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	345359	A. BUILDING _____ B. WING _____	C 02/04/2022

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ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/25/22 through 2/4/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RCSW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/25/22 through 2/4/22. 17 of the 32 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (K) CFR 483.25 at tag F689 at a scope and severity (K) CFR 483.35 at tag F725 at a scope and severity (K) CFR 483.70 at tag F835 at a scope and severity (K) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F600 began on 11/8/21 and was removed on 1/30/22. Immediate Jeopardy for F689 example 1 began on 1/11/22 and was removed on 2/2/22. Immediate Jeopardy for F689 example 2 began on 1/29/22 and was removed on 2/2/22. Immediate Jeopardy for F725 and F835 began on 11/8/21 and was removed on 2/2/22. Substandard Quality of Care was identified at: CFR 483.25 at tag F686 at a scope and severity	F 000		

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

Electronically Signed | 03/04/2022

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F 000	Continued From page 1 (H) An extended survey was conducted.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		3/8/22

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F 580	Continued From page 2 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, physicians and Registered Dietician, the facility failed to notify the physician of significant changes in condition that included: 1) insulin and antibiotic medications not administered as ordered (Residents #409, #43, and #67); 2) incidents of Resident #29 physically abusing Residents #39 and #53; and 3) dietary recommendations (Resident #79). The facility also failed to notify the Responsible Party of an incident of resident-to-resident physical abuse (Residents #29 and #39) and of a resident's discharge from speech therapy (Resident #22). This was for 8 of 8 residents reviewed for notification of change (Residents #22, #29, #39, #43, #53, #67, #79, and #409). The findings included: 1. Resident #43 was admitted to the facility on 8/20/20 with diagnoses that included dementia	F 580	F 580 1. Resident #409 no longer resides at the facility. On 1/28/22, the Medical Director/Nurse Practitioner (MD/NP) for residents #43 and #67 was notified of the missed medication by the Interim Director of Nursing and Administrator. On 1/28/22, the MD/NP for Residents #29, #39 and #53 was notified regarding the resident-to-resident reporting by the Interim Director of Nursing and Administrator. On 1/28/22, the MD/NP was notified of the dietary recommendation by the Interim Director of Nursing. The Resident Representative (RR) for Residents #29 and #39 were notified of the resident to resident on 1/23/22 by Social Services. The RP for resident #22 was notified of Speech Therapy discontinuing on 1/25/22 by the Interim Director of Nursing.	

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F 580	Continued From page 3 and diabetes. A physician order dated 1/5/22 for Gentamicin Sulfate Solution 0.3% (eye drops antibiotics) 2 drops in both eyes 4 times daily for 7 days. Record review of Medication Administration Record (MAR) for the month of January 2022 revealed Resident #43 did not receive the Gentamicin medication scheduled to be administered on 1/5/22 at 5:00 PM, 1/6/22 at 9:00 PM, 1/7/22 at 12:00 PM, 1/7/22 at 5:00 PM, 1/7/22 at 9:00 PM, 1/8/22 at 9:00 AM, 1/8/22 at 12:00 PM, 1/8/22 at 5:00 PM, 1/8/22 at 9:00 PM, 1/9/22 at 12:00 PM, 1/9/22 at 5:00 PM, 1/9/22 at 9:00 PM, 1/10/22 at 9:00 AM, 1/10/22 at 12:00 PM, 1/10/22 at 5:00 PM, 1/10/22 at 9:00 PM, 1/11/22 at 12:00 PM, 1/11/22 at 5:00 PM, 1/11/22 at 9:00 PM, 1/12/22 at 9:00 AM, and 1/12/22 at 12:00 PM. The chart code documented by Nurses #7 and #8 for the medication that was not administered was #9 - other/see nurses notes. On 1/6/22 at 12:00 PM and 5:00 PM, the MAR was blank. Nurse #7 coded the medication as administered on 1/5/22 at 9:00 PM. Nurse #8 coded the medication as administered on 1/6/22 at 9:00 AM, 1/7/22 at 9:00 AM, 1/9/22 at 9:00 AM, and 1/11/22 at 9:00 AM. During a phone interview with the Medical Director (MD) on 1/31/22 at 11:04 AM, he revealed he did not recall there was an issue that Resident #43 did not receive eye antibiotic medication. If he was notified, he would have tried to reauthorize another prescription. The interim DON and Regional Director of Clinical Services (RDCS) were interviewed on 2/2/22 at 1:24 PM and revealed the doctor should have	F 580	2. On 2/28/22, the Unit Manager reviewed all residents with insulin order changes, antibiotic orders, resident abuse incidents, residents with dietary recommendations and therapy order changes from 1/1/22 to 2/28/22 to ensure MD/NP and RR notifications had been made. Those residents with unknown notification status, MD/NP and RR were notified and documented in the residents medical record. 3. Effective 3/8/22, the Director of Nursing, MD/NDS (spell out NDS?) Coordinator and Regional Nurse Consultant educated all current facility and agency licensed nurses on notifying the MD/NP and RP of changes in resident condition including; insulin order changes, antibiotic orders, dietary recommendations, therapy orders and resident abuse incidents. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the orientation process. The licensed nurse will notify the physician for additional orders if a medication (antibiotic eye drops/ointment) is not available for administration. The Director of Nursing will monitor MD/NP and RP notification in the daily morning clinical meetings. 4. Monitoring of MD/NP and RR notifications will be completed the Director of Nursing or Unit Manager for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as	

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F 580	Continued From page 4 been notified if they could not administer the medication. On 2/2/22 at 4:40 PM the Regional Director of Operations (RDO) revealed the doctor should have been notified by the nurses if they did not have a medication available. 2. Resident #67 was readmitted to the facility on 6/7/20 with diagnoses that included Alzheimer's disease and fibromyalgia. A physician order dated 12/6/21 for Tobramycin ointment 0.3% (antibiotics) 1 application in left eye 3 times daily for 7 days. Record review of Medication Administration Record (MAR) for the month of December 2021 revealed Resident #67 did not receive the Tobramycin medication scheduled to be administered on 12/6/21 at 8:00 PM, 12/7/22 at 8:00 AM, 12/7/21 at 1:00 PM, 12/7/21 at 8:00 PM, 12/8/21 at 8:00 AM, 12/8/21 at 1:00 PM, 12/8/21 at 9:00 PM, 12/9/21 at 8:00 AM, 12/9/21 at 1:00 PM, 12/10/21 8:00 PM, 12/11/21 at 8:00 AM, 12/11/21 at 1:00 PM, 12/11/21 at 8:00 PM, 12/12/21 at 8:00 AM ("hold/see nurses notes"), 12/12/21 at 1:00 PM, and 12/12/21 at 8:00 PM. The chart code documented by Nurses #10, #11, #13 as well as Medication Aides (MA) #3 and #4 for the medication that was not administered was #9 - other/see nurses notes. Nurse #10 coded the medication as administered on 12/6/21 at 8:00 AM and 1:00 PM. Nurse #1 coded the medication as administered on 12/8/21 at 8:00 PM. Nurse #14 coded the medication as administered on 12/9/21 at 8:00 PM. MA #4 coded the medication as administered on 12/10/21 at 8:00 AM and 1:00 PM.	F 580	necessary thereafter. The Director of Nursing will report findings of the monitoring to the QAPI committee monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with notification of MD/NP and RP with changes of condition.	

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During an interview with Physician #1 on 1/31/22 at 10:10 AM, he revealed he did not recall the missing Tobramycin medication for Resident #67 in December 2021. Physician #1 stated he would have expected pharmacy staff and nursing staff to contact him to reauthorize a new medication.

The interim DON and Regional Director of Clinical Services (RDCS) were interviewed on 2/2/22 at 1:24 PM. They revealed the nurses should have notified the doctor when they could not administer the missing Tobramycin medication for Resident #67. They stated the DON at the time should have performed the research to figure out why the medication was missing and contact the pharmacy.

On 2/2/22 at 4:45 PM the Regional Director of Operations (RDO) revealed the doctor should have been notified by the nurses if they did not have a medication.

3. Resident #22 was admitted to the facility on 9/2/21 with diagnoses that included dementia and muscle weakness.

The physician orders were reviewed for Resident #22 and revealed she was discharged from speech therapy (ST) as of 11/22/2021.

Review of nursing progress notes from 9/15/21 through 1/25/22 revealed there was no documentation that the RP was notified when ST services were discontinued in November 2021.

During a phone interview with the RP on 1/25/22 at 5:10 PM, she revealed Resident #22 was receiving ST and she was not notified when she

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was discharged due to lack of participation.

On 1/28/22 at 12:26 PM, the SW was interviewed and revealed no staff member at the facility was designated to notify family/RPs of therapy service changes. Since she began at the facility in 2016, she stated she has never notified RPs/families regarding therapy changes. However, she stated the speech therapist was in conversation with Resident #22's RP about her condition, goals, and treatment. She indicated she was aware the RP was upset about Resident #22 no longer receiving ST services.

During an interview with the Speech and Language Pathologist (SLP) on 1/28/22 at 12:58 PM, she revealed she had worked in the facility since 12/1/21. She stated she did not participate in Resident #22's ST discharge in November 2021. The SLP indicated she was unsure of who from the facility notified families/RPs of changes and discontinuations from therapy, but it was not anyone from the therapy team.

The interim DON and Regional Director of Clinical Services (RDCS) were interviewed on 2/2/22 at 12:17 PM. They revealed either the SW or therapy should have notified of changes to Resident #22's therapy services.

On 2/2/22 at 4:27 PM the Regional Director of Operations (RDO) revealed a staff member should have been assigned to contact families/RP of therapy changes.

4. Resident #409 was admitted to the facility on 1/24/22 with diagnoses that included end stage renal disease and type 2 diabetes mellitus

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A review of Admission Minimum Data Set (MDS) assessment revealed Resident #409 was cognitively intact. Resident # 409 required supervision to extensive assistance with activities of daily living (ADLs).

A review of a physician's order dated 1/25/22 revealed an order that read in part "Admelog SoloStar 100 UNIT/ML (milliliter) Solution pen-injector-INJECT AS PER SLIDING SCALE: IF 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400 - 450 = 6 units IF GREATER THAN 450 MG/DL NOTIFY MD AND DOCUMENT. SUBCUTANEOUSLY BEFORE MEALS AND AT BEDTIME FOR DM."

A review of Resident #409's medication administration record (MAR) revealed no blood glucose monitoring or administration of insulin for the following dates: 1/25/22, 1/26/22, 1/27/22, 1/28/22, and 1/29/22.

An interview was conducted with the Director of Nursing (DON) on 1/31/22 at 9:49 AM. The DON stated she had put Resident #409's orders in remotely. The DON stated that she had not verified the orders with the physician and expected that the day shift nurse would have contacted Resident #409's primary physician to verify the orders.

An interview was conducted with Nurse #10 on 1/31/22 at 11:18 AM. Nurse #10 stated that she did not notify the primary care physician because the orders had already been accepted.

Multiple attempts to contact Nurse #15 who worked 7:00 PM to 7:00 AM on 1/24/22 were

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unsuccessful.

An interview was conducted with the primary care physician on 2/1/22 at 9:57 AM. The physician stated that he was not notified that Resident #409 had not received any insulin. The physician stated that he was not notified that Resident #409 did not have an order for glucose monitoring before meals and at bedtime to administer the sliding scale insulin.

A follow up interview with the DON on 2/22/22 at 3:18 PM revealed that the primary physician had not been notified of the missing glucose monitoring and missed doses of sliding scale insulin.

5. Resident #29 was admitted to the facility on 5/10/21.

The Quarterly Minimum Data Set (MDS) Assessment dated 10/6/21 revealed Resident #29 had severe cognitive impairment.

5a. A nurse's note completed by Nurse #3 dated 12/23/21 revealed the nurse received a report of a resident-to-resident situation that occurred in the dining room when Resident #29 grabbed Resident #39 by the throat because he thought that Resident #39 was taking his food tray. This was communicated by the Medication (Med) Aide on duty. There was no documentation that the physician was notified of the incident.

On 1/27/22 at 6:40 AM Nurse #3 stated in an interview the Med Aide informed her of the incident in report. Nurse #3 stated she thought the information needed to be documented and that was all she did. She indicated she had not notified the physician or RP of the incident.

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On 1/27/22 at 5:30 PM, Physician #1 stated in an interview he was not notified of an incident on 12/23/21 with Resident #29 and Resident #39.

On 1/31/22 at 12:00 PM the Corporate Nurse stated in an interview that the physicians (Physician #1 or the Medical Director) were not notified after the incident on 12/23/21.

5b. A nurse's note dated 1/23/22 at 11:02 PM by Nurse #1 revealed Resident #53 was yelling help while in another resident's room. The Nursing Assistant (NA) found Resident #29 standing over Resident #53 attempting to hit Resident #53 with a chair and kicking her. Resident #53 was assessed and found to have a knot on the left side of her head and a busted lip with a deep gash. EMS (Emergency Medical Services) was called, and Resident #53 was taken to the Emergency Department for evaluation. There was no documentation that the RP or the physicians (Physician #1 and the Medical Director) were notified for Resident #29.

On 1/31/22 at 3:18 PM an interview was conducted with Nurse #2 who responded to the unit to assist with Resident #53 and Resident #29 on the evening of 1/23/22. Nurse #2 stated she assisted the NA and Nurse #1 stated she would call the doctor and the family.

On 1/31/22 at 3:18 PM an interview was conducted with Nurse #1 who stated Nurse #2 called the Medical Director but did not get an answer. Nurse #1 further stated she called Physician #1 who cared for Resident #29 in the facility, but she did not get an answer. Nurse #1

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said she knew she was to call the Director of Nursing (DON) if she couldn't get the doctor, but she failed to do that. Nurse #1 stated there was a lot going on and she did not call the RP for Resident #29.

A progress note, by the Social Worker dated 1/25/22 at 5:59 PM revealed the Responsible Party (RP) for Resident #29 was notified on 1/25/22 of an incident that happened on 1/23/22. There was a separate progress note, by the Social Worker dated 1/25/22 that the Medical Director was notified on 1/25/22 of the incident on 1/23/22.

On 1/27/22 at 4:10 PM, the Medical Director stated in an interview he had been notified of the incident that occurred on 1/23/22 with Resident #29 and Resident #53 on 1/25/22.

On 1/27/22 at 5:30 PM an interview was conducted with Physician #1 who stated he was not notified of an incident with Resident #29 on 1/23/22.

6. Resident #39 was admitted to the facility on 9/25/13.

The 10/28/21 Minimum Data Set assessment indicated Resident #39's had severe cognitive impairment.

A nurse's note completed by Nurse #3 dated 12/23/21 revealed the nurse received a report of a resident-to-resident situation that occurred in the dining room when Resident #29 grabbed Resident #39 by the throat because he thought that Resident #39 was taking his food tray. This

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was communicated by the Medication Aide (Med Aide) on duty. There was no documentation that the physician or the RP were notified of the incident.

On 1/27/22 at 6:40 AM Nurse #3 stated in an interview the Med Aide informed her of the incident in report. Nurse #3 stated she thought the information needed to be documented and that was all she did. She indicated she had not notified the physician or RP of the incident.

On 1/27/22 at 5:30 PM, Physician #1 stated in an interview he was not notified of an incident on 12/23/21 with Resident #29 and Resident #39.

On 1/31/22 at 12:00 PM the Corporate Nurse stated in an interview that the physicians (Physician #1 and the Medical Director) were not notified after the incident on 12/23/21.

7. Resident #53 was admitted to the facility on 9/3/21.

A nurse's note dated 1/23/22 at 11:02 PM by Nurse #1 revealed Resident #53 was yelling help while in another resident's room. The Nursing Assistant (NA) found Resident #29 standing over Resident #53 attempting to hit Resident #53 with a chair and kicking her. Resident #53 was assessed and found to have a knot on the left side of her head and a busted lip with a deep gash. EMS (Emergency Medical Services) was called, and Resident #53 was taken to the Emergency Department for evaluation. There was no documentation that the physician was notified for Resident #53.

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On 1/31/22 at 3:18 PM an interview was conducted with Nurse #2 who responded to the unit to assist with Resident #53 and Resident #29 on the evening of 1/23/22. Nurse #2 stated she assisted the NA and Nurse #1 stated she would call the doctor and the family.

On 1/31/22 at 3:18 PM an interview was conducted with Nurse #1 who stated Nurse #2 called the Medical Director (physician for Resident #53) but did not get an answer. Nurse #1 further stated she called Physician #1, who also cared for residents in the facility, but she did not get an answer. Nurse #1 said she knew she was to call the Director of Nursing (DON) if she couldn't get the doctor, but she failed to do that.

A progress note completed by the Social Worker dated 1/25/22 indicated that the Medical Director was notified on 1/25/22 of the incident that occurred on 1/23/22.

On 1/27/22 at 4:10 PM, the Medical Director (Physician for Resident #53) stated in an interview he had been notified of the incident that occurred on 1/23/22 with Resident #29 and Resident #53 on 1/25/22.
8 .Resident #79 was admitted to the facility on 12/13/21 with diagnoses that included stroke, end stage renal disease, and dysphagia (difficulty swallowing).

The Minimum Data Assessment (MDS) dated for 1/3/22 indicated resident was cognitively intact, had difficulty swallowing, and had a gastrostomy tube in place.

A dietary/nutritional note dated 1/10/22 at 12:41pm and written by the Registered Dietitian

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recommended adding 100mililter g tube water flushes every shift for g tube patency and to make sure Resident #79 stayed hydrated. A review was completed of the physician orders revealed no g tube flushes were in place.

An interview was completed with Med Aide #5 on 1/27/22 at 11:50am. She indicated there were no g tube flush orders in the physician's orders list.

A telephone interview was completed with the Registered Dietitian (RD) on 1/28/22 at 11:09am. She verified the Resident was reviewed on 1/10/22 due to be a new Resident to the facility. The RD indicated water flushes were recommended due to Resident #79 having a g tube. This was to make sure the g tube stayed patent (open) and for hydration purposes if his intake decreased.

A telephone interview was completed with the Director of Nursing on 2/1/22 at 9:41am. She indicated she had received the Dietitian recommendations from 1/10/22. She continued to state she had not been responsible for the recommendations in the past and was not told what to do with them when she started in the position of DON in December 2021.

A telephone interview was completed with Physician #1 on 2/1/22 at 10:03am. He indicated he did not see the 1/10/22 Dietitian recommendation. He further stated since Resident #79 had a diagnosis of end stage renal disease he would have rejected the flush recommendation.

An interview was completed on 2/1/22 at 4:00pm with the Regional Corporations Officer. She

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F 580	Continued From page 14 stated it was her expectation Dietitian recommendations be followed through in a timely manner.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		3/8/22

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F 584	Continued From page 15 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, the facility failed to provide a sufficient supply of linen to meet the needs of the residents on 4 of 5 halls (West, West Annex, East, East Annex halls). The facility also failed to maintain clean and sanitary wheelchairs for 3 of 3 reviewed (Wheelchairs #1, #2, and #3) and tube feed pumps/poles for 2 of 2 reviewed (Tube Feed Pump #1 and #2). The findings included: 1. a. Resident #23 was readmitted to the facility on 4/15/21. The most recent quarterly Minimum Data Set (MDS) dated 10/21/21 for Resident #23 was reviewed and revealed he was cognitively intact. During an interview with Resident #23 on 1/31/22 at 9:47 AM, he revealed there was a shortage of sheets and washcloths during the overnight shift sometimes. A nurse aide told him they were short on towels/washcloths and could not provide him a bed bath. He stated his bed sheets were changed in the morning when linens became available. b. Resident #19 was admitted to the facility on 5/6/21. The most recent quarterly Minimum Data Set	F 584	1) On 02/28/2022, Housekeeping Dept. stocked linen carts on West, West Annex, East, and East Annex halls with an ample supply of clean linens to meet the needs of residents. On 02/28/2022 Housekeeping Dept. cleaned and sanitized wheelchair #1, #2 and #3 and tube feed pumps/poles #1 and #2). 2) On 2/28/22, cognitively intact residents were interviewed by Administrator/Designee to assure that they had adequate linens and no concerns voiced. Observational rounds were also completed to monitor adequate linen availability on linen carts and in resident rooms. On 2/28/22, an audit of all wheelchairs and feeding poles was conducted by housekeeping and they are all without debris and dust and were clean and sanitary. 3) On 2/28/22, the Administrator/designee reeducated the Housekeeping Manger and Housekeeping Manager reeducated housekeepers by 3/7/22 on the expectation of maintaining adequate stock levels of linens to ensure resident availability and establishing a cleaning schedule for resident	

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(MDS) dated 11/2/21 for Resident #19 was reviewed and revealed he was cognitively intact.

During an interview with Resident #19 on 1/31/22 at 10:33 AM, he revealed whenever staff needed to change his sheets at night, they had to go search the other halls because his unit did not have any. He stated if staff could not find sheets, they used what they had, such as blankets, to change his bed. Resident #19 indicated washcloths and towels were short too.

During an interview with Nurse Aide (NA) #13 on 1/28/22 at 4:21 PM, she revealed the South hall was mostly stocked with linens on overnight shift but other halls (West, West Annex, East, and East Annex halls) would request linens from them, which included sheets and washcloths. If more linens were needed during the overnight shift, staff would have to wait until the laundry shift began at 6:00 AM the next morning. NA #13 indicated there was not an extra stock of linen available in the facility.

An interview was conducted with Nurse #1 on 1/26/22 at 11:45 AM, and she revealed there had been a linen shortage in the building for the last 1.5 years since she began working in the facility. During the overnight shift, she stated there were not enough washcloths and sheets available and staff checked all halls for additional supply. Nurse #1 further stated she reported the linen issue to the nurse who relieved her in the morning. She indicated staff would have to improvise and use what they could when sheets and washcloths were not available. Nurse #1 stated there was no back up linen storage, and staff would have to wait until the morning shift for linens to be replenished. She further stated staff

wheelchairs and feeding poles to ensure resident right to a safe, clean, homelike environment. Newly hired Housekeeping Managers and housekeepers will receive education during orientation.
Par levels for linens as well as set times for linen delivery have been established. Housekeeping Manager will have weekly linen sweeps throughout facility to assure that linens are stocked on the linen carts and accessible to all staff for back-up needs. The Housekeeping Manager will maintain a weekly cleaning schedule for wheelchairs and tube feeding poles.

4) Administrator/Designee will complete observation monitoring of linen carts and 2 resident rooms for availability and 2 residents with wheelchairs and 2 residents with feeding tubes for cleanliness and sanitation. Audits will be completed twice weekly for 12 weeks and results of monitoring will be discussed by the Administrator during monthly Quality Assurance Process Improvement (QAPI) meetings. Changes will be made to the plan as necessary to maintain compliance with resident right to safe, clean homelike environment

Date of Compliance: 3/8/22

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performed all care necessary to the best of their ability with limited supplies.

Nurse #7 was interviewed on 1/28/22 at 9:33 AM, and she revealed the overnight shift was always short of linens. She stated NAs were unable to perform resident care tasks without sufficient linens to the morning shift. These tasks included baths and sheet changes after incontinence care. Nurse #7 indicated some staff hid/hoarded linens for their next shift because linens were never replenished on overnight. She stated she would ask the other units if they had linen to spare and they said no.

An interview was conducted with Nurse #11 on 1/26/22 at 6:47 PM, and she revealed when she started her overnight shift for the past 3 months, there was no linen available for resident care (fitted shifts and towels). The night shift would warn her there was not any linen, and she notified management via the electronic medical record (EMR) dashboard forum. She stated they used gowns, pillowcases, and other materials to improvise for the lack of linen. Nurse #11 further stated she was unsure if there was a backup linen supply or when linens were replenished.

An interview was conducted with the Housekeeping Manager (HM) on 1/26/22 at 10:12 AM, and she revealed she told the Director of Nursing (DON) and the Administrator within the last month that linens were being hidden in the building by staff. She stated linens have been found in multiple locations of resident rooms including under a mattress while a resident room was deep cleaned. She stated a lot of the washcloths were being used as wipes because there were not any wipes available in the building.

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The HM indicated dirty linen was not being returned to the laundry room, so they had to retrieve it from the halls 3-5 times daily and new linens had to be supplied on the halls. She stated from 12/13/21 through 12/22/21, the following amounts of new linen were provided:
12/13/21 - 6 flat sheets and 96 washcloths delivered
12/14/21 - 2 flat sheets, 1 fitted sheet, and 6 washcloths delivered
12/15/21 - 2 flat sheets, 1 fitted sheet, and 3 washcloths delivered
12/16/21 - 11 fitted sheet and 20 washcloths delivered
12/17/21 - 18 pillowcases delivered
12/22/21 - 10 flat sheets, 5 fitted sheets, and 36 washcloths delivered

During an interview with the interim DON on 2/2/22 at 12:17 PM, she revealed she had heard that staff have been short of linen for at least 6 months. She stated she saw notifications had been posted on the EMR dashboard that the overnight shift was short of linens, including sheets and washcloths. The interim DON stated the HM was aware of this issue, and her expectation was for the HM to notify the Administrator of the linen concerns.

