no care plan for the unstageable pressure ulcer on the right buttock. She reported that the care plan for the right buttock should have been developed in October 2021 when the annual MDS was completed but it was not.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/13/22

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F 657	Continued From page 38 §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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise a care plan in the area of smoking (Resident #11), accidents (Resident #60), and nutrition (Resident #23). This was for 3 of 20 resident's care plans reviewed. The findings included:	F 657	1. Resident #11 care plan was not updated timely to reflect accurate smoking status per smoking assessment. Resident#11 care plan was updated on 12/13/2021 to reflect accurate smoking status. Resident # 60 care plan was not updated accurately to reflect fall intervention on 11/25/2021. Resident #60 fall care plan was updated on 12/13/2021	

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1) Resident #11 was admitted to the facility on 6/18/21.

The admission Minimum Data Set (MDS) assessment dated 6/24/21 indicated Resident #11 was cognitively intact and was coded with tobacco use.

Review of a "Safe Smoking Screen" dated 9/9/21 indicated Resident #11 was an independent smoker.

A quarterly MDS assessment dated 9/24/21 revealed Resident #11 was cognitively intact.

Resident #11's active care plan, last reviewed on 10/19/21, revealed the following focus areas:
- Resident is a safe. Resident #11 also likes to dip chewing tobacco.
- Resident is non-compliant with the smoking policy, keeping his cigarettes and lighters in his room when he is a supervised smoker and understands that his smoking materials are to be kept at the nurse's station in a locked box. The intervention included Resident #11 required supervised smoking.

Review of a "Safe Smoking Screen" with the date of 12/9/21 indicated Resident #11 was able to smoke independently.

On 12/15/21 at 1:58 PM, an interview was conducted with the Social Worker who confirmed Resident #11 was an independent smoker. She stated the safe care plan was incomplete and should have read safe smoker and the unsupervised care plan should have been resolved. The Social Worker further stated she had already revised the care plans to be an

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to reflect fall intervention. Resident #23 care plan was not updated to reflect accurate diet order. Resident #23 care plan was updated on 12/16/21 to reflect accurate diet order.

2. Initial audit completed by Minimum Data Set Coordinator by 1/13/2022 to ensure current diet orders are care planned, no further inaccuracies were noted during audit. Care plans for residents who smoke were reviewed by Director of Nursing and Minimum Data Set Coordinator by 1/13/2022 to ensure accurate smoking status are care planned no further inaccuracies were noted during audit. Falls that occurred from 12/13/2021 -1/13/2022 were audited by Minimum Data Set Coordinator by 1/13/2022 to ensure fall interventions were care planned on actual fall care plan and corrections were made to inaccuracies found by 1/13/2022.

3. Minimum Data Set Coordinator was reeducated by Regional Minimum Data Set Coordinator on 1/10/2021 Care Plan Timing and Revision. New Hires are educated upon hire and annually. The Minimum Data Set Coordinator will be responsible for initiating and updating resident care plans for smoking, falls and nutrition to ensure residents plan of care is accurate and comprehensive to reflect resident care needs.

4. Director of Nursing or Designee will audit 3 care plans of residents who smoke to ensure accurate care plan of smoking

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accurate reflection of Resident #11.

An interview occurred with the Director of Nursing on 12/15/21 at 3:00 PM and indicated the care plan should be an accurate representation of the resident.

2) Resident #60 was admitted to the facility on 11/22/21 with diagnoses that included muscle weakness and seizure disorder.

The admission Minimum Data Set (MDS) assessment dated 11/29/21 indicated Resident #60 had severe cognitive impairment and had 1 fall with injury since her admission to the facility.

Resident #60's active care plan included the following focus areas:
- The resident has had an actual fall with injury Poor Balance, Unsteady gait. This was initiated on 11/25/21 and last revised on 12/8/21. The interventions were to monitor/document/report as needed for 72 hours to physician any signs or symptoms of pain, bruises, change in mental status, new onset confusion/sleepiness/inability to maintain posture or agitation.
- The resident is high risk for falls related to psychotropic drug use, altered mental status, schizophrenia, delirium, traumatic brain injury and polypharmacy. This was initiated on 12/6/21 and revised on 12/13/21. The interventions were anticipate and meet the resident's needs; be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; follow facility fall protocol.

Review of Resident #60's medical record

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status, 3 random residents to ensure current diet order matches care plan, and 3 random residents with recent falls to ensure interventions are care planned accurately. Audits will be completed 5 x weekly for 4 weeks, 2 times weekly x 2 months and then monthly x 2 months or until substantial compliance is met. The Director of Nursing will report results of audits to Quality Assurance Performance Improvement committee monthly and changes will be made to the plan as necessary to maintain compliance with care plan revisions.

5. Date of Compliance 1/13/2022

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revealed an Interdisciplinary Departmental Team (IDT) meeting note for 12/5/21 indicating discussions were held regarding Resident #60's recent fall on 11/25/21 and was provided with non-skid socks.

On 12/15/21 at 11:33 AM, the Director of Nursing indicated the Assistant Director of Nursing (ADON) updated care plans following discussions regarding resident falls.

The ADON was interviewed on 12/15/21 at 12:43 PM and confirmed she updated care plans after IDT meetings when falls were discussed. The ADON reviewed Resident #60's care plan and indicated it was an oversight not to have placed encourage no-skid socks to the care plan.

3. Resident #23 was admitted to the facility on 7/31/19 with multiple diagnoses including an immune disease that impacts the brain and the spinal cord and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated 10/4/21 indicated that Resident #23's cognition was intact, and he was not on a mechanically altered diet.

Resident #23 had doctor's order dated 9/29/20 for puree and nectar thick liquid diet. On 8/30/21, his diet was changed to regular with thin liquids.

Review of Resident #23's care plan that was reviewed and revised on 10/4/21 was conducted. The care plan problem was "resident is at risk of nutritional decline related to receiving texture modified diet and thickened liquids, history of weight loss with weight refusals and wounds". The goal was "the resident will be free from chocking/aspiration and will maintain adequate

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F 657	Continued From page 42 nutritional status as evidenced by maintaining weight, no signs/symptoms of malnutrition and consuming at least 51-100% of meals daily through review date". Resident #23 was observed on 12/14/21 at 8:50 AM and on 12/15/21 at 12:50 PM. He was served regular with thin liquid diet. The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON verified that Resident #23's diet was changed from puree with thickened liquids to regular with thin liquids in August 2021. She stated that the care plan should have been revised when the resident's diet was changed but it was not. The MDS Nurse was interviewed on 12/16/21 at 9:20 AM. The MDS Nurse reviewed the care plan and stated that she was not aware that Resident #23's diet was changed from puree with thickened liquids to regular with thin liquids. She indicated that she should have revised the care plan in October 2021 when she completed the quarterly assessment.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide nail care and facial grooming for residents who required staff assistance with their	F 677	1. Resident #161 did not receive shaving per his preference. Resident #6 did not receive nail care as scheduled. Resident #22 did not receive nail care and shaving	1/13/22

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activities of daily living (ADLs). This was for 3 (Resident #6, Resident #161 and Resident #22) of 5 residents reviewed for ADLs. The findings included:

1. Resident #6 was admitted on 5/7/09 and readmitted on 9/15/20 with a diagnosis of a nonprogressive disorder if movement and posture caused by abnormal development, or damage to, motor control centers of the brain.

The quarterly Minimum Data Set dated 9/15/21 indicated severe cognitive impairment and he exhibited no behaviors. He was for extensive staff assistance for all of his ADLs.

Review of Resident #6's revised care plan dated 11/30/21 read he had an ADL self-care performance deficit related to his multiple hand and finger deformities. Interventions included staff checking his nail length, trim and clean them on his bath day as needed. Resident #6 was also care planned with the revision date of 11/30/21 for refusals of taking medications, showers, bed baths and shaving. There was no mention of nail care refusals.

An observation was conducted on 12/13/21 at 1:12 PM of Resident #6's fingernails. His nails were approximately ½ inch long, extended over the fingertips, jagged and appeared yellow in color. He exhibited bilateral hand contractures with a reddened indented area (no open area) to his left palm where his fingernail was touching his palm.

An observation was conducted on 12/14/21 at 3:50 PM of Resident #6's fingernails. His nails were unchanged from the observation on

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as scheduled and to his preference. Resident #161 now receiving shaving assistance as scheduled and to his preference. Resident #22 was shaven per his preference and received nail care from Wound Care nurse on 12/14/2021. Resident #6 is now receiving nail care performed as indicated.

2. Residents who require assistance for ACTIVITIES OF DAILY LIFE care can be affected by the deficient practice. Initial audit of residents completed on 12/16/21 by Director of Nursing to ensure nail care and shaving were performed as scheduled and per preference. Resident care plans and kardex updated as appropriate and care provided accordingly.

3. On 12/23/21 Licensed and Certified Nursing Staff were re-educated by Staff Development Coordinator and Director of Nursing to ensure all residents who require assistance with Activities of Daily Living (shower/bathing, nail care, and facial hair) are provided care to maintain proper grooming and hygiene. Education will be completed by 1/13/2022. Staff will not be permitted to work without completed education. New Hires are educated upon hire and annually.

4. Beginning 12/23/2021 the Director of Nursing or Designee will audit residents for Activities of Daily Living Care 5 times weekly for 4 weeks, then 2 times weekly for 2 months or until substantial compliance is met. The results of the

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12/13/21.
An observation was conducted on 12/15/21 at 8:48 AM of Resident #6's fingernails. His nails were very long and unkempt. There were wash clothes rolled up in both hands. unchanged from the observation on 12/14/21.

An interview was conducted on 12/15/21 at 2:20 PM with the Treatment Nurse (TN). She stated nail care was normally done on shower days. She stated she or the floor nurses cut the nails of the diabetic residents and the aides were responsible for cutting all other residents fingernails.

An observation was conducted on 12/15/21 at 2:26 PM of Resident #6's fingernails. His nails were very long and unkempt. There were wash clothes rolled up in both hands.

An interview was conducted on 12/15/21 at 2:51 PM with Nursing Assistant (NA) #7. She stated if a resident's fingernails were really long, she would report it to the nurse because she did not want to hurt anyone. NA #7 stated the wash clothes in Resident #6's hands were there as protection and she noted the length of his fingernails today and reported it to Nurse #7.

A telephone interview was conducted on 12/15/21 at 3:21 PM with Nurse #7. She stated she did not recall NA #7 reporting anything about Resident #6's fingernails. She further stated she was unsure why NA #7 would have reported it to her because Resident #6 was not a diabetic and the aides cut his fingernails.

An observation and interview was conducted on 12/15/21 at 4:00 PM with the Director of Nursing (DON). She noted the length and condition of

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audits will be reviewed monthly in Quality Assurance and Performance Improvement Meeting and any changes will be made as necessary. Continuation of the Audit will continue upon recommendation of the Quality Assurance Team and the Administrator.

Date Of Compliance- 1/13/2022

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Resident #6's fingernails and observed where his nails were making indentions in his palms. The DON stated she unsure why his nail care had not been provided recently but stated he also had a history of refusing ADLs assistance.

2. Resident #161 was admitted on 12/3/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

His admission Minimum Data Set (MDS) dated 12/9/21 indicated it was still in progress.

Review of Resident #161's baseline care plan dated 12/3/21 indicated he was cognitively intact. The baseline care plan did not mention anything about facial grooming assistance.

An observation and interview was conducted on 12/13/21 at 10:57 AM. Resident #161 was sitting up in bed. He was absent of odors but appeared disheveled. His facial hair was grown out and stated he had not been offered a shave since his admission on 12/3/21. Resident #161 stated prior to his admission, he either was clean shaven or wore he a closely trimmed beard without side burns.

During an observation on 12/14/21 at 1:35 PM, Resident #161 had a visitor. She indicated they were related. She stated Resident #161 never let his facial hair grow out as it was currently. The visitor stated she was wondering if she needed to get a barber to come in and groom Resident #161.

An interview was conducted on 12/14/21 at 2:51 PM with Nursing Assistant (NA) #7. She stated she had not worked with Resident #161 before,

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but she was not aware of any refusals of care.

An observation and interview was conducted on 12/15/21 at 9:10 AM with NA #1. She stated she was not aware that Resident #6 preferred to not have facial hair and she was under the impression that his visitor was shaving him when she came.

An observation and interview was conducted on 12/15/21 at 10:55 AM with Resident #161. He had been shaven as desired and stated he was very happy about it.

