STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 07/11/2022

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E 000	Initial Comments An unannounced Recertification survey was conducted on 07/05/22 through 07/08/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MD2411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/05/22 through 07/08/22. Event ID# MD2411. One of the two complaint allegations was substantiated resulting in deficiencies. Intake NC189842 Additional information was obtained on 7/11/22. Therefore, the exit date was changed to 7/11/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to assess a resident whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident observed to have medications at bedside (Resident # 7). Findings included: Resident #7 was admitted to the facility on 6/17/22 with multiple diagnoses including cellulitis	F 554	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Abbotts Creek Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements,	8/1/22

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

Electronically Signed | 07/22/2022

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F 554	Continued From page 1 of the left lower extremity. Resident # 7 had doctor's orders dated 6/18/22 for Flonase 1 spray both nostrils daily for allergies, Turmeric 500 milligrams (mgs) 1 tablet by mouth daily for supplementation and B-12 1 tablet by mouth daily for supplementation. The admission Minimum Data Set (MDS) assessment dated 6/24/22 indicated that Resident #7's cognition was intact. Resident #7 was observed on 7/5/22 at 10:30 AM and on 7/6/22 at 2:30 PM to have the Flonase nasal spray bottle, Turmeric bottle and B-12 bottle at bedside. When interviewed, Resident #7 stated that her husband had brought these medications from home for her to take. She verified that she had been taking these medications and the nurses knew about it. Review of Resident #7's medical records revealed that she did not have an assessment for self-administration of medication nor a doctor's order to self-administer medications. Nurse # 4 was interviewed on 7/7/22 at 9:20 AM. She stated that she had observed the bottles of Flonase, Turmeric and B-12 at Resident #7's bedside but she indicated that the resident did not have an order to self-administer medications. The Nurse added that she did not know who was responsible to assess the resident for self-administration since she works for an agency. The Director of Nursing (DON) was interviewed on 7/8/22 at 10:10 AM. The DON stated that she started as DON in June 2022. She did not know	F 554	facts, and conclusions that form the basis for the deficiency. F554 CFR(s): 483.10(c)(7),483.21(b)(2)(ii) (1) Resident # 7 offered a self-administration assessment by the Director of Nursing (DON) and she declined to self-administer and requested that medications be administered by a licensed nurse. All three medications were removed per Resident #7's request from bedside on 7/7/22 and put in medication cart with physicians orders in place. (2) All residents have the potential to be affected. Nursing leadership completed a 100% audit of all current resident's rooms on 7/22/22 to ensure no medication at bedside for residents who have not been assessed and approved for Self Administration of medication. No significant findings were noted. (3) The Director of Nursing (DON), RN supervisor, or designee will educate all licensed nurses on policy and procedures for Self-administering medications, assessment, obtaining physician orders, and ensuring that the care plan reflects the resident's status, starting 7/24/22 and completed by 8/1/22. Education included that residents who have not been assessed as able to self-administer medications shall not have medications at the bedside. All staff not in-serviced by 8/1/22 will be required to complete the in-service prior to working.	

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F 554	Continued From page 2 who was responsible for assessing the resident for self-administration of medication before she was the DON, however the policy stated that the DON was responsible for the assessment. She expected the nurses to inform her of resident's desire to self-administer medications. The DON added that she was not informed that Resident #7 was self-administering medications.	F 554	(4) The Director of Nursing (DON), RN supervisor, or designee will complete 5 random audits per week to ensure no medications are left at bedside for residents who are not assessed as able to Self-Administer Medications. Any issues identified will be corrected. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of compliance 8/1/22.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		8/1/22

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F 623	Continued From page 3	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 4 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to provide the resident and/or responsible party (RP) written notification of the reason for a hospital transfer for 1 of 1 resident reviewed for hospitalization	F 623	F623 CFR(s): 483.15(c)(3)-(6)(8) (1) Resident #66 was discharged on 5/18/22.	

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F 623	Continued From page 5 (Resident #66). The findings included: Resident #66 was admitted to the facility on 5/11/22. A Medicare 5-day Minimum Data Set (MDS) assessment dated 5/13/22 indicated Resident #66 had long and short-term memory problems and severely impaired decision-making skills. Resident #66's medical record revealed he was transferred to the hospital on 5/18/22 following a fall and laceration to the head. There was no documentation that a written notice of transfer was provided to the resident and/or RP for the reason for the transfer. During a phone call on 7/6/22 at 10:25 AM, with Resident #66's RP, she indicated she had not received anything in writing regarding the reason for hospital transfer on 5/18/22, although she was notified by phone. On 7/7/22 at 8:15 AM, an interview occurred with the Business Office Manager who was unaware a written reason for hospital transfer to the resident and/or RP was needed. The Administrator was interviewed on 7/7/22 at 8:17 AM and stated she thought the former Social Worker was sending this, but she had been separated from the facility since February 2022. The Administrator was not aware of any staff member doing this task currently and stated she would expect the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation.	F 623	(2) All residents have the potential to be affected. On 7/21/22 an audit was completed by the Business Office Manager and Medical Records Coordinator on residents Discharged for the last thirty days, and written notification of transfer/ discharge was sent per Regulation F623 to the resident/resident representative and State Long Term Care Ombudsman. (3) The Business Office Manager and Medical Records Coordinator will be educated by the Administrator, on the Notice requirements and transfer/Discharges policy and procedures by 7/22/22. The Social Services Director will be educated on Notice requirements and transfer/Discharge policy and procedures upon hire. (4) The Business Office Manager and Social Services Director will be responsible for timely review and issuing written transfer/discharge notifications. The Administrator will be responsible for auditing notifications 3x weekly for 1 month, then twice weekly for 1 month, then weekly for 1 month. The Administrator will review the audits, and the results will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 8/1/2022.	