An interview was conducted with the Regional Director of Operations (RDO) on 2/2/22 at 4:55 PM, and she revealed laundry needed to perform an inventory with a par level of linen supply per resident that included 1 overstock supply. On 2/2/22 at 6:00 PM, the RDO indicated she spoke to the HM, and laundry did have a par inventory of linen but were not using them. She stated she explained to the HM that this process must be implemented, and a backup supply in the laundry

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room must be initiated to prevent a shortage of linen supply.
2a. On 1/26/22 at 3:17 PM an observation was made in room 110. Wheelchair #1 ' s frame was observed to have a buildup of debris and both wheelchair wheel spokes/rims were covered with dust particles. During a second observation on 1/27/22 at 2:39 PM of Wheelchair #1 was observed in the same condition as on 1/26/22.

2b. On 1/27/22 at 2:34 PM an observation was made in room 105. Wheelchair #2 ' s frame was observed to have a buildup of debris and the wheelchair wheel spokes/rims were covered with dust particles.

2c. On 1/27/22 at 2:34 PM an observation was made in room 232. Wheelchair #3 ' s frame was observed to have a buildup of debris and the wheelchair spokes/rims were covered with dust particles.

In an interview on 1/28/22 at 10:31 AM the environmental services manager revealed staff followed a schedule and cleaned wheelchairs once a week at night. Staff would take the wheelchairs outside, use a disinfectant, hose the wheelchairs off and let dry overnight. She indicated it was her first week on the job and she was unable explain the condition of Wheelchairs #1, #2, and #3.

In an interview on 2/02/22 at 4:15 PM the corporate nurse indicated she would want staff to clean resident rooms or any equipment that needed cleaning.

3a. On 1/25/22 at 12:03 PM an observation was made in room 107. Tube Feed Pump #1 was

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F 584	Continued From page 20 observed with 5-6 dime size drops of a dried tan substance on the tube feed pole legs. A second observation of Tube Feed Pump #1 was conducted on 1/27/22 at 2:38 PM and revealed with 5-6 dime size drops of a dried tan substance on the tube feed pole legs. b. On 1/27/22 at 2:14 PM an observation was made in room 318. Tube Feed Pump #2 was observed to have 2-3 dime size drops of a dried tan substance on the face of the pump. In an interview on 1/27/22 at 2:45 PM the housekeeper revealed they wiped down all the surface areas and equipment with daily cleaning. She was unable to explain the condition of Tube Pumps #1 and #2. In an interview on 2/02/22 at 4:15 PM the corporate nurse indicated she would want staff to clean resident rooms or any equipment that needed cleaning.	F 584		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		3/8/22

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F 600	Continued From page 21 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interviews, the facility neglected to protect the residents' right to be free from abuse when Resident #29 physically abused Residents #39 and #53. Resident #53 sustained injuries that required Emergency Room evaluation. This was for 1 of 1 resident (Resident #29) reviewed for resident-to-resident abuse. Immediate Jeopardy began on 11/08/21 when the facility failed to implement effective interventions to protect residents from the physical abuse of Resident #29 resulting in the resident placing Resident #53 in a headlock and pulling her to the floor. Immediate Jeopardy was removed on 1/30/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee and agency in-services, orientation and training. The findings included: Resident #29 was admitted to the facility on 5/10/21 and had diagnoses of dementia with behavioral disturbance. A nurse's note dated 9/20/21 revealed Resident #29 yelled at another resident for being in his room and told him if he did not get out, he was going to make him get out. An entry on Resident #29's care plan dated	F 600	1) Resident #29 displayed aggressive behaviors against Resident #53 on 11/8/2021. Resident #29 was found standing over Resident #53 with her in a headlock position and pulled her onto the floor. Nurse #6 separated the two residents and explained to Resident #29 that it was not okay for him to do that. Resident #53 did not have any injuries related to this incident. Resident #29's care plan was updated on 11/9/2021 and noted the resident was physically aggressive (putting a resident in a headlock) related to dementia. The physician was notified on 11/8/2021 of incident. Resident #29 and Resident #53 were evaluated by the Nurse Practitioner on 11/9/2021. Medication changes were made for Resident #29 due to his behavior change; therefore, a psychiatric evaluation was not obtained. The initial report was submitted to the State Survey Agency on 11/8/2021 and final investigation finding submitted on 11/12/2021. The police were not notified of this incident. The interventions included to monitor Resident #29, document and report as needed any signs or symptoms of resident posing danger to self and others. Additionally, facility to obtain as indicated and put stop sign on the outside of the resident's room to deter other residents from entering his room. Resident #29 displayed aggressive behavior on 12/23/2021 against Resident	

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F 600	Continued From page 22 9/20/21 revealed the resident had a behavior problem (yelling at another resident and being rude and cursing at staff). The goal was for the resident to not harm self or others through the review date (1/31/22). The interventions included to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention and remove from the situation and take to an alternate location as needed. The Quarterly Minimum Data Set (MDS) Assessment dated 10/26/21 revealed Resident #29 had severe cognitive impairment and verbal behavioral symptoms directed towards others on 1-3 days during the lookback period. The MDS noted the resident was independent with transfers and ambulation in his room, in the corridor and on the unit. A nurse's note completed by Nurse #6 dated 11/8/21 at 7:58 PM revealed Resident #29 displayed aggressive behavior against another resident this shift. Resident found standing over a female resident (Resident #53) with her in a headlock position and pulled her onto the floor. This writer separated the two residents and explained to him that it was not okay for him to do that. Resident's previous behaviors have shown no signs of this as a potential incident, seemingly unpredictable and unavoidable. Will continue to monitor resident for behaviors and will inform oncoming shift. (Resident #53's 10/13/21 MDS indicated her cognition was moderately impaired and she had verbal behaviors on 1 to 3 days during the review period.) On 2/1/22 at 9:52 AM an interview was conducted with Nurse #6 who stated on 11/8/21 she heard	F 600	#39. Both residents were in the dining room when Resident #29 grabbed Resident #39 by the throat because he thought Resident #39 was taking his food tray. The residents were immediately separated by staff and increased monitoring (increase in frequency of being aware of his whereabouts, needs and behavior) was initiated and remained in place for the duration of the shift without further behaviors exhibited by the resident. A 24-hour reportable was not submitted to the State Survey Agency by the facility nor were the police notified at the time of the incident. For compliance purposes, a 24-hour report was sent to the State Survey Agency by the Regional Director of Operations on 1/29/2022 @ 3pm. Police were contacted on 1/29/2022 @ 10:30pm. Physician was notified of the incident on 1/28/2022 @ 1pm by the Administrator. The final investigation (5 day report) will be concluded and sent to the State Survey Agency. Resident #29 displayed aggressive behavior on 1/23/2022 against Resident #53. NA #1 stated that Nurse #1 told her she would be back in a few minutes and left the unit and she was the only staff on the floor. The NA stated she was in a room where 2 residents were trying to get out of bed, and she was trying to keep them from falling. The NA further stated there were 2 male residents trying to get out of the door to the unit and then she heard someone saying, “Help me. Help me. He’s going to kill me.” The NA stated she went to the room of Resident #29 and observed Resident #53 on the floor and	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

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Resident #53 saying: "Get off me." Nurse #6 further stated Resident #29 was behind Resident #53 and had his arm around her neck and pulled her to the floor. Nurse #6 stated another staff member helped her separate the two residents. Nurse #6 further stated there were no injuries for either resident. Nurse #6 stated she called the families of Resident #29 and Resident #53 and reported the incident to the previous Director of Nursing (DON). Nurse #6 stated she called the Medical Director who was the physician for Resident #53 and Physician #1 for Resident #29.

An entry on the care plan dated 11/9/21 noted the resident was "physically aggressive (putting a resident in a headlock) related to dementia." The interventions included monitor and document and report as needed any signs or symptoms of resident posing danger to self and others. Psychiatry consult as indicated and put stop sign on the outside of the resident's room to deter other residents from entering his room.

A progress note completed by Nurse #3 dated 12/23/21 at 1:55 AM noted the nurse received report of a resident-to-resident situation occurring in the dining room with this resident (Resident #29) grabbing Resident #39 by the throat because he thought the resident was taking his food tray. Nurse #3 indicated this was communicated to her by the Med Aide on duty. Residents were noted to currently both be in bed with monitoring being done by staff. (Resident #39's 10/28/21 MDS indicated severely impaired cognition and no behavioral symptoms.)

On 1/27/22 at 1:00 PM an interview was conducted with the Medication (Med) Aide #1 that was working on 12/23/21 when Resident #29 put there was blood on the floor. The NA stated she had no choice but to leave the room and went to the door to the unit and called down the hall to Nurse #2 that she needed help. The NA stated she and Nurse #2 went back to the room and she observed Resident #53 on the floor and Resident #29 was holding a wooden chair over her and she told him he better not do that and he dropped the chair and kicked Resident #53 in the head and stated to get this (racial slur) out of his room. The police were immediately notified of the incident on 1/23/2022. The physician was made aware by the Social Worker on 1/25/2022.

Resident #53 was sent to the emergency room for evaluation. The Emergency Room (ER) Record for Resident #53 dated 1/23/22 noted the resident was assaulted by another resident at the facility. The physical exam noted a lip laceration of the right upper lip and nasal swelling. Exam positive for neck pain at cervical back and laterally of the neck with signs of trauma and tenderness present. Pain with movement. Normal range or motion. A CAT scan of the head was negative and showed a small Right Malar (cheek) contusion. A CAT scan of the cervical spine showed a small right malar (cheek) contusion. Of note, Resident #53 had the above noted injuries when she arrived to the ER on 1/23/22. These injuries were sustained from an unwitnessed fall on 1/22/22. According to the ER report dated 1/22/22, Resident #53 arrived to the ER after sustaining an unwitnessed fall. Resident #53 had her

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F 600	Continued From page 24 his hands on the throat of Resident #39 in the dining room. Med Aide #1 stated she was setting up a supper tray for Resident #39 and Resident #29 thought the resident was getting his meal tray and he put both his hands around Resident #39's throat and she stopped him from going any further. Med Aide #1 stated that Resident #29 would get very upset if any of the residents started to go toward his room and would say that it was his room, and no one could go in there. On 2/2/22 at 9:08 AM a follow up interview was conducted with Med Aide #1. She stated on 12/23/21 when the incident occurred between Resident #29 and Resident #39 during the supper meal, she reported it to the nurse supervising her that evening. She was unable to recall who the nurse was or the time of the report. There were no new care plan interventions implemented after the 12/23/21 incident. A nurse's note completed by Nurse #1 dated 1/23/22 at 11:02 PM revealed Resident #53 was yelling "help" while in another resident's room. The Nursing Assistant (NA) found Resident #53 on the floor behind the door and Resident #29 was standing over Resident #53 attempting to hit her with a chair and kicked her. The assessment revealed Resident #53 had a knot on the left side of her head and a busted lip with a deep gash. 911 was called and Resident #53 was taken to the Emergency Department (ED) for evaluation. On 1/27/22 at 10:51 AM an interview was conducted with Nursing Assistant (NA) #1 who was working on the SCU on 1/23/22. NA #1 stated that Nurse #1 told her she would be back in a few minutes and left the unit and she was the	F 600	upper lip sutured by the ER Physician and she tolerated the procedure well. Administrator submitted 24-hour reportable to the State Survey Agency on 1/24/22 and initiated investigation; although, incident occurred 1/23/22. The police were immediately notified of the incident on 1/23/2022. 2) Because all residents are at risk when the facility fails to protect residents from being physically abused by other residents, the following plan has been formulated to address this issue: Resident #29 was placed on 1:1 staff supervision until seen by Psychiatry and deemed safe to remove from 1:1 supervision. Further, a care conference was held on 1/28/2022 with the facility Interdisciplinary Team (IDT) to include the Administrator, Director of Nursing, Social Worker and Resident #29's Responsible Party. The Psychiatrist and Medical Director were notified of the care conference by the Social Worker but unable to attend. The purpose of the care conference was to discuss on-going medication management and alternate interventions to manage residents' aggressive behavior towards others. On 1/28/2022, the plan of care was reviewed and revised by the IDT for Resident #29 to protect all residents at risk. This plan of care includes the following: 1:1 supervision until seen by psychiatry and deemed safe to remove from 1:1 supervision; intervene to protect the safety of others; remove from situation and take	

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F 600	Continued From page 25 only staff on the unit. NA #1 stated she was in a room where 2 residents were trying to get out of bed, and she was trying to keep them from falling. NA #1 further stated there were 2 male residents trying to get out of the door to the unit and then she heard someone saying, "Help me. Help me. He's going to kill me." NA #1 stated she went to the room of Resident #29 and observed Resident #53 on the floor and there was blood on the floor. NA #1 stated she had no choice but to leave the room and went to the door to the unit and called down the hall to Nurse #2 that she needed help. NA #1 stated she and Nurse #2 went back to the room and she observed Resident #53 on the floor and Resident #29 was holding a wooden chair over her and she told him he better not do that and he dropped the chair and kicked Resident #53 in the head and stated to get this (racial slur) out of his room. NA #1 stated she and Nurse #2 got the resident up and sat her in a chair and cleaned her up. NA #1 further stated Resident #29 was very angry and she had never seen him like this. NA #1 stated they had one Med Aide or Nurse and one NA on the unit and this was not enough staff to monitor the residents on the SCU. On 1/27/22 at 5:01 PM an interview was conducted with Nurse #2 who responded to NA #1's call for help on the night of 1/23/22. Nurse #2 stated NA #1 came on the hall next to the SCU and was hollering for help and when she got to the room, Resident #53 was standing in the doorway arguing and saying to get her out of his room. Nurse #2 stated that Resident #3 (a resident that resided in the room across the hall from Resident #29) was in his wheelchair at the door to keep Resident #29 from getting back in his room and Resident #53 was on the floor crying and had blood on her clothing and on the	F 600	to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause with consideration of location, triggers, time of day, persons involved and situations; document behaviors, potential causes and what de-escalates the behavior, stop sign on door of Resident #29 room to deter other residents from wandering into Resident #29 room. On 1/28/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility IDT (department heads), Regional Clinical Consultant and Regional Director of Operations on 1/28/2022 to review the behavioral management policy to ensure it included strategies to manage residents' behaviors toward others. Additionally, the committee discussed the incident(s) involving Resident #29 and developed an immediate action plan based upon root cause analysis to address and remove immediate and future risk potential. Based upon root cause analysis of each incident, Resident #29's primary trigger is individuals invading his personal space and his inability to make sound response decisions secondary to his cognition status and diagnosis of dementia. This was identified during the review of each incident with the involved residents and comments made by Resident #29. On 1/28/2022, the Administrator and Social Worker completed an audit for F600 via abuse questionnaire with cognitively intact residents and the Licensed Nurses completed body audits	

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floor. Nurse #2 further stated they tried to calm Resident #29 and directed him to the dining room to sit down but he sat down for a second and came back to the room and said to get her out of his room. Nurse #2 stated they were trying to get him back to the dining room and another resident was trying to get out of the door to the unit and she and NA #1 got Resident #53 up off the floor to sit in a chair. Nurse #2 stated NA #1 told her that Resident #29 hit Resident #53 with the chair and knocked her to the floor. Nurse #2 stated she called the Director of Nursing (DON) for extra hands, and they sent Resident #53 to the hospital. Nurse #2 further stated the DON told her to make sure to document what had happened and to call the family and the doctor. She stated by this time Nurse #1 had returned to the unit and stated she would call the doctor and the family. Nurse #2 was asked about the staffing on the SCU, and she stated there was one nurse or med aide and one NA and this was not enough staff for the unit. Nurse #2 further stated there had been issues with residents on the SCU getting out of the unit and onto the general population unit and that "traffic control" was the main issue. She explained that there were a few residents that got up all the time but were not steady and some residents would walk the hall at night and try to get out of the unit and some residents would wander into other resident's rooms which was what happened on the night of 1/23/22.

On 1/27/22 at 11:23 AM an interview was conducted with the Interim Director of Nursing (DON) who stated she received a phone call on 1/23/22 around 9:00 PM from Nurse #2 who told her about a situation between Resident #29 and Resident #53. The DON stated she called the Administrator to let her know what was going on.

on cognitively impaired residents to ensure other residents are free from abuse, including resident-to-resident. No additional concerns identified.
On 1/28/2022, the Administrator and Director of Nursing reviewed with the IDT, Licensed Nurses and Nurse Aides all residents on the secure unit with behaviors that could potentially affect the safety of other residents. Those identified as not currently having psychiatry services were referred to psychiatrist for consult and medication review.

3) On 1/28/2022, the administrative staff which includes the Administrator, Director of Nursing were educated by the Regional Director of Operations and the Regional Director of Clinical Services on responding to emergency situations such as physical abuse. This education will include strategies for prevention of physical abuse and identifying the likelihood based upon resident assessments and any exhibited behaviors. Effective 3/7/22, newly hired administrative staff will receive education prior to working during the orientation process.

Beginning 1/26/2022, current facility and agency staff on each shift, including Nursing, Activities, Social Work, Dietary, housekeeping and maintenance, will be re-educated by the Regional Director of Nursing and/or Administrator on F600 and the Prevention of Abuse or/and Neglect. The education will be communicated verbally and telephonically by the Director

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F 600	Continued From page 27 The DON stated the Administrator told them to call the physician and the family. The DON further stated at that time she received a text that the police were on the way to the facility, and she called the Administrator back and was told to keep the residents separated and do 15-minute checks on the two residents and she (Administrator) would deal with it in the morning. The DON stated she did not work on Monday (1/24/22) so she did not know what action was taken the next morning. Review of the ED Record for Resident #53 dated 1/23/22 noted the resident was assaulted by another resident at the facility. Emergency Medical Technicians (EMT) reported resident was "hit in the face with a wooden chair". The physical exam noted a lip laceration of the right upper lip and nasal swelling. Exam positive for neck pain at cervical back and laterally of the neck with signs of trauma and tenderness present. Pain with movement. Normal range or motion. A CAT (Computed Tomography) scan of the head was negative and showed a small Right Malar (cheek) contusion. A CAT scan of the cervical spine showed a small right malar (cheek) contusion. A CAT scan uses special x-ray equipment to help assess head injuries. Review of the police report dated 1/23/22 revealed a call was received regarding an assault on a female at the skilled nursing facility. The Nurse explained they would like the male resident (Resident #29) to be involuntarily committed. The report revealed that because of the resident's medical issues, the officer could not take the resident into custody. The female resident was picked up by EMS (Emergency Medical Services). The report indicated he advised the	F 600	of Nursing. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff. Beginning 1/28/2022, all staff will be educated by the Director of Nursing on the facility behavioral management policy to include managing resident behaviors and prevention of resident-to-resident altercations. This will include identifying contributing factors such as situational, physical environment, and organizational factors. An emphasis will be placed upon ensuring supervision of residents to aid in preventing physical assault between residents. If the resident is displaying aggressive behaviors towards others, the resident will be monitored closely which will include 1 to 1 observation if the resident continues to have behaviors. If the resident continues to have aggressive behaviors towards others despite facility interventions, the facility will transfer the resident (including Resident #29) to the hospital for an immediate psychological evaluation to protect risk to others. The education will be communicated verbally and telephonically by the Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. will utilize a master employee list to track completion of education. No staff will be	

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staff they could speak with the magistrate regarding the request for involuntary commitment orders. The case was closed.

A Skin/Wound note completed by Nurse #5 dated 1/25/21 at 8:40 AM revealed Resident #53 had a bruise along the bridge of her nose that measured 4 centimeters (cm) by 3 cm along with an abrasion that was 2.3 cm by 0.1 cm. The resident was noted to be sniffling during the examination and the resident was asked if she had a cold and the resident stated: "No, that man hit me across my nose." The right upper lip was swollen with abrasion 3.7 cm by 2.5 cm.

An interview was conducted on 1/27/22 at 4:10 PM with the Medical Director (MD) who cared for Resident #53 in the facility. The MD stated he had been notified (on 1/25/22) of the incident between Resident #29 and Resident #53 and had not seen Resident #53 since the incident on 1/23/22.

On 1/27/22 at 5:30 PM an interview was conducted with Physician #1 who cared for Resident #29 in the facility. The Physician stated Resident #29 had another resident (Resident #53) in a headlock several months ago and they were separated. Physician #1 stated he had not heard of any other issues with Resident #29 since that time and was not notified of an incident with this resident on 1/23/22.

On 1/27/22 at 6:04 AM an interview was conducted with Nurse #3 who worked on the night shift in the Secure Care Unit (SCU). Nurse #3 stated if anyone went toward the room of Resident #29, he would get very upset. Nurse #3 further stated a Velcro STOP sign was put across his door and this had been somewhat effective

allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

4) Effective 1/28/2022, the facility Administrator, Director of Nursing, Social Worker and Charge Nurse will perform facility tours (including off shifts and weekends) daily of the memory unit to observe for any residents with behaviors which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels every shift (including coverage during breaks and lunches) on the memory care unit to ensure adequate staff to provide supervision to residents to prevent physical abuse. Effective 3/7/22, monitoring will be conducted at a frequency of weekly for 8 additional weeks and as needed thereafter.
Effective 1/28/2022, the facility Administrator will conduct questionnaires weekly with Licensed Staff and Nurse Aides related to how to respond to residents with physical behaviors and interventions. Effective 3/7/22, monitoring will be conducted at a frequency of weekly for 8 additional weeks and as needed thereafter.
Results of monitoring will be discussed by the Administrator during monthly Quality Assurance Process Improvement (QAPI) meetings. Changes will be made to the plan as necessary to maintain compliance with Abuse and Neglect.

Date of compliance: 3/8/22

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but when Resident #29 came out of his room he would often forget to reattach the "STOP" sign in front of the door.

On 1/28/22 at 9:20 AM an interview was conducted with Med Aide #2 who stated Resident #29 would get very upset if anyone went in his room and had been aggressive a number of times with other residents and she had expressed a concern to the previous Director of Nursing that Resident #29 was going to hurt someone.

On 1/28/22 at 9:30 AM Nurse #17 stated in an interview that Resident #29's behaviors have escalated verbally and physically over the last couple of months. Nurse #17 further stated they have morning hall meetings, and the Administrator attended these meetings and the staff have expressed concerns during these meetings that Resident #29 was going to hurt somebody, and that he did not need to be on the SCU. Nurse #17 stated the staffing on the SCU was not adequate and the staff have expressed this concern to the Administrator but they were told that one Nurse or Med Aide and one NA was adequate staffing for the unit.

On 1/27/22 at 11:58 AM an interview was conducted with the Administrator who stated Resident #53 had a fall on 1/22/22 and busted her lip and had an abrasion. The Administrator further stated the next day (1/23/22) Resident #29 and Resident #53 had an interaction and she was in the midst of that investigation now. The Administrator stated that NA #1 was in another room and heard someone needed help and found Resident #29 holding a chair and believed Resident #53 was hit with the chair. The Administrator further stated it seemed to her if he

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hit her with a chair, she would have had other injuries and the NA assumed the resident was hit with the chair. The Administrator stated Resident #29 was moved off the unit the next morning. The Administrator further stated she interviewed both residents after the 11/8/21 incident and one resident resided on one end of the hall and the other resident resided on the other end of the hall and when she interviewed them, neither of the residents had any recollection of the event on 11/8/21. The Administrator stated head to toe assessments were done, statements were obtained, and the Physician and the families had been notified and the Nurse Practitioner reviewed both residents. The Administrator stated she was not aware that Resident #29 had kicked Resident #53 in the head during the incident on 1/23/22. The Administrator stated the police were notified and the family did not choose to press charges. The Administrator stated the STOP sign on the door was an intervention as a result of the 11/8/21 incident. The Administrator stated there had been concerns from the staff about the staffing on the SCU and that she believed two staff members for 13 residents on the SCU was adequate. The Administrator stated when one of the staff took a meal break there was still one person on the unit and if there was an issue, they should call for additional help. The Administrator stated she thought the incident on 11/8/21 was an isolated incident and she was not aware of the incident on 12/23/21.

The Administrator was notified of the Immediate Jeopardy at F600 on 1/28/22 at 1:32 PM.

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The facility provided a credible allegation of Immediate Jeopardy removal on 1/30/22. The allegation of Immediate Jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy Removal:

Resident #29 displayed aggressive behaviors against Resident #53 on 11/8/2021. Resident #29 was found standing over Resident #53 with her in a headlock position and pulled her onto the floor. Nurse #6 separated the two residents and explained to Resident #29 that it was not okay for him to do that. Resident #53 did not have any injuries related to this incident. Resident #29's care plan was updated on 11/9/2021 and noted the resident was physically aggressive (putting a resident in a headlock) related to dementia. The physician was notified on 11/8/2021 of incident. Resident #29 and Resident #53 were evaluated by the Nurse Practitioner on 11/9/2021. Medication changes were made for Resident #29 due to his behavior change; therefore, a psychiatric evaluation was not obtained. The initial report was submitted to the State Survey Agency on 11/8/2021 and final investigation finding submitted on 11/12/2021. The police were not notified of this incident. The interventions included to monitor Resident #29, document and report as needed any signs or symptoms of resident posing danger to self and others. Additionally, facility to obtain as indicated and put stop sign on the outside of the resident's room to deter other residents from entering his room.