An interview was conducted on 12/15/21 at 3:00 PM, the Director of Nursing (DON) stated it was her expectation that ADL dependent residents receive assistance with grooming and facial hair and any ADL refusals should be documented.

3) Resident #22 was originally admitted to the facility on 10/13/15 with diagnoses that included diabetes type 2 and peripheral vascular disease.

A quarterly Minimum Data Set (MDS) assessment dated 10/7/21 indicated Resident #22 had moderately impaired cognition and required extensive assistance with personal hygiene tasks.

A review of Resident #22's active care plan, last reviewed on 10/28/21, included a focus area for requiring minimal assistance with activities of daily living (ADLs), with the ability to participate in self-care. The interventions included to provide limited assistance of 1 staff member for personal hygiene and to provide assistance as required for completion of ADL tasks. There was another focus area for Resident #22 being resistant to

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care (diet, wound care, therapy, showers) but did not mention any refusals of nail care or shaving tasks.

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A review of the nursing progress notes from 12/31/20 to 12/15/21, revealed no refusals of nail care or shaving assistance documented.

An observation was made of Resident #22 on 12/13/21 at 11:30 AM while he was lying in bed watching TV. He was noted with a thick beard and long fingernails to both hands. When questioned if staff offered assistance with shaving, Resident #22 stated it had been "about 2 months ago" when he was last shaved and preferred to be clean shaven with just a trimmed moustache. Resident #22 also stated he would like to have his fingernails cut.

On 12/14/21 at 8:45 AM, Resident #22 was noted to be clean shaven with a small moustache present. He stated someone came the prior evening, offering to shave him but did not offer to cut his fingernails.

On 12/14/21 at 11:30 AM, a phone call was placed to Nurse Aide #8 (NA). She had been assigned to care for Resident #22 during the 3:00 PM to 11:00 PM shift. A message was left for a return call.

An interview was completed with NA #4, who was familiar with Resident #22, on 12/14/21 at 2:00 PM. She explained nail care and shaving should occur during scheduled shower days. NAs were to ensure nails were short, clean, and free of jagged edges but if the resident was diabetic the nurse would have to trim the fingernails. NA #4 was unable to state why Resident #22 had not

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been offered nail care or shaving.

On 12/14/21 at 2:21 PM an interview occurred with the wound nurse/unit manager. She explained nail care should occur on shower days. If the resident was a diabetic, the NAs could clean and file fingernails, but nurses would need to trim them. In addition, she explained shaving should also be completed on shower days and as needed. The wound nurse/unit manager stated Resident #22's shower days were Wednesday and Saturday on the 3:00 PM to 11:00 PM shift.

On 12/14/21 at 2:46 PM, the wound nurse/unit manager was observed completing nail care to Resident #22.

NA #7 was interviewed on 12/14/21 at 2:51 PM and stated nail care and shaving tasks were to be completed on scheduled shower days and when needed. Aides were able to provide nail care to all residents except they could not cut diabetic fingernails. NA #7 further stated most of the male residents at the facility liked having beards, but she would shave them if requested.

Another phone call was placed to NA #8 on 12/15/21 at 12:45 PM. A message was left for a return call that was not received during the time of the survey.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:35 PM and indicated NAs could clean and trim all resident's nails except diabetic fingernails, which nurses would need to trim. She stated it was her expectation for the NAs to monitor, clean and trim nails during personal care, retrieving a nurse for any diabetic nail care that was needed. Additionally, the DON stated it

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F 677	Continued From page 49 was her expectation that Resident #22 be free of unwanted facial hair and expected NAs to offer shaving during his scheduled shower days and during daily personal care tasks.	F 677		
F 686 SS=E	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, observations and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight (Residents #22, #34 and #57), failed to obtain a treatment order when a pressure ulcer was first identified (Resident #211), failed to transcribe physician orders for wound care following admission to the facility (Resident #211) and failed to provide treatment to the right buttock pressure ulcer as ordered (Resident #34). This was for 4 of 4 residents reviewed for pressure ulcers. The findings included:	F 686	1. Resident #22, #34, and #57 low air loss mattress was not set to correct weight. Resident air mattresses were set to the correct weight setting on 12/16/21. Resident #211 treatment order was not transcribed timely. Resident #211 treatment order was transcribed on 12/13/2021 and no treatments were missed Resident #34 received incorrect treatment to right buttocks pressure ulcer. Medical Director was consulted and no adverse effects indicated from incorrect treatment. 2. Residents currently on Low Air Loss	1/13/22

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1) Resident #22 was originally admitted to the facility on 10/13/15 with diagnoses that included venous ulcers to the lower extremities, peripheral vascular disease, and diabetes type 2.

A review of Resident #22's December 2021 physician orders revealed an order dated 5/29/20 to check air mattress function every shift for wound healing.

A quarterly Minimum Data Set (MDS) assessment dated 10/7/21 indicated Resident #22 had moderately impaired cognition and was coded with 1 stage 3 pressure ulcer, diabetic foot ulcers and had a pressure reducing device to the bed.

Resident #22's weight on 10/9/21 was 224.5 pounds (lbs.).

Review of Resident #22's active care plan, last reviewed 10/28/21, included the following focus areas:
- Resident has potential for pressure ulcer development related to decreased mobility, spending long periods of time in the wheelchair or bed and diagnosis of diabetes with diabetic ulcers, current lymphatic wounds to bilateral lower extremities and history of moisture associated skin damage (MASD). The interventions included a pressure reduction mattress in bed.
- Resident has actual impairment to the skin integrity: lymphademic wounds, bilateral rear thigh moisture breakdown and diabetic ulcers to the bilateral lower extremities. He is noncompliant with wound care at times. The interventions included a pressure relief device to the bed.

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Air Mattresses are at risk for deficient practice. On 12/16/21 a 100% audit was performed by the Director of Nursing, Wound Nurse and Staff Development Coordinator identifying residents currently on Low Air Loss Air Mattress Therapy to ensure proper setting. No other issues were identified in initial audit. For each resident identified, the Kardex and Care Plan were updated to reflect proper air mattress settings. Residents with wound care orders are at risk due to deficient practice related to order transcription and not performing wound treatments as ordered. An initial audit was completed by Regional Director of Clinical Services on 12/14/2022 for residents with wound care orders to ensure orders were transcribed timely. No other issues were identified. Residents receiving wound care treatments continue to receive treatments as ordered.

3. The following measures were put in place on 1/6/22 to ensure the Plan of Correction is effective and remains in compliance. Licensed Nursing staff are responsible for ensuring proper air mattress settings are in place and correct for resident, ensuring that newly obtained wound care orders are transcribed upon receipt, and properly executed per doctor□s order. Licensed Nursing Staff to include Wound Care Nurse were re-educated by Staff Development Coordinator/Director of Nursing or Designee to ensure all residents who require Low Air Loss Mattress therapy maintain the correct ordered setting, have

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F 686	Continued From page 51 Resident #22's weight on 11/10/21 was 223.4 lbs. and on 12/10/21 was 221.2 lbs. On 12/14/21 at 2:45 PM an observation was made with the Assistant Director of Nursing (ADON) of Resident #22's alternating pressure reducing mattress machine set at 80 lbs. The machine had settings from 80 to 400 lbs. and indicated to set according to the resident's weight per pounds. An interview occurred with Nurse #2 on 12/14/21 at 4:13 PM, who stated anyone who entered Resident #22's room should make sure the air mattress was functioning properly. She further stated when she checked the functionality of the mattress, she was just making sure it was plugged in and on. She wasn't sure who was responsible for ensuring the weight settings were correct. On 12/15/21 at 3:35 PM, an interview was held with the Director of Nursing (DON) and facility wound nurse. The DON stated normally after the alternating pressure reducing mattress had been placed on a resident's bed, the facility wound nurse would ensure the correct weight setting was entered. The facility wound nurse explained she took over the position late September 2021 and the alternating air mattress was already in place to Resident #22's bed. She was unaware she was to check for correct weight settings. Resident #22 was observed lying in bed watching TV on 12/15/21 at 4:00 PM. The alternating pressure reducing mattress machine was set at 80 lbs.	F 686	wound care treatment orders transcribed timely, and receive treatments per physician orders. They were also re-educated that only licensed Nursing staff are trained to make any changes to the settings in accordance with the physician order. Education completed by 1/13/21. Staff will not be permitted to work without completed education. All New Hires are educated upon hire. 4. Progress of audits are discussed in morning Stand-up meeting (Meeting of the Interdisciplinary Team). Beginning 1/6/22 the Director of Nursing, Staff Development Coordinator, Treatment Nurse and Unit Managers will continue to audit all residents daily requiring Low Air Loss Therapy to ensure settings in place. This will occur 5 times weekly for 4 weeks, then 2 times weekly for 2 months, and then monthly for 2 months or until substantial compliance is met. Director of Nursing or Designee will monitor wound care treatments performed by wound care nurse or other licensed nurse staff performing wound treatments to ensure treatment is administered per doctors order. This audit will occur 1 x weekly for 8 weeks, then monthly for 2 months until substantial compliance is met. To ensure new wound care orders are transcribed timely upon admit, Director of Nursing or Licensed Nurse Designee will monitor new admission orders within 24 hours of admission for 30 days and then reviewed Monday through Friday in morning Stand Up meeting or until substantial compliance is met. The results of the	

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F 686	Continued From page 52 2a) Resident #211 was admitted to the facility on 12/10/21 with diagnoses that included diabetes type 2, coronary artery disease and cellulitis of the right lower leg. The Admission Nursing Assessment on 12/10/21 revealed Resident #211 had a pressure area to his buttocks. A baseline care plan dated 12/11/21 indicated Resident #211 was cognitively intact and included a focus area for pressure ulcers. The interventions included to administer treatments as ordered and observe for effectiveness, observed dressing to ensure it was intact and report loose dressings to the nurse. Resident #211's December 2021 facility physician's orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed and there was no order or treatment documented for the left buttock pressure ulcer. Review of a Weekly Pressure Wound Observation Tool from 12/13/21 indicated the assessment was completed by the wound care nurse, accompanied by the wound care Nurse Practitioner (NP). The resident was noted to have a left buttock pressure wound measuring 3 centimeters (cm) in length, 2 cm in width and 0.1 cm in depth. The area was documented as admitted with from the hospital. A review of the physician orders and TAR, revealed an order dated 12/13/21 to cleanse the left buttock with normal saline, apply Medihoney and cover with a dry dressing every day shift.	F 686	audits will be brought to Quality Assurance Performance Improvement meeting by Director of Nursing and reviewed in our Quality Assurance and Performance Improvement Meeting each month. Review and any changes will be made as necessary. Continuation of the Audit will continue upon recommendation of the Quality Assurance Team and the Administrator. 5. Date of Compliance 1/13/2022	

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On 12/13/21 at 1:18 PM, the resident was observed sitting up in his bed consuming lunch. He stated he had his bandages changed for the first time since admission that morning.

A phone interview was completed with Nurse #4 on 12/14/21 at 12:55 PM. She was the nurse on duty at the time of Resident #211's admission on 12/10/21. She recalled he was admitted to the facility around 3:00 PM but all of his orders had already been placed in the Electronic Medical Record (EMR) system by the unit manager. Nurse #4 stated she completed his admission assessment and identified his wounds to include a pressure ulcer to his buttocks but did not review the discharge summary to see if buttock wound care orders were present nor did she reach out to the medical providers for orders, as she thought it had already been done.

