STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 04/12/2022

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WESTWOOD HEALTH AND REHABILITATION	**625 ASHLAND STREET ARCHDALE, NC 27263**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 3/28/22 through 3/31/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# JT2411.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 3/28/22 through 3/31/22. Additional information was obtained on 4/1/22. Event ID# JT2411 19 of the 30 complaint allegations were substantiated resulting in deficiencies at F550, F584, F677, F684, F686, F687, F689, F760, and F758. Intakes: NC00176537, NC00177549, NC00179310, NC00185756 and NC00186934. Immediate Jeopardy was identified on 4/8/22 at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F686 at a scope and severity of K. CFR 483.70 at tag F835 at a scope and severity of K. Immediate Jeopardy for tag F580 began on 3/20/22 and was removed on 4/9/22. Immediate Jeopardy for tag F686 began on 3/5/22 and was removed on 4/9/22. Immediate Jeopardy for tag F835 began on 3/5/22 and was removed on 4/9/22.	F 000		

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

Electronically Signed | 04/21/2022

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F 000	Continued From page 1 Substandard Quality of Care was identified at CFR 483.25 at tag F689 at a scope and severity of H, as well as the tag F686. Members of the survey team returned to the faciltiy on 4/12/22. An extended survey and validation of the credible allegations for the Immediate Jeopardies was completed. Please see event ID# JT2411. The survey exit date was changed to 4/12/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		5/10/22

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F 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to treat residents in a dignified manner by not covering the urinary drainage bag with a privacy cover for 1 of 5 sampled residents reviewed for dignity (Residents # 31). Findings included: Resident #31 was admitted to the facility on 2/11/22 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 2/28/22 indicated that Resident #31 had moderate cognitive impairment and he had an indwelling urinary catheter. Resident #31 had a physician's order dated 2/11//22 for the use of the indwelling urinary catheter for urinary retention. Resident #31 was observed up in wheelchair in his room on 3/28/22 at 9:30 AM. His urinary drainage bag was observed with no privacy	F 550	1. A privacy bag was placed on Resident #31 urinary drainage bag on 03/28/2022. The Nurse Manager educated Nurse Aide #5 on urinary drainage bags should be covered at all times to maintain resident's dignity on 04/07/2022. 2. A quality review was completed by the Nurse Manager of all residents with catheters to ensure urinary drainage bags are covered on 04/25/22. All urinary bags were covered. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing or designee educated nursing staff on residents rights related to ensuring urinary catheters bags are covered to maintain resident's dignity by 05/6/2022. Nursing staff that has not	

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F 550	Continued From page 3 cover. He stated that he went to the hospital on 3/25/22 and was back on 3/26/22 and his urinary bag did not have a privacy cover since he returned from the hospital which made him feel bad. Resident #31 was again observed on 3/28/22 at 12:45 PM up in wheelchair in the dining room. His urinary drainage bag did not have a privacy cover. A dark colored urine about 700 cc could be seen through the clear plastic urinary drainage bag. At 12:46 PM, the resident was observed wheeling himself out of the dining room to the hallway. The Nurse Consultant observed the resident and his urinary catheter bag with no privacy cover. She requested a staff member to get a privacy cover and to cover the resident's urinary drainage bag. The Assistant Director of Nursing (ADON) was interviewed on 3/29/22 at 12:04 PM. The ADON verified that she was assigned to Resident #31. She stated that the nursing staff were responsible to ensure that the urinary catheter bag was always covered with a privacy cover for dignity reason. She reported that she did not recognize that his catheter bag did not have a cover. She also indicated that the resident was discharged to the hospital and came back on the weekend (3/26/22) and the staff failed to replace the privacy cover to his urinary bag. Nurse Aide (NA) #5 was interviewed on 3/29/22 at 12:05 PM. The NA stated that she was assigned to Resident #31. She reported that the nurses were responsible in making sure the catheter bags were covered. The Director of Nursing (DON) was interviewed	F 550	completed the education will completed the education prior to working next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews of resident's with urinary drainage bags to ensure drainage bags covered on 2 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) Committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 550	Continued From page 4 on 3/31/22 at 1:59 PM. The DON expected nursing including nurses and NAs to ensure all urinary catheter bags had privacy cover.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to place a resident's call light within reach for 3 of 3 residents reviewed for accommodation of needs (Residents #8, #32 and #195). The findings included: 1) Resident #8 was admitted to the facility on 7/8/19 with diagnoses that included chronic obstructive pulmonary disease, diabetes type 2 and congestive heart failure. The annual Minimum Data Set (MDS) assessment dated 12/28/21 indicated Resident #8 had moderately impaired cognition and required extensive assistance with the completion of Activities of Daily Living tasks. Resident #8's care plan, last reviewed on 1/12/22, included a focus area for risk for falls related to confusion at times, poor safety awareness, problems with standing/sitting balance, incontinence, and psychotropic medication use.	F 558	1. 1. The call bell was placed within reach for Residents #8, #32 and #195 on 03/29/2022. A longer call cord was placed in Resident #195 room by the maintenance director on 03/29/2022. Nurse #1 is no longer employed by the facility. 2. A quality review was completed by the Executive Director or designee of current residents to ensure call lights are within reach at all times on 04/26/2022. Call lights were all within reach during review. An Ad hoc Quality Assurance Performance Improvement Committee was held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing or designee educated nursing staff on reasonable accommodations need/preferences related to ensuring call lights are within reach at all times by 05/06/2022. Nursing	5/10/22

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F 558	Continued From page 5 The interventions included to be sure the call light was within reach and encourage it's use. On 3/28/22 at 10:04 AM, an observation was made of Resident #8 who was sitting in a wheelchair at her bedside. The privacy curtain was pulled between her bed (the A bed) and the other bed (B bed). The call light was observed to be lying on the empty B bed out of reach of Resident #8. When asked how she would summon assistance if needed, she stated she would yell out for help if she was in her bed or open the door and look for someone if she was in her wheelchair and couldn't reach her call light. Resident #8 was observed lying her bed with her eyes closed on 3/28/22 at 3:00 PM. The call light remained draped over the B bed out of reach. On 3/29/22 at 8:30 AM, the Social Worker (SW) was observed going from room to room ensuring call lights were in reach. Resident #8's call light was observed to be in reach after he was secured to her bed by the SW. The SW was interviewed on 3/29/22 at 8:50 AM and stated each department head was responsible for completing morning room rounds, which included making sure the call lights were in reach. She was unable to explain why Resident #8's call light was not within her reach during the day of 3/28/22. Nurse Aide (NA) #1 was interviewed on 3/30/22 at 4:32 PM, was the assigned aide for Resident #8 and stated she was able to utilize the call bell for requests. NA #1 observed the call light draped over the bedside table and was unable to state why it was not placed within reach of Resident #8.	F 558	staff that has not completed the education will complete the education prior to working next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews of residents to call light within reach at all times on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 558	Continued From page 6	F 558		

On 3/29/22 at 9:00 AM, the Administrator stated she had asked department heads to make sure the call lights were within reach during their morning rounds this morning.

The Director of Nursing was interviewed on 3/31/22 at 1:59 PM and stated it was her expectation for call lights to be within reach of all residents at all times.

2) Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included a recent right hip fracture with surgical repair.

The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and required extensive assistance with personal care tasks.

Resident #32's care plan, last reviewed on 3/25/22, included the following focus areas:
- Activities of Daily Living (ADL) self-care performance deficit related to recent hospitalization from surgical repair of right hip, limited mobility, and decreased ability to complete her own ADLs. The interventions included to encourage the resident to use call bell for assistance.
- Risk for falls related to history of fall with fracture, limited mobility, and diuretic. The interventions included to be sure the resident's call light was within reach and encourage the use of it for assistance as needed.

On 3/28/22 at 9:45 AM, an observation was made of Resident #32 who was lying in bed with her eyes closed. The call light was observed to be

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F 558	Continued From page 7	F 558		

draped in the drawer of the bedside table with the drawer closed. The call bell was not within her reach.

Another observation occurred on 3/28/22 at 11:34 AM. Resident #32 was lying in bed watching TV. The call light remained in the closed drawer of the bedside table out of her reach. When asked how she would summon staff assistance if needed, Resident #32 stated she would either wait for someone to come in, walk by her room or yell out.

Resident #32 was observed sitting up in bed with lunch tray in front of her on 3/28/22 at 1:10 PM. The call light remained in the closed bedside table drawer out of reach.

On 3/29/22 at 8:42 AM, Resident #32 was observed to be sitting up in bed with breakfast tray in front of her. The call light was observed to on the floor beside the bed out of reach.

On 3/29/22 at 8:44 AM, the Social Worker (SW) was observed going into Resident #32's room, commenting on the call bell being on the floor and secured it to the bed.

The SW was interviewed on 3/29/22 at 8:50 AM and stated each department head was responsible for completing morning room rounds, to include call lights being in reach. She was unable to explain why Resident #32's call light was not within her reach during the day of 3/28/22.

Nurse Aide (NA) #1 was interviewed on 3/30/22 at 4:32 PM and was normally assigned to care for Resident #8. She stated all residents should have their call lights within reach at all times.

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F 558	Continued From page 8	F 558		

On 3/29/22 at 9:00 AM, the Administrator stated she had asked department heads to make sure the call lights were within reach during their morning rounds this morning.

The Director of Nursing was interviewed on 3/31/22 at 1:59 PM and stated it was her expectation for call lights to be within reach of all residents at all times.

3) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included history of a stroke affecting the left side.

The admission Minimum Data Set (MDS) assessment dated 3/6/22 indicated Resident #195 had moderately impaired cognition and required extensive assistance with personal care tasks.

Resident #195's care plan, included a focus area initiated on 3/13/22 for Activities of Daily Living (ADL) self-care performance deficit related to post hospitalization for therapy services for decreased mobility, ADL abilities and contracture of left upper arm as a result of a stroke. The interventions included to encourage the resident to use call bell for assistance.

On 3/28/22 at 11:30 AM, an observation was made of Resident #195 who was lying in bed with her eyes closed. The call light was observed to be draped in the bedside table drawer with the drawer closed which was located at the end of her bed. The call bell was not within her reach.

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F 558	Continued From page 9	F 558		

Another observation occurred on 3/28/22 at 12:30 PM. Resident #32 was sitting up in bed waiting for the lunch meal to arrive. The call light remained in the closed drawer of the bedside table out of her reach. When asked how she would summon staff assistance if needed, Resident #195 stated she would either wait for someone to come in, walk by her room or yell out.

Resident #195 was observed sitting up in bed eating lunch on 3/28/22 at 12:55 PM. The call light remained in the closed bedside table drawer out of reach.

On 3/29/22 at 8:40 AM, Resident #195 was observed to be sitting up in a wheelchair eating breakfast. The call light was observed to be on the floor between the end of her bed and beside table, out of reach.

On 3/29/22 at 8:48 AM, the Social Worker (SW) was observed going into Resident #195's room, commenting on the call bell being on the floor and secured it to the bed.

The SW was interviewed on 3/29/22 at 8:50 AM and stated each department head was responsible for completing morning room rounds, to include call lights being in reach. She was unable to explain why Resident #195's call light was not within her reach during the day of 3/28/22.

Nurse Aide (NA) #1 was interviewed on 3/30/22 at 4:32 PM,, was familiar with Resident #195 and stated all residents should have their call lights within reach at all times.

On 3/29/22 at 9:00 AM, the Administrator stated

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F 558	Continued From page 10 she had asked department heads to make sure the call lights were within reach during their morning rounds this morning. The Director of Nursing was interviewed on 3/31/22 at 1:59 PM and stated it was her expectation for call lights to be within reach of all residents at al	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		5/10/22

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F 561	Continued From page 11 facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to honor residents' choices related to showers and shampoos. This was for 2 of 5 residents (Residents #32 and #195) reviewed for Activities of Daily Living (ADL's). The findings included: 1) Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included muscle weakness, osteoarthritis, and chronic pain syndrome. The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and required extensive assistance for personal hygiene and was dependent on staff for bathing. A review of Resident #32's active care plan revealed a focus area, initiated on 3/9/22, for Activities of Daily Living (ADLs) self-care deficit related to recent hospitalization for surgical repair of right hip, limited mobility and decreased ability to complete her own ADLs. A review of Resident #32's nursing progress notes from 2/24/22 to 3/30/22 revealed no refusals of showers documented. A review of the medical records indicated Resident #32 was to receive a shower every Tuesday and Friday. Resident #32's personal care records were	F 561	1. 1. Resident #32 received a shower and shampoo on 04/09/2022. Resident #195 received a shower and shampoo on 03/31/2022. The Social Services Director interviewed Resident #32 and Resident #19 in regard to showers and shampoos to ensure receiving showers and shampoos per residents' choice. 2. A quality review was completed by the Social Services Director and Nurse Manager of current interview able residents to ensure residents are receiving showers and shampoos per residents' choice on 04/26/2022. Care plan, Kardex and shower schedule updated to reflect resident's shower and shampoos preference. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. Nursing staff that has not completed the education will completed the prior to working next scheduled shift. 3. The Director of Nursing or designee educated nursing staff on residents' choice related to receiving showers and shampoos by 05/06/2022. Nursing staff that has not completed the education will completed the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation.	

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F 561	Continued From page 12 reviewed and revealed she had received 1 shower from 3/1/22 to 3/29/22. She was showered on 3/4/22. There were no refusals of bathing assistance on the personal care record. On 3/28/22 at 9:50 AM, an interview occurred with Resident #32 who stated she couldn't recall receiving a shower since admission but would really like to get one. Stated the warm water helped her joint discomfort. Resident #32 was free from odors, but her hair was greasy in appearance. Nurse Aide (NA) #2 was interviewed on 3/30/22 at 11:45 AM, was familiar with the resident and often assigned to care for her on the day shift (7:00 AM to 3:00 PM). She explained that if a scheduled shower wasn't given on the day shift then the evening shift would be responsible to provide it. NA #2 reviewed Resident #32's personal care record and indicated she had provided a shower on 3/4/22 as documented but was unable to explain why no other showers were provided on Resident #32's scheduled days of Tuesday and Friday. An interview occurred with NA #1 on 3/30/22 at 4:32 PM. She was familiar with Resident #32 and cared for her on the evening shift (3:00 PM to 11:00 PM). NA #1 stated Resident #32 preferred to receive a bed bath and was provided to her on the scheduled shower days. On 3/31/22 at 2:00 PM, the Director of Nursing (DON) was interviewed and stated she had been employed at the facility for close to 2 months. The DON stated she expected showers to be provided/offered on the scheduled shower days and if a resident refused there should be	F 561	4. The Social Services Director and or Nurse Manager will conduct random Quality reviews by resident interviews of 5 residents to ensure resident receiving showers and shampoos per resident's choice 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAP) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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documentation on both the NA documentation as well as nursing progress notes.

2) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included history of stroke with left sided deficits, osteoarthritis, and unsteadiness on her feet.

The admission Minimum Data Set (MDS) assessment dated 3/6/22 indicated Resident #195 had moderately impaired cognition and required extensive assistance with Activities of Daily Living (ADLs) and was dependent on staff for bathing.

A review of Resident #195's active care plan revealed a focus area, initiated on 3/13/22, for ADL self-care deficit related to admitted post hospitalization for therapy services for decreased mobility, ADL abilities complicated by cognitive deficits and contracture of left upper arm.

A review of Resident #195's nursing progress notes from 3/1/22 to 3/29/22 revealed no refusals of showers documented.

A review of the medical records indicated Resident #195 was to receive a scheduled shower on Wednesday and Saturday first shift (7:00 AM to 3:00 PM) until 3/15/22. She changed rooms and the scheduled shower changed to Monday and Thursday on first shift.

Resident #195's personal care records were reviewed and revealed she had received 2 showers from 3/1/22 to 3/29/22. She was showered on 3/9/22 and on 3/17/22. There were no refusals of bathing assistance on the personal

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F 561	Continued From page 14 care record. On 3/29/22 at 9:10 AM, an interview occurred with Resident #195 who stated she couldn't recall receiving a shower or shampoo since admission but would really like to get one. Resident #195 was free from odors, but her hair was observed to be greasy, uncombed and her entire forehead had flaky, white skin. Nurse Aide (NA) #2 was interviewed on 3/30/22 at 11:45 AM, was familiar with the resident, had provided a shower to Resident #195 on 3/17/22 and stated she had received no refusals. An interview occurred with NA #1 on 3/30/22 at 4:32 PM. She was familiar with Resident #195 and cared for her on the evening shift (3:00 PM to 11:00 PM). NA #1 stated Resident #195 preferred to receive a bed bath. On 3/31/22 at 2:00 PM, the Director of Nursing (DON) was interviewed and stated she had been employed at the facility for close to 2 months. The DON stated she expected showers to be provided/offered on the scheduled shower days and if a resident refused there should be documentation on both the NA documentation as well as nursing progress notes.	F 561		
F 580 SS=J	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	F 580		5/10/22

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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 (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

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F 580	Continued From page 16 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, Nurse Practitioner #1, Physician and staff interviews, the facility failed to notify the Physician or Nurse Practitioner of a change in wound condition to Resident #32's right heel on 3/20/22. This was for 1 of 8 residents reviewed for pressure ulcers. Immediate Jeopardy began on 3/20/22 when staff had failed to notify the physician or Nurse Practitioner (NP) of a change in wound status for Resident #32's right heel which progressed to an unstageable pressure ulcer. Immediate Jeopardy was removed on 4/9/22 when the facility provided and implemented an acceptable credible allegation of the Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put into place and to complete staff training. The findings included: Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included a recent right hip fracture with surgical repair, and protein calorie malnutrition. A review of the hospital discharge summary dated 2/24/22 did not reveal any skin breakdown to Resident #32's buttocks or heels. A nursing progress note dated 2/24/22 indicated	F 580	1. 1. A late entry nursing progress note dated 03/22/2022 indicated Resident #32 was observed with eschar to her heel when a treatment was completed on 03/20/2022. On 03/20/2022 the facility failed to notify physician of change in wound. On 03/30/2022 new order noted for betadine to right heel pressure area. 2. On 04/08/2022, all residents have been assessed for change in condition to include vital signs and complete head to toe skin assessment. 47 total residents reviewed was completed by licensed nurses to identify residents with a change in condition related to pressure. On 04/08/2022 Physician/Nurse Practitioner notification via change in condition (SBAR) was completed with any new pressure areas. On 04/08/2022, all resident's progress notes for the last 30 days have been review for change in condition to include newly identified pressure areas. Change of conditions (SBARS) were reviewed along with progress note and skin sweep completed to identify any change noted and assessment complete. Information below was reviewed and verified by licensed nurse if change was identified. 47 total residents reviewed for: Family/Responsible Party Notification, Physician Notification, Physician order for treatment (if indicated), Appropriate	

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Resident #32 was admitted to the facility. Her skin was warm and dry with redness to the sacrum. No other mention of skin concerns in the progress note.

Review of a Change in Condition assessment for Resident #32, dated 3/5/22, timed 4:52 PM and completed by Nurse #5, read a pressure area was identified to the right heel. The assessment was marked unknown for treatment for last episode or if this symptom had occurred before. The Appearance section of the Assessment was summarized as "resident with pressure area to right heel". There was no description of the color or size of the area identified. The assessment noted the physician was notified and provided new orders.

A late entry, nursing progress note, written by Nurse #4 and dated 3/22/22 indicated Resident #32 had eschar (black, brown, or tan dead tissue that adheres to the wound bed or edges and may be firmer or softer than the surrounding skin) to the left heel when the treatment was completed on 3/20/22.

A review of Resident #32's medical record revealed there was no documentation to show the physician or NP were notified of the eschar found to Resident #32's right heel from 3/20/22 to 3/28/22.

A phone interview was conducted with Nurse #4 on 3/30/22 at 6:38 PM. She stated Resident #32 had eschar to the right heel when the treatment was completed on 3/20/22. Nurse #4 stated skin prep was already being utilized for the area and she left communication for the Assistant Director of Nursing (ADON) regarding her findings since

documentation, Interventions to prevent further changes and /or worsening of condition and Appropriate Care Plan Intervention put in place.
On 04/08/2022 Physician/Nurse Practitioner notification via change in condition (SBAR) was completed with any new pressure areas.
3. On 4/08/22, the Regional Director of Clinical Services and Executive Director initiated education to the Licensed Nurses, Medication Aides and Certified Nursing Aides. After 4/08/2022, Licensed Nurses, Medication Aides and Certified Nursing Aides not educated will receive this education prior to working their next scheduled shift), regarding physician notification of a change of condition related to residents with newly identified pressure areas, recognition and response to include the following: Evidence of a Licensed Nurse assessment, Physician's order (if indicated), Treatments have been performed per Physician's order and documented, Physician and responsible party notification of changes, Appropriate care plan is in place, Accurate documentation and Continued monitoring for change of condition related to.
On 04/08/2022, the Director of Clinical Services and/or Designee initiated education with Certified Nursing Assistants/Medication Aides regarding licensed nurse notification of a change of condition observation to include the following: Interact – Stop and Watch Tool
After 04/08/2022 Certified Nursing Assistants/Medication Aides not previously educated on change of

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the ADON had been helping with treatments due to the wound nurse was no longer at the facility. She could not recall notifying the physician or NP of the eschar present to Resident #32's right heel.

The ADON was interviewed on 3/30/22 at 10:05 AM and was unable to recall being told about the eschar to Resident #32's heel by Nurse #4. She added, if an Nurse Aide (NA) identified an area of concern during personal care they should report it to herself, the nurses, or Director of Nursing (DON). If a nurse identified an area of concern for a resident, they could report it to herself, the DON or directly to the physician/NP.

On 3/30/22 at 3:04 PM, an interview occurred with Nurse #2 who stated if skin concerns were observed on any resident they would either report it to the ADON, since she had been assisting with treatments, to the DON or directly to the physician or NP. She was unable to recall if this had occurred for Resident #32.

NP #1 was interviewed on 3/31/22 at 11:20 AM and reported since the treatment nurse was no longer at the facility there had been errors in wound care, which she had addressed with the ADON and DON. The NP stated she had assessed Resident #32 after her admission to the facility and had not identified any pressure ulcers to her heels, only a surgical wound to her right hip. She stated she would have expected to be notified when the area was first identified so proper treatment and oversight could have occurred.