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F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of restraints and alarms (Residents #17 and #40), skin conditions (Residents #22 and 63) and medications (Residents #6 and #44). This was for 6 of 21 resident records reviewed. The findings included: 1. Resident #17 was admitted to the facility on 1/20/22 with diagnoses that included dementia. A quarterly MDS assessment dated 4/14/22 indicated Resident #17 had severe cognitive impairment and was not coded for a wander/elopement alarm. Resident #17's active care plan, last reviewed 5/13/22 included a focus area wanders the facility and talking about leaving to go home. The interventions included a wander-alarm applied to the right ankle that was initiated on 2/3/22. On 7/6/22 at 2:39 PM, an observation occurred of Resident #17 while he was lying in bed watching TV. A wander-alarm bracelet was visible to his right ankle. A phone call was placed to the Clinical Reimbursement Coordinator (CRC) on 7/8/22 at 9:50 AM. A return call was not received during the	F 641	F641 CFR(s): 483.20(g) (1) Minimum Data Set (MDS), areas of restraints and alarms for residents #17 and #40, areas of skin conditions for residents #22 and #63, and areas of medications for residents #6 and #44 were corrected and modified by the Clinical Reimbursement Coordinator (CRC) on 7/20/21 to accurately reflect the resident□s status. (2) Any resident has the potential to be impacted by an inaccurate MDS assessment. The Director of Nursing (DON) and/or designee, will conduct an audit of the most recent MDS assessment on all current residents with wander alarms, wounds, and psychotropic medications to ensure accurate coding in the Minimum Data Set (MDS). Any assessment that has not been coded correctly will be modified/significant correction completed by 8/1/22. (3) The Director of Nursing (DON) or designee will educate the MDS Nurse on the accuracy and coding of the Minimum Data Set (MDS). MDS nurse to complete courses in Genesis online vital learn on coding of sections M, N, and P of the MDS by 8/1/22.	8/1/22

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F 641	Continued From page 7 course of the survey. An interview was conducted with the MDS Nurse on 7/8/22 at 10:14 AM. She reviewed the MDS assessment dated 4/14/22 and confirmed the wander/elopement alarms was not coded. She stated she was not the MDS Nurse at that time and would have been coded by the CRC, however the wander/elopement alarm should have been coded. An interview with the interim Director of Nursing and Administrator occurred on 7/8/22 at 11:41 AM. They both indicated it was their expectation for the MDS assessment to be coded accurately. 2. Resident #40 was admitted to the facility on 8/24/20 with diagnoses that included dementia. Resident #40's active care plan included a focus area that was initiated on 8/26/20 for risk for elopement related to cognitive loss/dementia and talks about searching for daddy. The interventions included a wander-alarm bracelet to the right ankle. A quarterly MDS assessment dated 5/16/22 indicated Resident #40 had severe cognitive impairment and was not coded for a wander/elopement alarm. On 7/7/22 at 2:34 PM, an observation was made of Resident #40 while she was lying in bed. A wander-alarm bracelet was visible to her right ankle. A phone call was placed to the CRC on 7/8/22 at 9:50 AM. A return call was not received during the	F 641	(4) The Director of Nursing (DON) or designee will audit 5 MDS assessments for one month, then three for two months to ensure accurate coding of the assessments. Any issues identified will be corrected. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of compliance 8/1/2022.	

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course of the survey.

An interview was conducted with the MDS Nurse on 7/8/22 at 10:14 AM. She reviewed the MDS assessment dated 5/16/22 and confirmed the wander/elopement alarms was not coded. She explained at that time she was new to the position and the CRC was checking to ensure her entries were correct before submitting. The MDS Nurse stated it was an oversight not to have coded the wander/elopement alarm for Resident #40.

An interview with the interim Director of Nursing and Administrator occurred on 7/8/22 at 11:41 AM. They both indicated it was their expectation for the MDS assessment to be coded accurately.

3. Resident #22 was originally admitted to the facility on 12/26/17. Her diagnoses included non-pressure chronic ulcers of the right leg.

An Infectious Disease progress note for 1/24/22 indicated Resident #22 had chronic open wounds over the right knee with tunneling and drainage with concern that the right knee prosthetic was infected causing abscesses.

A review of a form titled "Wound Evaluation and Management Summary" completed by the Wound Physician, and dated 5/2/22, revealed the following skin conditions:
- A traumatic wound to the right superior knee
- A traumatic wound to the right medial knee
- A shear wound to the right inferior knee
- A wound to the right lateral knee
- A wound to the right calf

A quarterly MDS assessment dated 5/4/22

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indicated Resident #22 had moderately impaired cognition. She was coded with five venous/arterial ulcers.

Resident #22's active care plan, last revised 5/19/22, included a focus area for actual skin breakdown related to right shin and knee wounds due to infected hardware.

A phone interview was completed with the VOHRA Wound Physician on 7/8/22 at 8:41 AM and explained Resident #22's wounds to her right knee and shin area were related to infection in her knee prosthetic and not venous/arterial related.

A phone call was placed to the CRC on 7/8/22 at 9:50 AM. A return call was not received during the course of the survey.

An interview was conducted with the MDS Nurse on 7/8/22 at 10:14 AM. She reviewed the MDS assessment dated 5/4/22 and verified Resident #22 was coded with 5 arterial/venous ulcers. She explained the entry was completed by the CRC, who should have reviewed the Wound Evaluation and Management Summary as well as physician progress notes to determine how to classify the wounds.