An interview occurred with the wound care nurse/Unit Manger on 12/14/21 at 2:21 PM and stated she couldn't recall assessing Resident #211's wounds at the time of his admission on 12/10/21. She recalled reviewing the discharge orders emailed from the hospital before the resident arrived but did not review any other orders that were sent with him from the hospital until Monday 12/13/21. The wound care nurse/Unit Manager stated Nurse #4 called her the evening of 12/10/21 and questioned how to address wounds to Resident #211 and she informed her to monitor, reinforce them if needed and she would assess him on Monday 12/13/21.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:00 PM. She confirmed completing the baseline care plan on 12/11/21 but did not identify no wound care orders were

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F 686	Continued From page 54 present for Resident #211's buttock pressure wound. The DON further stated she would have expected the admitting nurse to verify and ensure residents had wound care orders for any wounds they were admitted with. This would be accomplished through review of the hospital discharge paperwork or reaching out to the medical providers to obtain orders. On 12/16/21 at 10:44 AM, an interview occurred with the facility Nurse Practitioner (NP) and stated she would have expected for the staff to reach out to herself, the Medical Director or wound NP for wound care orders if a resident was admitted with pressure ulcers and did not have any orders to care for the areas. She was unaware Resident #211 did not have wound care to his buttocks from 12/10/21 to 12/13/21. A phone interview was completed with the wound NP on 12/16/21 at 11:00 AM and stated she would have expected for the staff to reach out to herself or the facility NP to obtain wound care orders if there were none present on the hospital discharge paperwork. She was unaware the resident had not received any wound care to his left buttock pressure ulcer from 12/10/21 to 12/13/21. 2b) Resident #211 was admitted to the facility on 12/10/21 with diagnoses that included diabetes type 2, coronary artery disease and cellulitis of the right lower leg. A review of Resident #211's hospital discharge summary and wound care documentation dated 12/10/21, indicated wounds were present to the right outer hip/thigh area, right lower leg, and right 2nd and 5th toes and he had a history of chronic	F 686		

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lower extremity wounds. The discharge instructions included to continue local wound care per the wound care nurse instructions. An order sheet included the following wound care orders:
- Clean right outer lower leg with wound cleanser, apply wound ointment and cover with foam dressing Monday, Wednesday, and Friday.
- Clean right 2nd toe with wound cleanser, apply wound ointment and cover with band-aid if needed on Monday, Wednesday, and Friday.
- Clean right outer hip and thigh area with wound cleanser, apply Aquacel AG (a wound dressing) and cover with a large foam dressing on Monday, Wednesday, and Friday.
- Clean right 5th toe with wound cleanser, apply wound ointment and cover with foam dressing on Monday, Wednesday, and Friday.

The Admission Nursing Assessment on 12/10/21 revealed Resident #211 had open areas to the right leg and right foot.

A baseline care plan dated 12/11/21 indicated Resident #211 was cognitively intact and had pressure ulcers present. The Pressure Ulcer Care Plan included a focus area for pressure ulcers. The interventions included to administer treatments as ordered and observe for effectiveness, observed dressing to ensure it was intact and report loose dressings to the nurse.

The December 2021 facility physician's orders did not include the hospital's discharge wound care orders provided on 12/10/21. The facility physician's orders revealed wound care orders were not transcribed or obtained until 12/13/21.

Review of a Weekly Pressure Wound Observation Tool dated 12/13/21 indicated the

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F 686	Continued From page 56 assessment was completed by the wound care nurse, accompanied by the wound care Nurse Practitioner (NP). Wound areas were noted to the right outer thigh, right outer foot, right lower leg, and right outer 5th toe. All areas were noted as being admitted with from the hospital. A phone interview was completed with Nurse #4 on 12/14/21 at 12:55 PM. She was the nurse on duty at the time of Resident #211's admission on 12/10/21 and recalled he was admitted to the facility around 3:00 PM but all of his orders had already been placed in the Electronic Medical Record (EMR) system by the unit manager. She went on to say normally the admitting nurse would review the discharge summary and orders from the hospital to ensure all orders had been transcribed correctly to the facility physician's orders. Nurse #4 stated she completed his admission assessment and was aware he had vascular ulcers present on his legs but did not review the discharge summary or enter any wound care orders into the EMR, as she thought it had already been done. An interview occurred with the wound care nurse/Unit Manger on 12/14/21 at 2:21 PM and stated she didn't assess Resident #211's wounds at the time of his admission on 12/10/21. She recalled reviewing the discharge orders emailed from the hospital before the resident arrived to the facility but did not review any other orders that were sent with him from the hospital until Monday 12/13/21. The wound care nurse/Unit Manager stated Nurse #4 called her the evening of 12/10/21 and questioned how to address wounds to Resident #211's legs. She informed her to monitor, reinforce them if needed and that she would assess them on Monday 12/13/21.	F 686		

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The Director of Nursing (DON) was interviewed on 12/15/21 at 3:00 PM and stated she would have expected the admitting nurse to verify the discharge summary and orders, ensuring all had been transcribed completely and accurately.

A phone interview was completed with the wound Nurse Practitioner (NP) on 12/16/21 at 11:00 AM and stated she would have expected the wound care orders from the hospital to have been transcribed to the facility physician's orders. She further stated if there were no orders present, staff could reach out to her for wound care orders until she or the wound care nurse could assess the areas. The NP added even if wound orders were for Monday, Wednesday, and Friday there would have been orders on how to care for the wounds should the areas need to be redressed.

3a. Resident #34 was admitted to the facility on 11/1/19 with multiple diagnoses including an immune disease that impacts the brain and the spinal cord and paraplegia. The annual Minimum Data Set (MDS) assessment dated 10/20/21 indicated that Resident #34's cognition was intact, and she had 2 stage IV and 1 unstageable pressure ulcers.

The wound doctor progress note dated 10/18/21 revealed that Resident #34 had 2 stage IV pressure ulcers on her right and left malleolus and 1 unstageable pressure ulcer on her right buttock. The right buttock pressure ulcer had 40% eschar, 20% granulation and 40% slough. The note on 12/1/21 indicated that the right buttock pressure ulcer had 25% eschar, 50% granulation, 15% slough and 10% fibrotic tissue.

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Resident #34 was care planned on 10/20/21 for left and right foot pressure ulcers. She did not have a care plan for her right buttock pressure ulcer. The approaches to the care plan for the left and right foot included assess, record and monitor wound healing (weekly) and measure in length, width and depth if possible, report improvement and decline to the doctor, educate resident/family/caregiver as to causes of skin breakdown, if resident refuses treatment, confer with the resident, interdisciplinary team (IDT) and family to determine why and try alternative method to gain compliance, document alternative methods, inform the resident/family/caregivers of any new area of skin breakdown and teach resident/family the importance of changing position for prevention of pressure ulcers, and encourage small frequent position changes.

Resident #34 had a doctor's order dated 11/25/21 to clean the right buttock pressure ulcer with normal saline (NS), apply zinc oxide to the peri wound, apply iodoform gel (an antimicrobial and highly absorbent used to treat pressure ulcers) mixed with collagen powder (a protein powder that helps with wound healing) to eschar and slough and pack with calcium alginate (highly absorbent and enhances wound healing), apply Thera honey to granulated tissue and cover with dry dressing daily.
Resident #34 was observed during the dressing change on 12/14/21 at 12:30 PM. The treatment to the right buttock pressure ulcer was provided by the Wound Nurse. When observed, the wound bed was covered with 40% slough/eschar and 60% granulation tissue. The Wound Nurse cleaned the pressure ulcer with Normal Saline, iodoform gel mixed with collagen powder was

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F 686	Continued From page 59	F 686		

applied to the eschar/slough, packed with wet to dry gauze and covered with dry dressing. The Wound Nurse was not observed to use calcium alginate to pack the wound nor Thera honey to the granulated tissue as ordered.

The Wound Nurse was interviewed on 12/14/21 at 3:05 PM. She stated that she did not use Thera honey since the wound did not have granulation tissue. She verified that she packed the eschar/slough of the wound with wet to dry gauze instead of calcium alginate. She indicated that she thought the order was changed.

The Director Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. She stated that the Wound Nurse informed her that she thought the treatment order for Resident #34's pressure ulcer on the right buttock was changed and therefore the order to use calcium alginate for packing and the Thera honey was not followed.

The Nurse Practitioner (NP) was interviewed on 12/16/21 at 10:47 AM. The NP stated Resident #34 was severely contracted on lower extremities, paraplegic and had chronic pain. She was on an air mattress, had a suprapubic catheter and had a good appetite. The resident was alert and oriented and at times refused care. Due to her comorbidities, her pressure ulcers were unavoidable. The NP added that she expected nursing to follow the treatment to the right buttock pressure ulcer as ordered.
The Wound NP was interviewed on 12/16/21 at 11:00 AM. The NP stated that Resident #34 was high risk for pressure ulcers due to her diagnoses. She was alert and oriented. She had chronic pain on her left shoulder/arm, and so she wanted to stay on her right side. She was on an

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F 686	Continued From page 60 air mattress and had an indwelling urinary catheter. Staff tried to reposition her, but at times she refused. Due to her diagnoses, her pressure ulcers were unavoidable. The Wound NP stated that she expected nursing to provide treatment to the right buttock pressure ulcer as ordered. 3b. Resident #34 was admitted to the facility on 11/1/19 with multiple diagnoses including an immune disease that impacts the brain and the spinal cord and paraplegia. The annual Minimum Data Set (MDS) assessment dated 10/20/21 indicated that Resident#34's cognition was intact, and she had 2 stage IV and 1 unstageable pressure ulcers. The assessment further indicated that the resident weighed 157 pounds (lbs.). Resident #34 was care planned on 10/20/21 for left and right foot pressure ulcers. She did not have a care plan for her right buttock pressure ulcer. The approaches to the care plan for the left and right foot included assess, record and monitor wound healing (weekly) and measure in length, width and depth if possible, report improvement and decline to the doctor, educate resident/family/caregiver as to causes of skin breakdown, if resident refuses treatment, confer with the resident, interdisciplinary team (IDT) and family to determine why and try alternative method to gain compliance, document alternative methods, inform the resident/family/caregivers of any new area of skin breakdown and teach resident/family the importance of changing position for prevention of pressure ulcers, encourage small frequent position changes.	F 686		

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Resident #34 was observed in bed on 12/13/21 at 11:05 AM and on 12/14/21 at 8:45 AM. She had an air mattress, and the machine had a setting selection in pounds (resident's weight). The resident's air mattress machine was set at less than 80 lbs. on both observations.

The Wound Nurse was interviewed on 12/14/21 at 2:45 PM. She stated that anybody was responsible for checking the air mattress to ensure it was working and at the correct setting. The Wound Nurse reported that the air mattress used at the facility should have been set according to the resident ' s weight. She observed the air mattress setting for Resident #34 and verified that the machine was set at less than 80 lbs.

Nurse #4, assigned to Resident #34, was interviewed on 12/15/21 at 9:30 AM. She stated that she worked at the facility for over a year. She reported that nursing staff were responsible to make sure the air mattress was functioning. She added that you would hear the machine beeping if not plugged in or if it was deflated. Nurse #4 indicated that she was not sure who was responsible for setting up the air mattress machine.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that the maintenance staff was responsible for the original setting of the air mattress. She reported that nurses should be monitoring the function and the setting daily. The DON indicated that the monitoring of the air mattress machine had not been completed since the facility did not have consistent nursing staff. She verified that the air mattress should be set according to the resident's

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F 686	Continued From page 62 weight 4. Resident #57 was admitted to the facility on 3/16/2019 with diagnoses that included diabetes type two, unstageable pressure ulcer, and peripheral vascular disease. A quarterly Minimum Data Set (MDS) assessment dated 11/21/2021 indicated Resident #57 had moderately impaired cognition, was at risk for pressure ulcers, had no current pressure ulcers, and had a pressure reducing device to the bed. Review of Resident #57's active care plan, last reviewed 11/5/2021, included the following focus area: - The resident is at risk for further skin breakdown related to history of right plantar heel warts/callouses, immobility, preference to staying in bed, and incontinent of bowel and bladder. Wound care recommendations by the wound nurse practitioner dated 7/13/2021 included pressure redistribution mattress per facility protocol as well as continuing pressure ulcer prevention program for Resident #57. Resident #57's weight on 12/2/2021 was 268 pounds (lbs.). On 12/14/2021 at 12:45 PM observed the control panel to the air mattress was positioned at the bottom of the bed against the wall with an oxygen concentrator and a bedside table positioned in front of the control panel. Unable to determine settings.	F 686		

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F 686	Continued From page 63 On 12/14/2021 at 2:46 PM accompanied the wound care nurse into resident's room. Observed the resident's air mattress setting at 450lbs. When asked who was responsible for setting up and monitoring the air mattress settings, the wound care nurse stated anyone could set the mattress settings and check the functionality. An interview occurred with Unit Nurse Manager #2 on 12/14/21 at 3 :01 PM, who stated any nursing staff assigned to Resident #57 should make sure the air mattress was functioning properly and set correctly. She further stated she would check the functionality of the mattress if it was alarming or if the resident complained about it, otherwise she was just making sure it was plugged in and on. She wasn't sure who was responsible for ensuring the weight settings were correct. On 12/15/21 at 3:35 PM, an interview was held with the Director of Nursing (DON) and wound care nurse. The DON stated normally after the alternating pressure reducing mattress had been placed on a resident's bed, the facility wound nurse would ensure the correct weight setting was entered. The facility wound nurse explained she took over the position late September 2021 and the alternating air mattress was already in place to Resident #57's bed. She was unaware she was to check for correct weight settings.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		1/13/22