Resident #29 displayed aggressive behavior on 12/23/2021 against Resident #39. Both residents were in the dining room when Resident #29

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grabbed Resident #39 by the throat because he thought Resident #39 was taking his food tray. The residents were immediately separated by staff and increased monitoring (increase in frequency of being aware of his whereabouts, needs and behavior) was initiated and remained in place for the duration of the shift without further behaviors exhibited by the resident. A 24-hour reportable was not submitted to the State Survey Agency by the facility nor were the police notified at the time of the incident. For compliance purposes, a 24-hour report was sent to the State Survey Agency by the Regional Director of Operations on 1/29/2022 @ 3pm. Police were contacted on 1/29/2022 @ 10:30pm. Physician was notified of the incident on 1/28/2022 @ 1pm by the Administrator. The final investigation (5-day report) will be concluded and sent to the State Survey Agency.

Resident #29 displayed aggressive behavior on 1/23/2022 against Resident #53. NA #1 stated that Nurse #1 told her she would be back in a few minutes and left the unit and she was the only staff on the floor. The NA stated she was in a room where 2 residents were trying to get out of bed, and she was trying to keep them from falling. The NA further stated there were 2 male residents trying to get out of the door to the unit and then she heard someone saying, "Help me. Help me. He's going to kill me." The NA stated she went to the room of Resident #29 and observed Resident #53 on the floor and there was blood on the floor. The NA stated she had no choice but to leave the room and went to the door to the unit and called down the hall to Nurse #2 that she needed help. The NA stated she and Nurse #2 went back to the room and she observed Resident #53 on the floor and Resident

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#29 was holding a wooden chair over her and she told him he better not do that and he dropped the chair and kicked Resident #53 in the head and stated to get this (racial slur) out of his room. The police were immediately notified of the incident on 1/23/2022. The physician was made aware by the Social Worker on 1/25/2022.

Resident #53 was sent to the emergency room for evaluation. The Emergency Room (ER) Record for Resident #53 dated 1/23/22 noted the resident was assaulted by another resident at the facility. The physical exam noted a lip laceration of the right upper lip and nasal swelling. Exam positive for neck pain at cervical back and laterally of the neck with signs of trauma and tenderness present. Pain with movement. Normal range or motion. A CAT scan of the head was negative and showed a small Right Malar (cheek) contusion. A CAT scan of the cervical spine showed a small right malar (cheek) contusion. Of note, Resident #53 had the above noted injuries when she arrived to the ER on 1/23/22. These injuries were sustained from an unwitnessed fall on 1/22/22. According to the ER report dated 1/22/22, Resident #53 arrived to the ER after sustaining an unwitnessed fall. Resident #53 had her upper lip sutured by the ER Physician and she tolerated the procedure well.

Administrator submitted 24-hour reportable to the State Survey Agency on 1/24/22 and initiated investigation; although, incident occurred 1/23/22. The police were immediately notified of the incident on 1/23/2022.

Because all residents are at risk when the facility fails to protect residents from being physically abused by other residents, the following plan has

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been formulated to address this issue: On 1/23/2022 at approximately 9:30pm (21:30) Resident #29 was placed on 1:1 staff supervision until seen by Psychiatry and deemed safe to remove from 1:1 supervision. Further, a care conference was held on 1/28/2022 with the facility Interdisciplinary Team (IDT) to include the Administrator, Director of Nursing, Social Worker and Resident #29's Responsible Party. The Psychiatrist and Medical Director were notified of the care conference by the Social Worker but unable to attend. The purpose of the care conference was to discuss on-going medication management and alternate interventions to manage residents' aggressive behavior towards others. On 1/28/2022, the plan of care was reviewed and revised by the IDT for Resident #29 to protect all residents at risk. This plan of care includes the following: 1:1 supervision until seen by psychiatry and deemed safe to remove from 1:1 supervision; intervene to protect the safety of others; remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause with consideration of location, triggers, time of day, persons involved and situations; document behaviors, potential causes and what de-escalates the behavior, stop sign on door of Resident #29 room to deter other residents from wandering into Resident #29 room.

On 1/28/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility IDT (department heads), Regional Clinical Consultant and Regional Director of Operations on 1/28/2022 to review the behavioral management policy to ensure it included strategies to manage residents' behaviors toward others. Additionally, the committee discussed the

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incident(s) involving Resident #29 and developed an immediate action plan based upon root cause analysis to address and remove immediate and future risk potential. Based upon root cause analysis of each incident, Resident #29's primary trigger is individuals invading his personal space and his inability to make sound response decisions secondary to his cognition status and diagnosis of dementia. This was identified during the review of each incident with the involved residents and comments made by Resident #29.

On 1/28/2022, the administrative staff which includes the Administrator, Director of Nursing were educated by the Regional Director of Operations and the Regional Director of Clinical Services on responding to emergency situations such as physical abuse. This education will include strategies for prevention of physical abuse and identifying the likelihood based upon resident assessments and any exhibited behaviors.

Beginning 1/26/2022, current facility and agency staff on each shift, including Nursing, Activities, Social Work, Dietary, housekeeping and maintenance, will be re-educated by the Regional Director of Nursing and/or Administrator on F600 and the Prevention of Abuse or/and Neglect. The education will be communicated verbally and telephonically by the Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

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Beginning 1/28/2022, all staff will be educated by the Director of Nursing on the facility behavioral management policy to include managing resident behaviors and prevention of resident-to-resident altercations. This will include identifying contributing factors such as situational, physical environment, and organizational factors. An emphasis will be placed upon ensuring supervision of residents to aid in preventing physical assault between residents. If the resident is displaying aggressive behaviors towards others, the resident will be monitored closely which will include 1 to 1 observation if the resident continues to have behaviors. If the resident continues to have aggressive behaviors towards others despite facility interventions, the facility will transfer the resident (including Resident #29) to the hospital for an immediate psychological evaluation to protect risk to others. The education will be communicated verbally and telephonically by the Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

On 1/28/2022, the Administrator and Social Worker completed an audit for F600 via abuse questionnaire with cognitively intact residents and the Licensed Nurses completed body audits on cognitively impaired residents to ensure other residents are free from abuse, including resident-to-resident. No additional concerns identified.

On 1/28/2022, the Administrator and Director of Nursing reviewed with the IDT, Licensed Nurses

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and Nurse Aides all residents on the secure unit with behaviors that could potentially affect the safety of other residents. Those identified as not currently having psychiatry services were referred to psychiatrist for consult and medication review.

Effective 1/28/2022, the facility Administrator, Director of Nursing, Social Worker and Charge Nurse will perform facility tours (including off shifts and weekends) daily of the memory unit to observe for any residents with behaviors which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels every shift (including coverage during breaks and lunches) on the memory care unit to ensure adequate staff to provide supervision to residents to prevent physical abuse.

Effective 1/28/2022, the facility Administrator will conduct questionnaires weekly with Licensed Staff and Nurse Aides related to how to respond to residents with physical behaviors and interventions.

Effective 1/28/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged date of IJ Removal: 1/30/22

On 1/31/22 the Credible Allegation of Immediate Jeopardy removal was validated by onsite verification. Multiple interviews were conducted with regular staff as well as agency staff who stated they had received education on abuse and neglect and examples of each were included in the training. The staff stated the education included who to notify if abuse was suspected

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F 600	Continued From page 38 and the requirements of notification to the DON, Administrator, state agency and law enforcement. The staff stated the education also included prevention of resident-to-resident abuse. Verification of this education for staff was completed on 1/30/22 and the facility's Immediate Jeopardy removal date of 1/30/22 was validated.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		3/8/22

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F 609	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to file a report with the state agency within 2 hours for 3 incidents of resident-to-resident abuse (11/8/21, 12/23/21 and 1/23/22) that involved 2 of 3 residents reviewed for abuse (Resident #53 and #39). The findings included: 1. A progress note dated 11/8/21 documented by Nurse #1 revealed Resident #29 displayed aggressive behaviors against another resident and was found standing over Resident #53 with her in a headlock position. On 2/1/22 at 9:52 AM an interview was conducted with Nurse #1 who stated she heard Resident #53 saying "Get off me." The Nurse further stated she observed Resident #29 behind Resident #53 and he was behind her and had his arm around her neck and pulled her to the floor. The Nurse stated there was no injury to either resident. The Nurse further stated she reported the incident to the previous Director of Nursing. Review of the 24-hour report submitted to the state revealed the facility became aware of the incident on 11/8/21 at 5:45 PM. The 24-hour report filed with the state was signed by the Administrator on 11/9/21 and was not submitted to the state agency within 2 hours of the incident. On 1/31/22 at 12:00 Noon an interview was conducted with the Corporate Nurse who stated a 24-hour, 5-day report was filed with the state agency but was not filed within 2 hours.	F 609	1) 11/8/21 abuse incident involving Resident #53 was reported with NC state agency on 11/8/21 outside the 2-hour window. 12/23/21 abuse incident involving Resident #39 and abuse incident on 1/23/22 involving Resident #53 were reported to North Carolina (NC)state agency but, were not reported timely within 2 hours per regulation. 2) On 3/7/22, the Regional Director of Nursing completed an audit of reported abuse incidents and grievances from 2/6/22-3/6/22 to ensure all reported allegations of abuse were reported timely within the 2 hour timeframe to NC state agency. No additional abuse incidents were identified as not being reporting timely. 3) On 3/7/22, the current Administrator was educated by the Regional Director of Nursing on the timely reporting of abuse allegation within 2 hours of reported incident to NC state agency per facility Abuse and Neglect policy and F609 regulation. Newly hired Administrators will receive education during the orienation process and prior to working. The Administrator is the designated Abuse Coordinator and will be responsible for the timely reporting to NC state agencies for all allegations of abuse. Effective 3/7/22, all current facility and agency staff have been educated on the facility Abuse and Neglect policy and	

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F 609	Continued From page 40 On 2/3/22 at 12:50 PM the Administrator stated in an interview that the incident on 11/8/21 seemed like an isolated incident. The Administrator stated she could not say if a 2-hour report was filed to the state agency, but she did not think so. 2. A progress note dated 12/23/21 at 1:55 AM documented by Nurse #3 revealed she had received report of a resident-to-resident situation that occurred in the dining room with Resident #29 grabbing Resident #39 by the throat because he thought the resident was taking his food tray. This was communicated by the Medication (Med) Aide (Med Aide #1) on duty. On 1/27/22 at 1:00 PM an interview was conducted with Med Aide #1 in the presence of the Administrator, the Social Worker and the Corporate Nurse. The Med Aide stated she was setting up the meal trays at supper on the Secured Care Unit (SCU) and Resident #29 thought Resident #39 was getting his meal tray and he put both hands on Resident #39's throat and she stopped him from going any further. The Med Aide stated she reported the incident to the nurse that was supervising her but could not remember who she told. The Administrator and the Social Worker stated they were not aware of this incident. The Corporate Nurse stated she asked Nurse #3 why she did not report the incident and the Nurse stated the Med Aide showed her what the resident did, and she did not think it was abuse. On 1/31/22 at 12:00 Noon the Corporate Nurse stated the administrative staff were not aware of the incident on 12/23/21 so there was not a 2-hour or a 24-hour/5-day report filed with the	F 609	reporting all allegations of abuse to the Administrator (Abuse Coordinator)immediately. During education, all staff were questioned if they have witnessed or had heard of any additional abuse allegation and no additional concerns were reported. 4) Effective 3/7/22, the Administrator or Social Worker will complete abuse questionnaires with 5 staff members to ask if they have witnessed or heard of any abuse allegations. Abuse reportables and grievences will also be reviewed to ensure timely reporting of abuse allegations to NC state agency within 2 hur timeframe. Monitoring will be completed 1X week for 4 weeks and 1X a month for 2 months as needed to ensure compliance. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with Abuse reporting. Date of Compliance: 03/08/2022	

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state agency.

3. A progress note dated 1/23/22 at 11:02 PM revealed Resident #53 was yelling help while in another resident's room and the NA (NA #1) observed Resident #29 standing over Resident #53 who was on the floor and was attempting to hit her with a chair and kicked her. EMS (Emergency Medical Services) was called, and the resident was taken to the Emergency Department for evaluation.

On 1/27/22 at 10:51 AM NA #1 stated in an interview she was in a room with 2 residents, and she heard someone say "Help me. Help me. He is going to kill me." The NA stated she went in the room of Resident #29 and Resident #53 was on the floor and there was blood on the floor. The NA stated the nurse was on break and she went to the door and called out for help and when she returned to the room Resident #29 was holding a wooden chair over Resident #53 and she told him to not do it and he threw the chair down and kicked Resident #53 in the head.

On 1/27/22 at 5:01 PM an interview was conducted with Nurse #2 who responded to the NA #1's call for help on 1/23/22. The Nurse stated when she arrived at the room of Resident #29, Resident #53 was on the floor crying and had blood on her clothing and on the floor. The Nurse stated she notified the Director of Nursing (DON) who told her to make sure to document what had happened and to call the families and the doctor. The Nurse stated she called the DON back to let her know the police were on the way and the DON contacted the Administrator who told them to put Resident #29 on 15-minute checks and she

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F 609	Continued From page 42 would deal with the situation in the morning. The Nurse stated by this time Nurse #1 was back from her break and said she would take over from there. On 1/31/22 at 12 Noon an interview was conducted with the Corporate Nurse who stated on 1/23/22 the 2-hour report to the state agency was not done.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		3/8/22

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F 655	Continued From page 43 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission to address the immediate needs for 1 of 1 resident reviewed for new admission. (Resident #409) The findings included: Resident #409 was admitted to the facility on 1/24/22 with diagnoses that included end stage renal disease, type 2 diabetes mellitus and left toe amputation. A review of the 5 Day Admission Minimum Data Set (MDS) assessment dated 1/26/22 revealed Resident #409 was cognitively intact. Resident # 409 required supervision to extensive assistance with activities of daily living (ADLs). Resident #409 was at risk for pressure ulcer, had a surgical wound and application of dressings to feet. Resident #409 had received antibiotics 2	F 655	F 655 1. The facility was unable to complete a baseline nor comprehensive care plan due to Resident #409 discharging from the facility on 1/29/2022. 2. All new admission residents have the potential to be affected. On 2/10/22, the Director of Nursing completed an audit of baseline care plans for residents admitted 1/23/22-2/9/22. A comprehensive care plan was completed for residents without a baseline care plan not completed within 48 hours. 3. Effective 3/7/22, The Director of Nursing, MDS Coordinator, Regional Director of Clinical Services provided education to all current facility and agency licensed nurses, Dietary Manager, Social Service Director, Therapy Director and	

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F 655	Continued From page 44 days of the look back period for a left toe infection. On 1/25/22 at 9:27 AM Resident #409 was observed sitting on the side of the bed. His left foot was on the floor and the dressing had a small amount of pink colored drainage near the top. An interview was conducted with the MDS nurse on 2/2/22 at 2:20 PM. The MDS nurse stated there was no baseline care plan for Resident #409. The nurse stated that she had not been able to see Resident #409 to complete the baseline care plan. An interview was conducted with the Director of Nursing on 2/2/22 at 4:53 PM. The DON stated that she expected newly admitted residents to have a baseline care plan in place within 48 hours to meet the immediate needs of the resident.	F 655	Activities Director on guidelines for accurate completion of baseline care plans within 48 hours of admission. The admitting nurse or Social Services will complete the baseline care plan in collaboration with the resident and/or resident representative within 48 hours of admission. A copy of the care plan will be offered and documented as accepted or declined. Baseline care plans will be monitored in daily clinical meetings. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the orientation process. 4. The MDS Coordinator will complete audits of baseline care plan all new admissions three times weekly for eight (8) weeks, then weekly for 4 weeks and as necessary thereafter to ensure regulatory compliance. The Director of Nursing will report findings of the monitoring to the QAPI committee monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with baseline care plans. 5. Alleged Compliance date: 3/8/22	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		3/8/22

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F 684	Continued From page 45 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and primary care physician interview, the facility failed to follow physician orders to monitor a resident's blood sugar that had the potential for missed doses of sliding scale insulin medication for 1 of 1 resident reviewed for medications (Resident #409). The findings included: Resident #409 was admitted to the facility on 1/24/22 with diagnoses that included end stage renal disease, type 2 diabetes mellitus and left toe amputation. A review of the 5 Day Admission Minimum Data Set (MDS) assessment dated 1/26/22 revealed Resident #409 was cognitively intact. Resident #409 's MDS did not indicate that he had received any insulin injections prior to admission. A review of a physician's order dated 1/25/22 revealed an order that read in part "Admelog SoloStar 100 UNIT/ML (milliliter) Solution pen-injector-INJECT AS PER SLIDING SCALE: IF 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400 - 450 = 6 units IF GREATER THAN 450 MG/DL NOTIFY MD AND DOCUMENT. SUBCUTANEOUSLY BEFORE MEALS AND AT BEDTIME FOR DM." The order was in confirmation pending status on the electronic medical administration record. There were no other medications ordered for DM.	F 684	F684 1. The facility was unable to implement the physician order for Resident #409 due to resident discharging from the facility on 1/29/2022. 2. All residents who are diabetics have the potential to be affected; therefore, on 3/2/22 the Director of Nursing completed an audit of all diabetic resident orders to ensure orders have been confirmed and transcribed onto the Medication Administration Record (MAR) with blood glucose monitoring, sliding scale insulin and routine insulin administration if indicated per physician orders. 3. Effective 3/7/22, the Director of Nursing, MD/NPS Coordinator and Regional Nurse Consultant provided education to all current facility and agency licensed nurses on confirming pending resident orders during medication administration to ensure insulin and blood glucose monitoring orders are not missed or omitted. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the orientation process. The Director of Nursing will monitor the confirmation of pending orders daily in the morning clinical meetings. 4. The Director of Nursing and/or Unit	

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F 684	Continued From page 46 A review of Resident #409's Medication Administration Record for January 2022 revealed no order for blood glucose monitoring. Resident #409 was discharged from the facility on 1/29/22. A review of the hospital emergency department summary dated 1/29/21 revealed that Resident #409 had an elevated glucose level of 184. (A normal blood glucose level is 70 -105 and since the blood sugar level is 184 the glucose is elevated.) An interview was conducted with Nurse #10 on 1/31/22 at 11:18 AM. Nurse #10 stated the admission nurse was responsible for putting in the orders from the hospital discharge summary of a newly admitted resident. Nurse #10 stated that Resident #409's insulin medication did not show on the MAR for her to administer. An interview was conducted with the Director of Nursing (DON) on 1/31/22 at 9:49 AM. The DON stated that an order would not show up on the MAR until a nurse confirmed the order. The DON stated she had put Resident #409's orders in remotely. The DON stated that it was Nurse #15's responsibility to review and accept the pending confirmation on an order. The order for Admelog insulin was pending and there was no order for monitoring blood sugars. A follow up interview was conducted with Nurse #10 on 1/31/22 at 3:49 PM. Nurse #10 was able to show there was Admelog insulin pen on the cart for Resident #409. Nurse #10 stated that she saw the insulin pen in the left top drawer but thought that the medication was administered on another shift since it did not show up for her to	F 684	Manger will complete an audit of diabetic residents to ensure orders have been confirmed regarding blood glucose monitoring, sliding scale and insulin administration. Monitoring will be completed for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report findings of the monitoring to the QAPI committee monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with glucose monitoring and insulin administration. Compliance date: 3/8/22	

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F 684	Continued From page 47 administer during her 7:00 AM to 7:00 PM shift. Nurse #10 stated that she did not recall seeing a pending confirmation for the medication in the physician orders. An interview was conducted with the primary care physician on 2/1/22 at 9:57 AM. The physician stated that he was not made aware that Resident #409 had not received any insulin since admission. The physician stated that he expected Resident #409 to have an order for glucose monitoring before meals and at bedtime to administer the sliding scale insulin. He further stated that he had no recollection of the facility notifying him for glucose monitoring or the missed insulin doses. Resident #409 was at risk for complications related to high or low glucose levels. A follow up interview was conducted with the DON on 2/2/22 at 3:18 PM. The DON stated she expected that the nurses caring for the resident would verify the order with the physician. The DON also stated that she expected the nurse to get an order from the physician for glucose monitoring with the frequency of blood sugar checks.	F 684		
F 686 SS=H	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	F 686		3/8/22

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F 686	Continued From page 48 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, physician, and wound clinic nurse interviews, the facility failed to assess and identify skin changes for 1 of 4 residents who was at risk for pressure ulcer development. (Resident #40). Findings included: Record review of hospital discharge record dated 11/17/21 revealed Resident #40 had a surgical debridement (removal of dead tissue) of necrotic sacral pressure ulcer. Resident #40 was admitted to the facility on 11/17/21 with diagnoses which included multiple sclerosis, contractures and paralysis of the lower extremities, and a stage 3 pressure ulcer to sacrum. Record review of Resident #40 ' s facility admission assessment dated 11/17/21, completed by Nurse #8, revealed skin was normal with no skin integrity issues documented. Record review of Weekly Pressure Wound Observation Tool dated 11/18/21 completed by Wound Nurse revealed Resident #40 had a stage 4 sacral pressure ulcer with measurements of 12 x 0.8 x 1.6 centimeters (cm). The wound bed had 50% granulation (new tissue) and 20% slough (yellow, stringy) tissue with moderate drainage	F 686	F686 1. Resident #40 had a head-to-toe skin assessment completed on 1/31/21 by the licensed nurse. The new skin areas identified were communicated to the attending care physician and treatment orders received and transcribed by the licensed nurse. The wound NP or attending physician will continue to manage the residents' care with weekly and as needed monitoring. Licensed nurses continue to monitor residents' skin weekly and with changes in skin condition and report changes to the attending physician. 2. All residents have the potential to be affected; therefore, 100% of the current residents received a head-to-toe skin assessment by the wound NP and licensed nurses by 3/7/22. Any new area(s) identified were communicated to the residents' attending care physician and Resident Representative (RR). Any new orders were reviewed by the wound nurse and physician for appropriate documentation (complete order and skin assessment) and implementation of recommendations. 3. The Director of Nursing, Wound	

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F 686	Continued From page 49 and no odor. Record review of in-house wound provider report dated 11/18/21 revealed Resident #40 ' s sacral pressure wound measurements were 12 x 0.8 x 1.6 cm. The wound had granulation tissue and slough tissue, with moderate drainage, and no odor present. Treatment recommendation clean with Dakin ' s, moist to dry Dakin ' s dressing, cover with dry clean dressing, change twice daily and with every incontinence episode. The treatment plan was discussed with the facility staff which included facility pressure ulcer prevention protocol and turn and reposition. Record review of Resident #40 ' s Minimum Data Set (MDS) Admission Assessment dated 11/19/21 revealed she was cognitively intact and was total dependence on staff for bed mobility, transfers, bathing, and personal hygiene. Resident #40 had a stage 4 pressure ulcer to sacrum. She was at risk for pressure ulcer development and was not on a turn/repositioning program. A physician order dated 11/20/21 for Dakin ' s moist to dry, dry clean dressing, change twice a day and with every incontinence episode. Record review of the Registered Dietitian (RD) progress note dated 11/22/21 Resident #40 ' s Admission RD Assessment revealed she was at increased risk for weight loss related to pressure ulcer and variable PO (by mouth) intake. RD recommendations for multivitamin daily, vitamin C twice daily, zinc sulfate daily, Prostat (liquid protein) twice a day for wound healing and house supplement twice daily for weight management and nutritional support.	F 686	Nurse and Regional Director of Clinical Services provided education to current facility and agency licensed nurses on completing and documenting weekly skin assessments. The certified aides were educated on communicating newly identified skin area on the residents to the charge nurse. The licensed nurse will review resident skin condition upon admission, weekly and with changes in condition. Nurse aides will complete body audits during ADL care and will report skin concerns to the licensed nurse verbally, written and/or via a POC clinical alert. New skin concerns will be reported to the physician and/or nurse practitioner upon findings by the licensed nurse for follow-up treatment. The wound nurse will monitor weekly wound assessments and treatment orders for completion of documentation. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the orientation process. Completed: March 7, 2022 4. The Director of Nursing will complete quality assurance monitoring of five (5) random residents with or without pressure ulcers for documented completion of weekly skin assessments and physician notifications and treatment orders. Monitoring will be competed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the	

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F 686	Continued From page 50 A physician order dated 11/23/21 for Dakin ' s moist to dry, dry clean dressing, change daily and with every incontinent episode. Record review of Resident #40 ' s care plan dated 11/23/21 revealed a care plan for a stage 4 pressure ulcer to sacrum. Interventions in place which included monitoring effectiveness of treatment, monitoring of any skin changes, and weekly treatment documentation to include measurement of each area of skin breakdown with width, length, depth, type of tissue and exudate (drainage). Resident #40 care plan for nutritional problem or potential nutritional problem related to pressure wound. Interventions in place which included RD evaluation and supplements as ordered. Record review of the Weekly Skin Review dated 11/24/21 revealed Resident #40 had an open, pre-existing area to sacrum. No other skin integrity issues documented. Record review of the Weekly Pressure Wound Observation Tool dated 11/25/21 completed by Wound Nurse revealed Resident #40 had a stage 4 sacral pressure ulcer with measurements of 12 x 11 x 1 cm. The wound bed had 50% granulation tissue, 50% slough tissue with moderate drainage and no odor. Record review of in-house wound provider report dated 11/25/21 revealed Resident #40 had a bedside debridement (cleaning of wound) with post procedure wound measurements of 12 x 11 cm. The treatment plan was discussed with the facility staff which included facility pressure ulcer prevention protocol and turn and reposition.	F 686	plan as necessary to maintain compliance. Compliance date: 3/8/22	

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Record review of RD progress note dated 11/26/21 revealed Resident #40 had significant weight loss. Resident #40 had nutritional supplement in place twice daily and new recommendation for house supplement and fortified foods at all meals.