An interview with the interim Director of Nursing and Administrator occurred on 7/8/22 at 11:41 AM. They both indicated it was their expectation for the MDS assessment to be coded accurately.

4. Resident #63 was admitted on 5/9/21 with a diagnosis of Congestive Heart Failure and a pressure ulcer to her right heel.

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The quarterly Minimum Data Set (MDS) assessment dated 3/4/22 indicated Resident #63 was cognitively intact and was coded for a stage 4 pressure ulcer acquired at the facility. The MDS assessment dated 3/4/22 was completed by the corporate Clinical Reimbursement Coordinator (CRC).

A wound care observation and resident interview was completed 7/7/22 at 11:50 AM with Resident #63. Resident #63 stated the pressure ulcer to her right heel had been open for 6 years. She continued that the area would improve then re-open and never completely healed.

Resident #63 was care planned on 5/9/21 for a stage 2 pressure ulcer to her right heel. This care area was last revised on 5/21/22

The most recent quarterly MDS assessment dated 6/4/22 was also coded for a stage 4 pressure ulcer acquired at the facility. The MDS assessment dated 6/4/22 was completed by the MDS Nurse.

An interview was completed on 7/6/22 at 3:12 PM with the MDS Nurse. She stated she began working at the facility for approximately 6 months as the Assistant Director of nursing (ADON) then began training as the MDS Nurse in mid-May 2022. She stated the corporate CRC worked remotely and trained her on how to complete a MDS assessment. She stated the corporate CRC reviewed all her MDS assessment's until her training ended about 2 weeks ago.

The MDS Nurse stated she completed the 6/4/22 quarterly MDS assessment and copied what the corporate CRC had coded on Resident #63's

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quarterly MDS assessment dated 3/4/22. She stated she was aware that Resident #63 had non-healing right heel pressure ulcer for as long as she had worked at the facility, but thought the corporate CRC knew more about coding the MDS assessment so she coded what the corporate CRC had coded on the quarterly MDS assessment completed 3/4/22.

A telephone message was left for the corporate CRC to return surveyor's call on 7/8/22 at 9:50 AM.

The Administrator and Interim DON were made aware on 7/8/22 at 11:30 AM that a message was left for the corporate CRC to return the surveyor's call. They suggested letting the facility attempt to contact the corporate CRC but no return phone calls were received.

An interview was completed on 7/8/22 at 11:42 AM with the Administrator and the Interim DON. The Administrator stated Resident #63's quarterly MDS assessment dated 3/4/22 and 6/4/22 should be coded accurately and reflect that her pressure ulcer was present on her admission on 5/9/21 and not facility acquired.

5. Resident #6 was admitted on 1/26/21 with a diagnosis of Parkinson's Disease.

The quarterly Minimum Data Set (MDS) assessment dated 3/31/22 indicated Resident #6 was coded as taking an antipsychotic medication. The MDS assessment was completed by the corporate Clinical Reimbursement Coordinator (CRC).

Resident #6's was care planned last revised on

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F 641	Continued From page 12	F 641		

12/1/21 for the use of psychotropic medications related to her psychosis.

Review of Resident #6's March, April, May, June and July 2022 Physician orders did not include any orders for an antipsychotic medication. The orders did however include an order dated 3/18/22 for Lamictal (anticonvulsant) for psychosis.

An interview was completed on 7/8/22 at 10:15 AM with the MDS Nurse. She stated she began working at the facility for approximately 6 months ago as the Assistant Director of nursing (ADON) then began training as the MDS Nurse in mid-May 2022. She stated her MDS training ended about 2 weeks prior to the Interim DON starting on 6/21/22. The MDS Nurse stated the corporate CRC completed Resident #6's quarterly MDS assessment dated 3/31/22 and coded her Lamictal as an antipsychotic. She was unable to explain why the MDS assessment was coded inaccurately.

A telephone message was left for the corporate CRC to return surveyor's call on 7/8/22 at 9:50 AM.

The Administrator and Interim DON were made aware on 7/8/22 at 11:30 AM that a message was left for the corporate CRC to return the surveyor's call. They suggested letting the facility attempt to contact the corporate CRC but no return phone calls were received.

An interview was completed on 7/8/22 at 11:42 AM with the Administrator and the Interim DON. The Administrator stated Resident #6's medications should have been coded accurately

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F 641	Continued From page 13 on the quarterly MDS assessment dated 3/31/22 and was unable to explain why her Lamictal was coded as an antipsychotic. 6. Resident #44 was admitted to the facility on 5/30/22. Resident #44 had a doctor's order dated 5/30/22 for Buspirone (an antianxiety medication) 150 milligrams (mgs) 1 tablet by mouth daily for depression. The admission Minimum Data Set (MDS) assessment dated 6/6/22 indicated that Resident #44 had received an antianxiety medication for 3 days during the assessment period. Review of the May and June 2022 Medication Administration Records (MAR) revealed that Resident #44 had received the Buspirone for 7 days during the assessment period (May 31 - June 6, 2022). The MDS Nurse was interviewed on 7/8/22 at 10:25 AM. The MDS Nurse stated that she thought Buspirone was an antidepressant medication and indicated that it was an error on her part. The Director of Nursing (DON) and the Administrator were interviewed on 7/8/22 at 11:45 AM. The Administrator stated that she expected the MDS to be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		8/1/22