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F 688	Continued From page 64 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to implement the restorative program as recommended by the occupational therapist (OT) for 1 (Resident #30) of 2 sampled residents reviewed for limitation in range of motion (ROM). Findings included: Resident #30 was admitted to the facility on 6/6/16 with multiple diagnoses including Alzheimer's disease and cerebrovascular accident (CVA). The quarterly Minimum Data Set (MDS) assessment dated 10/18/21 indicated that Resident #30 has severe cognitive impairment and has impairment in range of motion on one side of upper and lower extremities. Resident #30 was evaluated and treated by the OT from 4/8/21 through 4/27/21 for contracture of the right hand. The OT discharge summary dated 4/27/21 revealed that a restorative program for passive range of motion to the right upper	F 688	1. The facility failed to apply a splinting device as recommended by therapy for Resident #30. Splint is now applied per therapy recommendation. 2. Nursing Leadership to include Director of Nursing, MINIMUM DATA SET Coordinator and Unit Manager conducted an audit of all current residents with splints to ensure they have appropriate intervention/orders/care plan in place. No additional issues were identified for eight residents with splints. Audit to be completed by 1/13/2022. 3. Nursing staff is responsible for applying splints and other restorative program measures as recommended by Therapy department. Therapy Department is responsible or notifying nursing staff of new splint and other restorative order, educating staff on how to apply splints and documenting said education, and	

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F 688	Continued From page 65 extremity (2 x 10 reps each joint) and splint/brace application (right palm protector to be worn 6-8 hours per day as tolerated) was recommended. The recommendation was provided to Nurse Aide (NA) #1 and Nurse # 1. Resident #30's care plan reviewed on 10/11/21 revealed a problem "resident requires assistance with mobility related to CVA, right upper arm and right knee flexion contractures." The goal was "resident will have complications of immobility minimized with staff intervention through next review." The approaches included to apply the right-hand splint up to 4 hours daily (added on 3/6/21) and to provide gentle range of motion with care as resident tolerates. Resident #30 was observed on 12/13/21 at 9:30 AM, and 1:18 PM and on 12/14/21 at 8:40 AM. The resident's right hand was contracted (fist position) and there was no splint/palm protector noted. NA #1 was interviewed on 12/14/21 at 1:10 PM. NA #1 stated that she used to work as restorative aide, but the position was eliminated and now she worked on the floor as NA. She verified that she had received the recommendation for the restorative program for Resident #30, she thought it was the time when the restorative aide position was eliminated. The Director of Nursing (DON) was interviewed on 12/14/21 at 3:40 PM. The DON stated that Resident #30 had an order for splint application for 4 hours in 2019 but that was discontinued. The DON indicated that Resident #30 was reevaluated and treated by OT from 4/8/21 through 4/27/21. She stated that Nurse #1 who	F 688	ensure therapy recommendations are communicated to Interdisciplinary Team in order for nursing to initiate order and care plan appropriately. Director of Nursing to educate nursing staff to include, Licensed Nurses, Certified Nursing Aids, and Contract nursing staff on applying splints per recommendations. Education will be added to New Hire Orientation. Education to be completed by 1/13/2022. Staff will not be permitted to work until education completed. Director of Nursing will verify that new splints that are communicated to the Interdisciplinary Team have application education completed by therapy to nursing staff, and that orders and care plans are initiated and added to the Kardex. Director of Nursing or designee will audit 5 Residents with splints 3x per week x 4 weeks then weekly x 8 weeks to ensure their splints are applied per physician order and care plan interventions. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QUALITY ASSURANCE PERFORMANCE IMPROVEMENT by the Director of Nursing monthly. At that time, the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 1/13/2022	

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F 688	Continued From page 66 received the OT recommendation dated 4/27/21 for Resident #30's restorative program, was no longer employed at the facility. She reported that Nurse #1 did not follow through with the recommendation and therefore the restorative program for the PROM and splint application was never implemented.	F 688		
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 and resident interviews and record review, the failed to secure bleach used by a resident for personal use (Resident #56) for 1 of 4 residents reviewed for accidents. The findings included: Resident #56 was admitted on 1/16/18 with cumulative diagnoses of End Stage Renal Disease (ESRD), Diabetes and Schizophrenia. The quarterly Minimum Data Set dated 11/15/21 indicated Resident #56 was cognitively intact and she exhibited no behaviors. She was also coded for supervision with her personal hygiene. Resident #56's revised care plan dated 11/4/21 indicated the preferred to use bleach to keep her skin clean. Interventions included the facility was	F 689	1. The facility failed to secure bleach used by a resident for personal use. Resident #56 had bleach secured in a locked closet on 12/15/2021 by Unit Manager. Resident #56 educated by Administrator and Social Worker that personal bleach products must be secured and to notify staff when she brings it in and it will be safely secured for use when needed. Resident has previously been care planned for this practice and noncompliance. 2. 100% audit completed on 12/15/2021 by Director of Nursing to ensure no other residents had unsecured bleach products. No other unsecured bleach products identified.	1/13/22

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F 689	Continued From page 67 to ensure the bleach was stored away in the resident's closet and not out openly in her room. During an interview with Resident #56 on 12/15/21 at 10:57 AM, observed on the left side of her bed in the corner in front of a dresser were 2 half gallon bottles of bleach. She stated she used the bleach on her skin on occasion. She stated her skin itches on occasion due to her ESRD but stated she diluted it prior to use. Resident #56 did not currently have a roommate. An interview was conducted on 12/15/21 at 11:00 AM with Nursing Assistant (NA) #6. She stated the staff and management had tried to get her to stop using the bleach, but she refused. Resident #56 and staff were supposed to keep the bleach secured. NA #6 stated Resident #56 preferred to perform her own personal hygiene. An interview was conducted on 12/15/21 at 11:07 AM with Medication Aide (MA) #1. She stated Resident #56 refused to allow the staff to secure the bleach in her closet because she stated she could not get to it and needed it to be accessible. An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing. She stated Resident #56 insisted on using bleach and water to wash with at times. She stated the bleach was supposed to be secured in her closet when not in use.	F 689	3. Administrator to educate nursing staff to ensure bleach is kept secured in locked closet. No staff will be permitted to work until educated after 1/13/2021. New hires will be educated upon hire. Residents are provided lock and key to secure personal belongings. Personal items that could pose a risk to other residents, will be stored in a locked location to be accessed at the resident□s will and returned to locked location. Resident #56 had a sign placed on her closet to remind her to store personal care item in locked closet after use. Resident Medication Administration Record was updated for staff to sign off on Resident #56 bleach stored securely in locked closet. 4. Activities Director or Designee to audit resident #56 plus 2 random residents 3x/week x 2wk; weekly x 2 months and monthly x 2 months to ensure no hazardous chemicals are left unsecured. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement committee by Administrator. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5.Date of Compliance 1/13/2022	

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F 691	Continued From page 68	F 691		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide colostomy care for 1 of 2 residents reviewed for ostomy care (Resident #59). The findings included: Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included colostomy status. The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and required extensive assistance for toileting and personal hygiene tasks. He was coded for an ostomy. A review of Resident #59's active care plan revealed a focus area initiated 12/2/21, that resident had an alteration in gastrointestinal status related to having a colostomy in place. The interventions read "staff to empty and change colostomy per MD orders or requested". The December 2021 physician orders included an order, dated 11/19/21, for the colostomy bag to	F 691	1. Resident #59 was provided colostomy care on 12/15/21. 2. Residents with ostomy□s are at risk to be affected by deficient practice. Initial audit completed by Director of Nursing, Staff Development Coordinator, and Wound Nurse on 12/17/2022 to identify residents with an ostomy and ensure care was provided. No other issues were identified through initial audit. Kardex and Care plan for residents with ostomy□s was updated to ensure care provided as needed. 3. Nursing staff educated by 1/13/2022 by Director of Nursing or Designee to ensure residents who require assistance with ostomy care are provided necessary assistance needed. Staff will not be permitted to work without completed education. New Hires are educated upon hire and annually. 4. Director of Nursing or Designee will	1/13/22

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F 691	Continued From page 69 be checked and emptied every shift with replacement as required. Nursing progress notes were reviewed from 11/19/21 through 12/16/21 and revealed a documented incident where his clothing was stained due to leakage from the colostomy bag on 11/20/21. An interview occurred on 12/13/21 at 9:32 AM with Resident #59, who stated at times it was difficult to get staff to care for his ostomy consistently, causing the device to leak onto his clothing and skin. He pulled back his gown to reveal his colostomy bag was approximately ¾ full with semi-solid contents. On 12/15/21 at 8:28 AM, Resident #59 was observed lying flat in his bed with his gown pulled down to waist level, wristwatch in place and dried brown substance noted to the gown and bed sheets. He began to explain he was waiting to get cleaned up because his colostomy bag leaked around 6:08 AM that morning. He stated the nurse aide (NA) had informed the nurse on duty, but she did not come in to care for the device. Resident #59 indicated the Director of Nursing (DON) had just left his room after changing the device. A phone interview was conducted with Nurse #3 on 12/15/21 at 8:34 AM. She confirmed she had been assigned to care for Resident #59 the night prior and had just left the facility. The nurse went onto say she had not received communication that there was a problem with Resident #59's ostomy bag until she was getting ready to leave the facility between 7:00 AM to 7:30 AM. Nurse #3 continued to state sometimes Resident #59	F 691	audit residents with ostomy for proper care 5 times weekly x 4 weeks, then 2 x weekly x 2 months or until substantial compliance is met. Audits initiated on 12/20/21. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement committee by the Director of Nursing monthly. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Completion date is 1/13/2022_.	

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F 691	Continued From page 70 would ask for it to be changed even when it didn't need to be and that she had told him it didn't need to be changed on a number of occasions. She stated the communication between herself and the Nurse Aide was not good and that was the reason she didn't address the issue early this morning. On 12/15/21 at 8:47 AM, an interview occurred with Nurse Aide #3 (NA). She had been assigned to care for Resident #59 during the 3rd shift and was asked to stay over to provide personal care to Resident #59 by the Director of Nursing (DON). She explained around 6:00 AM she had entered the resident's room to provide morning care and assist him up for breakfast. She noticed his gown was soiled with brown stains and observed his ostomy had leaked around the stoma causing the adhesive to the ostomy system to come loose from his skin. She went on to say she cleaned around the ostomy site as best as she could and told the nurse the system had leaked and needed to be changed. NA #3 stated the nurse did not attend to Resident #59's ostomy bag, however the DON completed the care close to 8:00 AM. NA #3 stated she was able to get the resident cleaned up, dressed and up for breakfast starting 8:30 AM and added there were times nurses on the 3rd shift would tell Resident #59 they couldn't change his bag without assessing it. NA #3 stated she could empty and rinse out the ostomy bag or let the gas out when needed, but only the nurses could change the system out completely. An interview occurred with the DON 12/15/21 at 3:00 PM. She explained there was a communication error from the 3rd shift today regarding Resident #59's ostomy care and leakage that occurred. The DON stated when she	F 691		

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F 691	Continued From page 71 heard about the issue she went and changed out the ostomy system for him and the 3rd shift aide stayed over and assisted with his care. The DON further stated she would expect Resident #59's colostomy to be checked every shift as ordered and as needed to prevent leakage from the area.	F 691		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to display a cautionary safety sign indicating the use of oxygen for an oxygen dependent resident. This was for 1 (Resident #161) of 3 residents reviewed for respiratory care. The findings included: Resident #161 was admitted on 12/3/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #161's December 2021 Physician orders included an order dated 12/3/21 for oxygen via nasal cannula at 2-4 liters per minute continuous. His admission Minimum Data Set (MDS) dated 12/9/21 indicated it was still in progress.	F 695	1. The facility failed to display a cautionary safety sign indicating the use of oxygen for Resident #161. Cautionary safety sign was added to affected resident□s door on 12/16/2021 by Director of Nursing. 2. All residents have potential to be affected by this deficient practice. A 100% audit completed to ensure all residents currently using oxygen have correct cautionary safety sign indicating the use of oxygen. This was completed on 12/16/2021 by Director of Nursing and no other issues were identified. 3. Current Facility and Agency Nursing staff educated by the Administrator and	1/13/22

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F 695 Continued From page 72

Review of Resident #161's baseline care plan dated 12/3/21 did not mention the use of oxygen.