An interview was conducted with the DON on 3/31/22 at 2:00 PM and indicated she had been employed at the facility for close to 2 months. She

condition observation and Interact Stop and Watch Tool will be educated prior to working their next scheduled shift. Newly Hired Certified Nursing Assistants/Medication Aides will be educated during the Orientation process going forward. The Director of Nursing has been notified of this responsibility. Newly Hired Licensed Nurses, Medication Aides and Certified Nursing Aids, will be educated during the Orientation process by the Director of Nursing, going forward. The Director of Nursing has been notified of this responsibility.
Education is being provided in person and via phone. The Executive Director is tracking who has received education. Validation of understanding has been documented via post-test questionnaire. Post-test will be completed via phone by reading of multiple choice by nurse manager or Executive Director.
The Director of Nursing will review electronic record who had a change in condition to the morning meeting to ensure physician notification, to include new orders for wound care and assessments complete for change of condition. Completed change of conditions are noted in point click care and discussed during morning meeting to ensure documentation and notification are complete.
4. The Nurse Manager will conduct random Quality reviews of 5 resident's with wounds to ensure physician and RP notification completed when change in wound noted 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse

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F 580	Continued From page 19 reported there had been turn-overs in staff and there wasn't a full-time treatment nurse currently. The DON added she expected the nurse who identified the open area to document what the area looks like as well as report to the either the physician or NP. A phone interview was completed with the physician on 4/9/22 at 1:11 PM. When asked about being notified of Resident #32's pressure area to the right heel on 3/5/22, he stated he received multiple calls during the day and could not readily recall, however he would have instructed the nurse to use the facility standing orders and have the resident seen by the NP and wound physician. The physician stated he could not recall observing an area of eschar to Resident #32's right heel. The Administrator was notified of the Immediate Jeopardy on 4/8/22 at 10:05 AM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. A late entry nursing progress note dated 3/22/22 indicated Resident #32 was observed with eschar to her heel when a treatment was completed on 3/20/22. On 3/20/22 the facility failed to notify physician of change in wound. On 3/30/2022 new order noted for betadine to right heel pressure area.	F 580	Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 580	Continued From page 20 On 04/08/2022, all residents have been assessed for change in condition to include vital signs and complete head to toe skin assessment. 47 total residents reviewed was completed by licensed nurses to identify residents with a change in condition related to pressure. On 04/08/2022 Physician/NP notification via change in condition (SBAR) was completed with any new pressure areas. On 04/08/2022, all resident's progress notes for the last 30 days have been review for change in condition to include newly identified pressure areas. Change of conditions (SBARS) were reviewed along with progress note and skin sweep completed to identify any change noted and assessment complete. Information below was reviewed and verified by licensed nurse if change was identified. 47 total residents reviewed. - Family/Responsible Party Notification - Physician Notification - Physician order for treatment (if indicated) - Appropriate documentation - Interventions to prevent further changes and /or worsening of condition - Appropriate Care Plan Intervention put in place On 04/08/2022 Physician/NP notification via change in condition (SBAR) was completed with any new pressure areas. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.	F 580		

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F 580	Continued From page 21 On 4/08/22, the Regional Director of Clinical Services and Executive Director initiated education to the Licensed Nurses, Medication Aides and Certified Nursing Aides. After 4/08/2022, Licensed Nurses, Medication Aides and Certified Nursing Aides not educated will receive this education prior to working their next scheduled shift), regarding physician notification of a change of condition related to residents with newly identified pressure areas, recognition, and response to include the following: - Evidence of a Licensed Nurse assessment - Physician's order (if indicated) - Treatments have been performed per Physician's order and documented - Physician and responsible party notification of changes - Appropriate care plan is in place - Accurate documentation - Continued monitoring for change of condition related to On 4/08/22, the Director of Clinical Services and/or Designee initiated education with Certified Nursing Assistants/Medication Aides regarding licensed nurse notification of a change of condition observation to include the following: - Interact - Stop and Watch Tool After 4/08/2022 Certified Nursing Assistants/Medication Aides not previously educated on change of condition observation and Interact- Stop and Watch Tool will be educated prior to working their next scheduled shift. Newly Hired Certified Nursing Assistants/Medication Aides will be educated during the Orientation process going forward. The Director of Nursing has been notified of this responsibility.	F 580		

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Newly Hired Licensed Nurses, Medication Aides and Certified Nursing Aids, will be educated during the Orientation process by the Director of Nursing, going forward. The Director of Nursing has been notified of this responsibility.

Education is being provided in person and via phone. The Executive Director is tracking who has received education. Validation of understanding has been documented via post-test questionnaire. Post-test will be completed via phone by reading of multiple choice by nurse manager or Executive Director.

The Director of Nursing will review electronic record who had a change in condition to the morning meeting to ensure physician notification, to include new orders for wound care and assessments complete for change of condition. Completed change of conditions are noted in point click care and discussed during morning meeting to ensure documentation and notification are complete.

The facility alleges the removal of Immediate Jeopardy on 4-9-22.

On 4/12/22 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included:

The 4/8/22 facility audit was reviewed and revealed 3 current residents were identified with skin integrity concerns during a skin sweep. Change in condition assessments were completed and the Nurse Practitioner and

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responsible party were notified on 4/8/22.

Education to licensed nursing staff regarding provider notification of a change in condition related to newly identified pressure areas was reviewed and sign in sheets were provided.

Education for Nurse Aides and Medication Aides, regarding notification to a licensed nurse when a skin impairment was observed were reviewed and sign in sheets were provided.

Nurse #2 was interviewed on 4/12/22 at 11:30 AM and stated she had received recent education on notification to the physician or NP when a skin impairment was identified. In addition, a change in condition assessment would be completed and the responsible party and Nurse Manager would be made aware.

On 4/12/22 from 11:45 AM until 12:10 PM interviews of 4 Nurse Aides was conducted which revealed they had recently received education on reporting any observed skin concerns immediately to the charge nurse or Nurse Manager.

An interview occurred with the Administrator and interim Director of Nursing (DON) on 4/12/22 at 12:15 PM. The interim DON explained when changes in skin conditions or newly identified skin impairments were noted licensed nursing staff were to complete a change in condition assessment and notify the responsible party, physician/NP, dietician and if needed the wound physician. The Administrator stated the physician had asked for the facility staff to contact him during off hours rather than the on-call physician services as they were not familiar with the

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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 580	Continued From page 24 residents. The facility's Immediate Jeopardy removal date of 4/9/22 was validated.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		5/10/22

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	345450	A. BUILDING _____ B. WING _____	C 04/12/2022

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F 583	Continued From page 25 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide privacy to a resident during care by not closing the door during the dressing change causing the resident's buttocks exposed to the public for 1 of 6 sampled residents observed during care (Resident # 40). Findings included: Resident # 40 was admitted to the facility on 10/22/21 with multiple diagnoses including pressure ulcer to the right buttock, unstageable. The significant change in status Minimum Data Set (MDS) assessment dated 2/23/22 indicated that Resident #40 had moderate cognitive impairment and he had pressure ulcers. Resident #40 was observed during the dressing change on 3/29/22 at 2:45 PM. The Assistant Director of Nursing (ADON) was observed to provide the treatment to the resident's buttock/sacral area. The Nurse turned the resident to his right side facing the wall and his buttocks were facing the door. The door was wide open, and the resident's buttocks were exposed to the hallway. The ADON was interviewed on 3/30/22 at 10:50 AM. She stated that the privacy curtain between the residents and the door should be closed during the dressing change to prevent exposure of the resident's private areas. She reported that she didn't know that the door was open when she provided the dressing to the resident's buttock pressure ulcer.	F 583	1. 1. Assistant Director of Nursing (identified employee) no longer is employed by the facility as of 04/01/2022. 2. A quality review was completed by the Nurse Manager by observation of nurse providing wound care to ensure privacy provided by closing door and privacy curtains on 04/19/2022. No concerns identified during review. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nurse Manager educated nursing staff on personal privacy related to ensuring privacy is provided by closing of door and privacy curtain when care is being provided by 05/06/2022. Nursing staff that has not competed the education will completed the education prior to working next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews by observation of staff providing care to ensure privacy being provided by closing of door and privacy curtain of 2 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit)	

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F 583	Continued From page 26 The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON expected nursing to provide privacy by closing the door and pulling the privacy curtain between the residents to provide privacy during the dressing change.	F 583	and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 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);	F 584		5/10/22

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F 584	Continued From page 27 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with resident and staff, the facility failed to address a peeling ceiling for 1 of 1 reviewed for environment (Room #126). The findings included: Resident #5 was admitted to the facility on 3/15/2021. The resident's quarterly Minimum Data Set (MDS) dated 3/25/2022 indicated the resident was mildly cognitively impaired. An interview was conducted with Resident #5 on 3/30/2022 at 3:29 PM. She stated the ceiling in room #126 was peeling over her and debris would sometimes drop onto her bed. She stated she made the staff aware but could not remember who she made aware or when she made them aware. On 3/30/2022 at 3:30 PM the popcorn ceiling was observed to be peeling in multiple locations with some areas located over the resident's bed. There was no debris observed on the resident's bed at that time.	F 584	1. 1. Room 126's peeling ceiling was repaired by the Maintenance Director on 04/22/2022. 2. A quality review was completed by the Maintenance Director and Executive Director to identify any other resident rooms peeling areas on ceiling on 04/15/2022. 24 resident rooms were identified with areas on ceiling that need repair. Identified rooms will be repaired by 05/06/2022. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Maintenance Director on timely repairing of peeling areas on ceiling on 04/22/2022. 4. The Executive Director will conduct random Quality reviews by observation of ceiling in 5 areas in building to include resident rooms 2 times a week for 8 weeks then weekly for 4 weeks. The	

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F 584	Continued From page 28 The facility grievance log from September 2021 through March 2022 did not reveal a grievance regarding the ceiling by Resident #5 or her responsible party. On 3/31/2022 at 12:30 PM an interview was conducted with the director of facility's maintenance. He stated he was aware of the ceiling in Resident #5's room. He further stated during the pandemic he was unable to get to some of the routine maintenance such as the ceilings. He had a list of repairs he was working on and the resident's ceiling was on that list.	F 584	Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries,	F 640		5/10/22

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F 640	Continued From page 29 and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit an Annual Minimum Data Set (MDS) assessment within the required time frame for 1 of 1 resident selected to be reviewed for submission of Resident Assessments within the required time frame (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 8/12/18.	F 640	1. 1. Resident #1 Annual Minimum Data Set (MDS) was transmitted by the Regional MDS Nurse on 03/27/2022. 2. A quality review was completed by the Regional MDS Nurse to ensure resident's annual MDS transmitted timely on 04/20/2022. No assessments were identified as being out of compliance with transmission guidelines. An Ad hoc Quality Assurance	

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F 640	Continued From page 30 A review of Resident #1's most recent completed MDS was dated 2/17/22 and was coded as an annual assessment. On 3/30/22 at 11:30 AM, an interview was conducted with the Regional MDS Consultant who stated the Annual MDS assessment for Resident #1 was completed on 2/17/22 but not transmitted until 3/27/22, when she was reviewing information left behind by the former MDS Nurse. The Administrator was present during the interview with the Regional MDS Consultant on 3/30/22 at 11:30 AM and added the former MDS nurse left abruptly 2 weeks ago. The Regional MDS Consultant was assisting the facility with the MDS assessments until a permanent MDS nurse was hired.	F 640	Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Regional MDS Coordinator educated the new MDS Coordinator on transmitting resident assessments timely on 04/26/2022. 4. The Regional MDS Coordinator will conduct random Quality reviews of MDS assessments to ensure transmitted timely of 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Activities of Daily Living (Resident #195), medications (Resident #195) and discharge disposition (Resident #45). This was for 2 of 23 residents reviewed.	F 641	1. Resident #195 MDS was corrected in the areas of ADL, medications and discharge disposition to accurately reflect the resident and submitted by the Regional MDS Nurse on 04/19/2022. Resident #195 MDS was corrected to include antibiotic administration/ received to accurately reflect the resident and	5/10/22

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The findings included:

1) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included history of a stroke with left sided deficits, muscle weakness and dementia.

A review of Resident #195's March 2022 physician orders included an order dated 3/4/22 for Augmentin (an antibiotic) 875-125 milligrams (mg) 1 tablet by mouth every 12 hours for aspiration pneumonia for 7 days.

The admission Minimum Data Set (MDS) assessment dated 3/6/22 indicated Resident #195 had moderately impaired cognition and required supervision for eating, extensive assistance with bed mobility, dressing, transfers and was dependent on staff for bathing. The toileting and personal hygiene sections were coded as the activity occurred only once or twice during the seven day look back period. The bowel and bladder section of the assessment indicated Resident #195 was occasionally incontinent of bladder and always incontinent of bowel. She was not coded for antibiotic use.

A review of the nursing progress notes from 2/28/22 through 3/30/22 revealed Resident #195 required assistance with Activities of Daily Living (ADLs) to include personal hygiene and toileting tasks.

An interview occurred with Nurse Aide (NA) #2 who was familiar with Resident #195. She stated extensive to total assistance was required for personal care and toileting tasks. Staff provided assistance with toileting and incontinence care every 2 to 3 hours and as needed.

submitted by the Regional MDS Nurse on 03/31/2022.Resident #45 MDS was corrected in the areas of ADL, medications and discharge disposition to accurately reflect the resident and submitted by the Regional MDS Nurse on 03/31/2022.

2. A quality review was completed on the current residents MDSs in the areas of ADL, medications and discharge disposition to validate the most recent MDS assessment have been coded to accurately reflect the status of the residents by the Regional MDS on 05/10/2022.

An ADHOC Quality Assurance Performance Improvement Committee was held by 05/10/2022 to formulate and approve a plan of correction for the deficient practice.

3. The Regional MDS Coordinator educated the new MDS Coordinator on accurately coding of ADLs, medications and discharge disposition by 05/10/2022.

4. The Regional MDS Coordinator will conduct random Quality reviews of 5 residents MDS assessments of section G ADL coding, section N medications and section A in regards to discharge disposition to ensure MDS coded accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the QAPI committee.

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F 641	Continued From page 32 The MDS Nurse Consultant was interviewed on 3/31/22 at 12:55 PM, who reviewed the 3/6/22 MDS assessment as well as Resident #195's medical record. She verified the toileting and personal hygiene areas were marked as the activity occurred only once or twice. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the NA's but should have been coded as extensive assistance for personal hygiene and toileting tasks. Stated she took from the documentation as she was unable to complete interviews with staff and Resident #195 at the time of the assessment. The MDS Nurse Consultant further stated antibiotic use should have been coded for 2 days and felt it was an oversight. 2. Resident #45 was admitted to the facility on 11/12/21 and was discharged to the community on 12/29/21. The nurse's note dated 12/29/21 at 3:56 PM revealed that Resident #45 was discharged to home at 10 AM with medications. Resident #45's discharge Minimum Data Set (MDS) assessment dated 12/29/21 was reviewed. The assessment under "discharge status" indicated that the resident was discharged to the hospital on 12/29/21. The MDS Nurse who completed this assessment was no longer an employee of the facility. The Regional MDS Nurse Consultant was interviewed on 3/31/22 at 1:06 PM. She verified that the facility had no MDS Nurse, and she was currently helping them with their MDS assessments. She reviewed the nurse's note and	F 641	Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 641	Continued From page 33 the MDS assessment dated 12/29/21 and verified that the discharge MDS was coded incorrectly, it should have been coded discharged to the community instead of hospital. The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON stated that the facility did not have an MDS Nurse and the Regional MDS Nurse was helping them. She stated that she expected the MDS assessments to be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with residents, staff, Nurse Practitioner #1, and Nurse Practitioner #2, the facility failed to administer medications as ordered (Residents #17, and #15) for 2 of 7 residents whose medications were reviewed. The findings included: 1. Resident #17 was admitted to the facility on 12/3/2014 with diagnoses that included vascular dementia and hypertension. The resident's significant change Minimum Data Set (MDS) dated 2/6/2022 indicated Resident #17 was moderately cognitively impaired, required extensive assistance with all activities of daily	F 658	1. 1. The Medical Director/Nurse Practitioner was notified of missed medication of Resident #15 and Resident #17 on 03/31/2022. The Medication Aide was educated by the Nurse Manager of administering medications as ordered, use of emergency back –up kit and notification of MD if medications not administered as ordered for further orders on 4-19-22. 2. A quality review was completed by the Nurse Manager of current resident's medication administration records of medications stating not given due to unavailable and/or waiting on delivery from pharmacy on 4-26-22. 2 medications	5/10/22

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F 658	Continued From page 34 living, toileting, and personal hygiene. The resident received anticoagulant 6 out of 7 days, antidepressant 5 out of 7 days, and antipsychotic 6 out of 7 days during the assessment period. The resident's care plan, last updated on 2/17/2022, had a focus for antipsychotic therapy, mood disorder, and dementia. Interventions for each included administering medications per physician's orders. Resident #17's medical record revealed the resident had physician's orders for the following medications: Memantine extended release 28 milligrams (mg) orally daily for dementia. The order had a start date of 8/1/2020 with no end date. Metoprolol 100 mg orally twice daily for hypertension (high blood pressure). The order had a start date of 2/1/2022 with no end date. A review of the resident's Medication Administration Records (MAR) for March 2022 indicated the following medications were not given on March 20th; Memantine (6:00pm), and Metoprolol (9:00 am and 5:00pm). The Medication aide documented the missed administration due to waiting on delivery. On 3/30/2022 at 11:25 AM an interview was conducted with the Medication Aide. She reviewed the March 2022 MAR and stated she did not give the medication because they were not available, she was waiting for them to be delivered by pharmacy. When asked if any of the medication were available in the emergency kit, she stated she did not know. When asked if the physician or nurse practitioner had been notified, she stated she had not called them.	F 658	documented waiting on pharmacy on 4-25 -22. Nurses re-educated on administering medications as ordered, use of emergency back-up kit and notification of MD if medications not administered as ordered for further orders. A medication cart audit to medication administration record review was conducted to ensure medications ordered are noted in medication cart by the Nurse Manager on 4-20-22. Medications with less than week supply was reordered at that time. A 100% medication administration record to medication cart audit was complete by Omnicare Nurse on 4-27-22. 26 medications were not available at time of audit. All medications identified were immediately ordered. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 4-28-22 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager educated nurses and medication aides on administering medications as ordered, use of back-up emergency kit and notification of MD/NP if medications not administered as ordered for further orders by 5-6-22. Omnicare representative will educate nurses and medication aides on ordering of medication, returning medication and use of back up on 5-4-22. Nursing staff that has not completed the education will completed the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation.	

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F 658	Continued From page 35 On 3/31/2022 at 11:27 AM an interview was conducted with the Nurse Practitioner. She stated she had noticed missed administrations on the MARs and she had asked about them. The NP stated she would expect to be notified if medications are not available or not given. 2. Resident #15 was admitted to the facility on 11/9/19 with multiple diagnoses including diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 1/20/22 indicated that Resident #15 had severe cognitive impairment. Resident #15 had physician's orders for Metformin (used to treat diabetes mellitus) 500 mgs by mouth twice a day (9 AM & 5 PM) for type 2 diabetes mellitus on 9/8/20. Review of the March 2022 Medication Administration Records (MARs) revealed that Resident #15 did not receive Metformin on 3/20/22 (5 PM dose), 3/21/22 (9 AM dose), 3/22/22 (9 AM dose) and 3/23/22 (9 AM dose). The MARs revealed that T40 was assigned to Resident #15 on 3/20/22, 3/22/22 and 3/23/22 when the Metformin was not administered due to "not available or waiting from the pharmacy". Nurse #2 was interviewed on 3/30/22 at 12:10 PM. The Nurse reported that the facility had back up medications in the medication room that were available if needed. The list of medications in the back up was reviewed and Metformin was included in the list of back up medications. The Medication Aide (MA) was interviewed on 3/30/22 at 12:15 PM. The MA verified that T40 was her initial on the March 2022 MARs. She	F 658	4. The Nurse Manager will conduct random Quality reviews of medication administration records to ensure medications administered as ordered on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement committee (QAPI). Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 658	Continued From page 36 stated that she did not administer the Metformin since it was not available, or she could not find them in the medication cart. She stated that she was aware that there were back up medications in the medication room, but she didn't know why she was not utilizing the back medications. The MA reported that she had notified the Nurse when the medication was not available and was told to reorder them from the pharmacy. The pharmacy often responded that it was "too early for refill". The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. She stated that she just started as DON at the facility end of February 2022. The DON stated that she expected the nurses including the MA to inform her when a medication was not available or could not be found in the medication cart or medication room. She would help the nurse/MA find the medication. She reported that the reason might be that the medication was available in the cart but was labeled in generic form.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #8, #32, #34, and #38). This was for 4 of 17 residents reviewed for dependency on staff for Activities of Daily Living (ADLs).	F 677	1. 1. Resident #8, #32, #34, and #38 was provided nail care to include cleaning and trimming their nails on 03/31/2022. 2. A quality review was completed by the Nurse Manager on current residents on Activities of Daily Living (ADL) care	5/10/22

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F 677	Continued From page 37 The findings included: 1) Resident #8 was originally admitted to the facility on 7/8/19 with diagnoses that included diabetes type 2, mild cognitive impairment, and history of a stroke. The annual Minimum Data Set (MDS) assessment dated 12/28/21, indicated Resident #8 had moderately impaired cognition and required extensive assistance for personal hygiene. A review of Resident #8's active care plan, last reviewed on 1/12/22, revealed the following focus areas: - ADL self-care deficit that read, in part, "related to stroke, diabetic with neuropathy and dementia. Alert with confusion at times. Prefers to do for herself. Does not allow staff to assist much of the time". The interventions included to check nail length and trim and clean on bath day and as needed. Report any changes to the nurse. - Resident has a behavior problem of smearing bowel movement on the walls, refuses staff assistance with ADL's. A review of Resident #8's nursing progress notes from 1/1/22 to 3/30/22 revealed no refusals of nail care documented. On 3/28/22 at 10:04 AM, Resident #8 was observed while lying in her bed. She was noted to have a light and dark brown substance under long fingernails to both hands. Resident #8 stated she couldn't recall the last time her nails were attended to, but they were "longer than I like to wear them".	F 677	specific to nail care on 04/20/2022. Identified residents were provided nail care to include cleaning and trimming at that time. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing re-educated nursing staff on all shifts, including part-time and prn on ADL care specific to nail care by 05/06/2022. Nail care will be monitored on shower list sheet to ensure nail care offered and completed. Staff will not be allowed to return to work until education is complete. 4. The Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided nail care with Activities of Daily Living (ADL) care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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Nurse Aide (NA) #2 was interviewed on 3/30/22 at 11:45 AM. She was familiar with the resident and often assigned to care for her on the day shift (7:00 AM to 3:00 PM). Stated Resident #8 was very independent, had not provided care to her fingernails and was unaware her nails needed attention. She added nail care was to be completed with personal care and showers or when there was a need.

Resident #8 was observed on 3/30/22 at 4:20 PM, while sitting in her wheelchair beside her bed. Her nails to both hands remained long with a light and dark brown substance under them. Resident #8 stated "they still haven't been cut".

An interview occurred with NA #1 on 3/30/22 at 4:32 PM. She was familiar with Resident #8 and cared for her on the evening shift (3:00 PM to 11:00 PM). She stated Resident #8 was independent with her personal care and it had been a while since she had cared for Resident #8's nails but would look at them. NA #1 added nail care was to be completed when personal care and showers were provided or whenever there was a need.

On 3/31/22 at 10:57 AM, Resident #8 was observed sitting in her wheelchair beside her bed. Her fingernails to both hands were cut shorter but a light and brown substance remained under them to both hands.