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F 655	Continued From page 14 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 15 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 2 sampled residents reviewed who were newly admitted (Residents # 58 & # 115). Findings included: 1. Resident # 115 was admitted to the facility on 7/1/22 with multiple diagnoses including neurogenic bladder. Resident #115 was observed in bed with a suprapubic catheter in place. Review of Resident #115's medical records revealed that she did not have a baseline care plan developed as of 7/7/22. The Minimum Data Set (MDS) Nurse was interviewed on 7/8/22 at 10:25 AM. The MDS Nurse reported that the admitting Nurse was responsible for initiating the baseline care plan and she reviewed the baseline care plan the next day during the clinical meeting. She stated that the baseline care for Resident #115 was missed. The Director of Nursing (DON) and the Administrator were interviewed on 7/8/22 at 11:45 AM. The Administrator stated that the MDS Nurse was responsible for developing the baseline care plan and not the nurses. She added that she would inform the MDS Nurse of this.	F 655	F655 CFR(s): 483.21(a)(1)-(3) (1) Resident #58 Baseline Care Plan has been completed on 7/8/22. Resident #115 has a Care Plan completed on 7/8/22. (2) All newly admitted residents have the potential to be affected. The MDS Nurse to complete a thirty-day lookback audit for all new admissions on 7/25/22 to ensure that Baseline Care Plans have been completed in a timely manner. Any corrections will be completed at the time of the audit. (3) Education to be provided by the Director of Nursing or designee for the MDS nurse and all Licensed Nurses to include that the written Baseline Care Plan should be completed within 48 hours post admission and include the initial goals of the Resident, a summary of the residents medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Any staff who has not completed education and/or training prior to or on 8/1/22 will be required to complete education prior to working. (4) Director of Nursing or designee to audit all new admissions weekly for four weeks to ensure that Baseline Care Plans are completed timely and accurately, and randomly thereafter. Any issues identified	

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F 655	Continued From page 16 2. Resident #58 was readmitted to the facility on 6/16/22 with multiple diagnoses including end stage renal disease and was receiving hemodialysis. Review of Resident #58's medical records revealed that she did not have a baseline care plan developed as of 7/7/22. The Minimum Data Set (MDS) Nurse was interviewed on 7/8/22 at 10:25 AM. The MDS Nurse stated that Resident #58 was a resident at the facility but was discharged to the hospital. When she was discharged, her care plan was canceled and was never reinstated upon readmission. She reported that the admitting Nurse was responsible for initiating the baseline care plan and she reviewed it the next day during the clinical meeting. She stated that the baseline care for Resident #58 was missed. The Director of Nursing (DON) and the Administrator were interviewed on 7/8/22 at 11:45 AM. The Administrator stated that the MDS Nurse was responsible for developing the baseline care plan and not the nurses. She added that she would inform the MDS Nurse of this.	F 655	will be corrected. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/2022	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		8/1/22

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F 656	Continued From page 17 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to develop and implement a comprehensive care plan in the area of hemodialysis (Resident #33).	F 656	F658 CFR(s): 483.21(b)(1) (1) Resident # 33 comprehensive care plan for the area of dialysis was	

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F 656	Continued From page 18 This was for 1 of 2 residents reviewed for dialysis. The findings included: Resident #33 was admitted on 5/17/22 with a diagnosis of End Stage Renal Disease (ERSD). The admission/5-day Minimum Data Set (MDS) assessment dated 5/24/22 indicated Resident #33 was cognitively intact and the MDS was coded for dialysis. Review of Resident #33 admission comprehensive care plan did not include a care area with interventions for her hemodialysis. Review of the care plan revealed it was completed by the Interim Director of Nursing (DON). An interview and observation was completed with Resident #33 on 7/5/22 at 1:00 PM. She stated she went to hemodialysis on Monday, Wednesday and Friday. She presented her left arm for observation. There was a large fistula noted to her upper left arm. She stated she reminded the staff and lab technicians that no blood pressure (B/P) or lab work were to be completed on her left arm. An interview was completed on 7/8/22 at 10:15 AM with the MDS Nurse. She stated she began working at the facility for approximately 6 months ago as the Assistant Director of nursing (ADON) then began training as the MDS Nurse in mid-May 2022. She stated the corporate Clinical Reimbursement Coordinator (CRC) worked remotely and trained her on how to complete a comprehensive care plan. She stated the corporate CRC reviewed all her care plan's s up until her training ended about 2 weeks prior to the	F 656	completed on 7/8/22. (2) All residents on Dialysis have the potential to be affected. The MDS Nurse to complete an audit on 7/25/22 for all residents that receive dialysis to ensure that a comprehensive care plan have been completed. Any corrections will be completed at the time of the audit. (3) The MDS nurse will be educated by 7/29/2022 by the Director of Nursing or designee to include the facility policy and procedure for completing a comprehensive person-centered care plan for each resident within seven days of the completion of the comprehensive MDS assessment. (4) Director of Nursing or designee to audit all new admissions monthly for two months to ensure that a comprehensive care plan has been completed timely and accurately. Any issues identified will be corrected. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/2022	

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F 656	Continued From page 19 Interim DON starting on 6/21/22. She stated Resident #33 should have been comprehensively care planned for her hemodialysis and interventions implemented but it must have been overlooked. An interview was completed on 7/8/22 at 10:49 AM with the Interim DON. She stated she was working remotely for a week or so in June 2022 and she was tasked to do care plan reviews and audits. She stated it was during this time, she completed Resident #33's comprehensive care plan but did not think to care plan her for hemodialysis. The Interim DON stated it was an oversight and she should have care planned the resident for dialysis. An interview was completed on 7/8/22 at 11:42 AM with the Administrator and the Interim DON. The Administrator stated Resident #33 should have been comprehensively care planned to include hemodialysis. She stated there was some transitioning going on then and somehow her comprehensive care plan was not fully completed or implemented.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		8/1/22