An observation and interview was conducted on 12/13/21 at 10:57 AM. Resident #161 was sitting up in bed wearing his oxygen. He confirmed he was dependent on continuous oxygen. There was no oxygen in use signage anywhere on his door or his door frame.

An observation was completed on 12/14/21 at 8:46 AM. Resident #161 was sleeping in bed wearing his continuous oxygen. There was no oxygen in use signage anywhere of his door or his door frame.

An interview was conducted on 12/15/21 at 8:15 AM with Medication Aide (MA) #1. She stated whenever a resident was ordered oxygen, the nurses placed an oxygen in use sign on the resident's door.

An observation was conducted on 12/15/21 at 2:40 PM. Resident #161 was sitting up in his wheelchair in his room wearing his continuous oxygen. There was no oxygen in use signage anywhere of his door or his door frame.

An interview was conducted on 12/15/21 at 3:00 PM, the Director of Nursing (DON) stated all residents to include Resident #161 should have a sign on the door indicating oxygen was in use. She stated she would correct it immediately.

An observation was conducted on 12/15/21 at 4:00 PM. There was a "Oxygen In Use" magnet sign on Resident #161's door frame.

F 695

Director of Nursing on need for signage for residents on oxygen. Nursing staff are responsible for placing signage as indicated when a resident admits with orders for oxygen or when a new order for oxygen to be used is initiated. Signage will be made available at nurses station for ease of access. Education completed by 1/13/2022. Licensed Nursing staff will ensure residents who require oxygen have appropriate safety signs indicating use of oxygen. New Hires are educated upon hire. Staff will not be permitted to work before receiving education.

4. Director of Nursing or nursing designee will monitor compliance by auditing rooms with oxygen in use, 5 rooms per week for 4 weeks, 5 rooms bi-weekly for 4 weeks and 5 rooms monthly for 2 months. Administrator or Director of Nursing will monitor for completion and bring findings to Quality Assurance Performance Improvement committee meetings.

5. Date of compliance: 1/13/22

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F 756	Continued From page 73	F 756		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		1/13/22

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take

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F 756	Continued From page 74 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 and interviews with staff, Pharmacy Consultant, facility Nurse Practitioner, Psychiatric Nurse Practitioner, and Medical Director, the Pharmacy Consultant failed to identify the facility's need to monitor residents for side effects of psychotropic medications (Residents #59 and #60) and the need for a gradual dose reduction (Resident #6). In addition, the facility failed to act upon recommendations made by the Pharmacy Consultant (Resident #59). This deficient practice affected 3 of 13 residents whose medications were reviewed. 1a) Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included major depressive disorder, insomnia, and anxiety disorder. A review of the physician's orders included the following: - An order dated 11/19/21 for Duloxetine (an antidepressant medication) 60 milligrams (mg) by mouth twice a day for depression. - An order dated 11/19/21 for Sertraline (an antidepressant medication) 50 mg by mouth once a day for depression. - An order dated 11/22/21 for Trazodone (an antidepressant medication) 25 mg by mouth at bedtime for insomnia. Review of a Pharmacy Consultant medication review note for 11/22/21 did not reflect the need for monitoring side effects of the psychotropic medications.	F 756	The facility failed to ensure pharmacy recommendation was followed timely for resident #59 and monitor for psychotropic side effects for residents #59 and #60. The Director of Nursing reviewed psychotropic medications for GRADUAL DOSE REDUCTION needs on Resident #6 which was completed on 9/13/2021. Psychotropic Side Effect Monitoring was added to Resident #59 and #60 on 01/13/2022. Pharmacy Recommendation that was missed for Resident #59 was acted upon and Director of Nursing notified Medical Director of delay in timeliness of entering order. No adverse effects from deficient practice. 2. Residents that take psychotropic medications could be affected by the deficient practice. By reviewing all residents on psychotropic medications and ensuring GRADUAL DOSE REDUCTION□s have been attempted or contraindicated as required by Centers for Medicare and Medicaid Services. 100% of Pharmacy Recommendations for November 2021 and December 2021 reviewed by Director of Nursing to ensure they were all reviewed and completed on 12/16/2021. Director of Nursing added psychotropic side effect monitoring to residents that are currently taking psychotropic medications and completed on 12/20/2021. Psychotropic side effect monitoring checks off added to the	

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F 756	Continued From page 75 The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and displayed verbal behavioral symptoms directed towards others 1 to 3 days during the 7 day look back period. He was coded as receiving 7 days of antidepressant medications. A review of Resident #59's nursing progress notes from 11/19/21 to 12/14/21 included refusal of meals and medications, yelling out at staff and increased agitation regarding his personal care. Resident #59's Medication Administration Records (MARs) from 11/19/21 to 12/14/21 indicated he received Duloxetine, Sertraline and Trazodone as ordered. The MAR did not list any side effect monitoring that may be displayed from the medications. On 12/13/21 at 9:32 AM, Resident #59 was observed lying in bed watching TV. He was pleasant and talkative. On 12/15/21 at 3:00 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need to monitor for side effects of psychotropic medications and further stated she expected the Pharmacy Consultant to identify any irregularities regarding Resident #59, to include the need for side effect monitoring with the use of psychotropic medications. A phone interview was completed with the Pharmacy Consultant on 12/16/21 at 11:26 AM. She explained she referred to the nursing and physician progress notes to monitor for side effects related to psychotropic medications. She	F 756	admission check list to be added upon admission if indicated. 3. Education was provided by the Administrator and Director of Nursing to the Pharmacist Consultant, Medical Director, and Psych Nurse Practitioner on 12/20/2022 regarding expectations of assessing psychotropic medications need for Gradual Dose Reduction and side effect monitoring. Education was provided to the Unit Manager by Director of Nursing on timeliness and completion of Pharmacy Recommendations. Education provided to licensed nursing staff regarding psychotropic side effect monitoring. Education completed by 1/13/2022. New Hires are educated upon hire. Staff will not be permitted to work before receiving education. Monthly Pharmacy regimen reviews will be monitored to ensure recommendations are completed timely by nursing staff and side effect monitoring is in place. Review will be completed by the Director of Nursing and Administrator monthly times 8 months or until substantial compliance is met. Director of Nursing will review monthly pharmacy recommendations to ensure Gradual Dose Reductions were attempted as indicated and need for side effect monitoring is documented for residents on psychotropic medications. If gradual dose reduction was not attempted, contraindication is documented by pharmacist or Medical Director in electronic medical record. New admissions on ordered psychotropics will be reviewed by Director of Nursing or	

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added monitoring was accomplished with staff documentation and would not have recommended side effect monitoring on a daily basis.

1b) Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included major depressive disorder, insomnia, and anxiety disorder.

A review of the physician's orders revealed an order dated 11/22/21 for Ativan (an antianxiety medication) 0.5 milligrams (mg) by mouth every 8 hours as needed (PRN) for anxiety.

The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and displayed verbal behavioral symptoms directed towards others 1 to 3 days during the 7 day look back period. He was not coded as receiving any antianxiety medication.

Review of the medical record revealed a Pharmacy Consultant Communication to Physician/Prescriber form dated 11/22/21 stating per the guidelines the PRN Ativan would need to have a stop date added or discontinue the medication. The form was signed as "per" the Nurse Practitioner with wound nurse/unit manager signature dated 11/30/21.

Resident #59's December 2021 Medication Administration Record (MAR) indicated on 12/14/21 Ativan 0.5mg by mouth every 8 hours PRN anxiety had a discontinue date entered at 9:00 AM.

The wound nurse/unit manager was interviewed

F 756

Designee Monday through Friday for 4 weeks, then weekly for 2 months or until substantial compliance is met to ensure side effect monitoring is in place.

4.The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by bringing data gathered from audits to Quality Assurance Performance Improvement meeting monthly for 6 months by administrator or Director of Nursing and reviewed by Quality Assurance Performance Improvement team.

Date of Compliance: 1/13/2022

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on 12/15/21 at 11:05 AM and explained she assisted the Director of Nursing (DON) with pharmacy recommendations. She reviewed the pharmacy recommendation for Resident #59 dated 11/22/21, as well as the December 2021 MAR and stated it was an oversight not to have entered a stop date of 14 days when the Ativan 0.5mg PRN pharmacy recommendation was addressed on 11/30/21.

On 12/15/21 at 3:00 PM, an interview occurred with the DON, who stated she felt the delay in processing the pharmacy recommendation for the Ativan 0.5mg PRN stop date was an oversite.

2) Resident #60 was admitted to the facility on 11/22/21 with diagnoses that included schizophrenia, psychotic disorder, anxiety disorder, bipolar disorder, major depressive disorder, and dissociative identity disorder.

A review of the physician orders revealed the following medications with an order date of 11/22/21:
- Escitalopram (an antidepressant medication) 5 milligrams (mg) by mouth once a day for depression.
- Lorazepam (an antianxiety medication) 1.5 mg by mouth three times a day for anxiety.
- Olanzapine (an antipsychotic medication) 2.5 mg by mouth at bedtime.

Review of a Pharmacy Consultant medication review note for 11/23/21 did not reflect the need for monitoring side effects of the psychotropic medications.

The admission Minimum Data Set (MDS)

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assessment dated 11/29/21 indicated Resident #60 had severe cognitive impairment and displayed no behaviors. She was coded as receiving 6 days of antipsychotic and 7 days of an antianxiety and antidepressant medication.

A review of Resident #60's nursing progress notes from 11/22/21 to 12/15/21 did not include any behavior issues.

Resident #60's Medication Administration Records (MARs) from 11/22/21 to 12/15/21 indicated she received Escitalopram, Lorazepam and Olanzapine as ordered. The MAR did not list any side effects that may be displayed from the medications for licensed nursing staff to monitor.

On 12/15/21 at 10:41 AM, Resident #60 was observed walking around in her room. She was pleasant and talkative.

On 12/15/21 at 3:00 PM, an interview occurred with the Director of Nursing (DON), who stated she was aware of the need to monitor for side effects of psychotropic medications. The DON further stated she expected the Pharmacy Consultant to identify any irregularities regarding Resident #60, to include the need for side effect monitoring with the use of psychotropic medications.

A phone interview was completed with the Pharmacy Consultant on 12/16/21 at 11:26 AM. She explained she referred to the nursing and physician progress notes to monitor for side effects related to psychotropic medications and would not have recommended side effect monitoring daily.

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3. Resident #6 was admitted on 5/7/09 and readmitted on 9/15/20 with a diagnosis of Schizophrenia.

The quarterly Minimum Data Set dated 9/15/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded as receiving an antipsychotic medication once during the 7 day look back period.

Review of Resident #6's December 2021 Physician orders included an order dated 9/17/20 for Risperdal Consta Suspension reconstituted 25 milligrams (mg). Inject 25 mg intramuscularly one time a day every 14 days for psychosis. Risperdal Consta Suspension is a long lasting injectable antipsychotic.

Review of Resident #6's revised care plan dated 11/30/21 read he received an antipsychotic medication for behavior management of psychosis. Interventions included target behaviors and side effect monitoring. The care plan did not mention assessment for a gradual dose reduction (GDR) of his Risperdal.

Review of the Consultant Pharmacist monthly notes from 1/22/21 to 11/23/21 did not include any documentation regarding the need to assess the continued use of Resident #6's Risperdal at the current dosage or documented evidence supporting a failed GDR.

Review of the Physician and facility Nurse Practitioner (NP) progress notes since 2/17/21 to 8/11/21 did not include any documented evidence that a Risperdal GDR was considered, assessed or any evidence of why a GDR was contraindicated or failed.

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Review of the psychiatric NP visit notes dated 6/30/21, 8/31/21 and 9/29/21 did not include any documented evidence that a Risperdal GDR was considered, assessed or evidence of why a GDR was contraindicated or failed.

Review of Resident #6's nursing notes regarding his behaviors from 12/9/20 to 12/10/21 included medication refusal, shower refusal, being rude to his roommate, an unsuccessful attempt to kick another resident's wheelchair and noncompliant with wearing a mask.