The Assistant Director of Nursing (ADON) was interviewed on 3/31/22 at 12:37 PM and stated she had been employed at the facility 3 months. She explained nail care should be completed during the residents scheduled shower and/or with personal care daily. She stated the NAs

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should ensure resident's nails were shot, to the resident's preference, not jagged and clean. The ADON stated she was unaware Resident #8 needed nail care.

On 3/31/22 at 2:00 PM, the Director of Nursing (DON) was interviewed and stated she had been employed at the facility for close to 2 months. She stated it was her expectation for nail care to be provided during personal care tasks and if a NA was unable to complete the task she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #8 as there was no documentation to show this had or had not been completed or attempted.

2) Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included muscle weakness, osteoarthritis, and chronic pain syndrome.

The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and required extensive assistance for personal hygiene and was dependent on staff for bathing.

A review of Resident #32's active care plan revealed a focus area, initiated on 3/9/22, for Activities of Daily Living (ADLs) self-care deficit related to recent hospitalization for surgical repair of right hip, limited mobility and decreased ability to complete her own ADLs.

A review of Resident #32's nursing progress notes from 2/24/22 to 3/30/22 revealed no refusals of nail care documented.

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On 3/28/22 at 9:50 AM, Resident #32 was observed while sitting up in her bed. She was noted to have a light brown substance under fingernails to both hands. Resident #32 stated she liked her medium length fingernails but didn't like them "dirty" underneath.

Resident #8 was observed on 3/29/22 at 8:42 AM while sitting up in her bed and was noted to have a light brown substance under the fingernails to both hands.

Nurse Aide (NA) #2 was interviewed on 3/30/22 at 11:45 AM. She was familiar with the resident and often assigned to care for her on the day shift (7:00 AM to 3:00 PM). She stated nail care was completed with personal care and scheduled showers or if there was a need. NA #2 stated she could not recall completing nail care to Resident #32 and was unaware of a need.

An interview occurred with NA #1 on 3/30/22 at 4:32 PM. She was familiar with Resident #32 and cared for her on the evening shift (3:00 PM to 11:00 PM). She stated nail care was to be completed as needed with personal care and during scheduled showers. She could not recall providing nail care to Resident #32 or that she had a need for nail care to be completed.

The Assistant Director of Nursing (ADON) was interviewed on 3/31/22 at 12:37 PM and stated she had been employed at the facility 3 months. She explained nail care should be completed during the residents scheduled shower and/or with personal care daily. She stated the NAs should ensure resident's nails were shot, to the resident's preference, not jagged and clean. The

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ADON stated she was unaware Resident #32 needed nail care.

On 3/31/22 at 2:00 PM, the Director of Nursing (DON) was interviewed and stated she had been employed at the facility for close to 2 months. She stated it was her expectation for nail care to be provided during personal care tasks and if a NA was unable to complete the task she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #32 as there was no documentation to show this had or had not been completed or attempted.

3. Resident #38 was admitted to the facility on 3/7/22 with multiple diagnoses including Congestive Heart Failure (CHF). The admission Minimum Data Set (MDS) assessment dated 3/13/22 indicated that Resident # 38's cognition was intact, no rejection of care and he needed extensive assistance with personal hygiene.

Resident #38's care plan dated 3/13/22 was reviewed. One of the care plan problems was the resident had an activity of daily living (ADL) self-care performance deficit related to progressing decline in ADL function. The approaches included to provide personal hygiene care; the resident required extensive assist to total care for personal hygiene.

Resident #38 was observed in bed on 3/28/22 at 9:50 AM. His fingernails were long approximately ¼ to ½ inch beyond the end of his fingertip and dirty with brown/ black substance underneath his nails. The resident stated that nobody had been trimming nails at the facility.

Resident #38 was again observed on 3/29/22 at

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12:02 PM and on 3/30/22 at 2:01 PM. He was in bed and his fingernails remained the same long and dirty. He stated that his nails had not been trimmed for a while and he needed help to trim them.

Nurse Aide (NA) #5, assigned to Resident #38, was interviewed on 3/30/22 at 2:01 PM. She stated that resident's fingernails were trimmed during their shower days or as needed. The NA observed the resident's fingernails and verified that they were long and dirty. She was observed to cut the resident's nails and the resident stated, "thank you for trimming my nails". NA #5 commented that it might be due to short staff and the staff did not have the time to trim resident's nails.

The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. She stated that she expected the NAs to trim resident ' s nails during their shower days and or when needed.

4. Resident #34 was admitted to the facility on 8/5/21 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 3/2/22 indicated that Resident #34 had moderate cognitive impairment, no rejection of care and he needed one-person physical assist with personal hygiene.

Resident #34's care plan dated 3/2/22 was reviewed. One of the care plan problems was the resident has an activity of daily living (ADL) self-care performance deficit related to cognitive deficit and weakness. The approaches included to provide personal hygiene care; the resident required assistance of one staff with personal

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F 677	Continued From page 43 hygiene. Resident #34 was observed in bed on 3/28/22 at 9:46 AM. His fingernails were long approximately ½ inch beyond the end of his fingers, jagged and dirty with black substance underneath his nails. He stated that the staff had not assisted him with nail care in a long time. Resident #34 was again observed on 3/29/22 at 12:02 PM and on 3/30/22 at 2:01 PM. He was in bed and his fingernails were still long, jagged, and dirty. He stated that it had been a while his fingernails were not trimmed, and he needed help with trimming them. Nurse Aide (NA) #5, assigned to Resident #34, was interviewed on 3/30/22 at 2:01 PM. She stated that resident's fingernails were trimmed during their shower days or as needed. The NA observed the resident's fingernails and verified that they were long, jagged, and dirty. She was observed to cut the resident's nails. NA #5 commented that it might be due to short staff and the staff did not have the time to trim resident ' s nails. The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. She stated that she expected the NAs to trim resident ' s nails during their shower days and or when needed.	F 677		
F 684 SS=G	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	F 684		5/10/22

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F 684	Continued From page 44 assessment of a resident, the facility must ensure that residents receive treatment and care in 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 reviews, observations, Orthopedic Surgeon, Orthopedic Nurse, Facility Nurse Practitioner (NP) and staff interview, the facility failed to provide care to a surgical wound by not monitoring for signs and symptoms of infection and by not removing the staples as ordered (Resident #48). In addition, the facility failed to provide non-pressure related wound care as ordered (Residents #95 #3 & # 195). This was for 3 of 4 sampled residents reviewed for non-pressure wounds (Residents #48, #95 & #195). Resident #48 was sent to the emergency room (ER) due to change in level of consciousness/unresponsiveness and was diagnosed with wound infection. Findings included: 1. Resident #48's hospital history and physical dated 12/29/21 revealed that Resident #48 was admitted to the hospital after a mechanical fall at home. The resident sustained left hip femoral neck fracture and left wrist fracture. The resident underwent hemiarthroplasty (a surgical procedure that involves replacing half of the hip joint) of the left hip and closed reduction and casting of the left wrist on 12/29/21. Resident #48 was discharged to the facility of 1/5/22 for rehabilitation (rehab). The hospital note further indicated follow up visit to the orthopedic clinic on 1/13/22.	F 684	1. Resident #48 and #95 no longer reside at the facility. Resident #3 was provided wound care as ordered on 03/31/2022. Resident #195 was provided wound care as ordered on 03/31/2022 . Resident #195 was evaluated by wound care specialist on 3-30-22. Resident #3 was evaluated by wound care specialist on 03/30/2022. 2. A quality review was completed by Nurse Manager by completion of skin integrity reviews of current residents to identify any non-pressure or surgical related wound to ensure order present and being completed by 05/10/2022. An ADHOC Quality Assurance Performance Improvement Committee was held by 05/10/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager educated nurses on providing care to surgical wound, monitoring for sign and symptoms of infections, following MD orders in relation to removing staples, and surgical care and providing wound care to non-pressure related wounds per MD orders on 03/10/2022. Nursing staff that has not completed the education will completed the education prior to working next	

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F 684	Continued From page 45 Resident #48 was admitted to the facility on 1/5/22 with multiple diagnoses including fracture of left femur status post hemiarthroplasty on 12/29/21. The admission Minimum Data Set (MDS) dated 1/11/22 indicated that Resident #48 had moderate cognitive impairment and she had a surgical wound. The nurse's notes from 1/5/22 through 1/19/22 were reviewed. There were no notes to indicate that the left hip surgical wound was assessed for any signs/symptoms of infection. The note dated 1/5/22 (admission) did not mention of the left hip surgical wound having staples (written by Nurse #1). Nurse #1 was not available for interview. Nurse #2, assigned to Resident #48 on 1/6/22, 1/7/22, 1/11/22 and on 1/12/22 was interviewed. She stated that when a resident was admitted with a surgical wound, the dressing was left in place until the follow up appointment with the surgeon. She stated that she was aware that there were staples on Resident #48's surgical wound. Nurse #2 indicated that the nurses were supposed to monitor the surgical wound for signs/symptoms of infection, but she didn't know why there were no wound assessments on the progress notes. She reported that the Appointment Scheduler was responsible for all the appointments. The nurse's note dated 1/13/22 at 10:30 AM revealed that the responsible party (RP) of Resident #48 was informed that the resident tested positive for COVID and was moved to the quarantine hall.	F 684	scheduled shift. Newly hired staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews of residents□ treatment administration record to ensure treatments of surgical wounds and non-pressure wound Care completed and signed on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random quality reviews by observation of non-pressure or surgical wound care on 5 random residents with non-pressure or surgical wound care to ensure treatment being provided per MD order and nurse assessing for signs and symptoms of infection. The Nurse Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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The care plan dated 1/18/22 was reviewed. The care plan problem was "the resident has fractures related to fall, left hip replacement and cast to left wrist". The goal was the resident will not develop complications and will minimize signs/symptoms of pain. The approaches included instruct resident regarding the healing process, treatment, and complications, and follow up and to monitor/document/report as needed (edema, bruising/discoloration of skin, skin temperature changes, and loss of sensation).

The nurse's note dated 1/18/22 at 8:05 PM (written by Nurse #5) revealed that resident had a change in mental status, not responding appropriately, on call provider was notified with an order to send the resident to the ER for evaluation and treatment. Nurse #5 was not available for interview.

The ER note dated 1/18/22 revealed that Resident #48 was seen in the ER with her left hip wound clearly infected. The resident was given Ancep (an antibiotic medication) I gram intramuscular (IM) and 0.9 % Sodium Chloride bolus in ER and was prescribed 2 antibiotic medications for the wound infection. The ER note further indicated that it was strongly recommended that the facility obtain daily pictures of the wound and to track its progress.

The nurse's note dated 1/19/22 at 4:56 AM revealed that Resident #48 was back from ER with 2 antibiotic medications (Doxycycline and Cephalexin) ordered for wound infection.

The nurse's notes from 1/19/22 through 1/24/22 were reviewed. There were no wound assessments/pictures taken to track the wound

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progress.

The MDS dated 1/24/22 indicated that Resident #48 was discharged to the community on 1/24/22.

The ER note dated 1/25/22 revealed that Resident #48 presented in the ER with altered mental status. She was sent to the nursing facility for rehab on 1/5/22 and was discharged to home on 1/24/22. She had worsening confusion and lethargy and slept most of the day. She has had some chills but no documented fevers. She has also worsening pain to the left hip and still has the staples in place after the surgery on 12/29/21. On examination, the incision over lateral left hip from recent hemiarthroplasty with staples in place, induration surrounding erythema and purulent drainage from the middle of the incision. The note further indicated that the staples should have been removed several weeks ago which may be causing some of this infection. The resident was admitted and was treated with Vancomycin and Zosyn (both were antibiotic medications).

The Social Worker (SW) was interviewed on 3/29/22 at 10:30 AM. The SW reported that the Appointment Scheduler was responsible for scheduling appointments and transporting residents to and from the appointments. The SW reported that she called the orthopedic clinic today (3/29/22) regarding Resident #48 and she was told that a staff member had called on 1/12/22 to cancel the appointment due to COVID positive residents and staff at the facility. The appointment was rescheduled for 1/27/22.

The Appointment Scheduler was interviewed on 3/29/22 at 11:25 AM. He stated that he was not

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aware of Resident #48's appointment with the orthopedic on 1/13/22. When asked to see his calendar book for appointments, he responded that he did not have a calendar book for appointments in January and February 2022. He added that the Administrator just gave him a calendar in March of 2022. When the book was observed, there were no appointments listed for January and February 2022. The Scheduler denied calling the orthopedic clinic regarding Resident #48 on 1/12/22. He reported that the NP and the ADON had been helping him with the appointments by informing him of the dates of scheduled appointments.

The Assistant Director of Nursing (ADON) was interviewed on 3/29/22 at 12:01 PM. The ADON stated that the Appointment Scheduler was responsible for all the appointments. The admitting nurse was supposed to give a copy of the appointment to the Scheduler, and he entered the appointment in his book. If for some reason the resident was not able to go to the scheduled appointment, the Scheduler called the clinic to inform of the reason why the appointment was cancelled. The call should have been documented on his book.

The Orthopedic Surgeon was interviewed on 3/31/22 at 8:03 AM. The Surgeon reported that he performed the surgery for Resident #48. The resident had fractured her left hip and wrist from a fall at home. He performed the left hip hemiarthroplasty on 12/29/21 and she was discharged to the nursing facility on 1/5/22 for rehab. On 1/6/22, she was seen in the ER. She removed the cast on her wrist and a splint was replaced. Upon her discharged, a follow up appointment was made for 1/13/22 for removal of

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the staples and to x-ray her wrist. The Surgeon stated that their office had a recorded communication with the facility staff. Review of the recorded communication, he stated that the facility had called on 1/12/22 and stated that the facility had number of staff and residents who were COVID positive, and the appointment was cancelled. The office staff had given an order to the facility staff to remove the staples and to change the dressing to the surgical wound daily. A follow appointment was rescheduled for 1/27/22. On 1/19/22, Resident #48 was sent to the ER due to change in condition and was found to have an infection to the incision site. The resident was sent back to the facility on 2 antibiotic medications. The Surgeon did not understand as to why the staples were not removed in the ER. The Surgeon reported that Resident #48 was again seen in ER on 1/25/22 and the surgical site was clearly infected, and the staples were still in the wound. He indicated that he expected the staples removed in 2 weeks after surgery or else it could cause infection to the wound.

The NP was interviewed on 3/31/22 at 11:12 AM. The NP stated that she had seen Resident #48 on 1/13/22 and on 1/20/22 (virtual visit). On 1/13/22 visit, she observed the surgical site with staples and there were no signs/symptoms of infection noted. On 1/20/22, she had a virtual visit and saw the surgical site, it was infected with staples in place. The wound had brownish-yellowish drainage. The resident was already on 2 antibiotic medications for the wound infection. She indicated that the staff should have called the orthopedic clinic to get an order to remove the staples at the facility if the resident was unable to go to the clinic. She also expected the nursing

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staff to assess/monitor the surgical wound for signs/symptoms of infection and to report to the Physician or NP. The NP reported that she had issues with appointments/consults not followed up by the staff and were missed. The facility had several turn- over in nursing and administrative staff including the Director of Nursing (DON).

The Orthopedic Nurse had called and was interviewed on 4/1/22 at 3:06 PM. She stated that she was the nurse at the orthopedic clinic. She stated that their office had a recorded communication with the facility. She reported that Resident #48 had a scheduled appointment on 1/13/22 for the removal of her staples. On 1/12/22, the Scheduler had called to cancel the appointment for the resident due to COVID positive residents and staff at the facility. The Nurse gave a verbal order to the Scheduler to remove the staples at the facility and to change the dressing to the surgical site. The Scheduler had requested to fax the order for the removal of the staples and dressing change to the facility and she faxed the order on 1/13/22. The Orthopedic Nurse provided the recorded communication documentation and were reviewed. The documentation verified that the Scheduler had called the clinic and talked to the Orthopedic Nurse on 1/12/22 at 2:41 PM. The Nurse informed the Scheduler that the appointment was rescheduled to 1/27/22 and to remove the staples at the facility and to change the dressing. The Scheduler had requested to fax the order for the removal of the staples and the dressing change to the facility. A copy of the faxed letter to the facility dated 1/13/22 was reviewed and the order indicated to remove the staples on 1/13/22 and to apply Benzoin (used to treat wounds) and ½ inch steri-strips, may leave

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the wound uncovered if there is no drainage, otherwise continue dry dressing.

The DON was interviewed on 3/31/22 at 1:59 PM. The DON stated that she started as DON of the facility end of February 2022 and she was not around when Resident #48 was at the facility. She reported that she reviewed Resident#48's records and did not see any documentation regarding care provided to the surgical wound. She indicated that the nursing staff should have monitored the wound for signs/symptoms of infection and to inform the physician or the NP. She also reported that there was a break in the system for the appointments/consults. The DON expected nursing to provide her and the Scheduler a copy of the appointment/consult upon admission and she would ensure the appointments were followed through.

2. Resident #95 was admitted to the facility on 3/14/22 with multiple diagnoses including right foot diabetic ulcer and left foot second toe amputation. The admission Minimum Data Set (MDS) assessment dated 3/20/22 indicated that Resident #95 had moderate cognitive impairment and he had diabetic ulcers and a surgical wound.

Resident #95 had physician's orders dated 3/17/22 to clean right ankle wound and cover with dry dressing twice a day and to apply Dakin's solution (used to prevent and treat wound infection) to the left foot amputated toe and cover with dry dressing twice a day (9 AM & 5 PM).

The care plan problem dated 3/27/22 revealed that Resident #95 had actual skin impairment, resident was admitted with surgical wound (left

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foot 2nd toe) and had diabetic ulcers (right foot). The approaches included monitor/document location, size, and treatment.

The March 2022 Treatment Administration Records (TARs) for Resident #95 were reviewed. The TARs revealed that the treatment to the right foot and left foot was not provided at 5 PM on 3/18/22, 3/19/22, 3/20/22, 3/22/22, 3/24/22 and 3/28/22 and at 9 AM on 3/25/22, and 3/27/22.

On 3/29/22 at 2:15 PM, the Assistant Director of Nursing (ADON) was observed during the dressing change on Resident #95. The diabetic ulcer on the right foot did not have slough/necrosis noted. The nurse cleaned the ulcer with a skin prep and covered the wound with a dry dressing. The left foot surgical wound did not have signs or symptoms of infection. The Nurse applied a gauze soaked with Dakin's solution and covered with dry dressing. The Nurse was not observed to clean the wound prior to applying the clean dressing.

Resident #95 was interviewed on 3/29/22 at 3:20 PM. He stated that his dressings were changed mostly daily and twice a day occasionally.

The ADON was interviewed on 3/30/22 at 10:05 AM. The ADON stated that she was assigned to do the treatments when she was not assigned to work on the floor. She reported that if it was not signed off on the TAR, the dressing was not provided since she or the nurses didn't get the chance to do the treatment. She also reported that she always used the skin prep to clean the wounds.

Nurse #2 was interviewed on 3/30/22 at 10:10

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AM. The Nurse stated that the ADON had been assigned to do the treatments since the facility did not have a treatment nurse. When the ADON was assigned to work on the floor, the nurses were responsible to provide the treatments. She reported that when the TAR was not signed off, the treatment was not provided, it was possible that the nurse did not have the time to do it.

The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON stated that she started as DON of the facility end of February 2022. She reported that the facility had a big turn - over in nursing and administrative staff. She did not have a full-time treatment nurse. She expected nursing to provide the treatment as ordered.

3) Resident #3 was originally admitted to the facility on 2/16/17 with diagnoses that included an ulcer to the buttock area, peripheral vascular disease (PVD), and moderate protein-calorie malnutrition.

A quarterly Minimum Data Set (MDS) assessment dated 12/16/21 indicated Resident #3 was cognitively intact and had no pressure ulcers or other skin impairments.

Resident #3's active care plan, last reviewed on 12/30/21, included a focus area for potential impairment to skin integrity related to problems with mobility, incontinence, history of stroke, PVD with right and left above the knee amputations, anemia and protein calorie malnutrition. History of stage 3 pressure ulcer to the left buttock area. The interventions included:
- Administer treatments as ordered and monitor for effectiveness.
- Follow facility protocols for treatment of injury.

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- Notify nurse of any new areas of skin breakdown, redness, blisters, bruises, and discoloration noted during bath or daily care.

A review of Resident #3's physician orders from 6/2021 to 3/28/22 did not include any treatments to the buttock area.

The nursing progress notes were reviewed from 6/1/2021 to 3/28/22 and revealed a note on 6/30/21 that Resident #3 had developed an open area on the top of his scalp with new orders received from the physician for an antibiotic and wound care. This area was resolved on 7/26/21. There were no progress notes regarding skin integrity concerns for Resident #3's buttocks.

A Review of the Weekly Skin Integrity Review reports dated 12/16/21, 2/3/22, 3/10/22 and 3/24/22, revealed no skin integrity issues were noted.

A Nurse Practitioner (NP) progress note, dated 3/29/22, indicated Resident #3 was seen at the request of nursing staff to assess a potential area of breakdown to his buttocks. The note read that Resident #3 was assessed while in bed and was noted to have scar tissue to his buttocks where a previous wound had been with no open areas found. The note continued to state the site could certainly become compromised given the previous injury to his skin integrity and an order for a protective dressing was provided and request for continued monitoring of the site for an indication of any breakdown.

An interview occurred with Resident #3 on 3/28/22 at 12:00 PM, who stated he had skin breakdown to his left buttock area that had been

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present since his admission. He stated, "they just put a pad on it when I ask". Resident #3 stated the area was tender, but his routine pain medication helped to alleviate the discomfort.

On 3/29/22 at 11:03 AM, an observation was made of Resident #3 and Nurse Aide (NA) #4 during personal care. Resident rolled to his left side, where a dark colored protective dressing was observed in place to his left inner buttock region. Resident #3 stated the NA's changed the dressing when asked which was every 2 to 3 days and denied having a nurse changing the dressing since the former treatment nurse had left. He further stated that either he or the NA's will go and get more protective dressings and keep them in the bedside table. NA #4 opened the bedside table to reveal 4 to 5 packages of the protective dressing. She confirmed replacing the dressing when asked by Resident #3 and stated she never questioned it because the nurses provided the dressing and thought they were aware of what was under the dressing. NA #4 added the area underneath had the appearance of pink, "raw" skin.

On 3/29/22 at 11:08 AM, an observation was made of Resident #3's left inner buttock that was covered by the protective dressing with the Assistant Director of Nursing (ADON). She commented being unaware of any breakdown or an order for a protective dressing for Resident #3. The dressing was removed with a dark moist substance present on the dressing. There was no odor or drainage, but the area was the size of a 50-cent piece and was bright pink in color. The ADON stated the protective dressing that was in place was not the appropriate treatment for the area and replaced with a different type of

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protective dressing. The ADON was unable to state if the area was open, a shear or a pressure area, but would report to the facility NP for her to assess the area further.