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F 684	Continued From page 20 by: Based on record reviews, observations, Medical Director, Wound Physician and staff interviews, the facility failed to provide treatments as ordered by the physician to non-pressure related wounds on the lower extremity for 1 of 2 residents reviewed for skin conditions (Resident #22). The findings included: Resident #22 was originally admitted to the facility on 12/26/17. Her diagnoses included non-pressure chronic ulcers of the right lower leg and deep incisional surgical site infection. An Infectious Disease progress note dated 1/24/22, revealed Resident #22 had chronic open wounds over the right knee with tunneling and drainage due to right knee prosthetic infection. There were open areas around the right knee and an abscess to the right mid-shin. A quarterly Minimum Data Set (MDS) assessment dated 5/4/22, indicated Resident #22 had moderately impaired cognition and displayed no behaviors or refusal of care during the look back period. She was coded with 5 venous/arterial ulcers and received application of nonsurgical dressings and ointments other than to her feet. A physician progress note dated 5/27/22 indicated Resident #22 had chronic infection of the right knee prosthetic and has declined surgical intervention. There are several areas on the right leg that drain, and the wound physician monitored weekly. Review of the active care plan, last revised	F 684	F684 CFR(s): 483.25 (1) The wound care orders for Resident # 22 have been corrected on 7/8/22 by the DON. Resident # 22 is receiving wound treatments as ordered. (2) All Residents with wounds have the potential to be affected. An audit was completed on 7/22/2022 by the Nursing Leadership Team for all Residents with wound care orders to ensure proper transcription. Any issues or discrepancies identified will be corrected during the audit. (3) Education to be provided by the Director of Nursing or designee for all Licensed Nurses regarding Wound Orders. Education to include that each Wound Order is noted in PCC upon rounding with wound MD, ensuring that each Wound Order is followed/completed per MD Order, and documentation in PCC of notification or new orders obtained. Any staff who has not completed education and/or training prior to or on 8/1/22 will be required to complete education prior to working. (4) Nursing Managers will audit for new wound care orders five times a week for four weeks and then weekly thereafter to ensure proper transcription of wound care orders. Any discrepancies or issues will be corrected during the audit. Results of this audit will be brought to Quality Assurance and Performance	

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F 684	Continued From page 21 6/12/22, revealed a focus area for actual skin breakdown of the right shin and knee due to infected hardware. The interventions included to provide wound treatments as ordered and weekly wound assessment by in-house wound doctor to include measurements and description of wound status. a) The active physician orders included an order dated 4/28/22 to pack the right inferior knee wound with Iodoform packing strips (a gauze strip used for open and/or infected wounds), apply Calcium Alginate (a wound dressing used to manage drainage and provide a moist environment for healing), cover with a thick dressing, and wrap with gauze once a day. A review of a "Wound Evaluation and Management Summary" completed by the Wound Physician and dated 5/2/22 indicated the right inferior knee, shear wound measured 3.8 centimeters (cm) in length and 0.6 cm in width and to continue the current treatment. The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 revealed the right inferior knee wound measured 4 cm in length and 0.8 cm in width. The order was changed to Calcium Alginate to the wound, cover with a dry dressing and wrap with gauze daily. A review of the June 2022 and July 2022 Medication Administration Records (MARs) and Treatment Administration Records (TARs) for Resident #22, did not reveal a change in the treatment order as recommended on 6/20/22 by the Wound Physician.	F 684	Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/22	

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F 684	Continued From page 22	F 684		

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the packing strip that was present to the right inferior knee wound, cleaned the wound and replaced the packing strip, covered with a dry dressing, and wrapped the extremity in a gauze wrap. Nurse #3 stated the Wound Physician measured the wound weekly.

b) The active physician orders included an order dated 4/28/22 to pack with right lateral (side) knee wound with Iodoform packing strips, apply Calcium Alginate, cover with thick dressing, and wrap with gauze once a day.

A review of a "Wound Evaluation and Management Summary" completed by the Wound Physician and dated 5/2/22 indicated the right lateral knee wound measured 1.1 cm in length, 0.6 cm in width and 0.2 cm in depth. The facility was to continue with the current treatment.

The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 revealed the wound to the right lateral knee measured 0.8 cm in length, 0.5 cm in width and 0.1 cm in depth. The orders were changed to Calcium Alginate to the wound, cover with a dry dressing and wrap with gauze daily.

A review of the June 2022 and July 2022 MARs and TARs for Resident #22, did not reveal a change in the treatment order as recommended on 6/20/22 by the Wound Physician.

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F 684	Continued From page 23	F 684		

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the packing strip from the right lateral knee wound, cleaned the wound and replaced the packing strip, covered with a dry dressing, and wrapped the extremity in a gauze wrap. Nurse #3 stated the Wound Physician measured the wound weekly.

c) The active physician orders included an order dated 4/28/22 to pack the right superior (upper) knee wound with Iodoform packing strips, apply Calcium Alginate, cover with thick dressing, and wrap with gauze once a day.

A review of a "Wound Evaluation and Management Summary" completed by the Wound Physician and dated 5/2/22 indicated the right superior knee measured 0.6 cm in length, 0.4 cm in width and 0.1 cm in depth. The facility was to continue the current treatment.

The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 indicated the wound to the right superior knee measured 1 cm in length, 0.9 cm in width and 0.1 cm in depth. The orders were changed to Calcium Alginate to the wound and wrap with gauze daily.

A review of the June 2022 and July 2022 MARs and TARs for Resident #22, did not reveal a change in the treatment order as recommended on 6/20/22 by the Wound Physician.