Record review of Wound Clinic Treatment Report dated 11/30/21 revealed Resident #40 ' s sacral pressure ulcer measurements were 13 x 8.5 x 3.0 cm with undermining (extends under the skin) of 4 cm from 5 o ' clock to 7 o ' clock. The wound bed observed with moderate pink granulation tissue, minimal necrotic tissue, and no odor. The treatment plan included silver cell dressing to cover with dry dressing and tape changed daily rinse with saline. Offloading will make sure resident in a low-air-loss mattress and on a turn schedule. Follow-up in two weeks.

Record review of the Weekly Skin Review dated 11/30/21 revealed Resident #40 had an open, pre-existing area to sacrum. No other skin integrity issues documented.

Record review of RD progress note dated 12/13/21 revealed Resident #40 continued with significant weight loss with interventions in place. New recommendations for Glucerna supplement twice daily and ice cream with lunch and supper.

Record review of Wound Clinic Treatment Report dated 12/14/21 revealed Resident #40 ' s sacral pressure ulcer had improved with measurements of 10 x 6 x 3.0 cm with unchanged undermining. The wound bed observed with moderate pink granulation tissue, minimal necrotic tissue, and no odor. The treatment plan included silver cell

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dressing cover with dry dressing and tape to be changed daily rinse with saline. Follow-up in 1 week.

Record review of the Weekly Skin Review dated 12/20/21 revealed Resident #40 had an open, pre-existing area to sacrum with treatment in place. No other skin integrity issues documented.

Record review of the Weekly Skin Review dated 12/28/21 revealed Resident #40 had an open, pre-existing area to sacrum with treatment in place. No other skin integrity issues documented.

Record review of Resident #40 ' s electronic medical record revealed the Weekly Skin Review was not completed the weeks of 12/6/21, 12/13/21, 1/3/22, 1/10/22, 1/17/22, and 1/24/22.

Record review of Resident #40 ' s Weekly Pressure Wound Observation Tool was not completed for the months of December or January.

A physician order dated 1/3/22 for Hydrogel-soaked cling dressing to sacral wound on time a day for wound care.

During an interview on 1/25/22 at 2:32 pm Resident #40 revealed she had pressure ulcers to her heels but was not sure if they were getting better or worse.

During an observation of wound care on 1/27/22 at 10:32 am Resident #40 sacral pressure ulcer observed to have a strong odor and slough covering wound bed. No rinsing or cleansing of wound prior to new dressing placed. Resident #40 observed with a round, approximately half

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dollar size wound with black base on side of right foot that did not receive treatment.

During an interview on 1/27/22 at 10:35 am the Wound Nurse stated she thought the foot wound was a vascular wound, and she did not treat the foot wound. She stated she was pretty sure Resident #40 had the wound on her foot upon admission but was unable to state why no documentation was available about the wound. The Wound Nurse stated Resident #40 was seen initially by in-house wound provider but was changed to the wound clinic for wound management but was not sure about treatment of the foot wound or if the physician was aware of it. The Wound Nurse stated Resident #40 would benefit from an air mattress, but she stated she did not receive a recommendation from wound clinic or a physician order for the air mattress. The Wound Nurse was unable to state when Resident #40 was last seen at the wound clinic. She stated the Weekly Pressure Ulcer Observation Tool was required to be completed every week. The Wound Nurse reported she worked on a medication cart at times and did not complete the Weekly Pressure Ulcer Observation Tool as required.

During an interview on 1/27/22 at 11:54 am the Director of Nursing (DON) stated she expected Resident #40 to have an air mattress because of the stage 4 sacral pressure ulcer. She stated a recommendation for an air mattress could come from the Wound Nurse, Physician, or wound clinic but she was not aware of a recommendation for air mattress.

During a telephone interview on 1/27/22 at 5:30 pm Physician #1 revealed he was not certain if he

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had seen the wound on Resident #40 ' s foot. He stated that he would have ordered a treatment if he was aware. Physician #1 stated the nurse was able to make a recommendation for an air mattress for Resident #40 and he would have approved the order. Physician #1 was not notified of recommendation from wound clinic for a low-air-loss mattress.

Record review of RD progress note dated 1/28/22 revealed Resident #40 continued with significant weight loss with multiple interventions in place. RD recommendations for discontinue house supplement and increase Glucerna to three times a day between meals, Prostat twice daily, assist with eating, and update food preferences.

During an interview on 1/28/22 at 11:20 am the RD revealed Resident #40 was followed since admission related to risk for inadequate nutrition and presence of pressure ulcer. She stated multiple interventions were implemented including ice cream, fortified foods, supplements, and updating food preferences but Resident #40 continued to have weight loss. The RD stated Resident #40 continued to be seen by RD related to weight loss and nutritional support for wound healing.

During an interview on 1/31/22 at 9:50 am Nurse Aide (NA) #10 revealed that Resident #40 had a wound on her backside. She stated she would tell the nurse if new skin issues were seen. She stated she turns and repositions every two hours. NA #10 stated that Resident #40 had pillows under her legs, but she had not noticed wounds on Resident #40 ' s feet.

During an interview on 1/31/22 at 9:58 am NA #16

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revealed Resident #40 had a wound on her backside and one on her foot. She was not able to recall when she first noticed the wound on the foot but stated she told the nurse that was working.

During an interview on 1/31/22 at 10:08 am Nurse #10 revealed Resident #40 had a sacral pressure ulcer but did not recall any other wounds. She stated that she does not recall being told by NA about a new wound on her foot at any time and she did not observe any foot wounds for Resident #40. Nurse #10 stated the Weekly Skin Review was to be completed by the cart nurse, but it was not scheduled on a specific day. She stated the assessment would generate in the electronic medical record for the nurse to know it was assigned so she was not able to state why the Weekly Skin Review was not completed for Resident #40.

During an interview on 1/31/22 at 11:07 am Nurse #8 revealed she observed a sacral pressure ulcer for Resident #40 upon admission but was unable to state why she did not document on the admission assessment. Nurse #8 stated she was not aware of foot wounds for Resident #40. Nurse #8 reported the Weekly Skin Review was required to be completed for all types of wounds and it was done weekly. She was unable to state why the Weekly Skin Review was not completed for Resident #40.

During an interview on 1/31/22 at 12:49 pm the Wound Nurse revealed she was not aware Resident #40 had not been seen by the wound clinic since December and she was not able to state if the physician was aware. She stated Resident #40 was COVID positive in the

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beginning of January and the wound clinic would not take COVID positive at the office. The Wound Nurse stated that she did not measure the sacral pressure ulcer for Resident #40 because the physician did not ask her to. She was unable to state why she did not obtain wound measurements of sacral pressure ulcer or new observed wounds to the foot to notify the physician of the status of Resident #40 ' s wounds. The Wound Nurse did not recall if she received information from the wound clinic regarding treatment recommendations, low-air-loss mattress, and turning and repositioning for Resident #40. She reported nursing was expected to put a copy of the wound clinic consult report under her door, but it was not being done. She stated the administration was aware of the problem. The Wound Nurse stated she did not try to contact the wound clinic to obtain a copy of the report when Resident #40 returned from the appointments.

During an interview on 1/31/22 at 4:11 pm the Regional Director of Operations revealed the expectation was for all wounds to be discussed in clinical meeting and weekly during the risk meeting. She is not certain when the facility had the risk meeting, but wounds would have been discussed including interventions and progress of wounds. The Regional Director of Operations stated the low-air-loss mattress was placed for Resident #40 on 1/28/22.

Record review of Physician #1 ' s progress note dated 1/31/22 revealed Resident #40 was seen via telehealth for follow-up to sacral pressure wound. Physician #1 ' s assessment revealed diagnoses of failure to thrive, and inanition (lack of nourishment) for Resident #40.

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Review of Weekly Pressure Wound Observation Tool dated 1/31/22 completed by Wound Nurse revealed the following wound information and measurements:

Wound #1: Sacral pressure wound, worsening. Measurements 12.4 x 11.8 x 1 cm, slough and necrotic (dead) tissue.

Wound #2: New wound to right heel, deep tissue injury, blister. Measurements 2.4 x 2.1 x 0 cm.

Wound #3: New wound to left lateral foot, unstageable with necrotic tissue. Measurements 3.5 x 3.6 x 0 cm.

Wound #4: New wound to right hip, stage 2. Measurement 2.5 x 2.5 x 0 cm.

Wound #5: New wound to right medial foot, unstageable with necrotic tissue. Measurements 2.8 x 3.0 x 0 cm.

During an interview on 2/1/22 at 6:45 am Nurse #11 revealed Resident #40 had a pressure ulcer to her sacrum but was not aware of other wounds. She stated she did not normally complete the Weekly Skin Assessment for Resident #40 because she worked the overnight shift, and it was normally completed on day shift.

During an interview on 2/1/22 at 9:38 am the DON revealed the Wound Nurse was responsible to complete the Weekly Pressure Wound Observation. She stated the Wound Nurse rounds with the in-house wound provider and was responsible to complete the assessment for all residents with pressure ulcers including any

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resident being seen by wound clinic. The DON stated the Wound Nurse was to review the wound clinic recommendations and order changes and was responsible to communicate with the physician and floor nurse. The DON reported the floor nurse assigned to Resident #40 was to complete the Weekly Skin Review as scheduled.

During an interview on 2/1/22 at 10:06 am Physician #1 revealed he would review wound clinic reports that were given to him and determine if new orders were needed. Physician #1 stated the Wound Nurse would review when he was not in facility and contact him when new orders needed. He does not recall receiving information from the wound clinic reports from 11/30/21 or 12/14/21 with the recommendations for Resident #40 treatment and to have a low-air-loss mattress but if he was told this recommendation he would approve the order for the mattress. Physician #1 reported the Wound Nurse completed a video telehealth visit on 1/31/22 and he observed the wounds and provided new orders for treatment and wound clinic consult for Resident #40.

During an interview on 2/2/22 at 1:06 pm the Regional Clinical Nurse revealed the skin assessment was to be completed upon admission for all residents and documented in the admission assessment. She was unable to state why the Weekly Skin Review and the Weekly Pressure Wound Observation Tool was not completed as required. She stated the Wound Nurse was responsible to complete both assessments for Resident #40. The Regional Clinical Nurse state the Wound Nurse was responsible to manage all wounds in the facility and she was responsible to review consult

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F 686	Continued From page 59 information for Resident #40 from the wound clinic. During an interview on 2/3/22 at 1:20 pm the Wound Clinic Nurse revealed that Resident #40 was seen in the clinic for management of a sacral pressure wound. He did not see any documentation or recall Resident #40 having wounds on her feet. He stated the facility received a call before the resident left the clinic with appointment information including measurements, treatment, interventions, and follow-up appointment. He stated the facility sent a carbon consult sheet that was also completed and sent back with Resident #40 with the same information. The Wound Clinic Nurse stated the facility was able to contact them if any questions regarding the appointment or if they did not receive the recommendations and information would be sent to the facility.	F 686		
F 689 SS=K	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 record review, staff interview and observation, the facility failed to provide supervision to prevent residents with severe cognitive impairment who displayed exit seeking behaviors from exiting the facility unsupervised	F 689	1) Based on record review, staff interview and observation, the facility failed to provide supervision to prevent Resident #21 and Resident #29, residents with severe cognitive impairment who	3/8/22

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F 689	Continued From page 60 for 2 of 2 residents (Resident #21, Resident #29) reviewed for wandering behavior. The facility also failed to implement 1 to 1 supervision for Resident #29. Immediate jeopardy began for Resident #21 on 1/11/22 when he exited the facility unsupervised and was observed by police near a local gas station approximately 0.75 miles from the facility at night. Immediate Jeopardy began for Resident #29 on 1/29/22 when he exited the facility unsupervised while he was supposed to be on 1 to 1 staff supervision. Immediate Jeopardy was removed on 2/2/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee and agency in-services, orientation, and training. The findings included: 1. Resident #21 was admitted to the facility on 10/8/21 with diagnoses that included vascular dementia with behavioral disturbance and difficulty in walking. The Admission Minimum Data Set (MDS) dated 11/4/21 indicated Resident #21's cognition was severely impaired. Resident #21 exhibited wandering behavior 1 to 3 days of the 7 days look back period. Resident #21 required supervision with one person assist for ambulation. Resident #21 received antipsychotic medication 6 of the 7 days during the MDS look back period.	F 689	displayed exit seeking and wandering behaviors, from exiting the facility unsupervised. On 1/11/22 Resident #21 was found unsupervised approximately 0.75 miles away from the facility by local law enforcement and returned to the facility at 8:30 PM with no injuries. Resident #21 returned to the facility at approximately 8:30 PM on 01/11/22. A full head to toe assessment was performed by Nurse #6 with no identified injuries. Resident #21‘s vital signs were within normal limits upon return. Resident #21 was placed on 15-minute checks, a wander guard was placed, the licensed nurse completed an updated Wandering Risk Assessment and care plan was updated to add use of wander guard to right leg. On 1/11/22 at 8:35pm, licensed nurse notified the Director of Nursing and resident responsible party (wife) of the incident and residents safe return and interventions for increased supervision to ensure resident safety. The Director of Nursing notified Administrator and the Medical Director was notified at 8:40pm. On 1/12/22, the Administrator conducted an Ad Hoc Quality Assurance Committee meeting with department heads to discuss incident, review elopement policy and initiate a performance improvement plan based on root cause analysis. Root cause analysis determined that the facility failed to ensure that increased supervision is provided for residents who are cognitively impaired and exhibit exit seeking and wandering behaviors are moved from the	

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Review of a behavior note dated 11/5/21 indicated that staff tried to redirect Resident #21 several times from going in other resident's rooms. Resident #21 became aggressive, grabbed staff arm, and scratched staff leaving open scratches to their arms.

A care plan dated 11/5/21 revealed a focus of elopement risk/wanderer (vascular dementia) related to disorientation to place and attempts to leave facility unattended. The goal was for Resident #21 not to leave facility unattended through the review date. The interventions included:
-Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.
-Ensure that the area that resident wanders in is safe.
-Report to MD changes in resident behavior.

Review of the medical record revealed that Resident #21 was transferred to the facility from a sister facility due to his exit seeking behavior and need for a special care unit. Review of a nursing note dated 1/6/2022 revealed Resident #21 was transferred from the SCU (Special Care Unit) to the COVID unit on 1/6/22.

Resident #21's care plan revealed no new interventions were implemented related to wandering/exit seeking when he was moved from the secured unit to the COVID unit.

On 1/27/22 at 8:30 AM an observation was conducted of the COVID unit. The COVID unit had one closed door at the front of the unit that led to the general population units. This door at the front of the unit did not alarm when opened.

secured unit to the unsecured unit. On 1/31/22, the root cause was revised by the Administrator, Director of Nursing, Regional Director of Operations and Regional Director of Nursing with additional root cause findings that the facility failed to ensure that there was an appropriate response system including 24/7 monitoring of doors when the door alarm system and egress was not properly functioning.
Resident #21 remained on isolation Covid unit with wander guard in place and 15-minute checks continued until resident returned to secured unit on 1/17/22. On 1/17/22, resident #21's Wandering Risk Assessment was updated and wander guard was removed.
On 1/29/22, while Resident #29 was assigned to be on 1:1 supervision, he was found unsupervised on the sidewalk of the road in front of the facility by a nurse aide coming in late to work at 7:30 AM. He returned to the facility with no injuries.
On 1/29/22, the licensed nurse assessed notified the resident representative, physician, administrator and standing director of nursing of unsupervised exit.
On 1/31/22, the Regional Director of Operations verified current 1:1 supervision schedule for ongoing coverage For Resident #29 and began immediate staff education on the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage and the process during staff breaks and in the event of call-outs or late arrivals and

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F 689	Continued From page 62 The COVID unit had one exit door at the end of the unit that led to the exterior of the building. This door alarmed when pushed on and required a numerical code to be entered for the alarm to stop. An interview was conducted with NA #4 on 1/27/22 at 11:30 AM. NA #4 revealed that she had worked the 7:00 AM to 3:00 PM on 1/11/22. NA #4 stated she was aware of Resident #21's exit seeking behaviors when he was moved to the COVID unit. NA #4 stated Resident #21 regularly came out of his room and walked the hallway and was redirected back to his room. NA #4 stated that she would try to figure out what Resident #21 was looking for and would attempt to assist him. NA #4 stated Resident #21 could be easily redirected. She stated that Resident #21 had not displayed any aggressive behaviors towards her. NA #4 indicated there was malfunction on the exit door at the back of the unit on 1/11/22. She explained the door opened as soon as pushed and the alarm went off instead of waiting the normal 15 seconds before the door lock released and the door opened. NA #4 stated she was made aware of the issue with the doors locking by Nurse #8. An interview was conducted with Nurse #8 on 1/27/22 at 11:38 AM. Nurse #8 stated that she had worked with Resident #21 on 1/11/22 from 7:00 AM to 7:00 PM. Nurse #8 stated Resident #21 was up walking around the unit and stated he wanted to leave. Nurse #8 stated that she walked Resident #21 back to his room. Nurse #8 stated Resident #21 had opened the door at the front of the COVID unit (led to another unit in the facility and was not alarmed) and when she called his name he turned around and headed back inside	F 689	reporting concerns to Administrator or Director of Nursing immediately. On 2/1/2022, the Administrator (telephonically), Director of Nursing, Regional Director of Operations, Regional Director of Clinical Services and Medical Director (telephonically) conducted an Ad Hoc Quality Assurance Performance Improvement meeting to discuss root cause analysis of Resident #29 exiting the facility unsupervised on 1/29/22 and to implement additional corrective action to ensure sufficient staffing to provide 1:1 supervision until determined otherwise by the physician and IDT. Root cause analysis determined that the facility failed to maintain continuous resident supervision for Resident #29 who was assigned to have 1:1 monitoring during a shift change when Receptionist #1 left Resident #29 unsupervised after Receptionist #2 did not arrive timely and Nurse #9 did not agree to take over. 2) Residents who are cognitively impaired and exhibit exit seeking and wandering behaviors are at risk of exiting the facility. The following plan has been formulated to address this issue: On 1/11/22 at approximately 9:00pm, the charge nurse completed a 100% census verification and resident roll call was completed to ensure resident safety. All residents were accounted for and safe. Elopement drills were also completed on 1/12/22 by the Regional Director of Clinical Services. On 1/11/22 at approximately 9:30pm, the Maintenance Director arrived at the facility	

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the unit. Nurse #8 stated that she reported to Nurse #7 about Resident #21 trying to go out the COVID unit front door. Nurse #8 stated she was made aware of Resident #21's exit seeking behaviors when he was moved to the COVID unit. Nurse #8 stated the staff would redirect Resident #21 when he started walking in the hallway. Nurse #8 stated that she last saw Resident #21 at approximately 7:20 PM and he was on the bed in his room. Nurse #8 stated she was made aware that the lock on the exit door at the end of the COVID unit (that led to the exterior of the facility) was not working correctly during report with Nurse #7 on 1/11/22. Nurse #8 explained that the door would open as soon as pushed on and the alarm went off instead of waiting the normal 15 seconds before the door released and would open.

An interview was conducted with NA #3 on 1/28/22 at 9:23 AM. NA #3 stated she was made aware that Resident #21 had exit seeking behaviors when he was moved to the COVID unit. She indicated staff would redirect Resident #21 to his room. NA #3 stated Resident #21 would wander up and down the hallway and try to push open the exit doors. She spoke about the COVID unit reporting that staff regularly used the door at the end of the unit to enter and exit the facility. She indicated the door alarmed when it was opened. She explained that the alarm system panel was in another area of the building and staff on the COVID unit could not view the panel to see which location alarm was sounding, but they could punch in a code at the COVID unit exit door to turn the alarm off. NA #3 stated that she was made aware by Nurse #8 that there was a malfunction with the exit doors on 1/11/22 causing the door to open and alarm as soon as it

and completed a 100% door and alarm audit to ensure proper function and all doors observed to be properly alarming, but the 15-second egress was not properly functioning. On 1/7/22, all doors and alarms were confirmed to be properly functioning and recorded by the Maintenance Director. On 1/9/22, the fire alarm was sounding and the Maintenance Assistant verified all doors to be properly alarming, however the 15-second egress was not properly functioning, allowing the door to open with only a 1-2 second delay once door pressed. The disfunction was related to an electrical circuit board shorting out from the storm. The facility immediately implemented and documented a fire watch code (15-minute door checks) on 1/9/22. On 1/17/22, the egress was repaired and properly functioning.
Effective 1/17/22 in the event of door alarm or egress malfunction, the facility will implement and document 24/7 continuous door monitoring by staff as designated by the Administrator until door and alarm system are repaired and properly functioning.
Beginning 2/1/22, the Director of Nursing and Regional Director of Nursing completed elopement education with all current facility and agency staff, including dietary, maintenance and housekeeping. Education included the Elopement Policy and providing effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Education also included examples

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F 689	Continued From page 64 pushed on instead of waiting the 15 seconds before the door released and would open. NA #3 stated that she recalled seeing Resident #21 in his room after dinner on 1/11/22 because she picked up his tray. She stated Resident #21 was laying on his bed with a plaid shirt, pants, and socks on. The NA stated he had a pair of flip flops on the floor at the bedside. NA #3 stated Resident #21 had attempted to exit the COVID unit through the front door on 1/11/22 just before 7:00 PM. The NA stated that Nurse #8 assisted Resident #21 back to his room. NA #3 stated Nurse #7 came in at approximately 7:30 PM. She stated she heard an alarm when Nurse #7 came in and the nurse punched in the code to turn off the alarm. NA#3 stated at that time she was in the clean room (a room that is free of contamination) which was located 2 doors from the COVID unit exit door and did not see anyone pass the door during that time. NA#3 stated at approximately 7:40 PM Nurse #8 exited the building at the end of the COVID unit and the alarm did not go off. She revealed she did not report to anyone that the alarm didn't sound at when Nurse #8 left. NA #3 stated Nurse #7 left the facility through the COVID unit back door and stated she was going to get something to eat at approximately 7:45 PM and the alarm went off when she exited. NA #3 stated she after Nurse #7 left (approximately 7:45 PM) she was the only staff on the COVID unit until NA #5 came in. NA #3 reported that she heard the alarm go off for the COVID unit back door at approximately 8:00 PM when NA #5 came in. NA #3 stated that she and NA #5 were on the hall because Nurse #7 had not returned from getting her food. NA #3 stated she heard the COVID unit back door alarm at approximately 8:20 PM when Nurse #7 came back from getting her lunch. NA #3 stated Nurse #7 went back out	F 689	of effective techniques for resident redirection, effective monitoring of residents, supervision to ensure resident safety, response system in the event of a resident elopement, response system of a facility fire watch (15-minute door checks) and timely response to door alarms. facility and agency staff will not be permitted to work until receiving education On 2/1/22, the Director of Nursing and MDS Coordinator completed an audit of residents at risk of exiting the facility unsupervised who are cognitively impaired and exhibit exit seeking and wandering behaviors to ensure appropriate supervision and safety. For residents identified at risk for elopement, an updated Wandering Risk Assessment was completed by the licensed nurse and care plans updated to ensure appropriate interventions implemented based on resident risk. The Director of Nursing updated the Elopement Risk Binder to contain resident profiles, photographs, current Wandering Risk Assessment and care plan and placed binders at the nurses station and front lobby. Effective 2/1/22, all residents will be assessed for elopement risk by a Licensed Nurse upon admission, quarterly and with changes in resident condition. Residents identified at risk with exit seeking and wandering behaviors will have a care plan in place to ensure safety and profile, photo, Wandering Risk Assessment and care plan will be placed in the Elopement Binder at the nurses station and front lobby. Residents with wander guards will be monitored every	

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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 689	Continued From page 65 the COVID unit back door to get her computer and a bag. She stated Nurse #7 brought her belongings in and went inside the clean room to place them down. NA #3 stated Nurse #7 returned to the door and punched in the code to turn off the alarm. NA #3 stated she went to lunch at approximately 8:30 PM. NA #3 stated she did not know that Resident #21 was not in the building. Review of the 911 Communications Report dated 1/11/22 at 8:04 PM revealed that Resident #21 was seen walking in the middle of the road wearing grey sweatpants and blue shirt. The report further revealed Resident #21 had exited the facility from the COVID unit at the back of facility. A review of the weather conditions per Local Condition's website (www.localconditions.com) for Ahoskie's weather history indicated the temperature on 1/11/22 at 7:35 PM was 24 degrees Fahrenheit, 69 % humidity and there was no precipitation. An interview was conducted with the receptionist on 1/28/22 at 9:32 AM. The receptionist revealed that she received a phone call from a local police officer on 1/11/22 at approximately 8:00 PM. She stated that the police officer asked her if the facility had a resident by Resident #21's name. The receptionist stated that she reviewed the resident census and stated that there was a resident that resided there with that name. The receptionist reported that the officer told her Resident #21 was out at a local service station. She stated the officer informed her that the precinct received a call about a suspicious person. The receptionist stated that she placed	F 689	shift for placement and every day for function by the licensed nurse. Effective 2/1/22, residents with exit seeking and wandering behaviors who have an increased need for monitoring including a change in room location from the secured unit to the unsecured unit will be reassessed by the licensed nurse and care plan revised as appropriate to ensure increased interventions are implemented to ensure resident safety. This may include, but is not limited to, the addition of a wander guard, 15-minute checks or 1:1 observation as determined appropriate to ensure resident safety and supervision. Effective 2/1/22, the facility will ensure proper functioning and monitoring of the wander guard system and facility doors and alarm system. The Maintenance Director, Maintenance Assistant or Administrator will perform and document door and alarm safety checks at least weekly. Effective 2/1/22, the facility will conduct elopement drills on all shift monthly to ensure continued staff understanding of the facility process in the event of an elopement. 3) Effective 2/1/22, Maintenance Directors, and Assistance Maintenance Directors will receive education by the Administrator, Director of Nursing or Regional Director of Nursing on the wander guard system, door security system and process for system malfunctions. Education to include wander guard system and doors and alarm safety	

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the officer on hold and called the COVID unit and spoke to Nurse #7. The receptionist stated that she asked Nurse #7 if Resident #21 was in his room. The nurse stated that she would look, and Resident #21 was not in his room. The receptionist stated that officer did not bring Resident #21 to the front door, so she did not see him when he returned.