Nurse #2 was interviewed on 3/29/22 at 11:32 AM and stated she had been employed at the facility for close to two and half years and was familiar with Resident #3. She explained the former treatment nurse would provide the protective dressings to either Resident #3 or the NA's so they could apply to the left inner buttock area for "his piece of mind and protection". Nurse #2 went on to say, she had provided the protective dressings to the NA's when asked and was aware they were kept in his bedside table but was unaware of what was under the dressing as she had never completed a treatment or skin assessment on Resident #3. Nurse #2 explained that currently the ADON or Director of Nursing (DON) were completing the skin assessments.

An interview was conducted with NA #3 on 3/30/22 at 11:50 AM. She stated when she has rendered personal care to Resident #3 "over the past few years", there would be a protective dressing to his left inner buttock area and other times the dressing wouldn't be there. She recalled the area was pink in color when the dressing wasn't present and had reported this to the nurses and former treatment nurse.

On 3/30/22 at 4:32 PM, an interview occurred with NA #1 who stated she had observed the protective dressing on Resident #3's buttock area when providing personal care assistance but hadn't' questioned it as she thought nursing was taking care of the area.

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The DON was interviewed on 3/29/22 at 1:10 PM and stated she had completed Resident #3's skin review on 3/10/22 and 3/24/22. She explained she did not notice a protective dressing in place or skin breakdown/concerns to his buttocks area. The DON further stated she was unaware a protective dressing was being provided to Resident #3 and utilized without a physician's order and would have expected the nursing staff to obtain an order for use. The DON added that currently either herself or the ADON were completing skin assessments as the facility did not have a treatment nurse.

Nurse Practitioner (NP) #1 was interviewed on 3/31/22 at 11:20 AM and stated she was unaware Resident #3 was using a protective dressing on his buttocks area. She further stated she would have expected the nursing staff to obtain an order for its use as well as monitor the area for further breakdown as there was a history of a stage 3 pressure ulcer to the same area. The NP stated she assessed the area on the evening of 3/29/22, felt it was scar tissue from previous breakdown and provided an order for a protective dressing to be utilized.

4) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included repeated falls and chronic obstructive pulmonary disease.

The admission Minimum Data Set (MDS) assessment dated 3/6/22 indicated that Resident #195 had moderately impaired cognition and was coded with skin tears and moisture associated skin damage (MASD).

Resident #195's active care plan revealed a focus area, initiated on 3/13/22, for potential/actual

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impairment to skin integrity related to resident had multiple skin tears on her face and extremities related to falls, had a contracture of the left arm/hand and limited mobility. The interventions included to monitor/document location, size and treatment of skin injury and treatments as ordered.

A review of Resident #195's active physician orders included the following:
- An order dated 3/15/22 to clean skin tear to the right elbow with wound cleanser, apply triple antibiotic ointment and cover with a dry dressing every day until healed.
- An order dated 3/15/22 to clean skin tear to the right shin with wound cleanser, apply triple antibiotic ointment and cover with a dry dressing every day until healed.
- An order dated 3/25/22 to apply Nystatin (an antifungal) powder mixed with barrier cream to buttocks twice a day on the day and evening shifts for rash.

The March 2022 Treatment Administration Record (TAR) for Resident #195 was reviewed and revealed the treatment to the right elbow and right shin skin tears was not provided on 3/15/22, 3/17/22, 3/21/22, 3/23/22, 3/25/22, 3/26/22 and 3/27/22. The treatment for the buttock rash was not provided on the day shift on 3/25/22, 3/26/22, and 3/27/22 and on the evening shift on 3/25/22, 3/27/22, 3/28/22 and 3/29/22.

On 3/29/22 at 3:49 PM, the Assistant Director of Nursing (ADON) was observed providing wound and skin care to Resident #195. A skin tear was located on the left forearm, not the right elbow, and was approximated in a "C" shape. The area was scabbed with a very small open area in the

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middle of the wound. The ADON cleansed the area with wound cleanser and applied triple antibiotic ointment to the skin tear, covered with Vaseline gauze and a dry dressing. There were no open areas or skin tears observed to Resident #195's legs. An observation occurred of her buttocks which revealed a red, spotty rash to the entire buttock area and inner legs. The ADON applied the Nystatin powder mixed with barrier cream to the area.

The ADON was interviewed on 3/29/22 at 4:00 PM. When asked about the treatment order for the right elbow she stated the right and left must have gotten mixed up when the order was put in and that she liked to use Vaseline gauze, so the dressing didn't stick to the wound when it was removed and was aware it was not part of the treatment order. The ADON was unaware when the areas were healed to Resident #195's legs and stated the order should have been resolved.

Another interview occurred with the ADON on 3/30/22 at 10:05 AM, and stated she was assigned to do treatments when she wasn't assigned to work on a medication cart. She reported that if the treatment was not signed off on the TAR, the dressing was not provided since she or the nurses didn't get the chance to do the treatments.

On 3/30/22 at 3:04 PM, an interview occurred with Nurse #2, who worked the day shift (7:00 AM to 3:00 PM). Nurse #2 was assigned to Resident #195 on 3/17/22, 3/21 and 3/27/22. She explained the ADON had been assisting with treatments since the facility didn't have a treatment nurse. When the ADON was assigned to work on a medication cart, the nurses were

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F 684	Continued From page 60 responsible for treatments. She reported if the TAR was not signed off, the treatment was not provided. Nurse #3 was interviewed on 3/30/22 at 3:07 PM and indicated she normally worked the evening shift (3:00 PM to 11:00 PM) but would also work some on the day shift. Nurse #3 was assigned to Resident #195 on 3/23/22, 3/25/22, 3/26/22, 3/28/22 and 3/29/22. She explained evening shift nurses were responsible for completing treatments, if scheduled, and if the TAR was not signed off as completed it meant there wasn't enough time to get them completed. An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 2:00 PM and indicated she had been employed at the facility for close to 2 months. She reported there had been turn-overs in staff and administration and there wasn't a full-time treatment nurse currently. The DON added it was her expectation for nursing to provide the treatments as ordered.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		5/10/22

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F 686	Continued From page 61 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with resident's, staff, Nurse Practitioner #1, Physician, and wound Physician, the facility failed to complete scheduled weekly skin sweeps (a head-to-toe skin assessment), provide daily wound care treatments as ordered, and failed to thoroughly complete a comprehensive assessment on 3/5/22 for a change in wound status. All of these actions contributed to the facility failing to identify when Resident #32 developed an unstageable pressure area. In addition, the facility failed to follow wound physician recommendations (Residents #9 and #40), failed to provide wound care as ordered (Resident #9), failed to change gloves and sanitize hands when going from soiled to clean surfaces during wound care (Resident #9) and failed to set a pressure reducing mattress according to resident's weight (Residents #9 and #11). This was for 4 of 8 residents reviewed for wound care. Immediate Jeopardy began on 3/5/22 when a Change in Condition assessment did not thoroughly assess or document the change in wound status to Resident #32's right heel. In addition, staff failed to complete scheduled weekly skin sweeps and failed to provide daily wound care treatments as ordered for a resident that developed an unstageable pressure ulcer (Resident #32). Immediate Jeopardy was removed on 4/9/22 when the facility provided and implemented an acceptable credible allegation of the Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and	F 686	1. 1. The facility failed to complete scheduled skin assessments for a resident who developed an unstageable pressure injury and failed to provide wound care treatments as ordered (Resident #32). Resident #32 has been assessed by a Licensed Nurse on 4-8-22. Licensed Nurse completed chart review and skin sweep of Resident #32 on 4-8-22. Licensed Nurse notified Wound Specialist of current wound orders and protective measures. Recommendations to discontinue skin prep and pad and protection to bilateral heels. Clarification orders obtained for betadine solution daily to right heel and leave open to air after betadine is applied and float heels in bed and apply protective booties as tolerated. Medical Director assessed resident on 4-8-22 and noted the resident clinically stable. Care Plan was reviewed and updated to reflect protective booties as tolerated to promote healing. Resident #32 had interventions put into place by a Licensed Nurse and plan of care were reviewed and updated on 4-8-22. Resident #32 Kardex has been updated by the Nurse Manager and identified from the plan of care and communicated by the nurse that interventions on the Kardex for the nurse aides to review on 4-8-22. Wound care provided to Resident #9 per physicians orders on 4-15-22 by staff nurse. Assistant Director of Nursing	

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F 686	Continued From page 62 severity level of E (a deficiency that constitutes a pattern with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put into place and to complete employee in-service training. The facility was also cited at a scope and severity of E for example #1b (Resident #32), example #2 (Resident #9), example #3 (Resident #11), and example #4 (Resident #40). The findings included: 1) Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included a recent right hip fracture with surgical repair, and protein calorie malnutrition. The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and had no pressure ulcers only a surgical wound. A pressure reducing device was on the bed. Review of the Care Area Assessment (CAA) summary worksheet dated 3/9/22 indicated Resident #32 would be care planned for the risk for skin integrity issues related to limited mobility, surgical site present and incontinence of urine. The worksheet stated skin sweeps would be completed per protocol and the surgical site would be observed for complications. Resident #32's active care plan included a focus area that was initiated on 3/9/22 for potential/actual impairment to skin integrity related to right hip fracture repair, urinary incontinence, limited mobility and chronic kidney	F 686	(identified employee no longer employed by the facility) Pressure reducing mattress set per weight for resident #9 on 4-15-22. Resident #40 received wound care per physician recommendations on 4-12-22. 2. Current Facility Residents have the potential to be affected. a. Current Residents (47) had Braden Risk Assessments completed by a Licensed Nurse on 4-8-22 using a Braden Scale to determine those at risk for skin breakdown. b. Current residents determined to be at risk had a call placed to the Responsible Party as well as to their Physician for notification and further orders. i. These Residents had interventions put into place by a Licensed Nurse and their Plans of care were reviewed and updated on 4-8-22. ii. Kardexes have been updated by the Nurse Manager for each resident identified for the plan of care for nurse aides on 4-8-22. c. Current Residents (47) had Skin Sweeps performed by a Licensed Nurse on 4-8-22 to ensure that skin areas that are impaired have been addressed and appropriate interventions are in place. Current residents determined to have a new skin area of impairment had a call placed to their Responsible Party as well as to their Physician for notification and further orders. i. These affected Residents had interventions put into place by a Licensed Nurse and their Plans of care were	

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F 686	Continued From page 63 disease. The interventions included to encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry and use lotion on dry skin. 1a). A review of the hospital discharge summary dated 2/24/22 did not reveal any skin breakdown to Resident #32's heels. An Admission assessment completed by Nurse #4 on 2/24/22 was reviewed. The section for skin indicated a skin sweep was completed and skin was clear except for foot problems. Surgical site present to right thigh/hip area. Skin was noted to be warm and dry. The area for description of feet concerns read "Right toe(s)- toe nails long, dry and yellow. Left toe(s)- long, dry and yellow". There were no concerns marked for other foot problems, heel problems or drainage to the feet. The active physician orders included an order dated 2/27/22 for weekly skin sweeps. A review of Resident #32's medical record from 2/27/22 to 3/30/22, revealed no weekly skin sweeps were completed as ordered. A physician progress note dated 2/28/22 for Resident #32, read under Review of Systems there were no rashes or skin breakdown. The Physical Exam section of the progress note read "Skin: Inspection: No rashes or ulcers". A Nurse Practitioner (NP) progress note dated 3/1/22, indicated Resident #32's skin was inspected, with no skin breakdown noted other	F 686	updated, accordingly on 4-8-22. ii. Kardexes have been updated by the Nurse Manager on 4-8-22, accordingly. iii. The Facility has a Certified Wound Physician who makes rounds weekly for consultation, assessment, and treatment orders. The Certified Wound Physician's contract is currently in place. The Certified Wound Physician is available by phone and via telehealth for consultation, assessment and treatment orders. Newly admitted or acquired wounds identified through assessment are referred to Certified wound physician) by licensed nurses. iv. Director of Nursing reviewed most current wound physician recommendations on 4-27-22. 2 recommendations noted for vitamins addressed on 4-28-22 by the Director of Nursing. v. Director of Nursing reviewed current resident's with pressure relieving mattresses to ensure are at correct setting on 4-28-22. 4 residents noted with pressure relieving mattresses and all noted to on appropriate setting for residents weight or comfort. 3. On 4-8-22, the Regional Director of Clinical and or Executive Director conducted re-education with Licensed Nursing Staff to ensure the following: a. Licensed Nursing Staff and Nurse Aides - skin is assessed daily with care and weekly skin assessment is performed by a Licensed Nurse and documented in	

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than the surgical site to her right hip.

Review of a Change in Condition assessment for Resident #32, dated 3/5/22, timed 4:52 PM and completed by Nurse #5, read a pressure area was identified to the right heel. The assessment was marked unknown for treatment for last episode or if this symptom had occurred before. The Appearance section of the Assessment was summarized as "resident with pressure area to right heel". There was no description of the color or size of the area identified. The assessment noted the physician was notified and provided new orders.

Multiple attempts were made to contact Nurse #5 on 3/31/22 without success. Nurse #5 was scheduled to care for Resident #32 on 3/12/22, 3/13/22, 3/26/22 and 3/27/22.

Resident #32's physician orders were reviewed and revealed the following:
- An order dated 3/6/22 to apply skin prep to the right heel, pad and protect every day. This order was discontinued on 3/10/22.
- An order dated 3/10/22 to apply skin prep to both heels, pad and protect every day.

There was no documentation in Resident #32's medical record, from 3/5/22 to 3/22/22, explaining the impairment of her skin integrity to the right heel.

The March 2022 Treatment Administration Record (TAR) was reviewed for Resident #32 and revealed the following treatments were not documented as completed:
- Bilateral heel treatments were not documented as complete on 3/12/22, 3/13/22, 3/17/22,

the medical record.
b. Nurse Aides- inform charge nurse of any noted new skin breakdown with care.
c. Licensed Nursing Staff- notify the Resident's Physician within the course of their shift or within 24 hours of any new skin breakdown for further interventions and document skin assessment, notification, and new orders in the medical record.
d. Licensed Nursing Staff-Treatment orders are to be administered as per physician orders to include cleansing of wound and application of treatment as ordered for residents with documentation in the medical record, accordingly.
e. The Nurse Manager educated Nursing Staff was on 4-8-22, to include contract nursing staff. Nursing Staff not re-educated on 4-8-22, will not be allowed to work their next scheduled shift prior to being re-educated. The Executive Director will monitor daily according to schedule to ensure all staff are educated prior to the scheduled shift.
f. Executive Director informed Nurse Manager on 4-8-22 of newly hired staff will be educated during orientation period. Newly hired nursing staff will be educated by the Nurse Manager during the orientation period going forward.
g. The Nurse Manager educated Nursing Staff on following physicians orders to include recommendations for pressure relieving mattresses to include appropriate setting based on resident's weight and comfort by 5-6-22.
Nurse Manager has been re-educated by the Regional Director of Clinical Services

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F 686	Continued From page 65 3/21/22, 3/26/22 and 3/27/22. A late entry, nursing progress note, written by Nurse #4 and dated 3/22/22 indicated Resident #32 had eschar to the left heel when the treatment was completed on 3/20/22. A phone interview was conducted with Nurse #4 on 3/30/22 at 6:38 PM. She stated Resident #32 had eschar to the right heel when the treatment was completed on 3/20/22. Nurse #4 stated skin prep was already being utilized for the area and she left communication for the Assistant Director of Nursing (ADON) regarding her findings. Review of a wound physician progress note for 3/28/22, revealed Resident #32 was initially assessed for an area to her right heel. The progress note read an unstageable (due to necrosis- black, brown, or tan dead tissue that adheres to the wound bed or edges and may be firmer or softer than the surrounding skin) pressure area to the right heel of at least 23 days duration. There was no drainage or indication of pain. The area measured 3 centimeters (cm) in length and 4.2 cm in width. There was 100% of thick adherent black necrotic tissue. The dressing treatment plan was for Betadine every day to the area for 30 days, float her heels when in bed and use a sponge boot. The form indicated the pertinent history was obtained with nursing staff and Resident #32. A follow-up was scheduled for 7 days with the wound physician On 4/12/22 at 3:46 PM, a phone interview occurred with the wound physician. He explained he assessed Resident #32 on the evening of 3/28/22 for a possible pressure ulcer to her right heel. When asked about the documented	F 686	on 4-8-22 regarding conducting a weekly Wound Meeting with the Interdisciplinary Team to discuss residents who are identified to be at risk identified through skin sweeps and nurse assessment. New and or worsening skin issues will be discussed during morning meeting to ensure appropriate treatment and notification are in place. Verbal presentation of assessments and documentation presented to nurse manager on 4-8-22. 4. The Nurse Manager will conduct random Quality reviews of residents' treatment administration record to ensure treatments of pressure wounds completed and signed on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random quality reviews of weekly skin sweeps on 5 random residents to ensure skin assessed weekly and any wound identified and treatment ordered. The Nurse Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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duration of greater than 23 days, he stated he gathered this information based on what was told to him by the resident and her daughter who was at the bedside. He was told when Resident #32 was at the hospital they were not protecting her heels and she began to develop a sore to her right heel. The wound physician stated he based the duration of the wound on her hospital discharge date of 2/24/22 as the area clearly didn't evolve in a week or less. The wound physician added based on the look of the area it was highly plausible the right heel pressure area was present on admission to the facility. He described the area as dry heel eschar-noninfected skin. An order was provided to use Betadine daily and offload her heels. The wound physician further stated if the facility had completed the weekly skin sweeps as ordered he would have been able to clearly identify if Resident #32 was admitted with the pressure area to her right heel or when it first developed.

The active physician orders for Resident #32 included an order dated 3/29/22 for Betadine to the right heel every day for an unstageable pressure ulcer.

Resident #32 was observed on 3/28/22 at 9:50 AM, while she was sitting up in bed. A white dressing wrap was present to her right foot, a cloth protective boot was observed, turned around with the protection on top of her foot instead of on her heel. She stated she had a "sore" on her heel. When asked about how long the "sore" was present on her heel, she stated it started either when she was at the hospital or first got the facility "all my days have run together"

On 3/30/22 at 9:45 AM, the ADON was observed

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providing skin care to Resident #32. She explained Resident #32 was seen by the wound physician last evening and the area to her right heel was identified as an unstageable pressure ulcer due to eschar (tan, brown or black dead tissue that may be crusty) being present. She stated she couldn't state whether the area was present there or not before yesterday. The right heel was observed to have a dark black area to the entire heel, however there was no drainage or odor. When the ADON was asked to measure the wound, she stated "only the wound physician measured wounds". The ADON cleansed the area with skin prep and then applied a Betadine swab. Non-skid socks were replaced to her foot and a cloth protective boot was applied. The left heel was observed to be very dry in appearance with no red or dark colored areas present. Skin prep was applied to the left heel as ordered, by the ADON

The ADON was interviewed on 3/30/22 at 10:05 AM and explained the treatment order to Resident #32's right heel was recently changed to Betadine solution to the right heel every day related to an unstageable pressure ulcer per the wound physician. The ADON was unable to recall being told about the eschar to Resident #32's heel by Nurse #4. When asked about weekly skin sweeps, the ADON stated they were to be completed every week and that either she or the Director of Nursing (DON) completed them. She added, if an Nurse Aide (NA) identified an area of concern during personal care they should report it to herself, the nurses or DON. If a nurse identified an area of concern for a resident, they could report it to herself, the DON or directly to the physician or NP. The ADON was unable to state why there were no weekly skin sweeps

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completed for Resident #32 since her admission to the facility. She further stated she felt if they had been completed the unstageable pressure ulcer to the right heel could have been identified sooner.

An interview was completed with NA #2 on 3/30/22 at 11:45 AM who was familiar with Resident #32. She stated Resident #32 had her heels wrapped in a dressing when she provided personal care and had not observed her heel area.

On 3/30/22 at 3:04 PM, an interview occurred with Nurse #2 who stated weekly skin sweeps were completed by the ADON or DON since there wasn't a treatment nurse. Nurse #2 explained if the ADON was working on a medication cart, then the nurses were responsible for their own treatments. Resident #32's March 2022 TAR was reviewed with Nurse #2 and revealed she had completed wound care to Resident #32's heels last on 3/24/22. She was unable to recall any necrotic areas to Resident #32's heels when treatments were completed.

NP #1 was interviewed on 3/31/22 at 11:20 AM and reported since the treatment nurse was no longer at the facility there had been errors in wound care, which she had addressed with the ADON and DON. The NP stated she had assessed Resident #32 after her admission to the facility and had not identified any pressure ulcers to her heels, only a surgical wound to her right hip. She stated she would have expected to be notified when the area was first identified so proper treatment and oversight could have occurred. The NP stated the necrosis found to Resident #32's right heel could have been

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prevented if weekly skin sweeps as well as the wound treatments had been completed as ordered.

An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 2:00 PM and indicated she had been employed at the facility for close to 2 months. She stated she was unaware there were no weekly skin sweeps completed for Resident #32 or her treatments to her heels were not completed consistently as ordered. The DON stated she was unaware Resident #32 had an unstageable pressure area to her right heel until after she was seen by the wound physician on 3/28/22. She reported there had been turn-overs in staff and there wasn't a full-time treatment nurse currently. The DON added she was aware weekly skin sweeps were not occurring before she arrived at the facility and thought if she didn't complete them the ADON had. The DON stated it was her expectation for weekly skin sweeps to occur, so skin impairments were identified and treated in a timely manner.

A phone interview was completed with the physician on 4/9/22 at 1:11 PM. When asked about being notified of Resident #32's pressure area to the right heel on 3/5/22, he stated he received multiple calls during the day and could not readily recall, however he would have instructed the nurse to use the facility standing orders and have the resident seen by the NP and wound physician. The physician stated he could not recall observing an area of eschar to Resident #32's right heel.

The Administrator was notified of the Immediate Jeopardy on 4/8/22 at 10:05 AM.