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On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed to around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the packing strip from the right superior knee wound, cleaned the wound and replaced the packing strip, covered with a dry dressing, and wrapped the extremity in a gauze wrap. Nurse #3 stated the Wound Physician measured the wound weekly.

d) The active physician orders included an order dated 4/28/22 to apply a wet to moist gauze with Dakin's solution (a solution used as an antiseptic to clean infected topical wounds) to the right calf wound, cover with dry dressing, and wrap with gauze once a day.

A review of a "Wound Evaluation and Management Summary" completed by the Wound Physician and dated 5/2/22 indicated the right calf wound measured 3.8 cm in length, 3.5 cm in width and 3 cm in depth. The facility was to continue the current treatment.

A review of the "Wound Evaluation and Management Summary" completed by the Wound Physician on 5/16/22 indicated a change in the treatment of the right calf wound. The wound measured 2.9 cm in length, 1.5 cm in width and 2 cm in depth. The facility was to start using Calcium Alginate covered with a dry dressing and wrap with gauze daily.

The "Wound Evaluation and Management Summary" form completed by the Wound

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Physician on 6/20/22 revealed the wound to the right calf measured 2.5 cm in length, 1.8 cm in width and 0.1 cm in depth. The orders remained the same.

A review of the June 2022 and July 2022 MARs and TARs for Resident #22, did not reveal a change in the treatment order as recommended on 5/16/22 by the Wound Physician.

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed to around the knee area, shin, and calf area. There was no redness or odor present. Nurse #3 removed the dressing, cleaned the wound and reapplied a piece of Calcium Alginate, covered with a dry dressing and wrapped the extremity in a gauze wrap. Nurse #3 stated the Wound Physician measured the wound weekly. When asked about the Dakin's solution she stated that had been discontinued "a while back".

e) The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 5/23/22 revealed a wound to the right shin that measured 2.8 cm in length, 2.5 cm in width and 1.5 cm in depth. The orders were to pack with Iodoform gauze, cover with Calcium Alginate and cover with a dry dressing daily.

A review of the active physician orders, June 2022 and July 2022 MARs and TARs, for Resident #22, did not reveal an order for the treatment of the right shin wound.

The "Wound Evaluation and Management

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Summary" form completed by the Wound Physician on 6/20/22 revealed the wound to the right shin measured 1.8 cm in length, 1.7 cm in width and 1.1 cm in depth. There were no changes to the order.

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the packing strip that was present to the wound, cleaned the wound and replaced the packing strip, covered with a dry dressing, and wrapped the extremity in a gauze wrap. Nurse #3 stated the Wound Physician measured the wound weekly.

f) The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 revealed a wound to the right inferior calf that measured 3.4 cm in length and 2 cm in width. The facility was to apply Xeroform gauze (a non-adherent dressing with a mixture containing petroleum jelly) and wrap with gauze daily.

A review of the active physician orders, June 2022, and July 2022 MARs and TARs, for Resident #22, did not reveal an order for the treatment of the right inferior calf wound.

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor

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present. Nurse #3 removed the dressing to the wound, cleaned the area and applied a piece of Calcium Alginate, covered with a dry dressing, and wrapped the extremity in gauze. Nurse #3 stated the Wound Physician measured the wound weekly.

g) The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 revealed a shear wound to the right superior, lateral (upper and to the side) calf that measured 1.5 cm in length, 0.6 cm in width and 0.1 cm in depth. The facility was to apply Calcium Alginate and a dry dressing daily.

A review of the active physician orders, June 2022, and July 2022 MARs and TARs, for Resident #22, did not reveal an order for the treatment of the right superior, lateral calf wound.

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the dressing to the wound, cleaned the area and applied a piece of Calcium Alginate, covered with a dry dressing, and wrapped the extremity in gauze. Nurse #3 stated the Wound Physician measured the wound weekly.

h) The "Wound Evaluation and Management Summary" form completed by the Wound Physician on 6/20/22 revealed a wound to the right superior shin that measured 2 cm in length, 1.5 cm in width and 0.1 cm in depth. The facility was to apply Xeroform gauze and wrap with

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gauze daily..

A review of the active physician orders, June 2022, and July 2022 MARs and TARs, for Resident #22, did not reveal an order for the treatment of the right superior shin wound.

On 7/6/22 at 11:20 AM, wound care observation was completed with Nurse #3. She was observed removing the gauze wrap from Resident #22's right lower leg. Multiple small open areas were observed around the knee, shin, and calf area. There was no redness or odor present. Nurse #3 removed the dressing to the wound, cleaned the area and applied a piece of Calcium Alginate, covered with a dry dressing, and wrapped the extremity in gauze. Nurse #3 stated the Wound Physician measured the wound weekly.

An interview occurred with Nurse #3 on 7/6/22 at 12:00 PM, who stated she had followed the orders in the July 2022 MAR and was unaware there were changes or additions to the treatment orders for Resident #22. She added she thought the open areas on her knee and calf were to be covered with Calcium Alginate. She explained she went by what was in the MAR and did not look at the Wound Physician progress notes as someone else rounded with him weekly.