Review of the facility's nursing assistant documentation from 11/16/21 to 12/15/21 revealed no evidence of behaviors

An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing (DON). She stated the Consultant Pharmacist was still doing remote medication reviews each month and the Consultant Pharmacist called to let her know the monthly pharmacy report was ready to be printed and reviewed. The DON stated she did not recall receiving any recommendations regarding the need to reassess Resident #6 for a possible GDR of his Risperdal.

An interview was conducted on 12/15/21 at 3:47 PM with the Medical Director. He stated it was his expectation that the Consultant Pharmacist identify the need to address Resident #6's Risperdal in order to evaluate for a possible GDR or why a GDR was contraindicated.

A telephone interview was conducted on 12/16/21 at 10:37 AM with the psychiatric NP. He stated he only worked for the facility for the past year. He

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F 756	Continued From page 81 was unable to recall any documentation in Resident #6's medical record of a failed GDR. The psychiatric NP stated he has never received any pharmacy recommendations regarding the need to address a GDR of Resident #6's Risperdal. He stated the need to address timely evaluations of antipsychotic medications for continued use would come from the Consultant Pharmacist's recommendations. A telephone interview was conducted on 12/16/21 at 11:13 AM with the Consultant Pharmacist. She stated she did not recommend any Risperdal GDR's because of his mental illness diagnosis and that Resident #6 would decompensate. She was unable to provide written evidence of a failed or attempted GDR. An interview was conducted on 12/16/21 at 11:26 AM with the Administrator. She stated the facility was unable to find any evidence of GDR recommendations, failed GDR attempts or any documentation as to why contraindicated for Resident #6.	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	F 758		1/13/22

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F 758	Continued From page 82 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 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 and interviews with staff, Pharmacy Consultant, facility Nurse Practitioner	F 758	1.The facility failed to ensure a prn psychotropic medication was time limited	

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F 758	Continued From page 83 (NP), Psychiatric NP and Medical Director, the facility failed to attempt a gradual dose reduction (GDR) for a resident receiving an antipsychotic medication (Resident #6) and failed to ensure an as needed (prn) psychotropic medication was time limited in duration (Resident #59 and Resident #38). The facility also failed to identify target behaviors for antianxiety medication (Resident #57) and failed to monitor for side effects of a psychotropic medication (Resident 59 and Resident #60). This was for 5 of 13 residents whose medications were reviewed. The findings included: 1. Resident #6 was admitted on 5/7/09 and readmitted on 9/15/20 with a diagnosis of Schizophrenia. The quarterly Minimum Data Set dated 9/15/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded as receiving an antipsychotic medication once during the 7-day assessment period. Resident #6's December 2021 Physician orders included an order dated 9/17/20 for Risperdal Consta Suspension reconstituted 25 milligrams (mg). Inject 25 mg intramuscularly one time a day every 14 days for psychosis. Risperdal Consta Suspension is a long lasting injectable antipsychotic. Review of Resident #6's revised care plan dated 11/30/21 read he received an antipsychotic medication for behavior management of psychosis. Interventions included target behaviors and side effect monitoring. The care plan did not mention assessment for a GDR of his Risperdal.	F 758	for resident #59 and #38, failed to identify target behaviors for resident #57, and monitor for psychotropic side effects for residents #59 and #60. The Director of Nursing reviewed psychotropic medications for GRADUAL DOSE REDUCTION needs on Resident #6 which was completed on 9/13/2021. PRN medication for resident #38 was discontinued on 12/14/21 and resident #59 prn medication was discontinued on 12/14/21. Psychotropic Side Effect Monitoring was added to Resident #59 and #60 on 01/13/2022. Target behaviors for antianxiety medication were added to resident #57 on 1/13/2022. No adverse effects from deficient practice. 2. Residents that take psychotropic medications could be affected by the deficient practice by reviewing all residents on psychotropic medications and ensuring GRADUAL DOSE REDUCTION□s have been attempted or contraindicated as required by CENTERS FOR MEDICARE AND MEDICAID SERVICES. DIRECTOR OF NURSING added psychotropic side effect monitoring to residents that are currently taking psychotropic medications and completed on 01/13/2022. Psychotropic side effect monitoring checks off added to the admission check list to be added upon admission if indicated. Target behaviors were added to residents who take antianxiety medications and was completed on 1/13/2022. PRN psychotropics were reviewed to ensure all had time limited stop dates and this was	

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F 758	Continued From page 84 Review of the Physician and facility Nurse Practitioner (NP) progress notes since 2/17/21 to 8/11/21 did not include any documented evidence that a Risperdal GDR was considered, assessed or any evidence of why a GDR was contraindicated or failed. Review of the psychiatric NP visit notes dated 6/30/21, 8/31/21 and 9/29/21 did not include any documented evidence that a Risperdal GDR was considered, assessed or evidence of why a GDR was contraindicated or failed. Review of the Consultant Pharmacist monthly notes from 1/22/21 to 11/23/21 did not include any documentation regarding the need to assess the continued use of Resident #6's Risperdal at the current dosage or documented evidence supporting a failed GDR. An interview was conducted on 12/15/21 at 3:00 PM with the Director of Nursing (DON). She stated the Consultant Pharmacist was still doing remote medication reviews each month and the Consultant Pharmacist called to let her know the monthly pharmacy report was ready to be printed and reviewed. The DON stated she started utilizing the assistance of the treatment nurse and the assistant DON in September. The DON stated they had completed an audit of all residents prescribed antipsychotics but they were focused on behaviors and side effect monitoring. An interview was conducted on 12/15/21 at 3:47 PM with the Medical Director. He stated it was his expectation that the facility staff identify the need to address Resident #6's Risperdal to evaluate for a possible GDR or why a GDR was contraindicated.	F 758	completed on 12/17/2021. 3. Education was provided by the DIRECTOR OF NURSING to the Medical Director, and Psychiatric NURSE PRACTITIONER and Pharmacy Consultant regarding expectations of assessing psychotropic medications need for GRADUAL DOSE REDUCTION and side effect monitoring on 12/20/2022. Education provided to licensed nursing staff regarding psychotropic side effect monitoring, target behaviors for antianxiety medications, and prn psychotropic medications being time limited. Education completed by 1/13/2022. New Hires are educated upon hire. Staff will not be permitted to work before receiving education. Licensed nurses are responsible for ensuring residents receiving psychotropics have appropriate stop dates and residents are monitored for side effects and targeted behaviors are identified and monitoring is documented in the electronic medical record to ensure the safety of residents receiving psychotropic medications and prevent adverse effects or unnecessary medication use. Concerns will be reported to the physician as appropriate.Medical Director is responsible for ensuring PRN psychotropic medications have time limited stop dates to prevent adverse effects from unnecessary medications and will document rationale for any duration beyond 14 days if indicated. The Medical Director will review pharmacy recommendations and initiate gradual dose reduction orders unless	

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A telephone interview was conducted on 12/16/21 at 10:37 AM with the psychiatric NP. He stated he only worked for the facility for the past year. He was unable to recall any documentation in Resident #6's medical record of a failed GDR. The psychiatric NP stated he had never received any facility recommendations regarding the need to address a GDR of Resident #6's Risperdal. He stated the need to address timely evaluations of antipsychotic medications for continued use would come from the Consultant Pharmacist or the facility's recommendations

A telephone interview was conducted on 12/16/21 at 11:13 AM with the Consultant Pharmacist. She stated she did not recommend any Risperdal GDR's because of Resident #6's mental illness diagnosis. She stated it was left up to the Physician and the facility to decide if a GDR was appropriate or contraindicated.

An interview was conducted on 12/16/21 at 11:26 AM with the Administrator. She stated the facility was unable to find any evidence of GDR recommendations, failed GDR attempts or any documentation as to why contraindicated for Resident #6.
2a) Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included major depressive disorder, insomnia, and anxiety disorder.

A review of the physician's orders included the following:
- An order dated 11/19/21 for Duloxetine (an antidepressant medication) 60 milligrams (mg) by mouth twice a day for depression.
- An order dated 11/19/21 for Sertraline (an

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contraindicated and written rationale is provided as appropriate. Director of Nursing will review monthly pharmacy recommendations to ensure Gradual Dose Reductions were attempted or contraindicated with written rationale by the Medical Director. Residents with new psychotropic medication orders will reviewed during morning clinical meeting for appropriate stop dates and monitoring of targeted behaviors and side effects in the electronic medical record. Residents with active psychotropic medications will be reviewed during the weekly clinical risk meetings to monitor documentation of side effects and targeted behaviors, appropriate stop date or documented rationale for extended duration and gradual dose reductions or contraindications by the medical director to ensure residents are free from unnecessary psychotropic medication use.

4. The Director of Nursing or Unit Manager will audit five (5) residents with psychotropic medication orders for unnecessary medication use to include appropriate stop dates, gradual dose reduction attempts or documented contraindications, monitoring of targeted behaviors and adverse side effects. Monitoring will be completed 5 times weekly for 4 weeks, then 2 times weekly for 2 months, and then monthly for 2 months. The Director of Nursing will review results of the audits with the Quality Assurance and Performance Improvement Meeting each month and

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antidepressant medication) 50 mg by mouth once a day for depression.
- An order dated 11/22/21 for Trazodone (an antidepressant medication) 25 mg by mouth at bedtime for insomnia.

Review of a Pharmacy Consultant medication review note for 11/22/21 did not reflect the need for monitoring side effects of the psychotropic medications.

The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and displayed verbal behavioral symptoms directed towards others 1 to 3 days during the 7 day look back period. He was coded as receiving 7 days of antidepressant medications.

A review of the active care plan for Resident #59 revealed a focus area for use of antidepressant medication related to depression. The interventions included to administer antidepressant medications as ordered by the physician. Monitor and document side effects and effectiveness every shift.

A review of Resident #59's nursing progress notes from 11/19/21 to 12/14/21 included refusal of meals and medications, yelling out at staff and increased agitation regarding his personal care.

Resident #59's Medication Administration Records (MARs) from 11/19/21 to 12/14/21 indicated he received Duloxetine, Sertraline and Trazodone as ordered. The MAR did not list any side effect monitoring that may be displayed from the medications.

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changes will be made to the plan as necessary to maintain compliance with unnecessary psychotropic medication use.

Date of Compliance: 1/13/2022

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On 12/13/21 at 9:32 AM, Resident #59 was observed lying in bed watching TV. He was pleasant and talkative.

On 12/15/21 at 3:00 PM, an interview occurred with the Director of Nursing (DON), who stated there was no specific side effects that were monitored for psychotropic medications but rather the nurses would write a progress note based on the side effect that was exhibited. She added due to frequent staff turn-over, nursing staff may not understand that side effect monitoring was needed for psychotropic medications.

The Medical Director was interviewed on 12/15/21 at 3:47 PM and stated he would expect licensed staff to monitor for side effects to psychotropic medications.

The facility Nurse Practitioner (NP) was interviewed on 12/16/21 at 10:44 AM and stated she would expect psychotropic medications to have consistent monitoring for side effects.

A phone interview was completed with the Pharmacy Consultant on 12/16/21 at 11:26 AM. She explained she referred to the nursing and physician progress notes to monitor for side effects related to psychotropic medications. She added monitoring was accomplished with staff documentation and would not have recommended side effect monitoring on a daily basis.

2b) Resident #59 was admitted to the facility on 11/19/21 with diagnoses that included major depressive disorder, insomnia, and anxiety disorder.

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A review of the physician's orders revealed an order dated 11/22/21 for Ativan (an antianxiety medication) 0.5 milligrams (mg) by mouth every 8 hours as needed (PRN) for anxiety. This order for PRN Lorazepam was entered into the Electronic Medical Record (EMR) by Unit Nurse Manager #2 and had no stop date.

The admission Minimum Data Set (MDS) assessment dated 11/26/21 indicated Resident #59 was cognitively intact and displayed verbal behavioral symptoms directed towards others 1 to 3 days during the 7 day look back period. He was not coded as receiving any antianxiety medication.

Review of the medical record revealed a Pharmacy Consultant Communication to Physician/Prescriber form dated 11/22/21 stating per the guidelines the PRN Ativan would need to have a stop date added or discontinue the medication. The form was signed as "per" the Nurse Practitioner with wound nurse/unit manager signature dated 11/30/21, to continue the PRN order for 14 days.

Resident #59's December 2021 Medication Administration Record (MAR) indicated on 12/14/21 Ativan 0.5mg by mouth every 8 hours PRN anxiety had a discontinue date entered at 9:00 AM.