An interview was attempted with the local police officer who contacted the facility, but he was unable to be reached.

An interview was conducted with Nurse #7 on 1/28/22 at 7:15 AM. Nurse #7 stated she received a call on 1/11/22 at approximately 8:30 PM to pick up the COVID unit cell phone. Nurse #7 stated that she spoke with someone, unable to recall who she spoke with, who told her they had Resident #21. Nurse #7 stated she did not know what time Resident #21 had gone out the door. Nurse #7 stated that when you hear an alarm sounding, there is no way to see which door the alarm is sounding for. Nurse #7 stated that she did not see anyone leave out the building and she parked in the back of the facility near the COVID exit door. Nurse #7 stated Resident #21 was wearing blue shirt and grey sweatpants when the police brought him back to the facility. She was unsure of whether Resident #21 had on a long sleeved or short sleeved shirt. Nurse #7 stated she was not sure if Resident #21 was wearing shoes. Nurse #7 stated that she was told that Resident #21 was found down by the gas station. Nurse #7 stated that the DON called her and informed her of what to do for Resident #21. A head-to-toe assessment was conducted, and Resident #21 had a scrape to his knee but no other injuries. Nurse #7 stated that he was placed

checks weekly and 24/7 continuous door monitoring shall be implemented and documented in the event of malfunction until system is fixed. Effective 3/7/22, newly hired Maintenance Directors will receive education upon hire and prior to working during the orientation process.

Effective 2/1/22, the facility implemented a revised Safety Watch System to ensure continuous staff supervision for residents requiring 1:1 observation. The Administrator will ensure the 1:1 staff coverage is posted on the Safety Watch Schedule and assigned staff will utilize the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will utilize interventions per resident plan of care to distract, redirect and intervene as appropriate. Any concerns with following the plan of care will be reported to the Physician and Administrator and/or Director of Nursing immediately and additional interventions implemented as necessary.
Beginning 2/1/22, the Regional Director of Operations and Regional Director of

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F 689	Continued From page 67 on 15-minute watch for his safety. Review of a nursing note dated 1/12/22 at 7:11 AM revealed Resident #21 returned to the facility at 8:30 PM on 01/11/22. A full head to toe assessment was performed by Nurse #8 and Resident #21 was placed on 15-minute checks to ensure safety. Resident #21's vital signs were within normal limits. Resident #21's temperature was 97.4 and he had a small scrape to his left knee which was cleaned and required no dressing. Resident #21 remained on isolation for COVID. An interview was conducted with the DON on 1/27/22 at 9:40 AM. The DON stated that she was made aware of an issue with the locking of the exit doors on Sunday night 1/9/22. Staff reported that the alarm would sound when the door was pushed on and immediately opened instead of waiting the normal 15 seconds before you could open the exit door. The DON stated that the staff that work in the COVID unit were to use this exit to go in and out the unit. She indicated staff were trained to look to see who was at or around the door when the alarm sounded The DON stated that on 1/11/22 Receptionist #1 called her and stated the police had found Resident #21 and bought him back to the facility. The DON stated that she was not told where Resident #21 was when the police found him. The DON stated she was never notified that the COVID unit exit door opened without alarming at approximately 7:40 PM that evening (1/11/22) and indicated the staff should have reported any issues with the doors to maintenance and herself. The DON stated Resident #21was admitted to the special care unit (secured unit) because of his exit seeking behaviors. She revealed when he	F 689	Clinical Services will provide education to facility and agency staff on the Safety Watch System and the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage. Education will include the process of utilizing the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will receive education on utilizing interventions per resident plan of care to distract, redirect and intervene as appropriate and reporting any concerns with following the plan of care and Safety Watch System to the Administrator and/or Director of Nursing immediately. Staff not educated by 2/1/22 will receive education prior to working on the floor. Effective 2/1/22, staff assigned to provide 1:1 resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of	

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F 689	Continued From page 68 was transferred to the COVID unit (1/6/22) there no increase to the frequency of monitoring for Resident #21 was transferred. An interview was conducted on 1/26/22 at 4:11 PM with Maintenance Director. The Maintenance Director stated that the recent cold weather had caused the alarm system circuit board to burn up. He stated beginning on 1/9/22 the exit doors would continue to alarm but would open immediately instead of locking and waiting the 15 seconds for release per the egress code. The Maintenance Director stated that all staff including the DON and Administrator were made aware of the issue with the locking mechanism on the door. The staff were completing "Firewatch" every 30 minutes until the locking mechanism was fixed. The Maintenance Director stated the staff should have reported any issues with the doors to maintenance and he was never notified that the door opened without alarming at approximately 7:40 PM on 1/11/22. The Maintenance Director stated that he was called at 1/11/22 at 9:18 PM to come in to look at the doors and all alarms were working. The Director reported that Resident #21 was back in the building at that time. An interview was conducted with the Administrator on 1/27/22 at 1:11 PM. The Administrator stated that Resident #21 resided on the secured unit when he was admitted in October. She stated that Resident #21 was transferred from a sister facility due to his wandering behavior and the need for a locked unit. The Administrator stated that she was aware the exit door latch time had decreased from 15 seconds to 2 seconds on 1/9/22. The Administrator stated staff were to check the doors	F 689	call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. 4) Effective 2/1/22, the Maintenance Director will audit the wander guard system and door and alarm system weekly for proper function for 3 months. This will be documented in the TELS system (electronic system used for maintenance tracking) Effective 2/1/2022, the facility Administrator or Director of Nursing will conduct weekly questionnaires for 3 months with five (5) facility or agency staff to ensure proper understanding of providing effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Effective 2/1/22, the Administrator, Director of Nursing or Manager on Duty will and will review the Safety Watch Log to ensure continuous supervision is being provided and documented for residents assigned 1:1 observation. Monitoring will be conducted weekly for 3 months. The Administrator will report results of monitoring with the Quality Assurance Process Improvement Committee monthly and will make changes to the plan as necessary to maintain compliance with preventing resident accidents/hazards. Date of compliance: 3/8/22	

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every 30 minutes and place the findings on the Firewatch log (checks every 30 minute). The Administrator stated that she had not been made aware that Resident #21 had exhibited exit seeking behaviors during the day shift on 1/11/22. The Administrator stated staff should have reported Resident #21's exit seeking behavior to the DON and placed Resident #21 on more frequent observations. The Administrator stated she was made aware of Resident #21's elopement at approximately 8:30 PM when the staff notified her that the police were bringing him back to the facility. She indicated that a head-to-toe assessment was completed on Resident #21 and there was no injury. The Administrator stated that Maintenance Director came out to the facility to verify that the alarm was working. She stated that she remained on the telephone while the Maintenance Director walked and checked each door and there were no identified issues with the alarm

2. Resident #29 was admitted to the facility on 5/10/21 with diagnoses that included dementia with behavioral disturbance.

The Quarterly Minimum Data Set (MDS) dated 10/26/21 indicated Resident #29's cognition was severely impaired. Resident #29 did not exhibit wandering behavior during the look back period. Resident #29 was independent with ambulation and used a walker as mobility device.

A care plan updated 6/8/21 and currently in place revealed a focus of elopement risk related to disoriented to place, dementia with behavioral disturbances, and wandering. The goal was for Resident #29 will not leave facility unattended and his safety will be maintained through the review

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date. The interventions included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book.

Documentation of behavior observations, including wandering/pacing/exit seeking for Resident #29 were ordered by the physician for every shift on 10/21/21.

Review of a behavior note dated 12/14/21 indicated that staff tried to redirect Resident #29 away from an exit door he opened setting off the alarm. Resident #29 became aggressive, swung at the staff member with his hand and then his walker.

Resident #29 was moved from the secured memory care unit to a general hall on 1/24/22 after a resident-to-resident altercation per the medical record. There were no new interventions related to wandering implemented when he was moved to the unsecured unit.

On 1/28/22 Resident #29 was placed on 1:1 monitoring after he became combative with staff.

Review of a nursing note dated 1/29/22 at 8:26 AM by Nurse #9 revealed Resident #29 was noted to have walked out of the facility's front door after staff and redirected back inside. Physician #1, interim DON, responsible party (RP) and the Administrator were notified.

A review of the weather conditions per Local Condition's website (www.localconditions.com) for Ahoskie's weather history indicated the temperature on 1/29/22 at 7:35 AM was 31 degrees Fahrenheit, 83% humidity and there was

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no precipitation.

An interview was conducted with Nurse #1 on 1/31/22 at 2:50 PM, and she stated she was in the front lobby speaking to Receptionist #1 on the morning of 1/29/22 (time unknown). Receptionist #1 stated she was going to try to wait for the oncoming receptionist to relieve her from supervising Resident #29. Nurse #1 stated she did not agree that she would watch Resident #29 because the NA she was working with was pulled to another unit due to insufficient staffing. When Nurse #1 left the lobby to go back to her unit, Receptionist #1 and Resident #29 were in the lobby (time unknown).

Receptionist #1 was interviewed on 1/31/22 at 2:46 PM, and she revealed she was asked to stay over Friday night (1/28/22) by the Administrator to monitor Resident #29 1 on 1 but was not instructed when to stay until or who was to relieve her. She stated Nurse #1 agreed to watch Resident #29 when she left the building at 6:30 AM. She stated that was the last time she saw him sitting in the front lobby.

Nurse #10 was interviewed on 2/1/22 at 11:30 AM, and he revealed he worked the overnight shift on 1/28/22. He stated Resident #29 had been fighting with staff on the evening of 1/28/22 and was now on 1:1 monitoring. Nurse #10 further stated he last saw Resident #29 in the front lobby when he left the building at 7:30 AM on 1/29/22 and did not remember seeing Receptionist #1 with him. When Nurse #10 needed to leave the building without a receptionist present, he used the code to unlock the front door and pushed the door himself without using the automated release button. The

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front door was secured with a code. He stated he was certain there was no one behind him when he walked out because he stood out in front of the building when he left and took a picture of his schedule to send to his agency. Nurse #10 indicated his car was parked in front of the building.

An interview was conducted with Nurse #9 on 1/31/22 at 11:21 AM, and she revealed after she received report for the morning shift of 1/29/22 and checked on her residents, which included #29, she walked toward the lobby to locate Resident #29. At that time, NA #5 was escorting him back into the building, and she did not know how long he was out of the building. Nurse #9 stated she performed a skin check on him but did not document the assessment. She contacted the Administrator immediately after Resident #29 returned (time unknown) and was told Receptionist #1 was assigned to monitor him 1:1. She stated Receptionist #1 had already left the facility, and she was unsure if the oncoming receptionist had arrived.

During an interview with nurse aide (NA) #5 on 1/31/22 at 11:41 AM, she revealed she was late to work and arrived at the facility at 7:30 AM on 1/29/22. She stated she observed Resident #29 walking alone down the sidewalk in front of the building where cars park on the street just in front of the parking lot. He was walking towards the main road, and she met him while she was in her vehicle after recognizing him. NA #5 stated he was not wearing a jacket, but he was wearing long sleeves, pants, and shoes. She indicated it was cold outside and he appeared cold. He also seemed agitated when she instructed him to come inside, he slammed his walker down on the

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ground and that is when she called the facility's main number. No one answered the phone, so she contacted the Director of Nursing (DON) directly who came outside to help her. NA #5 was only with him a few minutes from the time she arrived to when Resident #29 was escorted back inside. NA #5 stated she was not sure how Resident #29 got out of the building, and the front door was always locked.

During an interview with the DON on 1/31/at 12:58 PM, she revealed that she was made aware of Resident #29 needing 1:1 supervision indefinitely by the Administrator on 1/28/22 at 6:00 PM. She stated she arrived to work at 7:00 AM on 1/29/22 but forgot to clock in. When she used the punch clock in the lobby at 7:27 AM, she saw Resident #29 in the lobby. The interview continued on 1/31/22 at 6:17 PM, and the DON stated she did not see a 1:1 monitoring partner with him. Receptionist #1 was assigned to monitor Resident #29, but she left at 6:30 AM before the oncoming receptionist arrived. She further stated Receptionist #1 was supposed to stay with Resident #29 until someone relieved her, but she did not know who that person should have been. She then went back to her hall assignment to give Nurse #10 report and was contacted by NA #5 at 7:36 AM via telephone that Resident #29 was outside by himself. She then went to the front lobby and saw NA #5 and Resident #29 entering the front door. Nurse #9 was assigned to provide care for Resident #29, who was also present in the lobby at this time.

An interview was conducted with the Administrator on 1/31/22 at 2:01 PM, and she revealed Resident #29 was placed on 1:1 monitoring Friday evening (1/28/22) at 6:00 PM.

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She stated Receptionist #1 accepted the supervision assignment and was willing to stay through the night until Resident #29 was handed off to the oncoming receptionist. The Administrator stated she was supposed to stay until she handed him off to the oncoming receptionist. The Administrator stated she was notified by Nurse #9 at 7:49 AM about Resident #29's elopement. She was told there were no nurse aides on duty on East Hall, the hall Resident #29 resided on, for the first shift which began at 7:00 AM. She stated she then called the DON at 7:56 AM. The Administrator stated Nurse #10 left the building after his shift ended and may have left the door open when Resident #29 got out.

The Corporate Consultant was notified of immediate jeopardy on 1/31/22 at 7:08 PM. The facility provided the following Credible Allegation of immediate jeopardy removal. Beginning 2/1/22, the Director of Nursing and Regional Director of Nursing completed elopement education with all current facility and agency staff, including dietary, maintenance and housekeeping. Education included the Elopement Policy and providing effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Education also included examples of effective techniques for resident redirection, effective monitoring of residents, supervision to ensure resident safety, response system in the event of a resident elopement, response system of a facility fire watch (15-minute door checks) and timely response to door alarms. Facility and agency staff will not be permitted to work until receiving education.

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On 2/1/22, the Director of Nursing and MDS Coordinator completed an audit of residents at risk of exiting the facility unsupervised who are cognitively impaired and exhibit exit seeking and wandering behaviors to ensure appropriate supervision and safety. For residents identified at risk for elopement, an updated Wandering Risk Assessment was completed by the licensed nurse and care plans updated to ensure appropriate interventions implemented based on resident risk. The Director of Nursing updated the Elopement Risk Binder to contain resident profiles, photographs, current Wandering Risk Assessment and care plan and placed binders at the nurse station and front lobby.

Effective 2/1/22, all residents will be assessed for elopement risk by a Licensed Nurse upon admission, quarterly and with changes in resident condition. Residents identified at risk with exit seeking and wandering behaviors will have a care plan in place to ensure safety and profile, photo, Wandering Risk Assessment, and care plan will be placed in the Elopement Binder at the nurse station and front lobby. Residents with wanderguards will be monitored every shift for placement and every day for function by the licensed nurse.

Effective 2/1/22, residents with exit seeking and wandering behaviors who have an increased need for monitoring including a change in room location from the secured unit to the unsecured unit will be reassessed by the licensed nurse and care plan revised as appropriate to ensure increased interventions are implemented to ensure resident safety. This may include, but is not limited to, the addition of a wanderguard, 15-minute checks or 1:1 observation as

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determined appropriate to ensure resident safety and supervision.

Effective 2/1/22, the facility will ensure proper functioning and monitoring of the wanderguard system and facility doors and alarm system. The Maintenance Director, Maintenance Assistant or Administrator will perform and document door and alarm safety checks at least weekly.

Effective 2/1/22, the facility will conduct elopement drills on all shifts monthly to ensure continued staff understanding of the facility process in the event of an elopement.

Effective 2/1/22, newly hired Maintenance Directors, Assistance Maintenance Director and Administrators will receive education by the Administrator, Director of Nursing or Regional Director of Nursing on the wanderguard system, door security system and process for system malfunctions. Education to include wanderguard system and doors and alarm safety checks weekly and 24/7 continuous door monitoring shall be implemented and documented in the event of malfunction until system is fixed.

Effective 2/1/22, the facility implemented a revised Safety Watch System to ensure continuous staff supervision for residents requiring 1:1 observation. The Administrator will ensure the 1:1 staff coverage is posted on the Safety Watch Schedule and assigned staff will utilize the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log.

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In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will utilize interventions per resident plan of care to distract, redirect and intervene as appropriate. Any concerns with following the plan of care will be reported to the Physician and Administrator and/or Director of Nursing immediately and additional interventions implemented as necessary.

Beginning 2/1/22, the Regional Director of Operations and Regional Director of Clinical Services will provide education to facility and agency staff on the Safety Watch System and the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage. Education will include the process of utilizing the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will receive education on utilizing interventions per resident plan of care to distract, redirect and intervene as appropriate and reporting any concerns with following the plan of care and Safety Watch System to the

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Administrator and/or Director of Nursing immediately. Staff not educated by 2/1/22 will receive education prior to working on the floor.

Effective 2/1/22, staff assigned to provide 1:1 resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained.

Effective 2/1/22, the Maintenance Director will audit the wanderguard system and door and alarm system weekly for proper function. This will be documented in the TELS system (electronic system used for maintenance tracking)

Effective 2/1/2022, the facility Administrator or Director of Nursing will conduct weekly questionnaires with five (5) facility or agency staff to ensure proper understanding of providing effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility.

Effective 2/1/22, the Administrator, Director of Nursing or Manager on Duty will and will review the Safety Watch Log to ensure continuous supervision is being provided and documented for residents assigned 1:1 observation. Monitoring will be conducted daily.

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Effective 2/1/2022, the Administrator or Regional Director of Operations and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

The facility alleges the removal of Immediate Jeopardy on 2/2/22.

The credible allegation of immediate Jeopardy removal was validated by onsite verification on 2/2/22 as evidenced by interviews with direct care, ancillary, and administrative staff, interviews with residents, record review and observations.

Review of the 100% census verification and resident roll call was completed on 1/11/22 and Elopement drill on 1/12/22.

Interviews conducted with nursing, housekeeping, dietary, therapy, medical record and other ancillary staff revealed they had attended training on the door alarm system, elopement education policy and procedures which included monitoring and managing residents with unsafe wandering and risk for elopement. The training included ways to modify behaviors and minimize risk associated hazards to prevent accidents and elopements. The education included tips for elopement prevention and that elopement risk were to be completed by licensed nurses upon admission, quarterly and with changes in condition. Staff education was also provided on 1:1 supervision and the process to follow to ensure resident safety without disruptions in continuous coverage, staff breaks, call outs or late arrivals. Reporting of issues to the Administrator or DON immediately.

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Inservice forms were reviewed and indicated the dates, topics discussed, and the trainer, and included attending staff signatures. No concerns were identified with these forms.

Review of schedule for 1:1 revealed it was started for Resident #29 on 1/27/22 but was not in place at the time of his unsupervised exit. The schedule indicated 1:1 has since been consistently implemented as indicated.

Review of a Wandering Audit revealed that on 2/1/22 a wandering audit was conducted of 100% of the residents.

Review of the wander guard system monitoring was conducted. No issues were identified with these checks.

An observation of the exit door and the locking mechanism was conducted, and the exit door alarmed when pushed but remained locked. After 15 seconds the locking mechanism released so that door was able to be opened.

Resident #21 was observed on 2/2/22 at 11:00 AM in the dining room sitting at the table. A nurse aide was in the dining room and other residents were in the dining room.

Resident #29 was observed on 2/2/22 at 11:23 AM in his room sitting up in the chair and a nurse aide was sitting in the room with Resident #29.

An interview was conducted with the Director of Nursing (DON) on 2/2/22 at 1:50 PM. The DON stated that she was responsible for monitoring the 1:1 tracking tool.

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F 689	Continued From page 81 The facility's Immediate Jeopardy removal date of 2/2/22 was validated.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and dietitian interview the facility failed to act upon dietitian recommendation to clarify diet order for 1 of 1 Residents (Resident #79) reviewed for nutrition. The findings included: Resident #79 was admitted to the facility on	F 692	F692 1. Resident #79 diet orders were implemented 1/30/22. 2. All residents have the potential to be affect. On 2/22/22, Director of Nursing (DON) and Unit Manager completed an audit of all current residents and all Registered Dietitian (RD)	3/8/22

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F 692	Continued From page 82 12/13/21 with diagnoses that included stroke, end stage renal disease, and dysphagia (difficulty swallowing). The Minimum Data Assessment (MDS) dated for 1/3/22 indicated resident was cognitively intact, had difficulty swallowing, and had a gastrostomy tube (tube into stomach used for nutrition if needed) in place. A care plan was initiated on 1/3/22 for dysphagia related to a recent stroke. The care plan included interventions to monitor for signs and symptoms of aspiration and shortness of breath. A review completed on 1/26/22 at 9:07am of Resident #79's Physician orders revealed a diet order was not included. A review was completed on 1/26/22 at 9:30am of Resident #79's electronic medical record (emr). A hospital discharge summary dated 12/13/21 indicated he was on a pureed diet with nectar thick liquids. A dietary/nutrition note dated for 1/10/22 requested Resident #79's diet be clarified by staff due to no diet being in his Physician order list. A lunch meal observation was completed on 1/26/22 at 12:46pm. Resident #79's meal tray consisted of pureed texture food with nectar thick fluids. A review of his meal tray ticket matched the food texture on the meal tray. An interview was completed with Med Aide #5 on 1/27/22 at 11:50am. She indicated there was no diet order listed in the Physician orders for Resident #79. She indicated she would verify with her Nurse a Resident's correct diet.	F 692	recommendations from 1/22/22-2/22/22 to ensure diet orders and RD recommendations accurately transcribed in the electronic medical record and dietary tray ticket. Clarification orders received by the attending physician and transcribed by the licensed nurse as appropriate. 3. By March 7, 2022 the DON and Unit Manager completed education to licensed nurses on ensuring all residents have appropriate and complete diet orders clarified by the attending physician, dietary communication ticket completed and order transcribed into Electronic Medical Record (EMR). Regional Director of Clinical Services educated the clinical management team (includes DON, Unit Manager, MDS Coordinator and Wound Nurse) on responsibilities of following through with RD recommendations. Education included implementation of RD recommendations as ordered by the physician, communication to the dietary department and order transcription into the EMR to reflect changes. The clinical team will review diet orders with each new admission during the morning clinical meeting. RD recommendation will be reviewed during the weekly risk meeting with the IDT. Newly hired licensed nurses or and agency nurses will receive education prior to working or as part of the orientation process. 4. The DON or Unit Manager will monitor diet orders of residents and RD recommendations for all new admissions	

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F 692	Continued From page 83 An interview was completed with the Dietary Manager on 1/28/22 at 10:24am. She stated the Nursing staff brought her newly admitted Residents and readmitted Resident's diet slips to input in the kitchen's meal tray system. She further stated the Resident's diet was printed out on the meal tray ticket for the dietary staff to fix the tray. The Dietary Manager verified Resident #79 was receiving pureed textured food with nectar thick fluids. A telephone interview was completed with the Registered Dietitian (RD) on 1/28/22 at 11:09am. She verified the Resident was reviewed on 1/10/22 due to be a new Resident to the facility. It was discovered a diet order had not been put into the Physician orders in the emr, therefore a diet clarification was requested. The RD stated the Dietitian recommendations were emailed to the Director of Nursing (DON) and Administrator to follow up with the Physicians on. A telephone interview was completed with the DON on 2/1/22 at 9:41am. She indicated she had received the Dietitian recommendations from 1/10/22. She stated she had not been responsible for the recommendations in the past and was not aware with how to handle the recommendations when she started in the position of DON in December 2021. She indicated she expected the nurse admitting the Resident to verify a Resident's diet from the discharging facility, put the diet in the physician's order in the emr, and take a diet slip to the kitchen. An interview was completed on 2/1/22 at 2:40pm with the Speech Language Pathologist. She stated Resident #79 was currently on a pureed	F 692	and RD recommendations for appropriate order transcription in the EMR and dietary tray ticket system. Monitoring will be completed weekly for twelve (12) weeks and as necessary thereafter. The Director of Nursing will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident's tube feeding diet orders and RD recommendation. Compliance date: 3/8/22	