On 7/8/22 at 8:41 AM, a phone interview was completed with the Wound Physician. He explained he was at the facility once a week to assess and measure wounds for the residents that were on his caseload. A nurse rounded with him where he relayed the measurements as well as any changes to the treatment orders. He stated he thought the nurse was reviewing the

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F 684	Continued From page 29 treatment orders for accuracy from week to week and expected the facility to follow his recommendations unless the Medical Director changed them. The Wound Physician stated there would have been no harm to performing treatments according to the April 2022 orders as wound care for Resident #22 was palliative. Her wounds would continue to occur with difficulty healing due to the infected knee prosthetic and her decline for surgical intervention. The interim Director of Nursing (DON) was interviewed on 7/8/22 at 9:15 AM. She reviewed Resident #22's active physician orders, June 2022 and July 2022 MARs and TARs as well as Wound Physician progress notes dated 6/27/22 and verified the orders did not coincide with what was recommended, and a few areas were not present on the active physician orders, June and July 2022 MARs or TARs. She explained she had been rounding with the Wound Physician and would write what he stated about the wounds on a piece of paper, and often stated to keep the treatments the same. The interim DON stated she failed to review the Wound Physician progress notes when they arrived at the facility (within 24 to 48 hours) and just kept Resident #22's treatment orders the same. The Medical Director was interviewed on 7/8/22 at 11:13 AM and stated he left wound care orders to the Wound Physician if he was following the resident for wound care. He added he would expect the facility to follow the wound care orders as recommended.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		8/1/22

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F 689	Continued From page 30 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure fall mats were in place according to the care planned fall safety interventions (Resident #40). This was for 1 of 5 residents reviewed for accidents. The findings included: Resident #40 was admitted to the facility on 8/24/20 with diagnoses that included dementia and repeated falls with a history of a hip fracture. Resident #40's active care plan, dated 3/21/22, included a focus area for risk for falls due to cognitive loss, lack of safety awareness and impaired mobility. The interventions included fall mats to both sides of the bed that were initiated on 8/26/20. A record review revealed Resident #40 rolled off the bed on 5/9/22. A quarterly Minimum Data Set (MDS) assessment dated 5/16/22 indicated Resident #40 had severe cognitive impairment and required limited to extensive assistance for Activities of Daily Living (ADLs). A wheelchair was used for mobility, and she was coded with 1 fall since the last assessment.	F 689	F689 CFR(s): 483.25(d)(1)(2) (1) Fall interventions for Resident #40 were reviewed for accuracy and the fall mat was placed on both sides of the bed on 7/8/22. (2) All Residents at risk for falls have the potential to be affected. The Nursing management completed an audit on 7/26/22, of all current Residents with fall mat interventions to ensure the fall mats are in place as ordered, and care planned. (3) The Director of Nursing or designee will educate clinical staff on Fall mat placement, fall interventions, and locating information on care planned interventions. Any staff who has not completed education and/or training prior to or on 8/1/22 will be required to complete education prior to working. (4) The Director of Nursing or designee will conduct weekly random audits of fall mats for compliance for three months. Any issues identified will be corrected. Results of this audit will be brought to	

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F 689	Continued From page 31 An observation occurred of Resident #40's bed on 7/5/22 at 2:00 PM. The bed was in the lowest position with a concave mattress present. There were no fall mats located in the room or bathroom. On 7/6/22 at 10:20 AM, an interview occurred with Nurse Aide (NA) #3, who was assigned to Resident #40. She indicated staff monitor for safety as Resident #40 will try to stand on her own from the wheelchair. She further explained when a scoop mattress was present on the bed to prevent her from rolling off the bed and the bed was kept in the lowest position when Resident #40 was in it. When asked about fall mats, she stated she was unsure and hadn't seen any fall mats being used for Resident #40. On 7/7/22 at 2:34 PM, an observation was made of Resident #40 lying in bed with her eyes closed. There were no fall mats present to either side of the bed. An interview occurred with Nurse #1 on 7/7/22 at 3:36 PM, who was assigned to Resident #40. She was unsure if fall mats were to present at bedside and stated that she had just started working that hall and was not familiar with the residents. The interim Director of Nursing (DON) was interviewed on 7/8/22 at 9:15 AM and stated fall mats should be in place to both sides of Resident #40's bed when she is in it. She explained the staff would remove them when she was up in the wheelchair for safety but was unaware they were not being used. She added it was her expectation for fall interventions to be	F 689	Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/22	

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F 689	Continued From page 32 implemented by the staff. The nurse supervisor was interviewed on 7/8/22 at 9:25 AM and stated Resident #40 should have fall mats to both sides of the bed and was unaware they were not being utilized.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview from the dialysis center staff, Physician, resident and facility staff, the facility failed to obtain orders for the care and monitoring of a dialysis resident (Resident #33) and failed to utilize the communication sheets to exchange information about resident's treatment and care with the dialysis center for 2 of 2 sampled residents reviewed for dialysis (Residents #33 & # 58). Findings included: 1. Resident #58 was originally admitted to the facility on 12/4/20 and was re-admitted on 6/16/22 with multiple diagnoses including end stage renal disease (ESRD) and was receiving hemodialysis. The quarterly Minimum Data Set (MDS) assessment dated 6/1/22 indicated that Resident #58 had severe cognitive impairment and was on	F 698	F698 CFR(s): 483.25(l) (1) Residents #33 and #58 have physician orders for obtaining vital signs after treatment and the monitoring of the arterial/vascular fistula for bleeding, signs, and symptoms of infection, removing the dressing to the fistula the following day after dialysis. Medical records put together a binder for residents #33 and #58 complete with dialysis communication forms. Resident # 33 comprehensive care plan for the area of dialysis was completed. Resident #58 Baseline Care Plan has been completed. (2) All Residents receiving dialysis have the potential to be affected. Nursing Leadership audited all Dialysis residents charts on 7/22/22 for these areas. Any corrections will be completed at the time	8/1/22