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The facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to complete scheduled skin assessments for a resident who developed an unstageable pressure injury and failed to provide wound care treatments as ordered (Resident #32). Resident #32 has been assessed by a Licensed Nurse on 4-8-22. Licensed Nurse completed chart review and skin sweep of Resident #32 on 4-8-22. Licensed Nurse notified Wound Specialist of current wound orders and protective measures. Recommendations to discontinue skin prep and pad and protection to bilateral heels. Clarification orders obtained for betadine solution daily to right heel and leave open to air after betadine is applied and float heels in bed and apply protective booties as tolerated. Medical Director assessed resident on 4-8-22 and noted the resident clinically stable. Care Plan was reviewed and updated to reflect protective booties as tolerated to promote healing. Resident #32 had interventions put into place by a Licensed Nurse and plan of care were reviewed and updated on 4-8-22. Resident #32 Kardex has been updated by the Nurse Manager and identified from the plan of care and communicated by the nurse that interventions on the Kardex for the nurse aides to review on 4-8-22.
Current Facility Residents have the potential to be affected.
Current Residents (47) had Braden Risk

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F 686	Continued From page 71 Assessments completed by a Licensed Nurse on 4-8-22 using a Braden Scale to determine those at risk for skin breakdown. a. Current residents determined to be at risk had a call placed to the Responsible Party as well as to their Physician for notification and further orders. b. These Residents had interventions put into place by a Licensed Nurse and their Plans of care were reviewed and updated on 4-8-22. c. Kardex's have been updated by the Nurse Manager for each resident identified for the plan of care for nurse aides on 4-8-22. Current Residents (47) had Skin Sweeps performed by a Licensed Nurse on 4-8-22 to ensure that skin areas that are impaired have been addressed and appropriate interventions are in place. Current residents determined to have a new skin area of impairment had a call placed to their Responsible Party as well as to their Physician for notification and further orders. a. These affected Residents had interventions put into place by a Licensed Nurse and their Plans of care were updated, accordingly on 4-8-22. b. Kardex's have been updated by the Nurse Manager on 4-8-22, accordingly. c. The Facility has a Certified Wound Physician who makes rounds weekly for consultation, assessment, and treatment orders. The Certified Wound Physician's contract is currently in place. The Certified Wound Physician is available by phone and via telehealth for consultation, assessment and treatment orders. Newly admitted or acquired wounds identified through assessment are referred to Certified wound physician) by licensed nurses.	F 686		

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 4-8-22, the Regional Director of Clinical and or Executive Director conducted re-education with Licensed Nursing Staff to ensure the following:
a. Licensed Nursing Staff and Nurse Aides - skin is assessed daily with care and weekly skin assessment is performed by a Licensed Nurse and documented in the medical record.
b. Nurse Aides- inform charge nurse of any noted new skin breakdown with care.
c. Licensed Nursing Staff- notify the Resident's Physician within the course of their shift or within 24 hours of any new skin breakdown for further interventions and document skin assessment, notification, and new orders in the medical record.
d. Licensed Nursing Staff-Treatment orders are to be administered as per physician orders for residents with documentation in the medical record, accordingly.
e. The Nurse Manager educated Nursing Staff was on 4-8-22, to include contract nursing staff. Nursing Staff not re-educated on 4-8-22, will not be allowed to work their next scheduled shift prior to being re-educated. The Executive Director will monitor daily according to schedule to ensure all staff are educated prior to the scheduled shift.
f. Executive Director informed Nurse Manager on 4-8-22 of newly hired staff will be educated during orientation period. Newly hired nursing staff will be educated by the Nurse Manager during the orientation period going forward.
The Nurse Manager has been re-educated by the Regional Director of Clinical Services on 4-8-22

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regarding conducting a weekly Wound Meeting with the Interdisciplinary Team to discuss residents who are identified to be at risk identified through skin sweeps and nurse assessment. New and or worsening skin issues will be discussed during morning meeting to ensure appropriate treatment and notification are in place. Verbal presentation of assessments and documentation presented to nurse manager on 4-8-22.

The Executive Director will be responsible for implementing and following through with the plan of correction to ensure compliance.

The facility alleges the removal of Immediate Jeopardy on 4-9-22.

On 4/12/22 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included:

The 4/8/22 facility audit was reviewed and revealed 3 current residents were identified with skin integrity concerns. The Nurse Practitioner and responsible party were notified, orders obtained and initiated as well as care plans and Kardex's updated. Progress notes were documented in each resident's medical record. Review of wound care was completed as ordered since 4/8/22.

Education regarding completing weekly skin sweeps and documenting in the medical record and completing treatments as ordered for licensed nursing staff was reviewed and sign in sheets were provided.

Education for Nurse Aides and Medication Aides regarding assessing residents' skin daily during

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personal care and reporting to the charge nurse when issues were noted was reviewed and sign in sheets were provided.

Review of Resident #32's medical record indicated the following had been completed on 4/8/22:
- A full skin sweep was completed on 4/8/22 with the notation of an area to the right heel that was dark red and black in color. No other skin concerns were observed.
- Clarification orders were received from the wound physician to discontinue skin prep, pad, and protection to bilateral heels and. Orders provided to use Betadine topically to the right heel every day, leave open to air after Betadine applied to dry then apply protective booties as tolerated and float the heels in bed as tolerated.
- An assessment was completed by the physician and noted the resident was clinically stable.
- The care plan was updated to include assess/record/monitor wound healing and update physician with any declines; pressure relief mattress; float heels in bed as tolerated; provide protective booties as tolerated; and recurring visits by the wound specialist.
- The Kardex was updated to include skin protection methods put into place.

A wound care observation of Resident #32 occurred with the interim Director of Nursing on 4/12/22 at 10:45 AM. Resident #32 was observed to be lying in bed watching TV. She had a pillow placed under knees and blue cloth protective booties to both feet. The right foot was observed with a black area on the heel. The area was dry in appearance with no drainage or odor noted. Wound care was provided as ordered with no concerns.

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Nurse #2 was interviewed on 4/12/22 at 11:30 AM and stated she had received recent education on completing weekly skin sweeps as scheduled as well as completing wound care as ordered until a treatment nurse was hired.

On 4/12/22 from 11:45 AM until 12:10 PM interviews of 4 Nurse Aides was conducted which revealed they had recently received education on reporting any observed skin concerns immediately to the charge nurse or Nurse Manager.

An interview occurred with the Administrator and interim Director of Nursing (DON) on 4/12/22 at 12:15 PM. The interim DON explained scheduled weekly skin sweeps were embedding into the Medication and Treatment Administration Records of the electronic medical record (EMR) system and would alert the nurse when one was due. In addition, the interim DON stated she reviewed the "Dashboard" feature of the EMR system multiple times during the day to ensure the scheduled skin sweep and skin treatments were completed as ordered. The interim DON stated she was covering as the wound nurse during the week and the Registered Nurse covered as the wound nurse on the weekends to ensure treatments were completed as ordered. The Administrator reported there were 2 meetings during the day (one in the morning and one in the afternoon) where wound care and concerns would be discussed. The Administrator added a wound care nurse had been hired and was due to start at the facility next week.

The facility's Immediate Jeopardy removal date of

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4/9/22 was validated.

1b) A nursing progress note dated 2/24/22 indicated Resident #32 was admitted to the facility. Her skin was warm and dry with redness to the sacrum. No other mention of skin concerns in the progress note.

Resident #32's active physician orders were reviewed and revealed the following:
- An order dated 3/9/22 to apply a thick layer of barrier cream to sacrum/buttocks twice a day for skin breakdown (at 9:00 AM and 5:00 PM).

The March 2022 Treatment Administration Record (TAR) was reviewed for Resident #32 and revealed the following treatments were not documented as completed:
- Sacrum/buttocks treatment at 9:00 AM on 3/12/22, 3/13/22, 3/17/22, 3/21/22, 3/26/22 and 3/27/22.
- Sacrum/buttocks treatment at 5:00 PM on 3/12/22, 3/13/22, 3/15/22, 3/16/22, 3/17/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22, 3/24/22, 3/25/22, 3/27/22, 3/28/22 and 3/29/22.

On 3/30/22 at 9:45 AM, the Assistant Director of Nursing (ADON) was observed providing skin care to Resident #32. An observation occurred of Resident #32's buttocks which revealed no redness or skin breakdown. The ADON stated the order should have read to apply barrier cream to buttocks for protection and explained this occurred during incontinence care with the Nurse Aide's(NAs).

The ADON was interviewed on 3/30/22 at 10:05

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AM and explained she was assigned to do treatments when she wasn't assigned to work on a medication cart. She reported that if the treatment was not signed off on the TAR, the treatment was not provided since she nor the nurses had the chance to do them. The ADON added she used skin prep to cleanse wounds unless the order stated to use wound cleanser.

On 3/30/22 at 3:04 PM, an interview occurred with Nurse #2, who worked the day shift (7:00 AM to 3:00 PM). Nurse #2 was assigned to care for Resident #32 on 3/17/22 and 3/21/22. She explained the ADON had been assisting with treatments since the facility didn't have a treatment nurse. When the ADON was assigned to work on a medication cart, the nurses were responsible for treatments. She reported if the TAR was not signed off, the treatment was not provided.

Nurse #3 was interviewed on 3/30/22 at 3:07 PM and indicated she normally worked the evening shift (3:00 PM to 11:00 PM). Nurse #3 was assigned to care for Resident #32 on 3/15/22, 3/16/22, 3/17/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22, 3/24/22, 3/25/22, 3/28/22 and 3/29/22. She explained evening shift nurses were responsible for completing treatments, if scheduled, and if the TAR was not signed off as completed it meant there wasn't enough time to get them completed. She was unable to state if the missed treatments were reported to the oncoming shift.

Multiple attempts were made to contact Nurse #5 on 3/31/22 without success. Nurse #5 was scheduled to care for Resident #32 on 3/12/22, 3/13/22, 3/26/22 and 3/27/22.

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An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 2:00 PM and indicated she had been employed at the facility for close to 2 months. She reported there had been turn-overs in staff and administration and there wasn't a full-time treatment nurse currently. The DON added it was her expectation for the ADON to provide and document treatments completed when she was responsible for wound care and if the ADON was working on the medication cart, she would have the same expectations for the nursing staff, who responsible for their own treatments.
2a. Resident #9 was admitted to the facility 3/5/2022 with diagnoses that included a stage 4 pressure injury to the left lateral shin.

The resident's admission Minimum Data Set (MDS) indicated the resident had moderate cognitive impairment, total dependent upon staff for all activities of daily living, personal hygiene, toileting, and eating. The MDS indicated Resident #9 had a stage 4 pressure injury, had positioning device for his bed and received wound care during the assessment period.

Resident #9's medical record revealed the resident was seen by the wound care physician on 3/28/2022 for a stage 4 pressure injury to the left lateral shin that measured 2.5cm x 1.8cm with light serous exudate. Recommendations for wound care were as follows:
Primary dressing of hydrogel with silver, secondary dressing of abdominal pad, and skin prep daily for 16 days.

The resident's medical revealed a physician's order for wound care that read:

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Clean open area to left lower lateral leg with wound cleanser, apply skin prep and cover with a dry dressing daily. The order was dated 3/28/2022.

On 3/30/22 at 3:15 PM an interview was conducted with the Assistant Director of Nursing (ADON)/treatment nurse regarding wound order not matching resident's active orders. She stated she does not get the orders from the wound physician; they go to the Director of Nursing (DON) and she puts the orders in the electronic medical record.

An interview was conducted with the DON on 3/31/2022 at 1:59 PM. She stated she does get the wound care physician's wound evaluation and management summary with all his recommendations. She further stated she did review the recommendations for Resident #9 dated 3/28/2022 and entered the orders in the electronic medical record. When asked to review the recommendations and the orders in the electronic medical record, she stated she was new at entering wound care orders and she did not realize the hydrogel with silver was part of the order.

2b. On 03/29/2022 at 2:45 PM during a wound care observation, the wound was observed to be open approximately 2 centimeters (cm) by 2 cm with dark exudate but free of any odor. The treatment nurse removed a visibly soiled dressing from the left lateral shin of Resident #9 and did not change gloves or perform hand hygiene prior to handing the clean wound care supplies to include the clean dressing.

An interview was conducted with the treatment

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nurse on 3/30/2022 at 10:50 AM. She stated she does not change gloves during wound care unless the wound has a lot of exudate and Resident #9's wound only had a little exudate.

On 3/31/2022 the DON was interviewed and stated she expected the treatment nurse to perform wound care per physician's order and in a manner that limits cross contamination.

2c. Dring an interview on 3/28/2022 at 11:06 AM the resident stated his mattress was the most uncomfortable mattress he had ever tried to sleep on.

Resident #9 had a physician's order for a pressure reducing mattress.

On 3/29/2022 at 12:00 observed Resident #9 lying on a pressure reducing mattress. The mattress settings indicated the mattress was set at 250 pounds (lbs.)

The medical record revealed the resident's last documented weight was on 3/11/2022 at 166.4 lbs.

On 3/29/2022 at 12:02 PM an interview was conducted with Nurse #2 who was assigned to resident. She stated she was not familiar with the resident's mattress. When asked about settings, she stated she was not aware of the settings or what they should be. She observed the mattress was set at 250lbs and she was not sure of the resident's weight. She stated the mattress was set up by maintenance and he may have information on how the mattress was set up.

On 3/29/2022 at 12:31 PM an interview was

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conducted with facilities maintenance. He stated he set the mattress up and made sure it was functioning properly, but the nurses were responsible for setting the weight and monitoring the mattress proper functioning.

An interview was conducted with the DON on 3/31/2022 at 1:59 PM. She stated she expected the pressure reducing mattress to be set correctly.

3. Resident #11 was admitted to the facility on 1/25/2020 with diagnoses that included Failure to thrive with protein-calorie malnutrition and pressure injuries.

The residents quarterly Minimum Data Set (MDS) dated 1/7/2022 indicated the resident was moderately cognitively impaired, was total dependent upon staff for bed mobility and all activities of daily living, toileting, and personal hygiene. The resident had not pressure injuries during the assessment period.

Resident #11's comprehensive care plan was last revised on 1/20/2022 and had a focus for skin impairment with a history of pressure injuries to bilateral heels, the sacrum, and the right hip.

An interview was conducted with Resident #11 on 3/30/2022 at 9:15 AM. She stated she had wounds, but they were all healed. She further stated she was told she had a special mattress to prevent any future pressure wounds. At the time of the interview the resident was observed on a pressure reducing mattress. The mattress settings were at the firmest level, 400 pounds, (lbs.).

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Resident #11's medical record revealed her last documented weight was 3/11/2022at 141.4 lbs.

On 3/29/2022 at 11:58 AM an interview with Nurse #2, nurse assigned to resident. She observed the pressure reducing mattress to be set at 400 lbs. When asked if that would be accurate for this resident, she stated it would not be accurate. She further stated the mattress was set up by facility's maintenance, but she was not sure who initially set the mattress to 400 lbs or who is responsible for checking the settings.

On 3/29/2022 at 12:31 PM an interview was conducted with facilities maintenance. He stated he set the mattress up and made sure it was functioning properly, but the nurses were responsible for setting the weight and monitoring the mattress proper functioning.

An interview was conducted with the DON on 3/31/2022 at 1:59 PM. She stated she expected the pressure reducing mattress to be set correctly.

4 a. Resident #40 was admitted to the facility on 10/22/21 with multiple diagnoses including diabetes mellitus and pressure ulcers. The significant change in status Minimum Data Set (MDS) assessment dated 2/23/22 indicated that Resident # 40 had moderate cognitive impairment and had stage 3 and unstageable pressure ulcers.

Resident #40 was care planned dated 2/21/22 for pressure ulcers to his right heel, right ankle, and sacrum. The approaches included to administer treatments as ordered and to monitor for effectiveness.

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Resident #40 had physician's orders dated 3/25/22 to wash the right ankle ulcer with wound cleanser and to apply Santyl (debriding agent used to treat wounds) and Dakin's solution (used to prevent and treat wound infection), wrap with gauze and kerlex daily, to clean and wash right heel ulcer, apply Santyl and Dakin's solution, wrap with gauze/kerlex daily and to apply calcium alginate with silver (highly absorbent dressing used to treat wounds) to sacral wound daily.

Resident #40 was observed during a dressing change on 3/29/22 at 2:45 PM. The Assistant Director of Nursing (ADON) was observed to provide the treatment. She was observed to remove the old dressing from the sacral wound and calcium alginate with silver was applied and covered with a dry dressing. Then, she proceeded to remove the old dressing from the right heel and the right ankle ulcers, Santyl and Dakin's solution were applied and covered with dry dressing and secured with kerlex. The ADON was not observed to clean the wounds after removing the old dressing and before applying the treatment and the clean dressing.

The ADON was interviewed on 3/30/22 at 10:50 AM. She stated that she always cleaned the ulcers with skin prep.

The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON expected the treatment nurse to follow the treatment as ordered and to clean the ulcers prior to applying the treatment and the new dressing.

4 b. Resident #40 was admitted to the facility on 10/22/21 with multiple diagnoses including

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diabetes mellitus and pressure ulcers. The significant change in status Minimum Data Set (MDS) assessment dated 2/23/22 indicated that Resident # 40 had moderate cognitive impairment and had stage 3 and unstageable pressure ulcers.

Resident #40 was care planned dated 2/21/22 for pressure ulcers to his right heel and right ankle, and sacrum. The approaches included to administer treatments as ordered and to monitor for effectiveness.

Resident #40 was followed by the Wound Physician weekly. The Wound Physician notes were reviewed and revealed that Resident #40 was seen on 2/21/22, 2/28/22, 3/7/22, 3/14/22 and 3/21/22. The note dated 2/21/22 revealed that Resident #40 had a stage 3 ulcer on his sacrum measuring 2.2-centimeter (cm) x 3.2 cm x 0.2 cm with no necrosis/slough. The right ankle was unstageable measuring 1 m x 1 cm with 100 % necrosis. The right heel ulcer was unstageable measuring 2.4 cm x 1.5 cm with 100% necrosis. The recommendation on every visit was to offload the ulcers with sponge boot and group 2 mattress (pressure reducing mattress which included alternating pressure mattress or low air loss mattress and mattress overlays).

Resident #40 was observed on 3/29/22 at 2:45 PM and on 3/30/22 at 8:05 AM. He was up in wheelchair. His bed was observed to have a regular mattress and not a group 2 mattress as recommended by the Wound Physician.

Nurse Aide (NA) #3 was interviewed on 3/30/22 at 8:07 AM. The NA stated that she was assigned to Resident #40 and had been working at the facility

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F 686	Continued From page 85 as NA for 8 years. She reported that she had not seen the resident wearing a boot when in bed. Nurse #2 was interviewed on 3/30/22 at 8:10 AM. She was assigned to Resident #40. She reported that the resident did not have an order for a boot nor a specialty mattress. The ADON was interviewed on 3/30/22 at 10:50 AM. The ADON stated that she did not have access to the Wound Physician notes. She verified that Resident #40 was not wearing a boot when in bed and he was not on a group 2 mattress. The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON reported that she just started as DON of the facility end of February 2022. She started going with the Wound Physician during his weekly rounds last Monday (3/28/22). She was aware during the round that the Wound Physician had recommended a boot and group 2 mattress for Resident #40. She reported that the boots and the group 2 mattress were ordered on Monday 3/28/22. The DON indicated that the facility did not have a full-time treatment nurse and she didn't know who had access to the Wound Physician notes. She stated that she expected the Wound Physician's recommendations to be followed in treating the pressure ulcers.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 687		5/10/22

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F 687	Continued From page 86 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Nurse Practitioner #1 interviews, the facility failed to provide or arrange foot care for a resident with thick and long toenails (Resident #32) for 1 of 2 residents who were reviewed for foot care. The findings included: Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included recent right hip fracture with surgical intervention, coronary artery disease and chronic pain syndrome. The admission nursing assessment dated 2/24/22 indicated there was a concern for Resident #32's feet as her toenails were very long, dry and yellow to both feet. A review of the active physician orders included an order dated 2/27/22 for podiatry services as needed. The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact. Resident #32's active care plan included a focus area, initiated on 3/9/22, for Activities of Daily	F 687	1. 1. Resident #32 was provided foot care by podiatrist on 04/14/2022. 2. A quality review was completed by the Nurse Manager on current residents on foot care specific to toenail care on 04/19/2022. Identified residents were referred to podiatrist for visit on 05/19/2022 and care will be provided. One resident was sent to podiatry on 04/14/2022, one resident's family refused outside podiatry and will be seen on 05/19/2022. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated Nurse Manager and current nurses on all shifts, including part-time and as needed (PRN) on referral process for needed foot care specific toenail care by 05/06/2022. Podiatry referral list will be located at nurses station along with next scheduled visit date. Immediate attention needed as identified by nurse or referring physician an outside appointment will be made by van scheduler. Staff will not be allowed to	

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F 687	Continued From page 87 Living (ADL) self-care performance deficit related to recent hospitalization from surgical repair of right hip, limited mobility and decreased ability to complete her own ADL's. A review of the Podiatry Group Schedule for 3/17/22 did not include Resident #32. On 3/28/22 Resident #32 was observed sitting up in bed with her feet from under the covers. Both feet were observed to have very long, thick, and yellowed toenails. During a skin care observation with the Assistant Director of Nursing (ADON) on 3/30/22 at 9:45 AM, Resident #32 commented that her toenails needed to be cut because neither herself nor her son could get them done prior to the hospitalization. The ADON stated she had observed the thick long toenails when she provided skin care to Resident #32 but wasn't sure if she had been on the list for the podiatrist last week or not. The Social Worker (SW) was interviewed on 3/30/22 at 10:34 AM and stated the podiatrist came to the facility every 3 months. The list of residents that needed podiatry services was compiled based on nursing staff and physician reports of needs. She was unaware Resident #32 had podiatry needs when the podiatrist was in the facility on 3/17/22. On 3/30/22 at 10:39 AM, the ADON was interviewed and stated she had been employed at the facility close to 3 months. She explained she wasn't aware of the protocol for resident's to be seen by the podiatrist and wasn't aware she needed to let the SW know.	F 687	return to work until education is complete. 4. The Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided foot care specific to toenail care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) Committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 687	Continued From page 88 Nurse Practitioner #1 (NP) was interviewed on 3/31/22 at 11:20 AM and stated based on the observation of Resident #32's toenails, she needed podiatry care and would have expected her to be placed on the list when she was admitted to the facility. The Director of Nursing (DON) was interviewed on 3/31/22 at 2:00 PM and explained she had been employed at the facility for close to 2 months. She stated she would have expected Resident #32 to have been placed on the podiatry consult list or have been told there was a need for a podiatry visit.	F 687		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to thoroughly investigate falls and implement interventions to prevent further falls (Resident #195). Resident #195 sustained a head laceration requiring sutures and sustained multiple skin tears as a result of repeated falls. The facility also failed to implement a fall intervention for a resident with a history of falling (Resident #36). This was for 2 of 3 residents reviewed for accidents.	F 689	1. 1. Resident #195 falls in the last 30 days were investigated to ensure interventions are in place to prevent further falls on 04/13/2022 by Nurse Manager, Director of Nursing, Therapy Manager, Social Services Director and Minimum Data Set Nurse. Resident #36 fall investigations in last 30 days were reviewed to ensure fall interventions are in place on 04/13/2022 by Nurse Manager,	5/10/22

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F 689	Continued From page 89 The findings included: 1) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included a nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain), repeated falls, muscle weakness, unsteadiness on feet, history of a stroke with deficits to the left side, osteoporosis, and dementia. The admission Minimum Data Set (MDS) assessment dated 3/6/22 indicated Resident #195 had moderately impaired cognition. She required extensive assistance for bed mobility and transfers, had limited range of motion to one upper extremity and used a wheelchair for mobility. She was coded with a history of falls prior to admission and 2 or more falls with no injury and 2 or more falls with minor injury since admission. a) A nursing progress note dated 3/4/22 and timed 3:06 PM, indicated Resident #195 fell while trying to get out of bed. She sustained a laceration to the right side of her head near the temple area, as well as skin tears to the top of her left hand, right knee, and right lower leg. The Nurse Practitioner (NP) was informed and provided an order for Resident #195 to go to the Emergency Room (ER) for evaluation of the head laceration. Resident #195's responsible party (RP) was informed as well. A different nursing progress note for 3/4/22 indicated Resident #195 returned from the ER with sutures in place to the right side of her forehead.	F 689	Director of Nursing, Therapy Manager, Social Services Director and Minimum Data Set Nurse. Resident #36 fall mat placed beside bed of resident on 04/08/2022. 2. A quality review was completed by Nurse Manager of last 30 days of falls to ensure investigation complete and new fall intervention implemented with each fall by 04/25/2022. Falls investigated with Interdisciplinary team to include Director of Nursing, Nurse Manager, Social Services Director, Minimum Data Set Nurse and Therapy Manager. Root cause completed to ensure appropriate intervention in place. 12 falls reviewed and 4 interventions noted not placed on care plan. Care plan updated to reflect current inventions on 04/25/2022. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Nurse Consultant educated the Nurse Manager on fall investigations to include root cause and new intervention must be implemented with each fall on 04/13/2022. The Nurse Manager educated nurses on initiating fall investigation with each fall and implementing a new fall invention with every fall by 05/06/2022. Nursing staff that has not completed the education will completed the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation.	