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F 692	Continued From page 84 diet with nectar thick liquids. She further stated she was currently working with him to upgrade his diet to a mechanical soft diet (soft foods) due to his improvement with swallowing. An interview was completed on 2/1/22 at 4:00pm with the Regional Corporations Officer. She stated it was her expectation diet orders were to be put into a Residents Physician order list in the emr when a Resident is admitted, or diet was updated.	F 692		
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 observation, record review, and staff interviews the facility failed to obtain a physician order for the use of supplemental oxygen and failed to post oxygen in use signage on resident door for 1 of 2 residents reviewed for oxygen. (Resident #47). Findings included: Resident #47 was admitted to the facility on 12/2/21 with diagnoses which included chronic respiratory failure, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD).	F 695	F695 1. Resident #47 order was placed for continuous oxygen at 2 liters/minute via nasal cannula for COPD and “oxygen in use” signage placed on her door the Director of Nursing 2/1/2022 2. A review of all residents with oxygen were monitored for appropriate order transcription in the Electronic Medical Record (EMR), and “oxygen in use” signage on the door by the Director of Nursing. Additional “oxygen in use”	3/8/22

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F 695	Continued From page 85 Record review of Resident #47 ' s admission assessment completed by Nurse #8 revealed she was on oxygen at 2 liters per minute (l/min) via nasal cannula (NC). During an interview on 2/3/22 at 2:46 pm Nurse #8 revealed oxygen required a physician order but was unable to state why a physician order was not entered in electronic medical record for Resident #47 upon admission. Resident #47 ' s Minimum Data Set (MSD) Admission Assessment dated 12/8/21 revealed resident was on oxygen. Record review of Resident #47 ' s care plan dated 12/10/21 revealed a care plan for oxygen continuous at 2 l/min via nasal cannula. Record review of physician orders revealed Resident #47 did not have a physician order for oxygen. During an observation on 1/25/22 at 1:36 pm Resident #47 had oxygen via NC at 3 l/min in place and the oxygen in use sign was not posted. During subsequent observations on 1/26/22 at 8:54 am, 1/27/22 at 2:51 pm, and 1/31/22 at 10:43 am, Resident #47 had oxygen via NC at 3 l/min and the oxygen in use sign was not posted. During an interview on 1/26/22 at 2:51 pm Nurse #16 revealed that oxygen required a physician order and that any nurse could obtain the order. She stated the oxygen in use signage was needed for the door. During an interview on 1/27/22 at 9:58 am Nurse	F 695	signage was placed in nursing supply room for easy accessibility. Completed 2/22/22 3. Effective 3/7/22, the Director of Nursing and Unit Manager provided education to all facility and agency licensed nurses on residents that require oxygen therapy must have an “oxygen in use” signage on their door and an order for oxygen usage must be transcribed in EMR. Education included that additional signage located in the nursing supply room for easy accessibility. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process. 4. The Director of Nursing or Unit Manager will complete monitoring of five (5) residents with identified need for oxygen for appropriate order and signage five (5) times weekly for four (4) weeks, weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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F 695	Continued From page 86 #10 revealed that a resident required a physician order for oxygen and a sign was to be placed on the resident door for the oxygen, but she was not sure where the signs were or if the facility had any. During an interview on 1/27/22 at 11:48 am the Director of Nursing (DON) revealed oxygen required a physician order. She stated the floor nurse was responsible to enter the physician orders in the electronic medical record. The DON reported she was not sure if the facility had the oxygen in use signs available for all rooms that needed them. During an interview on 1/27/22 at 5:30 pm Physician #1 stated the nurse was expected to notify him when orders were needed for residents. During an interview on 2/1/22 at 6:45 am Nurse #11 revealed the oxygen in use signs were to be on the door frame of the room but that she does not have access to the signs. She stated the signs are locked in the conference room and not available in the supply closet on units. During an interview on 2/1/22 at 3:56 pm the Regional Director of Operations reported she was not certain a physician order was needed for oxygen but would defer to nursing. During an interview on 2/2/22 at 12:50 pm the DON and Regional Corporate Nurse revealed the oxygen in use signage was placed on the door frame of the resident ' s room.	F 695		
F 725 SS=K	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		3/8/22

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F 725	Continued From page 87 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and physician and staff interviews, the facility failed to have sufficient staffing to prevent and protect Residents #53 and #39 from being physically abused by Resident #29 for 1 of 1 resident reviewed for resident-to-resident physical abuse (Resident #29) and to provide supervision to prevent residents with severe cognitive impairment (Resident #21 and Resident #29)	F 725	1) The facility failed to have sufficient staffing to 1) Prevent and protect Residents #53 and #39 from being physically abused by Resident #29 and 2) to provide supervision to prevent two residents with severe cognitive impairment (Resident #21 and #29) from exiting the facility unsupervised.	

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F 725	Continued From page 88 from exiting the facility unsupervised for 2 of 2 residents reviewed for wandering. Immediate Jeopardy began on 11/08/21 when the facility failed to have sufficient staff to protect residents from physical abuse resulting in Resident #29 placing Resident #53 in a headlock and throwing the resident to the floor. Immediate Jeopardy was removed on 2/2/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee and agency in-services, orientation and training. The findings included: This is cross-referred to: F600: Based on record review and physician and staff interviews, the facility neglected to protect the residents' right to be free from abuse when Resident #29 physically abused Residents #39 and #53. Resident #53 sustained injuries that required Emergency Room evaluation. This was for 1 of 1 resident (Resident #29) reviewed for resident-to-resident abuse. F689: Based on record review, staff interview and observation, the facility failed to provide supervision to prevent residents with severe cognitive impairment who displayed exit seeking behaviors from exiting the facility unsupervised for 2 of 2 residents (Resident #21, Resident #29) reviewed for wandering behavior. The facility also	F 725	2) Because all residents are at risk when the facility fails to provide sufficient staffing to 1) prevent and protect residents from being physically abused by Resident #29 or other residents and 2) to provide supervision: to prevent a residents with severe cognitive impairment (Resident #21 and #29) from exiting the facility unsupervised, the following plan has been devised: On 2/1/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional Director of Operations to discuss root cause analysis of the facilities failure to provide sufficient staffing levels to ensure supervision to keep residents free from physical abuse by other residents and to prevent unsupervised exits from the facility. The facility determined that administration and leadership failed to consider the number, acuity and diagnoses of the facility□s resident population and to implement systems to ensure staffing schedules were adjusted accordingly, to include coverage during staff breaks, late arrivals with shift changes, to factor in the additional staff required to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. 3) On 2/1/22, the Regional Director of Operations provided education to the Administrator and Director of Nursing	

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F 725	Continued From page 89 failed to implement 1 to 1 supervision for Resident #29. On 1/27/22 at 10:10 AM an interview was conducted with Nursing Assistant (NA) #18 who stated she worked on the SCU (Secured Care Unit). NA #18 stated 14 residents were too much for one nurse and one NA to monitor. She indicated that there were multiple resident on the SCU who wandered. She explained if the nurse was passing medications and she was in a room providing care to a resident there was no one to monitor or supervise the residents who were wandering in the hall. On 1/27/22 at 11:42 AM an interview was conducted with the Staffing Scheduler who stated she scheduled one nurse or Medication Aide (Med Aide) and one NA on the SCU, and she would schedule 2 NAs if the census reached 13-14 residents, if she had the staff. The Scheduler further stated if there was not enough staff, then "everyone helps out." The Staff Scheduler stated she used a computer program to do the staffing and the acuity of the unit was not taken into consideration when making out the schedule. The Scheduler stated none of the staff on the SCU have spoken with her about the staffing on the unit. The Interim Director of Nursing (DON) stated in an interview on 1/27/22 at 11:23 AM the staff on the SCU had told her there was not enough staff on the unit. The DON further stated they did not have the additional staff and if the agency staff did not pick up a shift they could not put more staff on the unit. The Administrator was notified of Immediate Jeopardy at F725 on 1/31/22 at 7:21 PM.	F 725	(DON) on daily discussions of sufficient staff scheduling to ensure residents with behaviors towards others and residents exhibiting exit seeking or wandering behaviors are factored in when determining appropriate staffing levels to protect all residents from harm. Education included considering current residents with wandering behaviors and behaviors towards others and additional staff to assign to ensure sufficient staffing to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Effective 3/7/22, newly hired Administrators and DONs will receive education during orientation and prior to working. Effective 2/1/22, the Administrator and Director of Nursing (DON)will discuss residents with behaviors towards others and residents exhibiting exit seeking or wandering behaviors daily to determine appropriate staffing levels to protect all residents from harm. The daily schedule will be adjusted considering current residents with wandering behaviors and behaviors towards others and additional staff will be assigned as determined to ensure sufficient staffing to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Staffing level needs will be communicated to the staff scheduler by the Administrator or DON during daily staff meetings and staff scheduled accordingly by the scheduler. Effective 2/1/22, the facility implemented a	

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F 725	Continued From page 90 The facility provided a credible allegation of Immediate Jeopardy removal on 2/1/22. The allegation of Immediate Jeopardy Removal indicated: Credible Allegation of Immediate Jeopardy Removal: The facility failed to have sufficient staffing to 1) Prevent and protect Residents #53 and #39 from being physically abused by Resident #29 and 2) to provide supervision to prevent two residents with severe cognitive impairment (Resident #21 and #29) from exiting the facility unsupervised. Because all residents are at risk when the facility fails to provide sufficient staffing to 1) prevent and protect residents from being physically abused by Resident #29 or other residents and 2) to provide supervision: to prevent residents with severe cognitive impairment (Resident #21 and #29) from exiting the facility unsupervised the following plan has been formulated to address this issue: On 2/1/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional Director of Operations to discuss root cause analysis of the facilities failure to provide sufficient staffing levels to ensure supervision to keep residents free from physical abuse by other residents and to prevent unsupervised exits from the facility. The facility determined that administration and leadership failed to consider the number, acuity and diagnoses of the facility's resident population and to implement systems to ensure staffing schedules were adjusted	F 725	revised Safety Watch System to ensure continuous staff supervision for residents requiring 1:1 observation. The Administrator will ensure the 1:1 staff coverage is posted on the Safety Watch Schedule and assigned staff will utilize the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will utilize interventions per resident plan of care to distract, redirect and intervene as appropriate. Any concerns with following the plan of care will be reported to the Physician and Administrator and/or Director of Nursing immediately and additional interventions implemented as necessary. Effective 2/1/22, the Regional Director of Operations and Regional Director of Clinical Services will provide education to facility and agency staff on the Safety Watch System and the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage. Education will include the process of utilizing the Safety Watch Log to	

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F 725	Continued From page 91 accordingly, to include coverage during staff breaks, late arrivals with shift changes, to factor in the additional staff required to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. On 2/1/22, the Regional Director of Operations provided education to the Administrator and Director of Nursing on daily discussions of sufficient staff scheduling to ensure residents with behaviors towards others and residents exhibiting exit seeking or wandering behaviors are factored in when determining appropriate staffing levels to protect all residents from harm. Education included considering resident acuity and diagnoses and additional staff to assign to ensure sufficient staffing to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Effective 2/1/22, the Administrator and Director of Nursing will discuss residents with behaviors towards others and residents exhibiting exit seeking or wandering behaviors daily to determine appropriate staffing levels to protect all residents from harm. The daily schedule will be adjusted to consider resident acuity and diagnoses and additional staff will be assigned to ensure sufficient staffing to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Effective 2/1/22, the facility implemented a revised Safety Watch System to ensure continuous staff supervision for residents requiring 1:1 observation. The Administrator will	F 725	document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of callouts or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observation will receive education on utilizing interventions per resident plan of care to distract, redirect and intervene as appropriate and reporting any concerns with following the plan of care and Safety Watch System to the Administrator and/or Director of Nursing immediately. Effective 3/7/22, newly hired facility and agency staff will receive education prior to working during the orientation process. Effective 2/1/22, staff assigned to provide 1:1 resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of callouts or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. 4) Effective 2/1/2022, the Administrator and Director of Nursing will make	

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F 725	Continued From page 92 ensure the 1:1 staff coverage is posted on the Safety Watch Schedule and assigned staff will utilize the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will utilize interventions per resident plan of care to distract, redirect and intervene as appropriate. Any concerns with following the plan of care will be reported to the Physician and Administrator and/or Director of Nursing immediately and additional interventions implemented as necessary. Effective 2/1/22, the Regional Director of Operations and Regional Director of Clinical Services will provide education to facility and agency staff on the Safety Watch System and the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage. Education will include the process of utilizing the Safety Watch Log to document coverage by signing and dating in and out times. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately	F 725	observational rounds to ensure adequate staffing levels are being provided based on acuity to prevent and protect residents from harm. Effective 3/7/22, monitoring will be conducted at least weekly for 3 months on 1) residents who exhibit exit seeking and wandering behaviors and 2) residents who have behaviors of aggression towards. Effective 2/1/22, the Administrator, Director of Nursing or Manager on Duty will and will review the Safety Watch Log to ensure continuous supervision is being provided and documented for residents assigned 1:1 observation. Effective 3/7/22, monitoring will be conducted weekly for 3 months. The Administrator will report results of monitoring with the Quality Assurance Process Improvement (QAPI) Committee monthly and will make changes to the plan as necessary to maintain compliance with sufficient staffing levels. Date of Compliance: 3/8/22	

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F 725	Continued From page 93	F 725		

and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained. Staff who are assigned 1:1 resident observations will receive education on utilizing interventions per resident plan of care to distract, redirect and intervene as appropriate and reporting any concerns with following the plan of care and Safety Watch System to the Administrator and/or Director of Nursing immediately.

Effective 2/1/22, staff assigned to provide 1:1 resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained.
Effective 2/1/2022, the Administrator and Director of Nursing will make observational rounds to ensure adequate staffing levels are being provided based on acuity to prevent and protect residents from harm. Monitoring will be conducted at least weekly on 1) residents who exhibit exit seeking and wandering behaviors and 2) residents who have behaviors of aggression towards.

Effective 2/1/22, the Administrator, Director of Nursing or Manager on Duty will and will review the Safety Watch Log to ensure continuous supervision is being provided and documented for residents assigned 1:1 observation. Monitoring will be conducted daily

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F 725	Continued From page 94 Effective 2/1/2022, the Administrator or Regional Director of Operations and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of IJ Removal: 2/2/22. On 2/2/22 the Immediate Jeopardy removal plan was validated by onsite verification. Interviews were conducted with the DON and the Staffing Scheduler who stated they had been in-serviced to hold daily discussions to ensure sufficient staff were scheduled to ensure residents with behaviors towards others was factored in when determining appropriate staffing levels to provide adequate supervision to keep residents safe from physical abuse from other residents. The DON stated she had attended a QAPI meeting on 2/1/22 with the Regional Interim Administrator and discussed staff scheduling, neglect, abuse, reporting of abuse, behaviors. Immediate Jeopardy was removed on 2/2/22.	F 725		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		3/8/22

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F 732	Continued From page 95 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post accurate daily nurse staffing information for 3 of the 7 days reviewed (1/26/22, 1/27/22, and 1/28/22). The findings included: During an observation on 1/26/22 at 3:32 PM revealed the daily nurse staffing information was dated 1/25/22 and was posted in the lobby. A observation on 1/27/22 at 1:47 PM revealed the daily nurse staffing information was still dated	F 732	1) On 01/26/22, 01/27/22, and 01/28/22 based on observation the facility failed to post accurate daily nurse staffing information. This cannot be correct for past dates. 2) n/a 3) On 2/28/22, the Director of Nursing (DON) provided education to the staffing coordinator on proper posting of the daily nurse staffing information. On Fridays, the Staffing Coordinator will post the proposed weekend schedule and the	

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F 732	Continued From page 96 1/25/22 and was posted in the lobby. On 1/28/22 at 8:37 AM a morning tour of the facility revealed the daily nurse staffing information was still dated 1/25/22 and was posted in the lobby. An interview with the scheduler on 2/01/22 at 11:10 AM revealed she was out sick last week and usually if she was out the Director of Nursing (DON) would complete the daily staff posting. She stated both the DON and Administrator were also out sick last week. In an interview was conducted with the Regional Director of Operations on 2/02/22 at 5:11 PM, she indicated she was unaware who was responsible for making sure the daily staffing form was posted each day. She reported she would find out who was responsible and make sure the daily staffing form was posted.	F 732	nurse supervisor will make changes to the posted schedule as necessary on weekends or in the absence of the Staffing Coordinator. Education to nursing supervisors was provided by the Director of Nursing by 3/7/22. Newly hired Staffing coordinators and nurse supervisors will receive education during the orientation process. 4) DON or designee monitor for proper nurse staff posting postings 2 times a week for 4 weeks and 1 time a week for 8 weeks. The DON will report audit findings with Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with nurse staff posting. Date of Compliance: 03/08/2022	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		3/8/22

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F 755	Continued From page 97 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to acquire prescribed medication for administration resulting in failure to administer a medication as ordered by the physician for 1 of 10 residents (Resident #67) whose medications were reviewed. Resident #67 was readmitted to the facility on 6/7/20 with diagnoses that included Alzheimer's disease and fibromyalgia. A physician order dated 12/6/21 for Tobramycin ointment 0.3% (antibiotics) 1 application in left eye 3 times daily for 7 days. The most recent quarterly Minimum Data Set (MDS) dated 12/23/21 revealed Resident #67 was cognitively intact. The December 2021 MAR for Resident #67 revealed the Tobramycin ointment was not	F 755	F755 1. Resident #67 Tobramycin eye drops was reordered and administered 2/9/22-2/16/22. 2. All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders for availability in the medication cart. Audit was conducted by the facility pharmacy consultant and licensed nurses prior to the survey exit on 2/4/22. 3. Effective 3/7/22, the Director of Nursing and Unit Manager educated the facility and agency licensed nursing staff on the facility policy and procedure relative to medication availability, ordering, reordering, and receiving to ensure	

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F 755	Continued From page 98 administered as ordered on the following dates: - 12/6/21 at 8:00 PM - 12/7/22 at 8:00 AM, 1:00 PM, and 8:00 PM - 12/8/21 at 8:00 AM, 1:00 PM, and 9:00 PM - 12/9/21 at 8:00 AM and 1:00 PM - 12/10/21 8:00 PM - 12/11/21 at 8:00 AM, 1:00 PM, and 8:00 PM, - 12/12/21 at 8:00 AM, 1:00 PM, and 8:00 PM Nursing progress and eMAR notes from 12/6/21 through 12/12/21 were reviewed for Resident #67 and revealed on 12/7/21 a nursing progress note written by Nurse #11 noted the Tobramycin medication was not in the building. She contacted pharmacy and they stated it was sent a few days ago. Nurse #11 documented she informed the DON at the time and pharmacy was going to send her paperwork to authorize a refill. An eMAR note also entered by Nurse #11 on 12/10/21 reported the Tobramycin medication was still not in the building, and she had already notified pharmacy. An interview was attempted with Resident #67 on 2/1/22 at 2:28 PM, but she had refused. During a phone interview on 1/30/22 at 7:15 PM with Nurse #11, who was the overnight nurse for Resident #67 on 12/6/21, 12/7/21, 12/10/21, 12/11/21 and 12/12/21, she revealed she contacted the pharmacy due to missing eye antibiotics for Resident #67. She stated the pharmacy said it was delivered, but it was not in the building. Nurse #11 indicated she documented this information in Resident #67's medical record and informed the DON at the time, who was supposed to get an email from pharmacy to authorize the medication be re-delivered.	F 755	medication administration as prescribed by the physician to prevent medication errors. Education included process of receiving nurse signing pharmacy delivery tickets, placing copy in Unit Manager mailbox, placing medication on medication cart and confirming receipt in the Electronic Medication Record (EMR). The Unit Manager will review delivery tickets and Pharmacy alerts on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. Newly facility and agency licensed nurses will receive education prior to working as a part of the orientation process 4. The Director of Nursing or Unit Manger will conduct random audits of 5 resident medication orders for availability and administration as ordered. Monitoring will be completed five (5) times weekly for 3 months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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During an interview on 2/1/22 at 10:58 AM with Nurse #10, who was the nurse on duty from 7:00 AM - 7:00 PM 12/6/21 through 12/9/21, she revealed she contacted the pharmacy twice about Resident #67's missing Tobramycin. They first told her it had not yet been delivered. During the second phone call, pharmacy said they delivered it with a signature received, but it was not in the building. Nurse #10 inquired with Nurse #11, and she informed her she had already spoken with the DON. Nurse #10 stated pharmacy told her they would send an authorization form to be signed by the DON at the time.

A phone interview on 2/1/22 at 3:09 PM with Nurse #1, who was the overnight nurse for Resident #67 on 12/8/21, revealed she could not recall any details regarding the missing Tobramycin for this resident.

A phone interview on 2/1/22 at 10:44 AM with Nurse #14, who was the overnight nurse for Resident #67 on 12/9/21, revealed she could not recall the date or the missing Tobramycin for this resident.

During an interview on 2/1/22 at 9:48 AM with medication aide (MA) #4, who was the MA for Resident #67 from 7:00 AM - 7:00 PM on 12/10/21 and 12/11/21, she revealed when a medication was not available, she would first go to the backup medication supply and see if it was stocked, but eye drops were not included in the backup inventory. She indicated since the Tobramycin was not available to administer to Resident #67 on both dates, she chose "reorder" in the "Summary" section of the MAR because MAs were not allowed to call pharmacy. MA #4

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stated pharmacy reorders usually would come the next day. She stated she notified Nurse #7 on 12/10/21, and she should have called the pharmacy.

A phone interview on 2/1/22 at 10:10 AM with Nurse #13, who was the nurse for Resident #67 from 7:00 AM - 7:00 PM on 12/11/21 and 12/12/21, revealed she called the pharmacy twice when she realized the Tobramycin was not available, and she was told it was delivered. She stated she told them it was not in the building, and they could not find the pharmacy requisition sheets. Nurse #13 notified the DON at the time, and she was not sure what happened thereafter.

During an interview with MA #3 on 2/1/22 at 9:40 AM, she revealed if a medication was not available, she would document a note that said, "awaiting medication" and notify the nurse on duty (Nurse #13 on 12/12/21). She stated she could not recall the details of the missing Tobramycin for Resident #67.

The Pharmacist in-charge (PIC) was interviewed on 2/1/22 at 10:49 AM. She revealed the pharmacy had received a new order for Resident #67 for Tobramycin to begin on 12/6/21. She stated this medication was filled on 12/5/21 and sent to the facility the same day; however, there was not a signed delivery form in the system returned by facility. On 12/6/21, Nurse #11 contacted the pharmacy because she could not find the ointment and requested for it to be resent. The PIC stated on 12/7/21, the facility asked for a refill and a "Refill Too Soon" notification was sent to the facility, which was faxed over and available via the online dashboard. The form could have been signed off

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F 755	Continued From page 101 by a nurse or supervisor and sent back to the pharmacy. The PIC indicated this notification form was never signed and returned. Multiple attempts were made to contact the previous DON, but she was unable to be reached during the investigation. The interim DON and RDCS were interviewed on 2/2/22 at 1:24 PM. They revealed the DON at the time should have performed the research to figure out why the medication for Resident #67 was missing and contact the pharmacy. Resident #67 should have received the Tobramycin medication as ordered, and if it was not available then it should have been rescheduled.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		3/8/22

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F 756	Continued From page 102 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 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 staff, Consulting Pharmacist and Medical Director interviews the facility failed to act on the Pharmacist recommendations for a stop date for psychotropic medications for 2 of 8 residents reviewed for unnecessary medications (Resident #53 and #38). The Consulting Pharmacist failed to request an AIMS (Abnormal Involuntary Movement Scale) test for 1 of 4 residents reviewed that required monitoring for abnormal involuntary movements. (Resident #53). The findings included: 1. Resident #38 was admitted to the facility on 4/30/21 with the diagnoses of schizoaffective disorder, borderline personality disorder, anxiety disorder, and a history of a stroke.	F 756	F756 1. Resident #38 order has been updates to reflect a 14 day stop date for the PRN psychotropic. Resident #53 PRN psychotropic medication order was discontinued. Resident #53 had a AIMS completed. 2. On 2/9//22, all residents with PRN psychotropic orders have the potential to be affected; therefore, all residents with PRN psychotropic medications orders were reviewed by the Unit Manager for the appropriate stop date and completed AIMS. All residents on antipsychotic medication have the potential to be affected; therefore, all residents on psychotropic	

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F 756	Continued From page 103 A Physician's order dated for 7/17/21 indicated Lorazepam 1mg every 4 hours as needed for anxiety was ordered without a stop date. The quarterly Minimum Data Set (MDS) dated for 11/15/21 indicated Resident #38 was cognitively intact. She was coded as having had less than 3 instances of rejection of care during the assessment period. Resident #38 was not coded as receiving a PRN psychotropic medication during the assessment period. A pharmacy consultation recommendation dated for 9/11/21, 10/13/21, 12/27/21 indicated Resident #38 had an order in place for PRN Lorazepam for greater than 14 days. The recommendation was to discontinue the medication or have the physician continue the order specifying a stop date. The bottom of the form where the provider would provide a stop date or authorize the discontinuation of the medication and sign was left blank for all three months. A telephone interview was completed on 1/31/22 at 5:03pm with the Medical Director. He indicated he did not recall seeing the referenced pharmacy consultation recommendations for Resident #38. The Medical Director further stated the facility's process for providing him the pharmacy recommendations for review was to leave them in an envelope at the front desk, he reviewed and signed them and would bring them back to the facility. He stated he has not been left any pharmacy recommendations in at least a month. A telephone interview was completed on 2/1/22 at 9:41am with the Director of Nursing (DON). She stated she was familiar with pharmacy consultations and that physicians were required	F 756	medication had an AIMS test conducted and documented in their medical record. 3. Effective 3/7/22, the Director of Nursing (DON) and Unit Manager (UM) educated the licensed facility and agency nursing staff on obtaining an order for a 14-stop date for all PRN psychotropic medication and completing an AIMS evaluation on residents who receive antipsychotic medication upon admission and quarterly. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process. The DON will be responsible for ensuring pharmacy recommendations are communicated to the physician and follow-up recommendations/orders are implemented by the licensed nurse. 4. The Director of Nursing or Unit Manger will conduct audits of 5 residents with PRN psychotropic medication orders for 14-day stop dates and antipsychotics for completed AIMs. Monitoring will be completed five (5) times weekly for 3 months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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to review and sign them, but she did not know how they were printed. The DON went on to state she had not printed any pharmacy consultation recommendations since she started the position in December.