On 12/14/21 at 9:30 AM, an interview was held with the Unit Nurse Manager #2 who verified entering the order for Ativan 0.5mg every 8 hours PRN anxiety on 11/22/21. She further explained she was aware PRN psychotropic medications required a stop date and could not explain why

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F 758	Continued From page 89 one was not requested at the receiving the order. The wound nurse/unit manager was interviewed on 12/15/21 at 11:05 AM and explained she assisted the Director of Nursing (DON) with pharmacy recommendations. She reviewed the pharmacy recommendation for Resident #59 dated 11/22/21, as well as the December 2021 MAR and stated it was an oversight not to have entered a stop date of 14 days when the Ativan 0.5mg PRN pharmacy recommendation was addressed on 11/30/21. On 12/15/21 at 3:00 PM, an interview occurred with the DON, who explained the Pharmacy Consultant completed reviews remotely and then would email the recommendations to her. She prints them off and has the Nurse Practitioner review what was needed, and the wound nurse/unit manager processes the orders provided. The DON felt the delay in processing the pharmacy recommendation for the Ativan 0.5mg PRN stop date was due to human error. She further stated she was aware PRN psychotropic medications required a stop date and felt licensed nursing staff needed reminders regarding this regulation. The facility NP was interviewed on 12/16/21 at 10:44 AM and stated she was aware PRN psychotropics required a stop date for reassessment and felt it was an oversight not to have included one when she wrote the order on 11/22/21 for Ativan 0.5mg every 8 hours as needed for anxiety. A phone interview was completed with the Pharmacy Consultant on 12/16/21 at 11:26 AM, who reported PRN psychotropic medications	F 758		

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were limited to at least a 14-day duration for reassessment of the need for the medication. She indicated an indefinite duration was not considered acceptable.

3) Resident #60 was admitted to the facility on 11/22/21 with diagnoses that included schizophrenia, psychotic disorder, anxiety disorder, bipolar disorder, major depressive disorder, and dissociative identity disorder.

A review of the physician orders revealed the following medications with an order date of 11/22/21:
- Escitalopram (an antidepressant medication) 5 milligrams (mg) by mouth once a day for depression.
- Lorazepam (an antianxiety medication) 1.5 mg by mouth three times a day for anxiety.
- Olanzapine (an antipsychotic medication) 2.5 mg by mouth at bedtime.

Review of a Pharmacy Consultant medication review note for 11/23/21 did not reflect the need for monitoring side effects of the psychotropic medications.

The admission Minimum Data Set (MDS) assessment dated 11/29/21 indicated Resident #60 had severe cognitive impairment and displayed no behaviors. She was coded as receiving 6 days of antipsychotic and 7 days of an antianxiety and antidepressant medication.

A review of the active care plan for Resident #60 revealed the following focus areas:
- Resident uses an antianxiety medication related to anxiety disorder. The interventions included to

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F 758	Continued From page 91 administer antianxiety medications as ordered by physician and monitor for side effects and effectiveness every shift. Monitor/document/report as needed any adverse reactions to antianxiety therapy to include drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking, and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects would be mania, hostility, rage, aggressive or impulsive behavior, hallucination. - Resident uses antidepressant medication related to depression. The interventions included to administer antidepressant medications as ordered by physician and monitor/document side effects and effectiveness every shift. Monitor/document/report as needed any adverse reactions to antidepressant therapy such as change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, no voiding, constipation, gait changes, balance problems, dry mouth. - Resident uses antipsychotic medications related to diagnosis of schizophrenia, bipolar, multiple personality disorder. The interventions included to administer antipsychotic medications as ordered by the physician and monitor for side effects and effectiveness every shift. Monitor/document/report as needed any adverse reactions of antipsychotic medications such as unsteady gait, tardive dyskinesia, frequent falls, refusal to eat, difficulty swallowing, weight loss. A review of Resident #60's nursing progress notes from 11/22/21 to 12/15/21 did not include any behavior issues.	F 758		

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Resident #60's Medication Administration Records (MARs) from 11/22/21 to 12/15/21 indicated she received Escitalopram, Lorazepam and Olanzapine as ordered. The MAR did not list any side effects that may be displayed from the medications for licensed nursing staff to monitor.

On 12/15/21 at 10:41 AM, Resident #60 was observed walking around in her room. She was pleasant and talkative.

On 12/15/21 at 3:00 PM, an interview occurred with the Director of Nursing (DON), who stated there was no specific side effects that were monitored for psychotropic medications but rather the nurses would write a progress note based on the side effect that was exhibited. She added due to frequent staff turn-over nursing staff may not understand that side effect monitoring was needed for psychotropic medications.

The Medical Director was interviewed on 12/15/21 at 3:47 PM and stated he would expect licensed staff to monitor for side effects to psychotropic medications.

The facility Nurse Practitioner (NP) was interviewed on 12/16/21 at 10:44 AM and stated she would expect psychotropic medications to have consistent monitoring for side effects.

A phone interview was completed with the Pharmacy Consultant on 12/16/21 at 11:26 AM. She explained she referred to the nursing and physician progress notes to monitor for side effects related to psychotropic medications. She added monitoring was accomplished with staff documentation and would not have

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ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

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recommended side effect monitoring on a daily basis.
4. Resident # 38 was admitted to the facility on 7/16/21 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 10/23/21 indicated that Resident #38 has severe cognitive impairment, and he did not have behaviors. The assessment further indicated that the resident did not receive an antianxiety medication during the assessment period.

Resident #38 had a doctor's order dated 11/1/21 for Ativan (an antianxiety drug) 0.5 milligrams (mgs.) by mouth every 12 hours as needed (PRN) for severe agitation indefinite. The order was written and was transcribed to the Medication Administration Records (MARs) by the Wound Nurse/Unit Manager.

The MARs for November and December 2021 were reviewed. The MARs revealed that the PRN Ativan 0.5 mgs. was still active with no stop date as of 12/14/21.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. The DON stated that the Unit Manager was the nurse who wrote the order for the PRN Ativan. The DON stated that the Unit Manager failed to verify the stop date from the doctor.

The Wound Nurse/Unit Manager was interviewed on 12/16/21 at 11:06 AM. She stated that she knew that PRN orders for psychotropic medications should have a stop date. She verified that she was the one who received the order for the PRN Ativan for Resident #38 and reported that she forgot to verify the stop date

F 758

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from the doctor.

5. Resident #57 was admitted to the facility on 3/16/2019 with most recent readmission 6/29/2021. Resident #57 was admitted with diagnoses that included Schizoaffective disorder, post-traumatic stress disorder, and major depressive disorder.

A quarterly Minimum Data Set (MDS) assessment dated 11/21/2021 indicated Resident #57 had moderately impaired cognition and did not exhibit behaviors during the assessment period. The MDS indicated Resident #57 received antidepressants, antianxiety, and antipsychotic medications during the assessment period.
The resident had an active physician's order for lorazepam 1 milligram (mg) by mouth daily at bedtime for anxiety dated 12/2/2021.

Resident #57's Medication Administration Records (MARs) for November and December 2021 revealed the target behaviors to be observed for antianxiety medication were listed as slurred speech and drowsiness. The side effects of the antianxiety medication were also listed as slurred speech, drowsiness. The start date was 5/4/2021.

On 12/15/2021 at 9:39 AM an interview was conducted with Nurse #2 who was assigned to Resident #57. She stated she was not familiar with the resident because she was agency staff.

On 12/15/2021 at 9:41 AM an interview was conducted with the Director of Nursing (DON) who stated target behaviors for Resident #57's anxiety would be crying, yelling, and refusal of care. When asked if slurred speech or

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F 758	Continued From page 95 drowsiness were appropriate target behaviors, she stated those would be side effects and not target behaviors. When asked why the target behavior and the side effects were the same, she stated when residents discharge to the hospital, their orders fall off and must be reentered when the are readmitted. She believed the side effects were erroneously entered as target behaviors when the resident reentered the facility after her most recent hospitalization.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to have a medication error rate of less than 5% as evidenced by 2 of 29 opportunities resulting in a medication error rate of 6.9% for 1 of 3 residents observed during the medication pass (Resident #40). Findings included: 1a. Resident #40 was admitted to the facility on 9/21/21. On 12/15/21 at 8:25 AM, Resident#40 was observed during the medication pass. Nurse #4 was observed to prepare the resident's medications including Amlodipine (antihypertensive drug)10 milligrams (mgs.) 1 tablet, Ferrous Sulfate (iron supplement) 325 mgs. 1 tablet, Renvela (used to lower phosphorous in the blood of residents receiving	F 759	1) The facility failed to ensure resident #40 was free from med errors by administering all crushed medications together via gastrostomy tube and giving a multivitamin with minerals when a multivitamin was ordered. Physician was notified of medication error and no adverse effects were noted. 2) Residents receiving medications by gastrostomy tube are at risk for the deficient practice. On 12/15/2021 a 100% audit was performed the Director of Nursing, Staff Development Coordinator, and Unit Managers identifying the residents that get their medications administered via Gastrostomy tube. For each resident receiving medications via	1/13/22

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dialysis) 800 mgs 2 tablets, Aspirin (used to prevent heart attack or stroke) 81 mgs 1 tablet, cinacalcet (lowers the amount of calcium in the blood) 30 mgs. 1 tablet and Prilosec (treats heartburn and gastroesophageal reflux disease) 40 mgs. 1 tablet. She was observed to crush all the medications together, dissolved the crushed medications in water and administered the dissolved medications via G tube.

Nurse #4 was interviewed on 12/15/21 at 9:35 AM. She stated that she always crushed the medications together and administered them via G tube. When asked about the facility's policy in administering medication through an enteral tube, she responded that she was not trained of the policy, but she might have forgotten it since it has been more than a year since she had her orientation/training.

The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. She stated that the facility's policy on administering medication through G tube was to administer the medication one at a time and to flush the tube with 15 milliliters (ml) of water between medications. The DON added that Nurse #4 had informed her of the error and indicated that Nurse #4 did not remember the policy.

1b. Resident #40 was admitted to the facility on 9/21/21. On 10/23/21, the resident has a doctor's order for Multivitamin 1 tablet via gastrostomy (G) tube daily for vitamin deficiency.

Resident#40 was observed during the medication pass on 12/15/21 at 8:25 AM. Nurse #4 was observed to prepare the resident's medications

F 759

gastrostomy tube, the care plan and order was accurate. No other issues were identified.

3) The following measures were put in place on 12/20/21 to ensure the Plan of Correction is effective and the facility remains in compliance. Nurse #4 was reeducated by Director of Nursing on 12/20/2022 on medication administration via gastrostomy tube per doctor order and facility policy. Licensed and Certified Nursing Staff were re-educated by Staff Development Coordinator and Director of Nursing to ensure all medications are administered per doctor order and per facility policy. New Hires are educated upon hire. Staff will not be permitted to work before receiving education. Beginning 12/21/2021 the Director of Nursing, Staff Development Coordinator, Treatment Nurse and Unit Managers will continue to audit 10 medication administrations a week daily for 4 weeks. This will occur 5 times weekly for 4 weeks, then 2 times weekly for 2 months.

4) Progress of daily audits are discussed in Clinical Morning Meeting, and Stand-up meeting (Meeting of the Interdisciplinary Team). The results of the audits will be brought to and reviewed by Director of Nursing to Quality Assurance and Performance Improvement Meeting and reviewed each month until substantial compliance is met.