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F 689	Continued From page 90 Review of the ER progress note for 3/4/22 revealed Resident #195 was seen due to a fall while trying to get out of the bed earlier in the day resulting in skin tears to her right leg, right knee, left hand and a laceration to her right forehead. Sutures were placed and she was held for an additional 6 to 7 hours in the ER for a repeat head CT (computerized tomography) scan that revealed no acute changes. A Fall Investigation Form dated 3/4/22 and completed by the Director of Nursing (DON), indicated Resident #195 was found on the floor next to her bed with a laceration to the forehead, and skin tears to the knee and back of her hand on 3/4/22. The form indicated she attempted to get up out of bed wanting to go home. The possible reasons listed for the fall was confusion, didn't know her own limits and weakness. There was no root cause identified for the fall. An intervention of lowered bed position was put into place. A progress note dated 3/7/22 indicated an Interdisciplinary Departmental Team (IDT) meeting occurred to discuss Resident #195's fall, that occurred on 3/4/22, with new interventions in place of lowering the bed position and placing fall mats at bedside. Resident #195's active care plan revealed a focus area, initiated on 3/7/22, for having had an actual fall with injury, poor balance. The interventions included bed in low position, floor mats at bedside and resident up in general lounge area to monitor for falls. Activities and snacks provided while up out of bed. A NP progress note dated 3/8/22 read Resident	F 689	4. The Executive Director or designee will conduct random Quality reviews of residents' fall investigations to ensure investigation complete and new fall intervention in place 2 residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random quality reviews by observation of residents to ensure fall interventions are in place on 2 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director and Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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#195 suffered a fall last week and was sent to the ER as she had struck her head. Sutures were applied.

b) A nursing progress note dated 3/14/22 indicated Resident #195 was observed lying on the fall mat beside the bed with a pillow at "approximately 1:20 PM". The bed was in the lowest position. Resident #195 had reinjured the healing skin tears to her right elbow and right shin. The facility NP and resident's RP were notified. The note indicated when Resident #195 was assisted back to bed, pillows were placed underneath the sheets to create a barrier to the edge of the bed.

A Fall Investigation Form, completed by the DON and dated 3/16/22, stated Resident #195 suffered a fall on 3/14/22 at 1:20 PM, where she was found lying on a pillow on the fall mat beside her bed, which was in the lowest position. The root cause of the fall was determined to be weakness, inability to stand and self-transfer. A scoop mattress was put into place to prevent her from rolling out of the bed. The Falls Investigation Form did not include the injuries that occurred at the time of the fall.

The Assistant Director of Nursing (ADON) was interviewed on 3/31/22 at 12:37 PM. She was on duty at the time of Resident #195's falls on 3/4/22 and 3/14/22 and stated they occurred because Resident #195 was getting up unassisted, wanting to go home. She felt the amount of falls that had occurred were due to Resident #195's wanting to go home, dementia, poor safety awareness and wanting someone to stay in her room and talk with her. The ADON explained falls were discussed during the morning meeting with

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all department heads but mostly the investigation portion was a collaboration of herself and the DON. She further stated the DON completed all the falls investigations but hadn't been to a morning meeting in a few weeks from having to work on a medication cart.

c) A Falls Investigation Form, completed by the DON and dated 3/16/22, indicated Resident #195 was found on the floor of her bedroom, lying on her back, close to the door on 3/16/22 at 3:30 AM. It was noted she had gotten out of bed without assistance. The report did not include a root cause of the fall and the updated intervention listed was a scoop mattress, which was the same intervention put into place after a fall on 3/14/22.

A nursing progress note could not be found related to the fall that occurred on the 11:00 PM to 7:00 AM shift on 3/16/22.

d) A nursing progress note dated 3/16/22 and timed 4:23 PM, revealed Resident #195 was found on the floor in her bedroom close to the door, lying on her back. She was observed wearing non-skid socks and was fully dressed and the wheelchair was behind her. She had last been seen during shift change while sitting up in the wheelchair. A skin tear was noted to the right forearm. Physician and resident's RP were notified.

A Falls Investigation Form, completed by the DON and dated 3/18/22, indicated Resident #195 was found on the floor of her bedroom, lying on her back on 3/16/22 with a skin tear present to her right forearm. The root cause was identified as confusion. The updated intervention listed a scoop mattress. The report did not thoroughly

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investigate how or why Resident #195 fell from the wheelchair and the intervention was the same one initiated after a fall on 3/14/22.

e) A nursing progress note dated 3/17/22 and timed 12:10 AM, indicated Resident #195 was found on the floor beside her bed with her lower body resting on the floor mat. An assessment revealed no injuries. The physician and RP were notified.

A NP progress note dated 3/17/22 read Resident #195 had suffered several falls since admission as she would get up unassisted. One of the falls resulted in a laceration to her right head with sutures required.

A Fall Investigation Form was not found for the fall that occurred on 3/17/22.

A progress note dated 3/18/22 indicated an Interdisciplinary Departmental Team (IDT) meeting occurred to discuss Resident #195's falls with new intervention of a scoop mattress placed on the bed to help with bed mobilization. This was the same intervention that was put into place after a fall on 3/14/22.

f) A nursing progress note dated 3/21/22 revealed Resident #32 had a fall at 2:00 PM and sustained a laceration over her right eye and three skin tears on her hands. The physician was made aware and gave an order for the resident to be seen in the ER for evaluation of the laceration to her head. Residents RP was made aware as well.

A Falls Investigation Form completed by the DON and dated 3/21/22 indicated Resident #195 had a fall on 3/21/22 at 2:00 PM and was found on the

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floor in her room with a laceration to eye and skin tears to her hand. She was sent to the ER for evaluation. The form listed the root cause as "weakness" and indicated the updated intervention was, "resident placed on early get up list and low bed with mats at the side. The intervention of the low bed and fall mats at bedside was the same intervention put into place after a fall on 3/4/22.

Another nursing progress note dated 3/22/22 revealed Resident #195 returned to the facility on 3/21/22 at 10:30 PM from the ER with sutures in place to her right forehead. A skin tear to her left forearm was identified as well.

A NP progress note for 3/23/22 read Resident #195 was sent to the ER following a fall recently where she had struck her head and suffered from some skin tears. A bruise was present to her right peri-orbital (around the eye) area.

Nurse #2 was interviewed on 3/30/22 at 3:20 PM. She was familiar with Resident #195 and was on duty at the time of her fall on 3/21/22 at 2:00 PM, when another laceration occurred to Resident #195's head. Nurse #2 stated staff had been trying to keep her busy during the day and would assist with placing her in bed after lunch which had seemed to help. She stated Resident #195 did try to get up unassisted and staff had to monitor closely for safety. Nurse #2 stated she was not involved with the fall's investigation process.

g) A nursing progress note dated 3/23/22 and timed 2:42 AM, indicated Resident #195 was observed on the floor in her room, scooting towards the doorway. There were no injuries

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noted. The physician and RP were notified.

A Falls Investigation Form completed by the DON and dated 3/23/22 stated Resident #195 was found on the floor in her doorway on 3/23/22 during the 11:00 PM to 7:00 AM shift. The root cause was listed as confusion, barefoot and impaired mobility. The updated intervention was non-skid socks at all times, placed on early get up list and monitor at all times.

A progress note dated 3/23/22 indicated an IDT meeting occurred to discuss Resident #195's recent fall and she was placed on the early get up lift for monitoring by staff. Resident to remain in bed while sleeping and up in common area when awake.

h) A Falls Investigation Form, completed by the DON and dated 3/23/22, indicated Resident #195 had a fall while trying to get up without assistance on 3/23/22 at 6:42 PM. The root cause was listed as "poor Activities of Daily Living (ADL)". The updated intervention was bed in low position, which had been the intervention for a fall that occurred on 3/4/22.

A review of the nursing progress notes did not reveal an entry for a fall that occurred on 3/23/22 at 6:42 PM.

i) A Falls Investigation Form completed by the DON and dated 3/27/22 revealed Resident #195 had an unwitnessed fall and was found on the floor on 3/25/22 at 4:30 AM. The root cause of the form read "repeated falls. If resident would have had on non-skid socks. Resident has dementia. Resident is unsteady on her feet". The intervention put into place was listed as resident

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placed on 1:1 due to high non-compliant behavior for remainder of the shift.

A review of the nursing progress notes did not reveal an entry for a fall that occurred on 3/25/22 at 4:30 AM.

On 3/28/22 at 11:30 AM, Resident #195 was observed lying in the bed with a fall mat to the left side of her bed and scoop mattress present.

Resident #195 was observed on 3/29/22 at 9:10 AM, sitting up in her wheelchair in her room. Scabbed areas were noted to her right forehead and a fading bruise was observed to the right eye area. Resident #32 commented the injuries had occurred because of a fall.

An interview occurred with Nurse Aide (NA) #2 on 3/30/22 at 11:45 AM and was familiar with Resident #195. She stated the resident became anxious at times and did attempt to get up on her own. Staff made sure her bed was in the lowest position when they assisted her to bed and kept a close eye on her for safety. NA #2 stated rounds were made every 2 to 3 hours for Resident #195 to ensure she was safe, and she would also look into her room as she walked by in the hallway.

Nurse #3 was interviewed on 3/30/22 at 3:50 PM. She was familiar with Resident #195 from the 3:00 PM to 11:00 PM shift. She stated the resident did become a little more agitated or restless in the evening hours and had been witnessed attempting to get out of her wheelchair or bed unassisted. Nurse #3 stated when she saw these behaviors, Resident #195 would either be assisted to bed or up to the wheelchair and placed where she could be monitored more

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closely. Nurse #3 stated Resident #195 should have rounds completed every 2 to 3 hours for incontinence care and staff would ensure she was safe at those times.

On 3/30/22 at 4:32 PM, NA #1 was interviewed. She was familiar with Resident #195 on the 3:00 PM to 11:00 PM shift and stated there were times increased restlessness was observed where Resident #195 would attempt to get up unassisted. NA #1 stated when she assisted her to bed, she ensured the bed was in the low position and a fall mat was next to the bed. If she was in bed and was restless, she would then assist Resident #195 up to her wheelchair and place her in a common area with snacks where she could be monitored more closely. NA #1 stated incontinence care was provided every 2 to 3 hours and she would ensure Resident #195 was safe before leaving the room.

A phone interview was completed with Nurse #4 on 3/30/22 at 6:38 PM. She was familiar with Resident #195 on the 11:00 PM to 7:00 AM shift and explained there were times when she arrived on duty and Resident #195 would be sitting up in her wheelchair. Nurse #4 stated on 3/29/22, Resident #195 didn't want to go to bed until 1:00 AM. If restlessness was observed she would attempt to find the cause, whether it was food/water needed, toileting assistance or the need to either go to bed or get up out of bed.

On 3/31/22 at 2:00 PM, the DON was interviewed and explained she had been at the facility for close to 2 months. She explained falls were discussed daily in the morning meeting with all department heads. However, she began a falls investigation as soon as they occurred and would

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review medications, progress notes regarding the falls and then went to the room and looked at every detail. She stated that she closed the falls investigations, out so fast that sometimes she forgot to complete the whole form completely and felt her quality of standard of care was to keep all the residents safe. She reviewed all the Fall Investigation Forms, she had completed for Resident #195 and felt a better job could be done with thoroughly explaining the root causes as well putting more effective interventions in place to prevent further falls from occurring.

Multiple attempts were made to contact Nurse #5 on 3/31/22 with no success. She was the nurse on duty at the time of Resident #195's falls on 3/16/22, and 3/23/22.
2. Resident #36 was admitted to the facility on 4/13/2021 with diagnoses that included hemiplegia following cerebral infarct (stroke).

The resident's quarterly Minimum Data Set (MDS) dated 3/8/2022 indicated the resident was severely cognitively impaired, was totally dependent upon staff for all activities of daily living, toileting, and personal hygiene. The resident had impaired range on upper and lower extremity and required a wheelchair for locomotion. Resident #36 did not have any falls during the assessment period.

Resident #36's comprehensive care plan, last updated 3/20/2022, had a focus for risk of falls or injury related to confusion, deconditioning, balance problems, and poor safety awareness. Interventions included keeping bed in low position and fall mat bedside.

A record review revealed the resident had

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documented falls on the following dates:
9/2/2021 Resident #36 was found on fall mat next to bed.
10/9/2021 Resident #36 was found on fall mat next to bed.
10/18/2021 Resident #36 was found on fall mat next to bed.
1/21/2022 Resident #36 was found on fall mat next to bed.
1/26/2022 Resident #36 was found on fall mat next to bed.

3/28/2022 at 9:44 AM Resident #36 was observed lying in bed, with eyes closed. The bed was in low position but there was no fall mat next to bed. Fall mat was folded up in corner of resident's room next to her wheelchair.

3/30/2022 at 11:19 AM observed Resident#36 lying in bed. The bed was in low position but there was no fall mat observed bedside. Fall mat was folded up in corner of room.

3/31/2022 at 9:20 AM Resident #36 was observed lying in bed. The bed was in low position with no fall mat bedside.

On 3/31/2022 at 9:30 AM an interview was conducted with the Nurse Assistant (NA)#2. She stated she was assigned to the resident's hall. When asked if the resident should have a fall mat next to her bed, she stated she was not sure. The NA stepped into the resident's room and observed the fall mat folded up in the corner of the room. She stated she did not work the hall often and was not familiar with the residents.

An interview was conducted with Nurse #2 on 3/31/2022 at 9:30 AM. When asked if the resident

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F 689	Continued From page 100 should have a fall mat next to her bed, the nurse stated she should. She further stated the staff would sometimes remove the fall mat and place it in the corner of the room to prevent it from being a tripping hazard, but if the resident was in the bed, the fall mat should be bedside. An interview was conducted with the DON on 3/31/2022 at 1:59 PM. She stated it was her expectation that fall interventions be implemented by staff.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		5/10/22

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F 690	Continued From page 101 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with residents, staff, and the facility's Nurse Practitioner, the facility failed to follow up on urology consultations (Residents #31& #17), and failed to administer an antibiotic as ordered (Resident #196) for 3 of 17 resident records reviewed. Findings included: 1. Resident #31 was admitted to the facility on 2/11/22 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 2/28/22 indicated that Resident #31 had moderate cognitive impairment and had an indwelling urinary catheter. Resident #31 had a physician's order on admission (2/11/22) for the use of the indwelling urinary catheter for urinary retention. On 2/16/22, there was an order to discontinue the catheter. If no void in 8 hours, to do in and out catheterization. If more than 300 cubic centimeters (cc) of urine returned, replace the indwelling urinary catheter. The nurse's note dated 2/16/22 at 11:56 AM	F 690	1. 1. Resident #31 appointment was made and will be seen by the urologist on 05/05/2022. Resident #17 appointment was made and will be seen by urologist on 04/26/2022. Nurse Practitioner was made aware of missed doses of Cephalexin for prophylaxis for recurrent Urinary Tract Infections (UTIs) for Resident #196 on 03/31/2022. The Medication Aide was educated by the Nurse Manager of administering medications as ordered, use of emergency back-up kit and notification of Medical Doctor (MD) if medications not administered as ordered for further orders on 04/19/2022. 2. A quality review was completed by Director of Nursing or designee of last 30 days of physician orders for urology consults to ensure appointment made and follow-up complete on 04/20/2022. No issues identified. A quality review was completed by the Nurse Manager of current resident's medication administration records of medications stating not given due to unavailable and/or waiting on delivery from pharmacy on	

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F 690	Continued From page 102 revealed that Resident #31's urinary catheter was removed without any problems. At 1:29 PM, the note indicated that the resident had voided without difficulty 3 times since the catheter was removed. The Nurse Practitioner (NP) progress note dated 2/24/22 revealed that" Resident #31 had difficulty urinating and had distended bladder. The urinary catheter was replaced and to obtain a urology consult". Resident #31 had a physician's order dated 2/24/22 to "make an appointment for urology consult due to increase difficulty voiding and he had benign prostatic hypertrophy (BPH)". The Appointment Scheduler was interviewed on 3/29/22 at 2:35 PM. The Scheduler checked his appointment book and stated that Resident #31 did not have a urology appointment scheduled. He indicated that nobody had informed him to make an appointment for urology consult. The Nurse Consultant was interviewed on 3/29/22 at 2:40 PM. The Nurse Consultant checked the medical records and was unable to find a urology consult for Resident #31. She stated that the order for the urology consult was missed. The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON stated that she started as DON of the facility in February 2022. She expected nursing to follow the system by providing her and the Appointment Scheduler a copy of all consult/appointments orders and she would ensure that the consult and appointments were followed through.	F 690	04/26/2022. 2 medications documented waiting on pharmacy on 04/25/2022. Nurses re-educated on administering medications as ordered, use of emergency back-up kit and notification of MD if medications not administered as ordered for further orders. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing or designee educated current nurses on process for consults and appointments by 05/06/2022. An appointment and transportation book is located at nurse's station. The receiving nurse will complete request form with resident's name, date of birth, face sheet, appointment with, reason for appointment, nurse requested and date requested. The Van Driver was educated by the Nurse Manager on process along with follow-up documentation with appointment date, time, MD name, address, office number and Responsible party name and date notified of appointment. The appointment and transportation book will be reviewed daily in morning meeting by the Executive Director or designee. The Nurse Manager educated nurses and medication aides on administering medications as ordered, use of back-up emergency kit and notification of MD if medications not administered as ordered for further orders by 05/06/2022. Nursing staff that has not completed the education will completed the education prior to working next	

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F 690	Continued From page 103 2. Resident #17 was admitted to the facility on 12/3/2014 with diagnoses that included neuromuscular dysfunction of the bladder with urinary retention. The resident's significant change Minimum Data Set (MDS) dated 2/6/2022 indicated Resident #17 was moderately cognitively impaired, required extensive assistance with all activities of daily living, toileting, and personal hygiene. The resident had a indwelling urinary catheter during the assessment period. The resident's care plan, last updated on 2/17/2022, had a focus for an indwelling suprapubic catheter. Resident #17's medical record revealed a physician's order for a 16 French suprapubic catheter. The order had a start date of 6/30/2021. Additionally, the resident had a physician's order, written by the facility's physician, to schedule a urology appointment for evaluation of lithotripsy (procedure to treat kidney stones). The order was dated 2/2/2022. There was no indication in the resident's medical record the urology appointment was ever made. On 3/29/2022 at 11:26 AM an interview was conducted with the facility appointment scheduler and transporter. He stated the nurses made him aware of residents who had referrals or consults that needed to be scheduled. He stated he did call the urologist office to schedule to make the appointment. The urologist office told him they would have their scheduler to call him, and they never called him back. The appointment scheduler and transporter stated he stated he	F 690	scheduled shift. Newly hired staff will be educated upon hire during orientation. 4. The Executive Director will conduct random Quality reviews of appointment transportation book to ensure appointment are made and follow-up completed 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random Quality reviews of medication administration records to ensure medications administered as ordered on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director and Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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was going to ask the Optum Nurse Practitioner (NP) if the resident could be seen by another urologist. He stated there was no appointment for the resident to see a urologist at that time.

An interview was conducted with Optum NP on 3/30/2022 at 9:24 AM. She stated she had conversations with the appointment scheduler and transporter regarding Resident #17's urology consult. He told her he called to schedule the appointment, but the urology office did not call him back. She further stated she expected residents to be scheduled for appointments in a timelier manner.

3) Resident #196 was admitted to the facility on 2/22/22 with diagnoses that included recent right hip fracture, and urinary incontinence.

A review of Resident #196's active physician orders revealed an order dated 2/22/22 for Cephalexin (an antibiotic) 250 milligrams (mg) 1 capsule by mouth once a day for urinary tract infection (UTI).

A Nurse Practitioner (NP) note dated 2/23/22 read, Resident #196 received Cephalexin 250 mg every day for prophylaxis due to recurrent UTI's.

The admission Minimum Data Set (MDS) assessment dated 2/28/22 indicated Resident #196 had severe cognitive impairment and was coded with six days of an antibiotic during the seven day look back period.

A review of the March 2022 Medication Administration Record (MAR) revealed the Cephalexin dose was not provided as ordered on 3/10/22 and 3/11/22. The nursing progress notes written by the Medication Aide (MA) indicated the

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medication was not provided due to "waiting for delivery".

On 3/30/22 at 8:58 AM, a medication pass occurred with the MA for Resident #196. She correctly retrieved all of Resident #196's medications except for Cephalexin 250mg. The MA indicated the medication was not available in the medication cart and was not provided to Resident #196. The MA stated the medication would need to be reordered from pharmacy and would be delivered this afternoon to the facility.

A review of the pharmacy's Emergency Drug Kit content list revealed Cephalexin 250mg was available in the facility.

The MA was interviewed again on 3/30/22 at 11:15 AM, and stated she was aware of the pharmacy's Emergency Drug Kit present in the medication room. When asked why she didn't retrieve the Cephalexin 250mg from the kit for Resident #196 she stated, "I don't know" and also indicated she didn't always call the practitioner when the medication wasn't available in the facility.

Nurse Practitioner #1 (NP) was interviewed on 3/31/22 at 11:20 AM and stated, at times she was unaware a medication was not given until she started reviewing the nursing progress notes and/or MARs. The NP added she would expect the nursing staff to notify her if a medication wasn't available in the facility then she would be able to inquire if it's available in the Emergency Drug kit or provide an order to hold the medication.