A telephone interview was completed on 2/1/22 at 3:30pm with the Pharmacy Consultant. He indicated once he finished the medication regimen reviews for Residents, the pharmacy consultations are uploaded to the pharmacy website. The facility is required to access the website to print the pharmacy consultations and distribute them to the Physicians for review. The consultant stated when a pharmacy consultation was not reviewed by the physician for the previous month, he would take into consideration when the recommendation was made and if the physician had time to review it. He further stated he expected the pharmacy consultation to be completed after the second recommendation.

An interview was conducted on 2/2/22 at 4:35pm with the facility's Corporate Nurse. She indicated it was her expectation that the facility followed through with pharmacy consultation reports in a timely manner.
2a. Resident #53 was admitted to the facility on 9/3/21 and had a diagnosis of schizophrenia and dementia with behaviors.

Review of the clinical record revealed an order for Clonazepam 0.5 milligrams (mg), give one tablet by mouth every 12 hours as needed for agitation and aggression. There was not a stop date for the medication. Clonazepam is a psychotropic medication that affects a person's mental state.

Review of a Consultant Pharmacist

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Recommendation to Physician form dated 11/22/21 revealed the Pharmacist documented the following: "Recommend discontinuing the PRN (as needed) use of Clonazepam for this Resident (#53), OR reorder for a specific number of the days per the following federal guideline: In accordance with State and Federal Guidelines, Psychotropic Drugs PRN are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Then he or she should document the rationale in the Resident's medical record and indicate the duration for the PRN order."

There was no written documentation from the Physician on the form and no documentation in the Physician's notes as to why the PRN medication needed to be continued.

The order for Clonazepam 0.5mg, give one tablet by mouth every 12 hours as needed was re-written on 12/16/21 with no stop date. There was no documentation in the physician's notes as to why the PRN medication needed to be continued.

There was a second recommendation from the Consultant Pharmacist on 12/27/21. The Recommendation to Physician form dated 12/27/21 revealed the Pharmacist documented the following: "Recommend discontinuing the PRN (as needed) use of Clonazepam for this Resident (#53), OR reorder for a specific number of the days per the following federal guideline: In accordance with State and Federal Guidelines, Psychotropic Drugs PRN are limited to 14 days, except when the attending physician or

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prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Then he or she should document the rationale in the Resident's medical record and indicate the duration for the PRN order."

On 1/31/22 at 5:03 PM the Medical Director (Physician for Resident #53) stated in an interview that the facility would leave the pharmacy recommendations for him to review in an envelope at the front desk and he would review and sign them and bring them back to the facility. The Medical Director further stated he had not seen any pharmacy recommendations in at least one month.

The Interim Director of Nursing (DON) stated in an interview she was familiar with pharmacy consultations and that the physicians were required to review and sign them, but she did not know how they were printed. The DON further stated she had not printed any pharmacy recommendations since she started the position in December 2021.

An interview was conducted with the Pharmacist Consultant on 2/1/22 at 3:30 PM. The Pharmacy Consultant stated once he finished the medication regimen reviews for residents, the pharmacy consultations were uploaded to the pharmacy website. The Pharmacy Consultant further stated the facility was required to access the website to print the pharmacy consultations and distribute to the physicians for review. The Pharmacist Consultant stated when a pharmacy consultation was not reviewed by the physician for the previous month, he would take into consideration when the recommendation was

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made and if the physician had time to review it. He further stated he expected the pharmacy consultation to be completed after the second recommendation. The Pharmacy Consultant stated that PRN psychotropic medication needs to have a 14 day stop date and he would expect the physician to review the medication after 14 days and either discontinue the medication or extend the medication and provide a rationale for continuing the medication.
On 2/1/22 at 4:37 PM the Corporate Nurse stated the Medical Director had seen both of the pharmacy recommendations for the stop date for the Clonazepam. The Corporate Nurse further stated he re-ordered the Clonazepam in December 2021, and this was his way of saying he wanted to continue the medication though he did not write anything on the pharmacy recommendation forms. The Corporate Nurse further stated the Medical Director did not document the reason he wanted to continue the medication in the clinical record.

The Medical Director stated in an interview on 2/2/22 at 2:00 PM that he could not recall if he saw recommendations for a stop date for the Clonazepam for Resident #53 dated 11/27/21 and 12/27/21 or not.

On 2/2/22 at 4:35 PM the facility's Corporate Nurse stated it was her expectation that the facility follow through with pharmacy consultation reports in a timely manner.

On 2/2/22 at 5:06 PM the Corporate Nurse stated in a separate interview that the Clonazepam for Resident #53 did not have a stop date and the staff continued to give the medication. The Corporate Nurse further stated the Nurse that put

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in the order should have entered a stop date.

2b. Resident #53 was admitted to the facility on 9/3/21 and had a diagnosis of dementia with behaviors and schizophrenia.

The admitting physician's orders included an order for Haldol 2 milligrams (mg) twice a day for behaviors. Haldol is an antipsychotic medication.

A review by the facility's Consulting Pharmacist dated 10/13/21 read: "No recommendations." There was a physician's order dated 12/7/21 for Seroquel 50mg 1.5 tablets every day for psychosis. Seroquel is an antipsychotic medication.

The Quarterly Minimum Data Set (MDS) Assessment dated 12/7/21 revealed Resident #53 had moderate cognitive impairment. The MDS revealed Resident #53 received an antipsychotic medication for 7 days during the lookback period.

The manufacturer's package insert for Seroquel revealed that Seroquel was an antipsychotic medication that can cause tardive Dyskinesia, a syndrome of potentially irreversible, involuntary movements and if signs and symptoms of tardive dyskinesia appear, drug discontinuation should be considered.

The manufacturer's package insert for Haldol revealed that Haldol was an antipsychotic medication that commonly causes abnormal involuntary movements (tardive dyskinesia) and if these occur the person might require an additional medication to control the movements.

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An AIMS (abnormal involuntary movement scale) test is a test conducted to detect tardive dyskinesia in persons on antipsychotic medications.

Review of the clinical record for Resident #53 failed to reveal the results of an AIMS (abnormal involuntary movement scale) test.

Review of the clinical record revealed the facility's Consulting Pharmacist reviewed the medications for Resident #53 on 10/13/21, 11/22/21 and 12/27/21. There were no recommendations from the pharmacist that an AIMS test be done.

On 2/1/22 at 10:43 AM review of the electronic clinical record revealed a message in red on the dashboard that noted an AIMS was overdue by 152 days.

On 2/2/22 at 12:38 PM an interview was conducted with the facility's Consulting Pharmacist who stated he missed the AIMS on admission and when the Clonazepam was ordered he was probably more focused on the stop date for the PRN Clonazepam and did not request the AIMS test to be done.

On 2/1/22 at 2:37 PM the Corporate Nurse stated in an interview that Resident #53 had been transferred from a sister facility and had not had an AIMS test since admission on 9/3/21. The Corporate Nurse stated the AIMS assessment is triggered on the assessment dashboard and prompts the nurses to do the AIMS test and they were supposed to be done quarterly. The Corporate Nurse stated the nurses on the floor were responsible for doing the AIMS when they

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F 756	Continued From page 110 are due. The Corporate Nurse further stated she would have liked for the Pharmacist to have recognized that the AIMS was missed and made the recommendation as the Pharmacist's review is part of their checks and balances.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		3/8/22

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F 758	Continued From page 111 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, staff, Pharmacist and interview the facility failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 2 of 8 residents reviewed for unnecessary medications. (Resident #38 and #53). The facility also failed to perform an AIMS (abnormal involuntary movement scale) test to monitor an antipsychotic medication for 1 of 4 residents that required monitoring for abnormal involuntary movements (Resident #53). The findings included: 1. Resident #38 was admitted to the facility on 4/30/21 with the diagnoses of schizoaffective disorder, borderline personality disorder, anxiety disorder, and a history of a stroke. A Physician's order dated for 7/17/21 indicated Lorazepam 1mg every 4 hours as needed for	F 758	F758 1. Resident #38 order has been updates to reflect a 14 day stop date for the PRN psychotropic. Resident #53 PRN psychotropic medication order was discontinued. 2. All residents with PRN psychotropic medication orders or antipsychotic medication orders requiring AIMs monitoring have the potential to be affected; therefore, all residents with PRN psychotropic medications orders and antipsychotic mediation orders were reviewed by the Unit Manager for the appropriate stop date and AIMs with corrections made if indicated. Completed 3/4/22 3. Effective 3/7/22, the Director of Nursing and Unit Manager educated the	

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F 758	Continued From page 112 anxiety was ordered without a stop date. The quarterly Minimum Data Set (MDS) dated for 11/15/21 indicated Resident #38 was cognitively intact. She was coded as having had less than 3 instances of rejection of care during the assessment period. Resident #38 was not coded as receiving a PRN psychotropic during the assessment period. A care plan last revised on 11/15/21 for use of anti-anxiety medication related to anxiety. The care plan included interventions of give medication as prescribed, monitor her frequently for increased confusion, unsteadiness, and any other adverse reactions. A pharmacy consultation recommendation dated for 9/11/21, 10/13/21, 12/27/21 indicated Resident #38 had an order in place for PRN Lorazepam for greater than 14 days. The recommendation was to discontinue the medication or have the physician continue the order specifying a stop date. The bottom of the form where the provider would provide a stop date or authorize discontinuation of the medication and sign was left blank. A telephone interview was completed on 1/31/22 at 5:03pm with the Medical Director. He stated PRN psychotropics were ordered for 14 days, he then reevaluated Residents and extended the stop date to 30 days if needed. He further indicated he did not recall seeing the referenced pharmacy consultations for Resident #38. He stated he would have included a stop date on the PRN Lorazepam. A telephone interview was completed on 2/1/22 at	F 758	licensed facility and agency nursing staff on obtaining an order for a 14-day stop date for all PRN psychotropic medications and completing AIMs assessment monitoring for residents with antipsychotic medications upon hire, quarterly and with changes in condition. The Director of Nursing will residents with psychotropic medication for compliance during morning clinical meeting. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process 4. The Director of Nursing or Unit Manger will conduct audits of 5 residents with PRN psychotropic medication orders for 14-day stop dates and antipsychotics for completed AIMs. Monitoring will be completed five (5) times weekly for 3 months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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F 758	Continued From page 113	F 758		

3:30pm with the Pharmacy Consultant. The consultant continued to state PRN psychotropic medications required an initial 14 day stop and the physician should have revaluated the Resident after the 14 days for the continued use of the medication and the rationale for it.

An interview was conducted on 2/2/22 at 4:35pm with the facility's Corporate Nurse. She indicated it was her expectation PRN psychotropic medications have an initial 14 day stop date and then have the physician review for continued use of medication.

2. Resident #53 was admitted to the facility on 9/3/21 and had a diagnosis of dementia with behaviors.
The Minimum Data Set Assessment dated 12/7/21 noted Resident #53 had moderate cognitive impairment and received an antipsychotic medication for 7 days during the lookback period.

2a. There was a physician ' s order dated 10/26/21 for Clonazepam 0.5 milligrams (mg) every 12 hours as needed for agitation and aggression. Clonazepam is a psychoactive medication that affects how the brain works. There was not a stop date for the medication. Review of the physician ' s visits revealed no rationale for the continuation of the Clonazepam.

Review of the Medication Administration Record (MAR) for Resident #53 revealed that 10 doses of Clonazepam was given in October 2021 past the 14-day expiration date. The MAR revealed the medication was given 4 times in December prior to December 27, 2021. The Clonazepam was re-ordered on 12/7/21 with no expiration date and

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4 doses were given after the 14-day expiration date.

On 2/2/22 at 5:06 PM the Corporate Nurse stated when the order for the Clonazepam was put in the computer, the Nurse should have put a stop date after 14 days for the medication. The Corporate Nurse further stated the nurse did not enter a stop date and the nurses continued to administer the medication.

2b. Resident #53 was admitted to the facility on 9/3/21 and had a diagnosis of dementia with behaviors and schizophrenia.
Resident #53 had admission physician ' s orders dated 9/3/21 for Haldol 2 milligrams (mg) twice a day for behaviors. On 12/7/21 there was a physician ' s order for Seroquel 50mg, give 1.5 tablets daily for psychosis. Both medications are antipsychotic medications.

Review of the manufacturer ' s package insert for Seroquel and Haldol revealed the medications could cause abnormal involuntary movements called Tardive Dyskinesia and if they occurred the person would need additional medical interventions.

An AIMS (abnormal involuntary movement scale) test is a test used to detect abnormal involuntary movements in persons on antipsychotic medications.

There were no results of a baseline AIMS test found on the clinical record. The electronic clinical record revealed a note in red on the dashboard that the AIMS was overdue.

On 2/2/22 the Corporate Nurse stated in an

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F 758	Continued From page 115 interview that Resident #53 had not had an AIMS test done since admission. The Corporate Nurse further stated the nurses on the floor were to do the AIMS test and they were done quarterly, and the nurses were prompted by the dashboard on the electronic clinical record as to when the AIMS test was due.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility failed to administer 21 doses of a medication prescribed to treat conjunctivitis per physician's orders resulting in the resident experiencing continued eye infection for 1 of 2 residents (Resident #43) reviewed for infections. The findings included: Resident #43 was admitted to the facility on 8/20/20 with diagnoses that included dementia and diabetes. The most recent quarterly Minimum Data Set (MDS) dated 11/26/21 revealed Resident #43 was severely cognitively impaired. A physician order dated 1/5/22 for Gentamicin Sulfate Solution 0.3% (antibiotics) 2 drops in both eyes 4 times daily for 7 days for Conjunctivitis. The January 2022 Medication Administration	F 760	F760 1. Resident #43 Gentamycin eye drops was reordered and administered 2/2/22-2/6/22. 2. All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders for availability in the medication cart. Audit was conducted by the facility pharmacy consultant and licensed nurses prior to the survey exit on 2/4/22. 3. Effective 3/7/22, the Director of Nursing and Unit Manager educated the facility and agency licensed nursing staff on the facility policy and procedure relative to medication availability, ordering, reordering, and receiving to ensure medication administration as prescribed by the physician to prevent medication errors. Education included process of	3/8/22

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F 760	Continued From page 116 Record (MAR) for Resident #43 revealed the Gentamicin solution was not administered as ordered on the following dates: - 1/5/22 at 5:00 PM - 1/6/22 at 9:00 PM - 1/7/22 at 12:00 PM, 5:00 PM, and 9:00 PM - 1/8/22 at 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM - 1/9/22 at 12:00 PM, 5:00 PM, and 9:00 PM - 1/10/22 at 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM - 1/11/22 at 12:00 PM, 5:00 PM, and 9:00 PM - 1/12/22 at 9:00 AM and 12:00 PM Electronic MAR (eMAR) notes from 1/5/22 through 1/12/22 were reviewed for Resident #43 and revealed "awaiting pharmacy" was documented by Nurse #7 for the Gentamycin medication administration on 1/6/22, 1/7/22, 1/8/22, 1/9/22, 1/10/22, and 1/11/22. A physician order dated 2/2/22 for Erythromycin Ointment 5 MG/GM (antibiotics) 1 application in both eyes 3 times daily for infection until 02/06/2022. Observations of Resident #43 on 1/25/22 at 11:46 AM, and 01/27/22 at 09:47 AM revealed her right eye was enlarged, red and swollen on the lower lid. During a phone interview on 1/28/22 at 9:27 AM with Nurse #7, she revealed she called the pharmacy about the missing Gentamicin medication, and they said it was signed for and delivered to the facility. She stated she let the interim Director of Nursing (DON) know that they did not have the Gentamicin medication available to give to Resident #43.	F 760	receiving nurse signing pharmacy delivery tickets, placing copy in Unit Manager mailbox, placing medication on medication cart and confirming receipt in the Electronic Medication Record (EMR). Education on notification to the attending physician if medication not available or administered as ordered for follow-up as indicated. The Unit Manager will review delivery tickets and Pharmacy alerts for on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. The DON will review the Electronic Medication Administration Record (EMAR) during morning clinical meeting to ensure compliance with administration for previous 24-hours and provide follow-up as necessary to ensure residents are free from significant medication errors. Newly facility and agency licensed nurses will receive education prior to working as a part of the orientation process. 4. The Director of Nursing or Unit Manger will conduct random audits of 5 resident medication orders for availability and administration per the EMAR as ordered. Monitoring will be completed five (5) times weekly for 3 months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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F 760	Continued From page 117	F 760		

During a phone interview on 1/27/22 at 12:03 PM, Nurse #8 revealed Resident #43 was prescribed, but never received, Gentamicin eye drops while she resided on the COVID unit. When she inquired with the pharmacy about the missing medication, they said it was received by a night shift nurse at the facility and an additional refill could not be sent over. Nurse #8 stated Nurse #7 notified the physician about this issue. Nurse #8 indicated on 1/6/22 at 9:00 AM, 1/7/22 at 9:00 AM, 1/9/22 at 9:00 AM, and 1/11/22 at 9:00 AM, the MAR showed she administered the Gentamicin to Resident #43. However, nurse #8 indicated this was a typing mistake, and she never administered this medication for Resident #43.

An observation of Resident #43 on 02/01/22 at 11:19 AM revealed her right eye was enlarged, red and swollen on the lower lid.

A nursing progress note dated 2/1/22 at 12:38 PM was reviewed and revealed Nurse #12 documented Resident #43 had redness and inflammation to right lower eyelid. Her left eye appeared to be swollen, and the physician was contacted. A verbal phone order was given to start Erythromycin ointment to right and left eye 3 times daily for the next 5 days.

During an interview with Nurse #12 on 2/1/22 at 11:23 AM, she observed Resident #43's right eye as pink and the lower lid inflamed on 2/1/22. She stated she saw it earlier that day and was going to inquire with the unit manager and nurse aide, since she last time she saw Resident #43 was 3 weeks prior. After discussing with staff, she indicated she was going to notify the physician.

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F 760	Continued From page 118	F 760		

Nurse #12 stated there were not any current interventions in place for the infected eye.

The Pharmacist in-charge (PIC) was interviewed on 1/27/22 at 1:44 PM. She revealed pharmacy filled the January 2021 Gentamicin prescription for Resident #43, and it was received by Nurse #11 on 1/6/22. The PIC indicated there were no notes/documentation on the prescription that the facility needed a new refill. If the facility called the pharmacy to let them know they could not find the medication, pharmacy would have told the facility it was already filled and sent over an authorization form to be signed for a refill.

During a phone interview with Nurse #11 on 1/30/22 at 7:15 PM, she revealed she could not recall any pharmacy delivery details for Resident #43 on 1/6/22.

During a phone interview with the Medical Director (MD) on 1/31/22 at 11:04 AM, he revealed he did not recall there was an issue that Resident #43 did not receive eye antibiotic medication. If he was notified, he would have tried to reauthorize another prescription. On 2/01/22 at 11:08 AM, the MD stated if the eye infection did not get better on its own, then that should have been addressed. He further stated the facility had not communicated with him about Resident #43's eye infection not resolving.

The interim DON and Regional Director of Clinical Services (RDCS) were interviewed on 2/2/22 at 12:17 PM. They revealed the pharmacy said the Gentamicin was delivered and this was confirmed. Resident #43 tested positive for COVID and was moved to the quarantined unit, but the medication did not follow her properly. The interim DON stated she was not aware of the

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F 760	Continued From page 119 missing Gentamicin medication for Resident #43 until last week when the pharmacist was in the building. When the pharmacist brought it to her attention, Resident #43 should have been evaluated to determine if treatment/follow-up would have been necessary. On 2/2/22 at 4:40 PM the Regional Director of Operations (RDO) revealed Resident #43 should have received the medication as prescribed. She stated this medication was necessary for her eye infection to be resolved.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		3/8/22

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F 761	Continued From page 120 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to monitor temperatures for 1 of 1 medication refrigerators (main medication room refrigerator), the facility failed to discard expired medications for 3 of 3 medication carts (West Hall, South Hall, and East Annex Cart 2) and failed to date opened medication for 1 of 3 medication carts. The facility also failed to ensure the medication cart was secured while unattended for 1 or 3 medication carts (East Annex Cart 1). The findings included: 1.An observation was conducted of the medication storage room on 1/31/22 at 3:20 PM with Nurse #10 present. Review of the temperature log for the month of January revealed the temperature had not been recorded on 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/28, 1/29, 1/30. An interview was conducted with Nurse #10 on 1/31/22 at 3:49 PM. Nurse #10 stated the night shift nurse was responsible for the checking the refrigerator and recording the refrigerator temperatures. An interview was conducted with the Interim Director of Nursing (DON) and Corporate RN on 1/31/22 at 4:30 PM. The DON stated refrigerator temperatures and checks were assigned to the night shift nurse. The DON stated she expected the refrigerator temperatures would be recorded daily.	F 761	F761 1. The facility was unable to correct/back date the missed recorded refrigerator temperatures in the medication storage room. All medication carts were monitored for proper insulin storage, labeling and dating on 2/1/22 by the licensed nurse. Nurse #12 was re-educated prior to the survey exit on ensuring the medication cart is locked at all times if not within view for security. 2. All the medication storage refrigerators were audited by the Director of Nursing prior to survey exit on 2/4/22 to ensure the mediations were being stored between 36-46 degrees F and temperatures were logged on the temperature log. All the mediation carts had an initial facility wide audit of all medications in the cart for proper storage, removal of expired medication and appropriate dates (open/expire) by the facility consulting pharmacy nurses prior to the survey exit on 2/4/22. On 2/1/22 The Director of Nursing reviewed all the medication carts to ensure they were locked when not in eyesight of the licensed nurse or medication aide 3. Effective 3/7/22, the facility and agency licensed nurses were educated by	

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F 761	Continued From page 121 2.During an observation of the West Hall medication cart on 1/31/22 at 3:32 PM revealed an opened and accessed insulin gargline with no opened and expiration date. The observation also revealed an Advair discuss that was opened 12/27/21. The manufacturer's label stated discard 30 days after opening. An interview was conducted with Nurse #10 on 1/31/22 at 3:49 PM. Nurse #10 stated that she did not realize that the expired medications were on the cart. An interview was conducted with the Interim Director of Nursing (DON) and Corporate RN on 1/31/22 at 4:30 PM. The DON stated she expected that expired medications would be discarded prior to expiration date. 3. During an observation of the South Hall medication cart on 1/31/22 at 3:58 PM revealed an opened bottle of One Daily Multivitamin with an expiration date of 12/21. The medication aide disposed of the medication immediately. An interview was conducted with Medication Aide #3 on 1/31/22 at 4:08 PM. Medication Aide #3 stated she had missed the expiration date on the bottle. . An interview was conducted with the Interim Director of Nursing (DON) and Corporate RN on 1/31/22 at 4:30 PM. The DON stated she expected that expired medications would be discarded prior to expiration date. 4. During an observation of the East Annex Hall medication cart 2 at 1/31/22 at 4:11 PM revealed an opened bottle of Dorzolamide eye solution with	F 761	the Director of Nursing or Unit Manger on reviewing the mediation refrigerator temperatures and logging the temperatures on the temperature log and to notify Maintenance Director and DON for repair or replacement if the temperatures are outside the recommended temperature ranges of 36-42 degrees. Facility and agency licensed nurses and medication aides were educated by the Director of Nursing or Unit Manager on ensuring medications are stored, dated and discarded as required by the manufacture. The licensed nurses and medication aides were educated on ensuring the medication carts are locked when not in eyesight by the Director of Nursing or Unit Manager. Newly hired facility and agency licensed nurses and medication aides will receive education during orientation and prior to working. 4. The Director of Nursing or Unit Manager will complete audits of med rooms/cart weekly for four (4) weeks and monthly for two (2) weeks to ensure medications continue to be stored, dated ad discarded as required and the medication refrigerator logs are completed and within the recommended temperature ranges and medication carts are secured while unattended. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Compliance date: 3/8/22	

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F 761	Continued From page 122	F 761		

an expiration date of 11/17/21. The manufacturers label stated discard 28 days after opening. The medication aide immediately discarded the eye solutions.

An interview was conducted with Medication Aide #4 on 1/31/22 at 4:20 PM. Medication Aide #4 stated she did not realize that medication was out of date.

An interview was conducted with the Interim Director of Nursing (DON) and Corporate RN on 1/31/22 at 4:30 PM. The DON stated she expected that eye medications would be discarded within 28 days as the label stated manufacturers .