5. Date of Compliance 1/13/2022

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F 759	Continued From page 97 including Multivitamin with Minerals 1 tablet. The Nurse was observed to crush all the medications and to administer them via G tube. Nurse #4 was interviewed on 12/15/21 at 9:35 AM. She reviewed the order on the Medication Administration Record (MAR) and observed the bottle of Multivitamin with Minerals. She verified that she administered Multivitamin with Minerals instead of Multivitamin by mistake. The Director of Nursing (DON) was interviewed on 12/15/21 at 3:40 PM. She stated that she expected nursing to follow the doctor's orders.	F 759		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff, review of resident council minutes and a test tray, the facility failed to provide food that that was palatable for 4 of 4 (Resident #11, #19, #59, and #261) reviewed for food. The findings included: On 12/13/2021 at 9:32 AM an interview was conducted with Resident #59 who resided on the	F 804	1. Residents observed to receive food that was not palatable and not holding proper temperatures. 2. Re-education of Culinary Staff on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability on 7/15/21 by Regional Clinical Services Director. Culinary Department will complete an initial Resident	1/13/22

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F 804	Continued From page 98 200 hall. He stated the food was repetitive and was served either cold or lukewarm. On 12/13/2021 at 9:51AM an interview was conducted with Resident #11 who resided on the 200 hall. He stated the food was barely warm or cold most of the time. On 12/13/2021 during a continuous observation of dining, kitchen staff pushed an enclosed tray delivery cart and a smaller rolling kitchen cart with meal trays to the 100 hall at 12:33 PM. The carts were left on the right side of the hall. At 12:42 PM nursing staff opened the enclosed tray delivery cart and began to dispense meal trays to the residents on the 100 hall. The doors to the delivery cart were left open during this time. At 12:45 PM on 12/13/2021 an interview was conducted with a family member of Resident #261 who resided on the 100 hall. She stated the chicken was barely warm and the tortilla shell was cold. At 12:52 PM on 12/13/2021 an interview was conducted with resident #19 who also resided on the 100 hall. He stated his food was closer to room temperature, barely warm. He further stated cold food had been an ongoing issue in the facility. The morning of 12/13/2021 residents on the 200 hall were observed being served breakfast in Styrofoam containers. The same was observed on the 200 hall during lunch on 12/14/2021. On 12/14/2021 at 12:03 PM an interview was conducted with the Interim Dietary Manager (IDM). She stated some residents received meals	F 804	satisfaction audit of alert& oriented residents (evidenced by BRIEF INTERVIEW FOR MENTAL STATUS) by no later than 1/13/2022. 3. Food Committee to occur Bi-Monthly, Hosted by CLINICAL SERVICES MANAGER , minutes to be recorded on Food Committee form and shared with QUALITY ASSURANCE PERFORMANCE IMPROVEMENT team. 4. All results will be discussed during food committee meetings. Test Tray Audits to be completed five (5) times weekly x 12 weeks by CLINICAL SERVICES MANAGER to check accuracy, condiments and proper temperature. This will occur in the repeating order of Breakfast on Monday & Thursday, Lunch on Tuesday & Friday, Dinner on Wednesdays. All results will be reported & discussed in INTERDISCIPLINARY TEAM stand up & stand down as deemed appropriate. Findings will be reported to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee. The QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee may modify this plan to ensure the facility remains in compliance. 5. Compliance date 1/13/2022.	

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F 804	Continued From page 99 on stryofoam because they did not have enough plates. An interview was conducted with the regional director of culinary operations on 12/14/21 at 12:22 PM. He stated he had been in the position for 2 months. He further stated the facility had been without a certified dietary manger for 3-4 months. He stated he was not in the facility every day and was not aware the staff had been serving meals on styrofoam. He further stated the styrofoam would not keep meals warm as well as meals served on plates with a lid and base. He stated he was not aware the facility did not have enough plates, lids, or bases until 12/13/2021 when the Interim Dietary Manager made him aware. He stated he was aware of ongoing resident concerns with food but he was not sure if food temperature was one of the concerns voiced by residents. On 12/14/2021 at 1:00 PM a test tray was provided. The tray contained green beans, rice, and fish nuggets that were only slightly warm, a roll that was room temperature. Resident council meeting minutes for August through November 2021 were reviewed and revealed residents voiced the following complaints regarding food: On 8/23/2021 there was no list of residents who attended. Residents requested more fried chicken, rice, gravy and less pasta. On 9/21/2021 there were 9 residents in attendance. Residents voiced concerns regarding little food variety, food not fully cooked, requested more breakfast options (other than oatmeal),	F 804		

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F 804	Continued From page 100 requested more hamburgers and again requested more fried chicken, rice, and gravy. On 10/26/2021 there were 6 residents in attendance who voiced concerns regarding lack of condiments with meals, potatoes without butter, not enough ketchup, no sour cream with tacos, no dressing for salad, and chicken nuggets with no dipping sauce. On 11/23/2021 there were 7 residents in attendance with ongoing concerns about the food not being palatable, little variety, A resident council meeting was held 12/15/2021 at 2:00 PM. There were 5 residents in attendance. The residents voiced multiple complaints about the food which included food being served cold, no condiments, and little variety. Attendees stated the facility had not been able to hire and keep a dietary manager and had not offered any answers or explanations regarding the ongoing food issues. On 12/16/2021 at 12:06 PM an interview was conducted with the Administrator. She stated the dietary issues should not be an ongoing problem.	F 804		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family	F 805	1. Resident #261 received wrong food	1/13/22

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F 805	Continued From page 101 interview and staff interviews, the facility failed to provide a resident with the correct food form to 1 of 2 (Resident #261) residents reviewed for nutrition. The findings included: Resident #261 was admitted to the facility on 11/29/2021 with diagnoses that included dementia and chronic kidney disease. The resident's admission Minimum Data Set (MDS) dated 11/29/2021 indicated the resident was severely cognitively impaired, required extensive assistance with all activities of daily living, personal hygiene and toileting. She was coded independent with eating, requiring meal set up only. Resident #261's active physician's orders revealed an order for regular diet, mechanical soft-ground meat texture with regular thin liquids dated 11/29/2021. Attempts to contact the registered dietician (RD) were unsuccessful. The resident's medical record contained the RD's review and recommendations dated 12/7/2021. The RD's documentation revealed the resident was on a mechanical soft diet, with no salt, no foods high in potassium, and thin liquids. The RD's documentation also revealed the resident was able to eat independently at times but noted several meals where staff documented the resident as total dependent for eating. On 12/13/2021 at 12:45 PM observed Resident #261's family member cutting up chunks of chicken in a tortilla shell. The family member was	F 805	form per diet ordered. 2. Residents receiving modified food forms are at risk to be affected by deficient practice. Initial audit of clinical charting system (ELECTRONIC MEDICAL RECORD) and menu management system to cross reference and ensure accuracy of diet orders completed by 1/13/2022 to ensure accuracy. No other discrepancies were identified during initial audit. 3. Re-education of Culinary Staff on Next Level policies & Procedures regarding Therapeutic & modified Diets by Clinical Services Manager by 1/13/2022. Staff will not be permitted to work without completed education. New Hires are educated upon hire and annually. Cook #1 educated by Clinical Services Manager by 1/13/2022. Culinary staff will be responsible to ensure that food form will be served per resident�s proper diet order and per tray ticket. 4. Audit to cross-reference dietary orders and menu management system to ensure accuracy will occur two times weekly x 12 weeks, completed by the Culinary Service Manager. Culinary Services Manager will monitor tray line two times weekly x 12 weeks checking tray ticket to ensure proper texture is plated by dietary staff. Any findings out of compliance will be recorded on the menu management system audit form. The Administrator will present results of the audits to the quality assurance committee.	

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F 805	Continued From page 102 interviewed and stated the resident could not eat the chunks of chicken and she was unable to cut the chicken. The family member stated some days the resident got a mechanical soft diet and some days she did not. The resident's meal ticket was on the left side of her tray and read mechanical soft diet. On 12/14/2021 at 11:45 AM an interview was conducted with the Interim Dietary Manager. She stated the cook plated the food and was responsible for making sure residents got the correct food form and diet. Cook # 1 was the cook on 12/13/2021 and plated Resident #261's lunch. An interview with Cook #1 was conducted 12/14/2021 at 12:00. She stated she plated Resident #261's lunch on 12/13/2021 and she was aware the resident had an order for a mechanical soft diet. She stated it was an oversight.	F 805	The QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee may modify this plan to ensure the facility remains in compliance. 5. Compliance date 1/13/2022.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		1/13/22

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F 812	Continued From page 103 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and dated opened food items (grits and pancake mix), failed to store food in closed containers (cereal and hamburger buns), failed to remove dented cans (sliced apples, sliced pears), failed to keep floor in dry storage free of debris for 1 of 1 dry storage rooms reviewed for food storage. The findings included: On 12/13/2021 at 9:43 AM a tour of the kitchen was conducted with the Interim Dietary Manager (IDM). The following were observed in the dry storage area: One open bag of grits in a sealed bag, not labeled with open date. One open bag of pancake mix in a sealed bag, not labeled with open date. One clear bag of cereal open to air, not in closed container. One package of hamburger buns open to air, not in closed container. Two dented cans, one contained sliced apples and one contained sliced pears. Packets of lemon juice and jelly were observed on the floor of the dry storage area under the food racks. During the observation an interview was	F 812	1. Unlabeled, undated, unsealed food items were discarded, dented cans moved to designated location separate from other cans, and debris on the floor in dry storage was removed by Culinary Services Manager at the time of the survey. 2. An initial audit of the kitchen was completed by the Senior Regional Dietary Manager on 12/14/2022 to ensure food was dated, labeled, sealed, dented cans removed, and dry storage floor was free of debris. Re-education of Next Level Culinary Staff on Next Level Policies & Procedures for Sanitation &Storage by 1/13/2022 by Regional Culinary Services Director. Staff will not be permitted to work without completed education. New Hires are educated upon hire and annually. 3. Sanitation audits, to include monitoring for food labeled and dated, food items sealed, dented cans stored in designated location separate from other cans, and dry storage floor free of debris, will be completed with a Next Level Regional Food Services Manager and the Facility Administrator one (1) time a week x 12 weeks on weekly sanitation audit	

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F 812	Continued From page 104 conducted with the IDM. She stated she was aware opened food should be placed in a closed container and should be labeled with the date the food was opened. When asked about dented cans, she stated at one time dented cans were pulled and placed in a separate area to be returned to the vendor, but they no longer had space to do that. She stated she was aware food in dented cans should not be served to residents. The IDM also stated the floor of the dry storage room is swept daily but it had not been swept that morning.	F 812	form. The CLINICAL SERVICES MANAGER will complete the manager checklist twice daily five (5) times a week x 12 weeks to ensure proper food storage and sanitation practices maintained. 4. Findings will be reported to the QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee by the Clinical Services Manager for review and recommendation. The Administrator will present results of the audits to the quality assurance committee x 3 months. The QUALITY ASSURANCE PERFORMANCE IMPROVEMENT committee may modify this plan to ensure the facility remains in compliance. 5. Compliance date 1/13/2022	
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide effective oversight to ensure the facility addressed resident counsel concerns regarding food, and failed to ensure residents received palatable food at an appetizing temperature. The findings included:	F 835	1. Facility failed to provide effective oversight to ensure the facility addressed resident counsel concerns regarding food and failed to ensure residents received palatable food at an appetizing temperature. 2. All residents have potential to be	1/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING ______ B. WING ______	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835

Continued From page 105

This tag is cross referenced to:

F565 Based on observation, resident council interviews, staff interviews and record review, the facility failed to resolve repeated grievances regarding the food voiced during resident council (RC) meetings. The facility also failed to provide evidence for the rationale of unresolved grievances about food. This was for 4 or 4 months reviewed for RC grievances.

F804-Based on observations, interviews with residents and staff, review of resident council minutes and a test tray, the facility failed to provide food that that was palatable for 4 of 4 (Resident #11, #19, #59, and #261) reviewed for food.

An interview was conducted on 12/16/21 at 12:06 PM with the Administrator. She stated the dietary issues should not be an ongoing problem.

F 835

affected by the deficient practice.

3. Re-education of Next Level Culinary Staff on Next Level Policies & Procedures regarding Nutritive Value, Appearance & Palatability by 1/13/2022 by Regional Culinary Services Director. Administrator will educate Interdisciplinary Team members on the proper procedure to address, resolve, and document resident council grievances and concerns and ensure resolutions are communicated to Activities Director. This education was completed by 1/13/22. Activities to maintain a resident council concern log and initiate grievance form as indicated to be shared with Interdisciplinary Team for resolution. Resolution to grievances and other resident council concerns to be resolved by department head responsible and shared with resident council by Activities Director at next monthly meeting.

4. Bimonthly food committee meeting will be held by Regional Dietary Manager to begin on 1/10/22 to ensure resident□s feedback is shared and residents stay informed. Administrator to attend monthly resident council meeting (with invitation) for next 3 months to ensure resident council grievances are documented, communicated, and resolved. Administrator to complete random audit of 3 residents x 3 times per week times 2 weeks, once a week x 2 weeks, and then monthly x 2 months or until substantial compliance is met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ACCORDIUS HEALTH AT MIDWOOD, LLC	**2727 SHAMROCK DRIVE** **CHARLOTTE, NC 28205**

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F 835	Continued From page 106	F 835	5. Compliance date 1/13/2022.	