The Director of Nursing was interviewed on

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F 690	Continued From page 106 3/31/22 at 2:00 PM. She felt that maybe the nursing staff didn't always know the generic versus brand name of a medication and therefore didn't always find it in the Emergency Drug Kit. She stated she would expect the nursing staff to let her know if a medication wasn't available so she could look thoroughly through the medication cart and medication room or try to locate it in the Emergency Drug Kit.	F 690		
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 record reviews, observations, Nurse Practitioner #1 and staff interviews, the facility failed to administer supplemental oxygen as ordered and to clarify an oxygen order (Resident #32). This was for 1 of 1 resident reviewed for respiratory care. The findings included: Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen and coronary artery disease.	F 695	1. 1. A clarification order for oxygen was obtained on 03/30/2022 for Resident #32. 2. A quality review was completed by the Nurse Manager of current residents with oxygen to ensure oxygen administered as ordered on 04/25/2022. No concerns identified. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice.	5/10/22

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F 695	Continued From page 107 Review of a dictation note from an on-call Physician's Assistant (PA) dated 2/26/22 revealed Resident #32's family member stated to nursing staff she had used 1 to 2 liters of oxygen at night when at home. This information was not in the hospital discharge information but due to diagnosis of COPD, an approval was given for 1 to 2 liters of oxygen via nasal cannula at night. A review of Resident #32's physician orders revealed an order dated 2/28/22 for "pulse ox (a noninvasive device that estimates the amount of oxygen in your blood) Oxygen use at bedtime 1-2 liters or as needed to bring oxygen up as needed for decreased oxygen saturations or at bedtime for shortness of breath as needed". A review of Resident #32's active care plan included a focus area, initiated on 2/28/22, for altered respiratory status/difficulty breathing related to anxiety and COPD. The interventions included oxygen as ordered. A nursing progress note dated 3/1/22, written by Nurse #3, read oxygen was used via nasal cannula at 2 liters. The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and used oxygen. Another nursing progress note written by Nurse #3 and dated 3/8/22 revealed Resident #32 used oxygen at 2 liters via nasal cannula at bedtime. A review of the March 2022 Medication Administration Record (MAR) revealed an entry for Pulse ox Oxygen use at bedtime 1 to 2 liters or as needed to bring oxygen up-as needed for	F 695	3. The Nurse Manager educated current nurses on respiratory care related to oxygen orders and ensuring resident receiving oxygen as ordered by 05/06/2022. Nurses not re-educated will not be allowed to work their next scheduled shift prior to being re-educated. 4. The Nurse Manager will conduct random Quality reviews of residents with oxygen to ensure residents receiving oxygen as ordered on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 695	Continued From page 108	F 695		

decreased oxygen saturations or at bedtime for shortness of breath as needed. The form was blank of any pulse oxygen saturations readings or nursing initials for oxygen.

Resident #32 was observed sitting up in her bed eating lunch on 3/28/22 at 1:10 PM. The oxygen regulator on the concentrator was set at 1.5 liters flow by nasal cannula.

On 3/29/22 at 12:45 PM, Resident #32 was observed lying in her bed with oxygen flowing at 1.5 liters flow by nasal cannula. She stated at home she had normally worn it at night, but the nurses put it on her during the day now since she had been admitted.

Resident #32 was observed lying in bed watching TV on 3/30/22 at 9:45 AM. Oxygen was flowing at 1.5 liters by nasal cannula.

An interview occurred with Nurse #2 on 3/30/22 at 2:33 PM. She was familiar with Resident #32, provided care to her on the 7:00 AM to 3:00 PM shift and wrote the order for oxygen use. The 2/28/22 oxygen order was reviewed, and Nurse #2 stated the order was confusing and should have included parameters for the use of oxygen. She verified the oxygen was connected to Resident #32 during the day shift of 3/28/22 through 3/30/22 but should have only been used at bedtime as stated in the order. She was unable to state why the oxygen was not disconnected during the day time hours. Nurse #5 stated she would obtain a clarification order from the facility Nurse Practitioner (NP).

On 3/31/22 at 11:20 AM, an interview was conducted with NP #1. She reviewed Resident

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F 695	Continued From page 109 #32's active physician orders and verified the oxygen order from 2/28/22 was very confusing and was not what was originally provided by the on-call PA at the time of admission. The NP stated she was contacted on 3/30/22 by Nurse #2 and provided a clarification order to check oxygen saturations every 8 hours. Place oxygen on at 2 liters via nasal cannula if the oxygen saturations dropped below 90%. The Director of Nursing was interviewed on 3/31/22 at 2:00 PM and stated she would expect the nursing staff to ensure oxygen was used as ordered as well as obtain a clarification order if there was a question.	F 695		
F 732 SS=C	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. (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.	F 732		5/10/22

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F 732	Continued From page 110 (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 record review, observation and staff interview, the facility failed to ensure the daily nurse staffing sheets were complete and accurate for 30 of 30 days of nurse staffing sheets reviewed (2/28/22 - 3/28/22). Findings included: The daily Nurse staffing sheets from 2/28/22 through 3/28/22 were reviewed. The sheets included the date, census and number of RN, LPN and CNA each shift (7A-3P, 3P-11P and 11P-7A). The sheets did not have the total hours worked for the Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nurse Aide (CNA). On 3/31/22 at 9:03 AM, the Nurse staffing sheet was observed on the wall. The sheet did not include the total hours worked for the RN, LPN and CNA.	F 732	1. 1. The staffing sheet was corrected to reflect daily nursing hours on 03/31/2022 by the Staffing Scheduler. 2. A quality review was completed by the staffing scheduler and the Executive Director of the last 30 days of staffing sheets and staffing hours corrected to reflect hours of nursing staff worked on 04/01/2022. No hours were reflected on last 30 days of sheets. New sheets made to reflect hours. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Director of Nursing educated the staffing scheduler on correct sheet and how to complete and update	

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F 732	Continued From page 111 The Staffing Scheduler was interviewed on 3/31/22 at 10:10 AM. She stated that she was responsible for completing and posting the daily nurse staffing sheet. She reported that she started her position 3 months ago and she was informed to use the nurse staffing sheet. She verified that the sheet did not include the total hours worked and she stated that she did not know that the regulation required for the total hours worked for the RN, LPN and CNA to be included in the sheet. The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. She reported that she started as DON of the facility end of February 2022. The DON stated that she expected the regulation on nurse staffing information to be followed and she was not aware that the nurse staffing sheet did not include the actual hours worked for the RN, LPN and CNA.	F 732	the staffing sheet with ongoing census and staffing hours on 03/31/2022. The Executive Director educated the Nurse Manager and nurses as to how to complete and updated the staffing sheet with ongoing census and staffing hours and changes by 05/06/2022. 4. The Executive Director or Nurse Manager will conduct random Quality reviews of staffing sheets to ensure accurately posted with nursing hours 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services 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 reviews, observations, and interviews with residents, staff, Nurse Practitioner #1, and Nurse Practitioner #2, the facility failed to ensure Resident #195 had transportation arrangements for a neurology appointment that was indicated on her hospital discharge instructions and failed to ensure Resident #3 had transportation arrangements for	F 745	1. 1. Resident #195 appointment was made and will be seen by neurology on 05/10/2022. Resident #3 appointment was made and seen prosthetic consult on 04/05/2022. Attending physician and responsible party was made aware of missed appointments on 03/31/2022.	5/10/22

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F 745	Continued From page 112 a scheduled prosthetic appointment, resulting in both residents missing the appointments. This was for 2 of 2 residents reviewed for medically related social services. The findings included: 1) Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain), repeated falls, major depressive disorder, insomnia, and anxiety disorder. A review of the hospital discharge records for Resident #195 dated 2/28/22, revealed she had a scheduled neurology appointment on 3/1/22 at 11:00 AM. The admission Minimum Data Set (MDS) assessment dated 3/6/22, indicated Resident #195 had moderately impaired cognition. On 3/29/22 at 11:23 AM, an interview occurred with the Resident Transporter and Scheduler. Resident #195's hospital discharge summary was reviewed in the area of upcoming appointments, and he stated he was unaware of the scheduled appointment on 3/1/22. The Resident Transporter and Scheduler stated the nurses would print a copy of the appointment section for new admits and provide to him but was unable to say if had received the appointment notification or not for Resident #195. The Resident Transporter and Scheduler further stated that recently the Assistant Director of Nursing (ADON) had been trying to make sure he was aware of upcoming appointments for new admissions, so appointments weren't missed. As of 3/29/22 at	F 745	2. A quality review was completed by Nurse Manager of last 30 days of physician orders for appointments or consults to ensure appointment made and follow-up complete 04/20/2022. No issues identified. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager educated current nurses and Social Services Director on process for consults and appointments by 05/06/2022. An appointment and transportation book is located at nurse's station. The receiving nurse will complete request form with resident's name, date of birth, face sheet, appointment with, reason for appointment, nurse requested and date requested. The Van Driver was educated by the Nurse Manager on process along with follow-up documentation with appointment date, time, Medical Doctor (MD) name, address, office number and Responsible party name and date notified of appointment on 4-13-22. The appointment and transportation book will be reviewed daily in morning meeting by the Executive Director. 4. The Executive Director will conduct random Quality reviews of appointment transportation book to ensure appointment are made and follow-up completed 2 times a week for 8 weeks then weekly for 4 weeks. The Executive	

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F 745	Continued From page 113 11:23 AM, Resident #195 had not been seen by neurology as scheduled at the time of hospital discharge. Nurse #2 was interviewed on 3/29/22 at 11:32 AM and stated when a new resident was admitted, the nursing staff would make a copy of the appointment section and either put it to the attention of the Resident Transporter and Scheduler at the nurse's station or on his door. On 3/31/22 at 11:20 AM, Nurse Practitioner #1 (NP) was interviewed and stated she had spoken with the Resident Transporter and Scheduler many times about resident appointments being missed and had recently started to make a copy of appointments that were already scheduled or needed to be scheduled and provided to him. She was unaware Resident #195 did not attend the scheduled neurology appointment and would see to it that it was rescheduled. An interview occurred with the ADON on 3/31/22 at 12:37 PM, stated she had been employed at the facility close to 3 months and tried to ensure the Resident Transporter and Scheduler had the upcoming scheduled appointments for new admissions. She added that due to her having to work the medication carts so frequently it was possible she missed the reminder of the scheduled appointment for Resident #195 for 3/1/22 when she was admitted. The Director of Nursing (DON) was interviewed on 3/31/22 at 2:00 PM and stated she he had been employed at the facility close to 2 months. The DON was under the impression the Resident Transporter and Scheduler was ensuring residents were going to their scheduled	F 745	Director will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 745	Continued From page 114	F 745		

appointments.

The Administrator was interviewed on 3/31/22 at 3:00 PM. She stated she was aware this had been a problem about 2 years ago with the Resident Transporter and Scheduler not following through with resident scheduled appointments and a plan had been put into place for this to not occur again. She stated he had done better for a while, but it must have fallen by the wayside when the COVID-19 pandemic hit.

2) Resident #3 was originally admitted to the facility on 7/30/21 with diagnoses that included peripheral vascular disease, and absence of the right and left legs above the knee.

Review of a Report of Consultation from a prosthetic provider, dated 12/1/21 revealed Resident #3's next appointment was scheduled for 12/8/21 at 11:00 AM.

A nursing progress note dated 12/1/21 read Resident #3 was seen a prosthetic provider and had follow-up appointment scheduled for 12/8/21.

A quarterly Minimum Data Set (MDS) assessment dated 12/16/21 indicated Resident #3 was cognitively intact.

Resident #3's active care plan, last reviewed 12/30/21, included a focus area for Activities of Daily Living (ADL) self-care deficit and included right and left above the knee amputations. The focus area noted he was followed by Biotech (a prosthetic company) regarding bilateral lower extremity prosthesis.

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Resident #3 was interviewed on 3/28/22 at 12:00 PM and stated he had started working with his leg prosthetics in 2021, knew he had a follow-up appointment but hadn't been back since the first of December 2021.

On 3/29/22 at 11:32 AM, Nurse #2 was interviewed. She had marked the Report of Consultation from the prosthetic provider, dated 12/1/21, as noted. Nurse #2 stated she was aware Resident #3 was working with a prosthetic provider for his lower extremities but couldn't explain why he didn't go to the scheduled appointment on 12/8/21. She stated the Resident Transporter and Scheduler would be the one to call the provider offices when a resident wasn't able to go but was unsure of any attempts or outcome, as these calls were not documented, "we just go by what he tells us".

An interview occurred with Nurse Practitioner #2 (NP) on 3/30/22 at 9:24 AM. She explained Resident #3 was under her care until 12/31/21, was aware Resident #3 was working with the prosthetic company and had many conversations with the Resident Transporter and Scheduler regarding getting Resident #3 to his appointments. The NP stated she was unsure of the status since Resident #3 was no longer under her care but knew prosthetic training was very important to him. When she inquired with the Resident Transporter and Scheduler regarding his follow-up appointments she would be told he had called the provider but had received no call backs.

On 3/30/22 at 10:15 AM, an interview occurred with the Resident Transporter and Scheduler. Resident #3's Report of Consultation from the

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F 745	Continued From page 116	F 745		

prosthetic company dated 12/1/21 was reviewed showing a follow-up appointment scheduled for 12/8/21 at 11:00 AM. The Resident Transporter and Scheduler stated he was aware Resident #3 had been going for a while prior to December 2021 but the office had switched locations and couldn't explain why the follow-up appointment was not kept or rescheduled.

On 3/31/22 at 11:20 AM, NP #1 was interviewed and stated she had spoken with the Resident Transporter and Scheduler many times about resident appointments being missed and had recently started to make a copy of appointments that were already scheduled or needed to be scheduled and provided to him. She was unaware Resident #3 had not attended his scheduled appointment on 12/8/21 with the prosthetic company as she had just taken over his care on 1/1/22.

The Director of Nursing (DON) was interviewed on 3/31/22 at 2:00 PM and stated she he had been employed at the facility close to 2 months. The DON was under the impression the Resident Transporter and Scheduler was ensuring residents were going to their scheduled appointments.

The Administrator was interviewed on 3/31/22 at 3:00 PM. She stated she was aware this had been a problem about 2 years ago with the Resident Transporter and Scheduler not following through with resident scheduled appointments and a plan had been put into place for this to not occur again. She stated he had done better for a while, but it must have fallen by the wayside when the COVID-19 pandemic hit.

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F 758	Continued From page 117	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented 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	F 758		5/10/22

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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 758	Continued From page 118 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 reviews, observations, and interviews with staff and Nurse Practitioner #1, the facility failed to transcribe the correct frequency per the physician order for an antidepressant medication resulting in an excessive dose being provided (Resident #195). This was for 1 of 7 residents whose medications were reviewed. The findings included: Resident #195 was admitted to the facility on 2/28/22 with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain), repeated falls, major depressive disorder, insomnia, and anxiety disorder. A review of the hospital discharge records for Resident #195 dated 2/28/22, revealed a discharge order for Trazodone (an antidepressant medication) 50 milligrams (mg) 2 to 3 tablets at bedtime as needed. The physician order summary for Resident #195 revealed an order dated 3/1/22 for Trazodone	F 758	1. 1. A clarification order was obtained for trazodone for Resident #195 on 04/05/2022. Nurse #5 was educated on 04/05/2022 on accurately transcribing orders. 2. A quality review was completed by Nurse Manager on current orders of antidepressant medication to ensure orders transcribed accurately on 04/19/2022. No concerns noted. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager educated nurses on accurately transcribing physician orders by 05/06/2022. The Regional Director of Clinical Services educated the Nurse Manager on reviewing physician orders daily in morning meeting and reviewing of new physician orders to ensure orders transcribed accurately on 04/13/2022. Nursing staff that has not	

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F 758	Continued From page 119 50mg 1 tablet by mouth every 3 hours as needed for behaviors related to major depressive disorder. The same order was renewed on 3/25/22. The admission Minimum Data Set (MDS) assessment dated 3/6/22, indicated Resident #195 had moderately impaired cognition and displayed other behavioral symptoms not directed towards others daily. The March 2022 Medication Administration Record (MAR) was reviewed and indicated Resident #195 received Trazodone as needed 10 times from 3/18/22 until 3/29/22. On 3/28/22, the MAR revealed Resident #195 received Trazodone at 1:16 AM and again at 4:38 AM by Nurse #4. On 3/30/22 at 3:50 PM, an interview occurred with Nurse #3 who cared for Resident #195 during the second shift (3:00 PM to 11:00 PM). She reviewed the Trazodone order and stated it was odd for it to be written as every 3 hours as needed but she didn't recall taking the order from the practitioner or physician. Stated she had provided the medication to Resident #195 in the evening hours but only once during a shift. The Director of Nursing (DON) was asked to find the original order and staff name for the Trazodone 50 mg, on 3/30/22 but was unable to locate such. A telephone interview was conducted with Nurse #4 on 3/30/22 at 6:38 PM. The order for Trazodone 50mg 1 tablet every 3 hours as well as the March 2022 MAR was reviewed. Nurse #4 indicated she was familiar with Resident #195	F 758	completed the education will completed the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews of residents' new physician orders to ensure orders are transcribed to electronic record accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random quality reviews of antidepressant medication to ensure transcribed correctly on 5 random residents receiving antidepressants 2 times a week for 8 weeks then weekly for 4 weeks to ensure antidepressants transcribed accurately per physician order. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 758	Continued From page 120 and provided care to her on the night shift (11:00 PM to 7:00 AM) and utilized Trazodone as needed when agitation and insomnia were present. She stated she had followed the order for the Trazodone as written and never questioned it. An interview occurred with Nurse Practitioner #1 (NP) on 3/31/22 at 11:20 AM. She reviewed the order for Trazodone and recalled verifying the medication at the time of Resident #195's admission, instructed the staff member (unable to remember name) a range of 1 to 2 or 2 to 3 was unacceptable and provided a clarification order for Trazodone at 50mg 1 tablet at bedtime as needed for insomnia. The NP further stated staff didn't always write the orders in the chart but instead just typed it into the Electronic Medical Record (EMR), so it was hard to track down how the order was obtained or by whom. The NP reviewed the medical record for Resident #195 during the interview and stated the original order came from the hospital to be used as needed at bedtime only. Several phone messages were left for Nurse #5 on 3/31/22 with no return call during the course of the survey. Nurse #5 was listed as the admitting nurse for Resident #195 on 2/28/22. An interview was conducted with the DON on 3/31/22 at 2:00 PM. She stated she had been employed at the facility for close to 2 months, but it was her expectation for orders to be transcribed correctly.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		5/10/22

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F 760	Continued From page 121 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 record reviews, pharmacy technician, Nurse Practitioner #1, and staff interviews, the facility failed to administer an anticoagulant (a medication that prevents blood clots, Residents #32 and #17) and an antipsychotic medication (Residents #15 and #17) in accordance with the physician's orders for 3 of 5 residents reviewed for unnecessary medications. The findings included: 1) Resident #32 was admitted to the facility on 2/24/22 with diagnoses that included a recent right hip fracture with surgical repair, coronary artery disease and long-term use of anticoagulants. The active physician orders were reviewed for Resident #32 and included an order dated 2/24/22 for Enoxaparin (an anticoagulant medication) 40 milligrams (mg) per 0.4 milliliters (ml). Inject 0.4 ml subcutaneously (SQ) in the evening for surgical aftercare for 30 days. Resident #32's active care plan included a focus area, initiated on 2/28/22, for use of an anticoagulant- post surgical on Lovenox (Enoxaparin) for 30 days. The interventions included to administer medications as ordered by physician. The admission Minimum Data Set (MDS) assessment dated 3/2/22 indicated Resident #32 was cognitively intact and received an	F 760	1. 1. The Medical Doctor/Nurse Practitioner (MD/NP) was notified of missed medication of Resident #32, #17, #15 and Resident #17 on 03/31/2022. The Medication Aide and Nurse #2 was educated by the Nurse Manager of administering medications as ordered, use of emergency back-up kit and notification of MD if medications not administered as ordered for further orders on 04/19/2022. 2. A quality review was completed by the Nurse Manager of current resident's medication administration records of medications stating not given due to unavailable and/or waiting on delivery from pharmacy on 04/26/2022. 2 medications documented awaiting on pharmacy on 04/25/2022. Nurses re-educated on administering medications as ordered, use of emergency back-up kit and notification of MD if medication not administered for further orders. A medication cart audit to medication administration record review was conducted to ensure medications ordered are noted in medication cart by the Nurse Manager on 04/20/2022. Medications with less than a week supply was reordered at that time. An Ad hoc Quality Assurance Performance Improvement Committee will	

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F 760	Continued From page 122 anticoagulant medication 6 out of 7 days during the assessment period. A review of the March 2022 Medication Administration Record (MAR) for Resident #32 revealed the Enoxaparin was not given at 5:00 PM on 3/18/22 and 3/19/22 and was documented as missed administration- waiting on delivery. A review of the facility's Emergency Drug Kit content list showed Enoxaparin 100 mg per 1 ml was available at all times in the facility's medication room. On 3/31/22 at 8:42 AM, a phone interview occurred with a Pharmacy Technician who was able to review the pharmacy fill dates for Resident #32's Enoxaparin. She explained a box of 10 syringes were sent to the facility on 3/18/22 and 3/26/22 and the medication was on an automatic reorder where the medication was sent to the facility when the current supply was at 1 to 2 syringes left. An interview occurred with Nurse #2 on 3/31/22 at 9:00 AM. She received the March 2022 MAR and stated she didn't give the medication on 3/18/22 because it was not available and was waiting for the delivery from the pharmacy. When asked if the medication was available in the emergency drug kit, she stated she didn't know because if the medication was listed under a different name it was difficult to find them. When asked if the physician or Nurse Practitioner (NP) was notified, she stated she couldn't recall calling them. NP #1 was interviewed on 3/31/22 at 2:00 PM and stated she had noticed missed administrations on the March MAR and had	F 760	be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager educated nurses and medication aides on administering medications as ordered, use of back-up emergency kit and notification of MD if medications not administered as ordered for further orders by 05/06/2022. Nurses and medication aides not re-educated by 05/06/2022 will not be allowed to work their next scheduled shift prior to being re-educated. Newly hired staff will be educated upon hire during orientation. 4. The Nurse Manager will conduct random Quality reviews of medication administration records to ensure medications administered as ordered on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct medication pass observations 2 times weekly for 8 weeks then weekly for 4 weeks on random nurses and medication aides. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 760	Continued From page 123	F 760		

questioned the nursing staff about them. The NP stated could not recall receiving a call regarding the missed Enoxaparin doses but would have expected to be notified. She would have been able to provide a hold order or question whether the medication was available in the emergency drug kit and provided a dosage order.
2. Resident #15 was admitted to the facility on 11/9/19 with multiple diagnoses including psychosis. The quarterly Minimum Data Set (MDS) assessment dated 1/20/22 indicated that Resident #15 had severe cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period.

Resident #15 had physician's order for Seroquel (an antipsychotic medication) 25 milligrams (mgs) 3 tablets by mouth at bedtime (9 PM) on 5/19/21 and Seroquel 50 mgs by mouth in AM (9 AM) for psychosis on 8/9/20.

Review of the March 2022 Medication Administration Records (MARs) revealed that Resident #15 did not receive the Seroquel on 3/4/22 (9 AM dose), 3/9/22 (9 PM dose), 3/14/22 (9 PM dose), 3/15/22 (9 AM dose), 3/16/22 (9 AM dose), 3/18/22 (9 AM dose), 3/19/22 (9 AM dose), 3/20/22 (9 AM and 9 PM doses), and on 3/25/22 (9 PM dose). The MARs revealed that T40 was assigned to Resident #15 on 3/4/22, 3/15/22, 3/16/22, 3/19/22, 3/20/22, 3/22/22 and 3/23/22 when the Seroquel and the Metformin were not administered due to "not available or waiting from the pharmacy".