3. On 1/31/22 at 8:25 am an unattended medication cart was observed angled in front of room 117 on the East Annex Hall with the push in lock in the out position and the cart key in the lock of the narcotic drawer. Nurse #12 was observed in room 117 with resident 117-A out of view of the medication cart from 8:25 am until 8:32 am. Nurse #12 exited room 117 and locked the medication cart and removed the keys from the narcotic drawer. She placed the keys in her pocket and returned to room 117.

During an interview on 1/31/22 at 8:47 am Nurse #12 revealed that the medication cart was required to be locked and the keys were to be taken when she left the cart. She stated she did not know why she left the keys in the narcotic lock and the cart unlocked when she was in the room.

During an interview on 2/1/22 at 3:30 pm the Director of Nursing revealed the medication cart was to be locked and the keys with the nurse

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F 761	Continued From page 123 when unattended.	F 761		
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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain 2 of 2 nourishment refrigerators (secured unit, east wing annex) clean, and in a sanitary manner to prevent cross contamination by failing to label and date open food, remove outdated food, clean up spills and remove excessive ice buildup. The findings included: 1. On 1/27/22 at 2:16 PM the nourishment room on the secured locked unit was observed. The refrigerator was noted with a thin pink liquid on	F 812	1) On 2/4/22, the Dietary Manger, properly disposed of undated/spoiled food items, defrosted freezers and thoroughly cleaned nourishment room refrigerators/freezers. 2) On 2/4/22, all facility nourishment room and kitchen refrigerators were audited for cleanliness, proper dating and storage of food items and freezers for proper defrost. No additional concerns wee identified on this date. 3) Dietary Manager was reeducated on 2/28/22 by the Administrator ensuring	3/8/22

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F 812	Continued From page 124 the middle shelf and pink liquid pooled underneath the 2 clear drawers. A second observation of the nourishment room on the secured locked unit, on 1/31/22 at 10:37 AM revealed the refrigerator was in the same condition. 2. On 1/31/22 at 8:50 AM an observation of the east annex nourishment room was conducted. The freezer compartment was observed with a heavy ice/frost buildup, an open half bottle of red frozen beverage, one boxed dinner frozen to bottom of freezer (unable to remove) second box of dinner frozen to bottom box. The refrigeration section was observed with 2 facility prepared bag lunches with a use by date of 1/28/22, and 1 grocery bag with food items no name/date. In an interview on 1/31/22 at 3:05 PM the housekeeper supervisor stated since food was inside the refrigerators, housekeeping staff were not allowed to clean inside they were responsible for cleaning the outside. In an interview on 2/01/22 at 3:42 PM the Regional Director of Operations stated they had a daily cleaning schedule and starting today, the dietary department would be responsible for cleaning the nourishment refrigerators.	F 812	proper dating/labeling and disposal of food items and cleaning schedule of the nourishment rooms refrigerators/freezers and ensuring proper defrost to maintain proper food procurement, storage and sanitation. Newly hired Dietary Managers will receive education during orientation and prior to working. 4) Administrator or designee will conduct nourishment room environmental rounds (refrigerator/freezer) 2 times a week for 4 weeks and 1 then once weekly for 8 weeks. Administrator will report audit findings with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Date of Compliance. 03/08/2022	
F 835 SS=K	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	F 835		3/8/22

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F 835	Continued From page 125 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 record review, observation, and interviews with physician and staff, the facility Administration failed to provide oversight and leadership to 1) ensure the facility was free from abuse and to prevent and protect Resident #53 and #39 from being physically abused by Resident #29, 2) provide supervision to prevent residents with severe cognitive impairment from exiting the facility unsupervised (Residents #21 and #29); and 3) provide sufficient staffing to meet the needs of the residents. Immediate Jeopardy began on 11/08/21 when the facility leadership failed to implement interventions to maintain a safe and abuse free environment for the residents resulting in Resident #29 placing Resident #53 in a headlock and pulling her to the floor. Immediate Jeopardy was removed on 2/2/22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee and agency in-services, orientation and training. The findings included: This tag is cross referenced to: F600: Based on record review and physician and	F 835	1) The facility Administration failed to provide effective oversight and leadership to 1) ensure the facility was free from abuse and to prevent and protect Resident #53 and #39 from being physically abused by Resident #29 and, 2) implement interventions to protect other residents during an investigation of resident to resident physical abuse; 3) provide supervision to prevent residents with severe cognitive impairment from exiting the facility unsupervised (Resident #21 and #29) and, 4) provide sufficient staffing to meet the needs of the residents. On 2/1/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional Director of Operations to discuss root cause analysis of the facilities failure to provide effective oversight and leadership to provide sufficient staffing to keep Residents #53 and #39 free from physical abuse by Resident #29 and facility failure to prevent Resident #21 and #29 from an unsupervised exit from the facility, and to implement interventions to protect other residents during an investigation of resident to resident physical abuse. Root cause determined that the Administrator and Director of Nursing did not have clear understanding of acuity-based staffing.	

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F 835	Continued From page 126 staff interviews, the facility neglected to protect the residents' right to be free from abuse when Resident #29 physically abused Residents #39 and #53. Resident #53 sustained injuries that required Emergency Room evaluation. This was for 1 of 1 resident (Resident #29) reviewed for resident-to-resident abuse. F689: Based on record review, staff interview and observation, the facility failed to provide supervision to prevent residents with severe cognitive impairment who displayed exit seeking behaviors from exiting the facility unsupervised for 2 of 2 residents (Resident #21, Resident #29) reviewed for wandering behavior. The facility also failed to implement 1 to 1 supervision for Resident #29. F725: Based on record review, observation, and physician and staff interviews, the facility failed to have sufficient staffing to prevent and protect Residents #53 and #39 from being physically abused by Resident #29 for 1 of 1 resident reviewed for resident-to-resident physical abuse (Resident #29) and to provide supervision to prevent residents with severe cognitive impairment (Resident #21 and Resident #29) from exiting the facility unsupervised for 2 of 2 residents reviewed for wandering. The Administrator was notified of the Immediate Jeopardy at F835 on 1/31/22 at 7:21 PM. The facility provided a credible allegation of Immediate Jeopardy removal on 2/1/22. The allegation of Immediate Jeopardy removal indicated:	F 835	Additionally, administration failed to implement interventions to protect other residents during an investigation of resident-to-resident physical abuse and failed to implement systems to ensure staffing schedules were adjusted to include coverage during staff breaks, late arrivals with shift changes, to factor in the additional staff required to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. 2) On 2/1/22, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Regional Director of Operations, Director of Nursing and Regional Director of Nursing on 2/1/22 to re-assess effective oversight and leadership to ensure 1)residents are protected from abuse, 2)interventions are implemented to protect other residents during an investigation of resident to resident physical abuse, 3) that supervision is provided and interventions are implemented to prevent unsupervised exits from the facility and 4) sufficient staffing levels are provided based on resident acuity to ensure resident safety. 3) On 2/1/22, the Regional Director of Operations provided education to the Administrator on effective administrative strategies and processes to ensure residents are protected from abuse, interventions are implemented to protect other residents during an investigation of	

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F 835	Continued From page 127 Credible Allegation of Immediate Jeopardy Removal: The facility Administration failed to provide effective oversight and leadership to 1) ensure the facility was free from abuse and to prevent and protect Residents #53 and #39 from being physically abused by Resident #29, 2) provide supervision to prevent residents with severe cognitive impairment from exiting the facility unsupervised (Resident #21 and #29) and 3) provide sufficient staffing to meet the needs of the residents. On 2/1/2022, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional Director of Operations to discuss root cause analysis of the facilities failure to provide effective oversight and leadership to provide sufficient staffing to keep residents free from physical abuse by other residents and to prevent unsupervised exits from the facility. Root cause determined that the Administrator and Director of Nursing did not have clear understanding of acuity-based staffing. Additionally, administration failed to implement systems to ensure staffing schedules were adjusted to include coverage during staff breaks, late arrivals with shift changes, to factor in the additional staff required to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. On 2/1/22, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Regional Director of	F 835	resident-to-resident physical abuse, that supervision is provided and interventions are implemented to prevent unsupervised exits from the facility and that sufficient staffing levels are provided based on resident acuity to ensure resident safety. Education included review of company Abuse, Neglect and Exploitation Policy, Elopement and Wandering Residents Policy, a system to ensure staffing schedules are adjusted to include coverage during staff breaks, late arrivals with shift changes and the process for providing acuity-based staffing utilizing the ABS (acuity-based system) to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Education of the ABS system included calculating staffing needs by adding the number of days at each RUG (Resident Utilization Grouper) level and case mix index divided by average daily census to determine number of staff needed. Newly hired Administrators will receive education upon hire during orientation. Effective 2/1/2022, the facility Administrator, Regional Director of Operations, Director of Nursing or Regional Director of Nursing will perform facility tours (including off shifts and weekends) daily to observe for any residents with behaviors which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels every shift (including coverage during breaks and lunches) on the memory care unit based	

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F 835	Continued From page 128 Operations, Director of Nursing and Regional Director of Nursing on 2/1/22 to re-assess effective oversight and leadership to ensure 1)residents are protected from abuse, 2) that supervision is provided and interventions are implemented to prevent unsupervised exits from the facility and 3) sufficient staffing levels are provided based on resident acuity to ensure resident safety. On 2/1/22, the Regional Director of Operations provided education to the Administrator on effective administrative strategies and processes to ensure residents are protected from abuse, that supervision is provided and interventions are implemented to prevent unsupervised exits from the facility and that sufficient staffing levels are provided based on resident acuity to ensure resident safety. Education included review of company Abuse, Neglect and Exploitation Policy, Elopement and Wandering Residents Policy, a system to ensure staffing schedules are adjusted to include coverage during staff breaks, late arrivals with shift changes and the process for providing acuity-based staffing utilizing the ABS (acuity-based system) to provide adequate supervision to keep residents safe from physical abuse by other residents and unsupervised exits from the facility. Education of the ABS system included calculating staffing needs by adding the number of days at each RUG (Resident Utilization Grouper) level and case mix index divided by average daily census to determine number of staff needed. Newly hired Administrators will receive education upon hire during orientation. Effective 2/1/2022, the facility Administrator, Regional Director of Operations, Director of Nursing or Regional Director of Nursing will	F 835	on resident acuity to ensure adequate staff to provide supervision to residents to prevent physical abuse. Effective 2/1/22, the Regional Director of Operations and/or the Regional Director of Clinical Services will be contacted by the Administrator and/or Director of Nursing when a resident-to-resident incident or unsupervised resident exit occurs to receive additional support and guidance and to ensure effective interventions to protect residents from harm. 4) Effective 2/1/2022, the Regional Director of Operations and/or Regional Director of Clinical Services will meet bi-weekly with the Administrator and Director of Clinical Services in person or telephonically to discuss administrative oversight and leadership effectiveness in ensuring compliance with regulation F600, F610, F689 and F725. Results of ongoing monitoring completed by the facility for F600, F610, F689 and F725 and F835 will be reviewed for completeness and effectiveness and additional support and interventions will be provided if necessary to maintain compliance. Effective 3/7/22, monitoring will continue bi-weekly for 3 months. The Administrator will report results of monitoring and administration meetings with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with F600, F610, F689 and F725. Date of compliance: 3/8/22	

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F 835	Continued From page 129	F 835		

perform facility tours (including off shifts and weekends) daily to observe for any residents with behaviors which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels every shift (including coverage during breaks and lunches) on the memory care unit based on resident acuity to ensure adequate staff to provide supervision to residents to prevent physical abuse.

Effective 2/1/22, the Regional Director of Operations and/or the Regional Director of Clinical Services will be contacted by the Administrator and/or Director of Nursing when a resident-to-resident incident or unsupervised resident exit occurs to receive additional support and guidance and to ensure effective interventions to protect residents from harm.

Effective 2/1/2022, the Regional Director of Operations and Regional Director of Clinical Services will meet at least bi-weekly with the Administrator and Director of Clinical Services in person or telephonically to discuss administrative oversight and leadership effectiveness in ensuring compliance with regulation F600, F689, and F725. Results of ongoing monitoring completed by the facility for F600, F689, F725 and F835 will be reviewed for completeness and effectiveness and additional support and interventions will be provided if necessary to maintain compliance.

Effective 2/1/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

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F 835	Continued From page 130 Alleged Date of Immediate Jeopardy Removal: 2/2/22. On 2/2/22 the Credible Allegation was validated by onsite verification. Interviews were conducted with the DON and the staffing scheduler who stated they had been in-serviced to hold daily discussions to ensure sufficient staff were scheduled to ensure residents with behaviors towards others was factored in when determining appropriate staffing levels to provide adequate supervision to keep residents safe from physical abuse from other residents. The DON stated she had attended a QAPI meeting on 2/1/22 with the Regional Interim Administrator and discussed staff scheduling, resident elopement, neglect, abuse, reporting of abuse, behaviors and the use of the Safety Watch Log. Resident #29 was observed to be monitored 1:1 by facility staff and the Safety Watch Log was reviewed and the documentation revealed no gaps in monitoring from 1/28/22 (when the monitoring tool was implemented) until 2/2/22. The Immediate Jeopardy was removed on 2/2/22.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		3/8/22

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 132 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain accurate records of medication administration for 1 (Resident #43) of 2 residents reviewed for infection. Findings included: Resident #43 was admitted to the facility on 8/20/20 with diagnoses that included dementia and diabetes. The most recent quarterly Minimum Data Set (MDS) dated 11/26/21 revealed Resident #43 was severely cognitively impaired. A physician order dated 1/5/22 for Gentamicin Sulfate Solution 0.3% (eye drops antibiotics) 2 drops in both eyes 4 times daily for 7 days. Record review of Medication Administration Record (MAR) for the month of January 2022	F 842	1) Resident #43 Gentamycin eye drops was reordered and administered and documented accurately on the Medication Administration Record (MAR) 2/2/22-2/6/22 by the licensed nurses. 2) All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders were audited to ensure availability in the medication cart. Audit was conducted by the facility pharmacy consultant and licensed nurses prior to the survey exit on 2/4/22. The MAR was reviewed for Residents with antibiotics to ensure accurate documentation of administration. No additional concerns identified. 3) Effective 3/7/22, the Director of Nursing and Unit Manager educated the	

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F 842	Continued From page 133 revealed Nurse #7 coded the medication as administered on 1/5/22 at 9:00 PM. Nurse #8 coded the medication as administered on 1/6/22 at 9:00 AM, 1/7/22 at 9:00 AM, 1/9/22 at 9:00 AM, and 1/11/22 at 9:00 AM. During a phone interview on 1/28/22 at 9:27 AM with Nurse #7, she revealed she contacted the pharmacy and let the Director of Nursing (DON) know the Gentamycin medication was not available in the facility. During a phone interview on 1/27/22 at 12:03 PM, Nurse #8 revealed Resident #43 was prescribed, but never received, Gentamicin eye drops while she resided on the COVID unit. Nurse #8 indicated on 1/6/22 at 9:00 AM, 1/7/22 at 9:00 AM, 1/9/22 at 9:00 AM, and 1/11/22 at 9:00 AM, the MAR showed she administered the Gentamicin to Resident #43. However, Nurse #8 indicated this was a typing mistake, and she never administered this medication for Resident #43.	F 842	facility and agency licensed nursing staff on the accurate documentation of medication administration and documentation when not available for administration. Education included process of receiving nurse signing pharmacy delivery tickets, placing copy in Unit Manager mailbox, placing medication on medication cart and confirming receipt in the Electronic Medication Record (EMR). Education on notification to the attending physician if medication not available or administered as ordered for follow-up as indicated. Education for documenting on the MAR when medication is not administered as ordered was also provided. The Unit Manager will review delivery tickets and Pharmacy alerts for on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. The DON will review the Electronic Medication Administration Record (EMAR) during morning clinical meeting to ensure compliance with documentation of administration or non-administration of medications as ordered for previous 24-hours and provide follow-up as necessary to ensure accurate documentation in resident records, Newly facility and agency licensed nurses will receive education prior to working as a part of the orientation process. 4) The Director of Nursing or Unit Manger will conduct random audits of 5 resident medication orders for availability and proper documentation of administration or non-administration per	

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F 842	Continued From page 134	F 842	the EMAR and as ordered. Monitoring will be completed 3 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Director of Nursing will report these finding to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with accurate resident medical records. Date of compliance: 03/08/2022	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/8/22

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F 880	Continued From page 135 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 136 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to (1) handle soiled linen in a sanitary manner to prevent the spread of infection for 2 of 2 rooms (110, 302) observed, (2) maintain a separate receiving area for dirty linen (3) failed to perform hand hygiene during meal tray delivery (Room 210, 211). The findings included: Review of the Handling Soiled Linen policy dated 10/29/20 read as: Policy: "It is the policy of this facility to handle, store, process and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen." Under the Policy Explanation and Compliance Guidelines: Reads as: #2. "All used lined should be handled using standard precautions and treated as potentially contaminated. #3. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible with minimum agitation to avoid contamination of air, surfaces, and persons." #4. Used or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. #5. If linen is heavily soiled, wet and/or presents a risk of leakage or soaking through, the linen shall	F 880	F880 1. On 3/4/22, a Quality Assurance Process Improvement (QAPI) meeting was conducted by the Administrator, Director of Nursing (DON), Infection Preventionist (IP), Medical Director Social Worker, Unit Coordinator, Therapy Director, Maintenance Director, Housekeeping Director, Activities Director and Minimum Data Set (MDS) Nurse to determine root cause analysis of the facilities failure to 1) handle soiled linen in a sanitary manner to prevent the spread of infection for 2 of 2 rooms (110, 302) observed, (2) maintain a separate receiving area for dirty linens and 3) to perform hand hygiene during meal tray delivery (Room 210, 211). The QAPI committee determined that the facility failed to ensure that effective infection surveillance monitoring was being routinely conducted to monitor for infection control practices with handling of soiled linens and hand hygiene during meals. 2. On 3/4/22, the Infection Preventionist completed infection control environmental surveillance rounds of all resident rooms, linen rooms and facility common areas/hallways to ensure proper handling of linens and hand hygiene while providing resident care, including during meal tray passes. No additional concerns were	

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F 880	Continued From page 137 be double bagged." 3. On 1/26/22 at 3:36 PM an observation was made in Room 110. The door to Room 110 was open the privacy curtained was pulled around Bed A and bed sheets, blanket and a towel were observed on the floor. The nurse aide (NA) #6 was observed to grab a trash bag from the trash can and bag up the soiled linen. On 1/26/22 at 3:43 PM nurse aide (NA) #6 revealed when she checked the resident he was very wet. She stated she provided his incontinent care, thinking trash bags were in the room. NA #6 stated she should have put the soiled linen in a bag and not on the floor that was how she had been taught. 4. On 1/28/22 at 1:10 PM an observation was made in Room 302. The door to the room was open and NA #7 was observed changing the sheets on bed A, the bed sheets, and blanket were observed on the floor. In an interview on 1/28/22 at 1:12 PM NA #7 stated the resident had finished eating, had food on the sheets and she wanted to clean him up. She indicated at the time she didn ' t have a bag and the nurse had to bring her one. NA #7 stated that she was trained to bag the soiled linen. In an interview on 2/02/22 at 10:48 AM the director of nursing (DON) stated linens should not be on the floor, staff had been trained to bag soiled linen. 2. Record review of Infection Prevention and Control Program Policy dated 11/1/20 revealed clean linen shall always be separated from soiled linen.	F 880	identified during this observation and proper infection prevention practices were being followed. 3. Effective 3/7/22, the Director of Nursing and Administrator provided education to all housekeeping staff and current facility and agency direct-care staff on the company policy Handling Soiled Linen policy related to the handling, storage, process and transport of linen in a safe and sanitary method to prevent the spread of infection and education provided on hand hygiene during resident care including meal tray pass. Newly hired facility and agency staff will be educated prior to working as a part of the orientation process. Housekeeping staff will be responsible for maintaining soiled linen bags in resident rooms, on housekeeping carts and in linen storage closet. Housekeeping staff will also be responsible for entering the soiled linen room for storage of soiled linens. Housekeeping will also be responsible for ensuring hand sanitizer wall mounted containers are filled at the start of each shift. The Housekeeping manager is responsible for monitoring housekeeping staff compliance with these duties. The designated Infection Preventionist will be responsible routine weekly infection control environmental surveillance rounds of all resident rooms, linen rooms and facility common areas/hallways to ensure proper handling of linens and hand hygiene while providing resident care, including during meal tray passes. Newly	

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F 880	Continued From page 138 During an observation on 1/26/22 at 9:04 am with the Housekeeping Manager of the laundry room the following was observed: a. A dirty white blanket was brought into the laundry room through the interior hall door and into the clean laundry area, not bagged, and placed in yellow linen bin near the washing machine on dirty side of laundry area. The laundry aide was on folding clean linen at the table on the clean laundry area. b. A yellow dirty linen container was brought to the laundry room through the interior hall door and into the clean linen area. The yellow dirty linen container was rolled through the clean linen area and placed in the dirty linen area at the side of the washing machine. During an interview on 1/26/22 at 9:15 am the Housekeeping Manager revealed the dirty linen containers were brought in the clean side of laundry since she worked here. She stated they would have to take it outside and bring back into the dirty side if they did not come through the hall door. The Housekeeping Manager stated there was one laundry aide and she would stop folding when dirty linen was brought through the clean side of the laundry room. During an interview on 1/27/22 at 9:04 am the Regional Housekeeping Manager revealed the dirty linen barrels were required to enter the laundry area on the dirty side and were not to come through the clean linen area. 3. Record review of Infection Prevention and Control Program Policy dated 11/1/20 revealed	F 880	hired housekeeping staff and facility and agency direct-care staff will receive education prior to working as a part of the orientation process. 4. The Infection preventionist or Nurse Manager will monitor infection control practices via visual observations of hand hygiene during mealtime and observations of staff handling and transport of soiled linens. One meal tray pass and rounding on all units/soiled linen storage rooms will completed three times weekly for four weeks, then weekly for eight weeks and as needed thereafter. The Director of Nursing or Infection Preventionist will bring results to our monthly Quality Assurance and Performance Improvement (QAPI) meeting monthly to present results and make changes to the plan as necessary to maintain compliance with infection prevention practices. 5. Alleged date of compliance: 3/8/22 6. Root Cause Analysis using 5-Whys Tool (see attachment) 7. Timeline (see attachment) 8. Attestation of Infection Control education and competency (see attachment)	

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F 880	Continued From page 139	F 880		

hand hygiene shall be performed in accordance with our facility ' s established hand hygiene procedures.

Record review of Handwashing/Hand Hygiene Policy dated 2001 and revised in August 2015 revealed use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations which included before and after eating or handling food and before and after assisting a resident with meals.

During an observation on 1/27/22 at 12:49 pm of meal delivery Nurse Aide (NA) #16 delivered lunch trays to residents on the 200 Hall. Two residents were not offered hand hygiene prior to eating lunch (room 210 and room 211).

During an observation on 1/27/22 at 12:50 pm NA#16 exited resident room after assisting with opening items and did not use hand sanitizer before retrieving another lunch tray from meal cart.

During an interview on 1/27/22 at 12:50 pm NA #16 revealed hand hygiene was supposed to be completed before the resident eats and that she was required to use hand sanitizer or soap and water between residents. She stated she did not offer any hand hygiene or use hand sanitizer between the tray delivery because she did not have any hand sanitizer with her.

During an interview on 1/28/22 at 12:05 pm the Director of Nursing (DON) revealed that hand hygiene was not required to be offered to residents prior to meals. The DON stated hand hygiene was required between interaction with

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F 880	Continued From page 140 residents.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to make repairs to the heated plate dispenser and the metal meal service cart. The findings included: During the meal observation on 1/27/22 at 8:44 AM kitchen staff were observed plating up the breakfast meal. The hot plate dispenser was observed cool to the touch. In an interview on 1/27/22 at 8:54 AM the dietary manager stated the hot plate dispenser had not worked in over 2 years. Continuing the 1/27/22 meal observation at 9:04 AM one of the front support bars on the starter cart was observed to move/slide off the frame, exposing the sharp, jagged edges of the stainless-steel support bar. In an interview on 2/01/22 at 11:09 AM the dietary manager revealed her district manager had called a repair man on 1/31/22 to fix the plate dispenser and he was working on getting the starter cart repaired. In an interview on 2/01/22 at 3:42 PM the Regional Director of Operations revealed the heated plate dispenser had been repaired and	F 908	F908 Essential Equipment Safe Operating Conditioning 1) On 02/07/2022, plate warmer was serviced by contracted vendor and it is now in proper working order. On 02/02/2022, contracted vendor serviced the stainless-steel meal cart and it is now in proper working order. 2) An environmental kitchen round was conducted on 2/4/22 by the Dietary Manager to observe for further improper/malfunctioning equipment; no concerns were identified. 3) On 2/28/22, the Administrator provided education to the Dietary Manager on routine inspection of kitchen equipment for proper function and reporting any concerns to the Administrator and documenting in the Maintenance log. Administrator will assist Dietary Manager with referrals from outside vendors as needed for repairs/replacement of equipment. 4) Administrator or designee will conduct environmental kitchen rounds weekly for 4 weeks, then monthly to ensure proper equipment function. Administrator will report results of audit findings with the	3/8/22

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F 908	Continued From page 141 they had called someone to come repair the starter cart.	F 908	Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Date of Compliance: 03/08/2022	