Nurse #2 was interviewed on 3/30/22 at 12:10 PM. The Nurse reported that the facility had back up medications in the medication room that were

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available if needed. The list of medications in the back up was reviewed and Seroquel was included in the list of back up medications.

The Medication Aide (MA) was interviewed on 3/30/22 at 12:15 PM. The MA verified that T40 was her initial on the March 2022 MARs. She stated that she did not administer the Seroquel since it was not available, or she could not find them in the medication cart. She stated that she was aware that there were back up medications in the medication room, but she didn't know why she was not utilizing the back medications. The MA reported that she had notified the Nurse when the medication was not available and was told to reorder them from the pharmacy. The pharmacy often responded that it was "too early for refill".

The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. She stated that she just started as DON at the facility end of February 2022. The DON stated that she expected the nurses including the MA to inform her when a medication was not available or could not be found in the medication cart or medication room. She would help the nurse/MA find the medication. She reported that the reason might be that the medication was available in the cart but was labeled in generic form.

3. Resident #17 was admitted to the facility on 12/3/2014 with diagnoses that included vascular dementia and long-term use of anticoagulant.

The resident ' s significant change Minimum Data Set (MDS) dated 2/6/2022 indicated Resident #17 was moderately cognitively impaired, required extensive assistance with all activities of daily living, toileting, and personal hygiene. The resident received anticoagulant 6 out of 7 days,

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antidepressant 5 out of 7 days, and antipsychotic 6 out of 7 days during the assessment period.

The resident ' s care plan, last updated on 2/17/2022, had a focus for antipsychotic therapy due to mood disorder and anticoagulant therapy due to a history of cardiovascular accident (stroke). Interventions for each included administering medications per physician ' s orders.

Resident #17 ' s medical record revealed the resident had physician ' s orders for the following medications:
Seroquel 12.5mg orally once daily at bedtime for psychosis. The order had a start date of 2/1/2022 and no end date.
Eliquis 5mg orally twice daily related to stroke. The order had a start date of 2/1/2022 with no end date.

A review of the resident ' s Medication Administration Records (MAR) for March 2022 indicated the 9:00 PM dose of Seroquel was not given. The Medication Aide documented she was waiting on delivery. The MAR also revealed on March 22nd Eliquis was not given at 9:00 AM and again the Medication Aide documented the missed administration as waiting on delivery.

On 3/30/2022 at 11:25 AM an interview was conducted with the Medication Aide. She reviewed the March 2022 MAR and stated she did not give the medication because they were not available, she was waiting for them to be delivered by pharmacy. When asked if any of the medication were available in the emergency kit, she stated she did not know. When asked if the physician or Nurse Practitioner (NP) had been

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F 760	Continued From page 126 notified, she stated she had not called them. On 3/31/2022 at 11:27 AM an interview was conducted with NP #1. She stated she had noticed missed administrations on the MARs and she had asked about them. The NP stated she would expect to be notified if medications are not available or not given.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/10/22

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F 761	Continued From page 127 Based on observations and staff interviews, the facility failed to keep unattended medications stored in a locked medication cart for 1 of 4 medication carts (B Hall Medication Cart). The findings included: A continuous observation of an unattended medication cart on the B Hall was made on 3/28/22 from 9:34 AM until 9:40 AM. The medication cart was noted to be unlocked with the push lock in the out position. The medication cart was at the entrance to B Hall where other residents, staff and visitors were present. The medication cart was verified to be unlocked by Nurse #2 at 9:40 AM. During an interview on 3/28/22 at 9:40 AM, with Nurse #2, she indicated it was not her assigned medication cart, but it should have been locked when the assigned nurse had walked away from the cart. Nurse #2 was observed locking the cart before returning to her assigned area. On 3/28/22 at 9:42 AM, Nurse #3 was observed coming from the dining room area on the C hall to the B Hall medication cart . Nurse #3 confirmed it was her assigned area for the day and stated she must have forgotten to lock the cart due to an emergency on another hall. She added that all medication carts are to be locked when unattended. An interview was conducted with the Director of Nursing on 3/31/22 at 2:00 PM and indicated Nurse #3 should not have left the medication cart unlocked while unattended. She stated nursing staff were responsible for securing the contents of the carts they were assigned.	F 761	1. The medication cart (B Hall) was locked on 03/28/2022. The medication aide was educated to ensure medication cart locked at all times when unattended. 2. A quality review was completed by the Nurse Manager to ensure medication carts locked on 03/28/2022. An ADHOC Quality Assurance Performance Improvement Committee was held by 05/10/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager re-educated licensed nursing staff to include medication aides on ensuring medication carts locked at all times when unattended by 05/10/2022. Nurses not re-educated will not be allowed to work their next scheduled shift prior to being re-educated. 4. The Nurse Manager will conduct random Quality reviews of medication carts to ensure medication carts are locked on 3 medication carts 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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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 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 reviews, observations, Nurse Practitioner #1, Physician, Orthopedic Surgeon, Orthopedic Nurse, Wound Physician, resident and staff interviews, the facility administration failed to provide effective oversight to ensure practitioners were notified when a change in a pressure area was identified, weekly skin sweeps were completed as ordered, and daily wound care was completed as ordered to a resident that developed an unstageable pressure area (Resident #32). In addition, the facility administration also failed to provide effective oversight to ensure wound care for pressure and non-pressure related wounds were completed as ordered (Residents #9, #40, #48, #95, #3 and #195), and residents were transported to scheduled appointments or had appointments rescheduled (Residents # 3, #17, #31 and #195). In addition, the facility administration also failed to provide effective oversight to ensure wound care for pressure and non-pressure related wounds were completed as ordered (Residents #9, #40, #48, #95, #3 and #195), residents had transportation arrangements for scheduled appointments or had appointments rescheduled (Residents #3, #17, #31 and #195), residents had podiatry care arranged (Resident #32), residents medications were administered as ordered	F 835	1. 1. The Director of Nursing/Nurse Manger failed to monitor systems to ensure weekly skin sweeps and wound treatments complete. Weekly skin sweeps and progress note/change of condition will be monitored daily in clinical meeting by reviewing of assessments in electronic chart. Completion of ordered treatments will be reviewed daily in the electronic chart by Director of Nursing/Nurse Manager. Weekly wound meetings will be held by DON/Unit Manager along with IDT team and monitored by Executive Director to ensure complete. The Executive Director will monitor daily clinical meeting and weekly wound meeting to ensure done. The facility failed to complete scheduled skin assessments for a resident who developed an unstageable pressure injury and failed to provide wound care treatments as ordered (Resident #32). Resident #32 has been assessed by a Licensed Nurse on 4-8-22. Licensed Nurse completed chart review and skin sweep of Resident #32 on 4-8-22. Licensed Nurse notified Wound Specialist of current wound orders and protective measures. Recommendations to	5/10/22

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F 835	Continued From page 129 (Residents #15, #17, #32, #195 and #196) and the facility was homelike (Room #126). Immediate Jeopardy began on 3/5/22 when the facility administration failed to implement effective systems and/or processes to ensure residents received the necessary care and services to assess for pressure ulcers, provide daily wound care as ordered and ensure physician or Nurse Practitioner notification occurred when there was a change in wound status for Resident #32. Immediate Jeopardy was removed on 4/9/22 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 level of E (a deficiency that constitutes a pattern with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: 1a) This citation was cross referred to F 686 K: Based on observations, record reviews, and interviews with resident's, staff, Nurse Practitioner #1, Physician, and wound Physician, the facility failed to complete scheduled weekly skin sweeps (a head-to-toe skin assessment), provide daily wound care treatments as ordered, and failed to thoroughly complete a comprehensive assessment on 3/5/22 for a change in wound status. All of these actions contributed to the facility failing to identify when Resident #32 developed an unstageable pressure area. 2) This citation was cross referred to F 580 J: Based on record review, Nurse Practitioner #1,	F 835	discontinue skin prep and pad and protection to bilateral heels. Clarification orders obtained for betadine solution daily to right heel and leave open to air after betadine is applied and float heels in bed and apply protective booties as tolerated. Medical Director assessed resident on 4-8-22 and noted the resident clinically stable. Care Plan was reviewed and updated to reflect protective booties as tolerated to promote healing. Resident #32 had interventions put into place by a Licensed Nurse and plan of care were reviewed and updated on 4-8-22. Resident #32 Kardex has been updated by the Nurse Manager and identified from the plan of care and communicated by the nurse that interventions on the Kardex for the nurse aides to review on 4-8-22. On 03/05/2022 resident #32 had a change in condition completed for pressure wound to R heel. MD was notified and new orders noted for skin prep to R heel. On 3/11/2022 order noted for skin prep to bilateral heels. A late entry nursing progress note dated 3/22/22 indicated Resident #32 was observed with eschar to her heel when a treatment was completed on 3/20/22. On 3/20/22 the facility failed to notify physician of change in wound. On 3/30/2022 new order noted for betadine to right heel pressure area. Resident #32 was provided foot care by podiatrist on 04/14/2022. Room 126's peeling ceiling was repaired by the Maintenance Director on 04/22/2022.	

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F 835	Continued From page 130 Physician and staff interviews, the facility failed to notify the Physician or Nurse Practitioner of a change in wound condition to Resident #32's right heel on 3/20/22. This was for 1 of 8 residents reviewed for pressure ulcers. The Administrator was notified of the Immediate Jeopardy on 4/8/22 at 7:56 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The Director of Nursing/Nurse Manger failed to monitor systems to ensure weekly skin sweeps and wound treatments complete. Weekly skin sweeps and progress note/change of condition will be monitored daily in clinical meeting by reviewing of assessments in electronic chart. Completion of ordered treatments will be reviewed daily in the electronic chart by Director of Nursing/Nurse Manager. Weekly wound meetings will be held by DON/Unit Manager along with IDT team and monitored by Executive Director to ensure complete. The Executive Director will monitor daily clinical meeting and weekly wound meeting to ensure done. The facility failed to complete scheduled skin assessments for a resident who developed an unstageable pressure injury and failed to provide wound care treatments as ordered (Resident #32). Resident #32 has been assessed by a Licensed Nurse on 4-8-22. Licensed Nurse	F 835	Medical Director/Nurse Practitioner was notified of missed medication of Resident #15 and Resident #17 on 03/31/2022. The Medication Aide was educated by the Nurse Manager of administering medications as ordered, use of emergency back –up kit and notification of MD if medications not administered as ordered for further orders on 4-19-22. Resident #48 and #95 no longer reside at the facility. Resident #3 was provided wound care as ordered on 03/31/2022. Resident #195 was provided wound care as ordered on 03/31/2022. Resident #195 was evaluated by wound care specialist on 3-30-22. Resident #3 was evaluated by wound care specialist on 03/30/2022. Resident #31 appointment was made and will be seen by the urologist on 05/05/2022. Resident #17 appointment was made and will be seen by urologist on 04/26/2022. Nurse Practitioner was made aware of missed doses of Cephalexin for prophylaxis for recurrent UTIs for Resident #196 on 03/31/2022. The Medication Aide was educated by the Nurse Manager of administering medications as ordered, use of emergency back –up kit and notification of MD if medications not administered as ordered for further orders on 4-19-22. Resident #195 appointment was made and will be seen by neurology on 05/10/2022. Resident #3 appointment was made and seen prosthetic consult on	

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F 835	Continued From page 131 completed chart review and skin sweep of Resident #32 on 4-8-22. Licensed Nurse notified Wound Specialist of current wound orders and protective measures. Recommendations to discontinue skin prep and pad and protection to bilateral heels. Clarification orders obtained for betadine solution daily to right heel and leave open to air after betadine is applied and float heels in bed and apply protective booties as tolerated. Medical Director assessed resident on 4-8-22 and noted the resident clinically stable. Care Plan was reviewed and updated to reflect protective booties as tolerated to promote healing. Resident #32 had interventions put into place by a Licensed Nurse and plan of care were reviewed and updated on 4-8-22. Resident #32 Kardex has been updated by the Nurse Manager and identified from the plan of care and communicated by the nurse that interventions on the Kardex for the nurse aides to review on 4-8-22. On 03/05/2022 resident #32 had a change in condition completed for pressure wound to R heel. MD was notified and new orders noted for skin prep to R heel. On 3/11/2022 order noted for skin prep to bilateral heels. A late entry nursing progress note dated 3/22/22 indicated Resident #32 was observed with eschar to her heel when a treatment was completed on 3/20/22. On 3/20/22 the facility failed to notify physician of change in wound. On 3/30/2022 new order noted for betadine to right heel pressure area. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Regional Vice President of Operations (RVPO) educated the ED on 4/8/2021 in regard	F 835	04/05/2022. Attending physician and responsible party was made aware of missed appointments on 03/31/2022 A clarification order was obtained for trazodone for Resident #195 on 04/05/2022. Nurse #5 was educated on 04/05/2022 on accurately transcribing orders. The Medical Doctor/ Nurse Practitioner was notified of missed medication of Resident #32, #17, #15 and Resident #17 on 03/31/2022. The Medication Aide and Nurse #2 was educated by the Nurse Manager of administering medications as ordered, use of emergency back –up kit and notification of MD if medications not administered as ordered for further orders on 4-19-22. 2. The Regional Vice President of Operations (RVPO) educated the ED on 4/8/2021 in regards to implementing effective systems or processes to ensure residents received the necessary care and services to assess for pressure ulcers and provide wound care treatments as ordered. During the facility's stand up and stand down meeting on residents' with pressure areas will be discussed and reviewed and chart review conducted by nursing manager and Executive Director. The Director of Nursing/Nurse Manager will report to the Executive Director daily during stand up/stand down meetings that wound dressings and skin assessments have been completed. The Executive	

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F 835	Continued From page 132 to implementing effective systems or processes to ensure residents received the necessary care and services to assess for pressure ulcers and provide wound care treatments as ordered. During the facility's stand up and stand down meeting on residents with pressure areas will be discussed and reviewed and chart review conducted by nursing manager and Executive Director. The Director of Nursing/Nurse Manager will report to the Executive Director daily during stand up/stand down meetings that wound dressings and skin assessments have been completed. The Executive Director educated on processes to monitor compliance of clinical meeting to include daily clinical and meeting and weekly wound meetings. The Executive Director will be responsible for implementing and following through with the plan of correction to ensure compliance. The facility alleges the removal of Immediate Jeopardy on 4-9-22. On 4/12/22 the credible allegation of Immediate Jeopardy removal was validated by onsite verification and included: Education regarding implementation of effective systems or processes to ensure residents will receive the necessary care and services to assess for pressure ulcers and provide wound care as ordered to the Administrator was reviewed and a signature sheet was provided. An interview occurred with the Administrator and interim Director of Nursing (DON) on 4/12/22 at 12:15 PM. The Administrator reported there were 2 meetings during the day (one in the morning and one in the afternoon) where the DON/Nurse	F 835	Director educated on processes to monitor compliance of clinical meeting to include daily clinical and meeting and weekly wound meetings. New Morning meeting form was implemented on 4-11-22 with discussion of Interdisciplinary team that includes: appointments, transportation, new or worsening skin issues, psychotropic medications new or changes and podiatry. Daily clinical meeting is also held that reviews new orders to include missed medications documented unavailable or waiting on pharmacy by Director of Nursing and Nursing Administration to include Nurse manager, Minimum Data Set Nurse and other interdisciplinary team members Social Services and therapy. 3. The Executive Director educated Nurse Manager on expectations of reviewing pressure areas during morning meeting (stand up)/stand down meetings to ensure treatments are completed as ordered with notification of change to physician and RP and weekly skin sweeps are completed on 04/08/2022. The Executive Director educated Nurse Manager on daily clinical meeting to include reviewing of orders, medication unavailable, wound treatments, follow-up with appointments and weekly skin sweeps. 4. The Nurse Manager will conduct random Quality reviews of residents' treatment administration record to ensure treatments of pressure wounds completed and signed on 5 random residents 2 times	

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F 835	Continued From page 133 Manager would report whether wound care and skin sweeps were completed. The Administrator added compliance would also be monitored in the weekly wound meetings as well. The facility's Immediate Jeopardy removal date of 4/9/22 was validated. This citation was cross referred to F 686 E for examples #1b, #2, #3 and #4: In addition, the facility failed to follow wound physician recommendations (Residents #9 and #40), failed to provide wound care as ordered (Residents #9 and #32), failed to change gloves and sanitize hands when going from soiled to clean surfaces during wound care (Resident #9) and failed to set a pressure reducing mattress according to resident's weight (Residents #9 and #11). This was for 4 of 8 residents reviewed for wound care. 3) This citation was cross referred to F584 D: Based on observations and interviews with resident and staff, the facility failed to address a peeling ceiling for 1 of 1 reviewed for environment (Room #126). 4) This citation was cross referred to F658 D: Based on record reviews, observations, and interviews with residents, staff, Nurse Practitioner #1, and Nurse Practitioner #2, the facility failed to administer medications as ordered (Residents #17 and #15) for 2 of 7 residents whose medications were reviewed. 5) This citation was cross referred to F684 G: Based on record reviews, observations, Orthopedic Surgeon, Orthopedic Nurse, Nurse	F 835	a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will conduct random quality reviews of weekly skin sweeps on 5 random residents to ensure skin assessed weekly and any wound identified and treatment ordered. The Nurse Manager will conduct random Quality reviews of 5 resident's with wounds to ensure physician and RP notification completed when change in wound noted 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report findings to the Executive Director. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. The Regional Director of Nursing will review daily clinical meeting notes and morning meeting 2 times a week for 8 weeks then weekly for 4 weeks to ensure compliance and any follow-up completed.	

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F 835	Continued From page 134	F 835		

Practitioner #1 (NP) and staff interviews, the facility failed to provide care to a surgical wound by not monitoring for signs and symptoms of infection and by not removing the staples as ordered (Resident #48). In addition, the facility failed to provide non-pressure related wound care as ordered (Residents #95 #3 & # 195). This was for 3 of 4 sampled residents reviewed for non-pressure wounds. Resident #48 was sent to the emergency room (ER) due to change in level of consciousness/unresponsiveness and was diagnosed with a wound infection.

6) This citation was cross referred to F687 D: Based on observation, record review, resident, staff and Nurse Practitioner #1 interviews, the facility failed to provide or arrange foot care for a resident with thick and long toenails (Resident #32) for 1 of 2 residents who were reviewed for foot care.

7) This citation was cross referred to F690 E: Based on record reviews and interviews with residents, staff, and Nurse Practitioner #1, the facility failed to follow up on urology consultations (Residents #31& #17) and failed to administer an antibiotic as ordered (Resident #196) for 3 of 17 resident records reviewed.

8) This citation was cross referred to 745 D: Based on record reviews, observations, and interviews with residents, staff, Nurse Practitioner #1, and Nurse Practitioner #2, the facility failed to ensure Resident #195 had transportation arrangements for a neurology appointment that was indicated on her hospital discharge instructions and failed to ensure Resident #3 had transportation arrangements for a scheduled prosthetic appointment, resulting in both residents

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F 835	Continued From page 135	F 835		

missing the appointments. This was for 2 of 2 residents reviewed for medically related social services.

9) This citation was cross referred to F758 D: Based on record review, observation and interviews with staff and Nurse Practitioner #1, the facility failed to transcribe the correct frequency per the physician order for an antidepressant medication resulting in an excessive dose being provided (Resident #195). This was for 1 of 7 residents whose medications were reviewed.

10) This citation was cross referred to F760 E: Based on record reviews, pharmacy technician, Nurse Practitioner #1, and staff interviews, the facility failed to administer an anticoagulant (a medication that prevents blood clots, Residents #32 and #17) and an antipsychotic medication (Residents #15 and #17) in accordance with the physician's orders for 3 of 5 residents reviewed for unnecessary medications.

An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 2:00 PM and indicated she had been employed at the facility for close to 2 months and had just started the process of looking at where deficiencies may be in the nursing department. She reported there had been turn-overs in staff.

The Administrator was interviewed on 3/31/22 at 3:00 PM. She stated she was aware this had been a problem about 2 years ago with the Resident Transporter and Scheduler not following through with resident scheduled appointments and a plan had been put into place for this to not occur again. She stated he had done better for a

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F 835	Continued From page 136 while, but it must have fallen by the wayside when the COVID-19 pandemic hit.	F 835		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the required dementia management training to 5 of 5 Nurse Aides (NAs) reviewed for required annual training (NAs #1, #2, #3, #4 & #5). Findings included: 1. Nurse Aide (NA) #1 was hired on 6/1/21. NA #1 training records for dementia training was requested. NA #1 did not have records that she	F 947	1. 1. Nurse Aide #1, #2, #3, #4 and #5 was provided Dementia Training on 04/21/2022 by Nurse Manager. 2. A quality review was completed by the Nurse Manager and Executive Director to identify any nurse aides without Dementia Management training on 04/27/2022. 14 nurse aides were identified without dementia training. The Executive Director and Director of Nursing will ensure annual	5/10/22

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F 947	Continued From page 137 was provided dementia training prior to 3/30/22. NA #1 was not available for interview. 2. NA #2 was hired on 9/14/20. NA #2 training records for dementia training was requested. NA #2 did not have records that she was provided dementia training prior to 3/30/22. NA #2 was interviewed on 3/30/22 at 2:01 PM. She reported that she did not receive dementia training at the facility. 3. NA #3 was hired on 9/16/21. NA #3 training records for dementia training was requested. NA #3 did not have records that she was provided dementia training prior to 3/30/22. NA #3 was not available for interview. 4. NA #4 was hired on 7/16/14. NA #4 training records for dementia training was requested. NA #4 did not have records that she was provided dementia training prior to 3/30/22. NA #4 was interviewed on 3/30/22 at 8:07 AM. She reported that she did not receive dementia training at the facility. 5. NA #5 was hired on 5/10/21. NA #5 training records for dementia training was requested. NA #5 did not have records that she was provided dementia training prior to 3/30/22. NA #5 was not available for interview. The Nurse Consultant was interviewed on 3/31/22 at 9:28 AM. She stated that she could not find any dementia training provided to the NAs including NAs #1, #2, #3, #4 and #5. The Nurse Consultant had no explanation as to why the annual dementia training was not provided.	F 947	Dementia Training is offered and complete for nurse aides. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 04/28/2022 to formulate and approve a plan of correction for the deficient practice. 3. The Nursing Manager educated current nurse aides on dementia management by 05/06/2022. Nursing staff that has not completed the education will completed the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation. The Executive Director will ensure yearly Dementia Training offered and complete for nurse aides. 4. The Nurse Manager will conduct random Quality reviews of current Nurse Aides to ensure annual dementia training is complete on 2 Nurse Aides 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 947	Continued From page 138 The Director of Nursing (DON) was interviewed on 3/31/22 at 1:59 PM. The DON stated that she just started as DON of the facility end of February 2022. She indicated that she expected all the NAs to be trained on dementia management on their hire date and then annually.	F 947		