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F 698	Continued From page 33 dialysis. Resident #58 did not have a care plan or a baseline care plan for dialysis upon readmission. Review of Resident #58's medical records revealed no on-going communication with the dialysis center regarding resident's care and treatment. There were no pre and post dialysis weights from the dialysis center and there were no laboratory results since readmission. The Nurse Supervisor was interviewed on 7/7/22 at 9:02 AM. She stated that a communication binder was sent with the resident during dialysis days. Review of the dialysis binder, there were only 6 communication sheets (1/12/22, 4/4/22, 4/13/22, 6/8/22, 6/13/22 & 6/20/22) in the binder for Resident #58 for the last 6 months. Nurse #4, assigned to Resident #58, was interviewed on 7/7/22 at 10:40 AM. She stated that she works for an agency and was not familiar with the dialysis communication sheets. The Dialysis Nurse was interviewed on 7/7/22 at 11:06 AM. She stated that the facility was supposed to bring the dialysis communication sheet with the resident during dialysis days. She reported that the dialysis nurse assigned to the resident completes the sheet with the pre and post weights and vital signs and returned the sheet back to the facility. She indicated that she was not sure if the sheets were received at the center or not since the dialysis center was not maintaining copies of the completed sheets. The Administrator was interviewed on 7/8/22 at 11:45 AM. She reported that the facility had just	F 698	of the audit. (3) Education completed on 7/6/22-7/8/22 for all licensed staff, including agency regarding Dialysis documentation, policy, and procedures, assuring dialysis communication forms are completed and sent with the resident. The Director of Nursing or designee will re-educate all licensed Nurses on policy and procedures, obtaining Physician orders for obtaining vital signs after treatment and the monitoring of the arterial/vascular fistula for bleeding, signs and symptoms of infection, removing the dressing to the fistula the following day after dialysis. Any staff who has not completed education and/or training prior to or on 8/1/22 will be required to complete education prior to working. (4) Nursing leadership to review dialysis documentation and communication forms in Clinical Morning Meeting 5 times a week for two months to ensure completion. Any issues identified will be corrected. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/22	

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identified 2 dialysis residents including Resident #58 who did not have communication sheets completed during dialysis days. She stated that she would educate all the licensed staff including the agency staff regarding dialysis documentation, policy and procedure and assuring that the dialysis communication sheets were completed and sent with the resident to the dialysis center.

2. Resident #33 was admitted on 5/17/22 with a diagnoses of End Stage Renal Disease (ERSD) and a right lower leg fracture.

The admission/5-day Minimum Data Set (MDS) dated 5/24/22 indicated Resident #33 was cognitively intact and the MDS assessment was coded for dialysis.

Review of Resident #33's July 2022 Physician orders included an order dated 5/18/22 which read the nurses were to check for a bruit (a loud swishing sound when listening to the fistula using a stethoscope) and thrill (vibrations felt when touching the fistula) every shift. There was an order dated 5/18/22 that read to document dry weights when Resident #33 returned from dialysis on Monday, Wednesday and Friday. Another order dated 5/26/22 was written for fluid restrictions of 1500 milliliters every day. There were no Physician orders for the monitoring of her arterial/vascular (AV) fistula for bleeding, signs and symptoms of infection, removing the dressing to her fistula the following day after dialysis and obtaining vital signs after returning from her dialysis treatments.

An interview and observation was completed with

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Resident #33 on 7/5/22 at 1:00 PM. She stated she went to hemodialysis on Monday, Wednesday and Friday. She presented her left arm for observation. There was a large fistula noted to her upper left arm. She stated she reminded the staff and lab technicians that no blood pressure (B/P) or lab work were to be completed on her left arm.

An interview was completed on 7/6/22 at 2:45 PM with the Administrator. She stated all dialysis residents to include Resident #33 took a notebook with the communication forms to each dialysis treatments for the dialysis staff and the facility to document her status pre and post dialysis treatment. She stated she was not aware that Resident #33's Physician orders did not include orders for monitoring her AV fistula for evidence of bleeding or obtaining Resident #33's vital signs upon her return from her dialysis treatments.

Another interview was completed on 7/7/22 at 8:50 AM with Resident #33. She stated upon returning from dialysis, the staff transferred her back to bed using a mechanical lift. She stated the staff did not take her vital signs upon her return from dialysis and she monitored her own fistula for bleeding after each dialysis treatment. Resident #33 stated she was given a form to take with her yesterday titled Hemodialysis Communication Record but she had only been given the form maybe one other time since her admission on 5/17/22.

An interview was completed on 7/7/22 at 9:00 AM with Nursing Assistant (NA) #5. She stated she was not trained on care of dialysis resident but she was aware that a weight needed to be

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obtained pre and post dialysis treatment.

An interview was completed on 7/7/22 at 9:02 AM with the Nursing Supervisor (NS). She stated it was her practice to obtain Resident #33's vital signs before and after her dialysis. The NS was unable to explain why there was no documented evidence that Resident #33's pre and post dialysis vital signs were obtained and entered into the electronic medical record. She stated Resident #33 took a dialysis communication notebook with her to every dialysis treatment for the facility and dialysis staff to communicate regarding the care and monitoring of Resident #33. The NS stated Resident #33's notebook should be located at the nurses station on the split hall.

An interview was completed on 7/7/22 at 9:05 AM with Nurse #8. She stated she was very familiar with how to monitor a dialysis resident and it was her practice to check a resident's vital signs following a dialysis treatment because the blood pressure often dropped after a treatment. She stated she also monitored for evidence of bleeding at the dialysis access site and keeping the dialysis site dressing in place for 24 hours. Nurse #8 stated the only Physician orders for Resident #33 were to obtain a pre and post weight and to check Resident #33's AV fistula for a thrill and bruit each shift.

An interview was completed on 7/7/22 at 9:10 AM with NA #4. She stated it was her practice to obtain a set of vital signs on all her residents first thing when she got to work but she was not working when Resident #33 returned from dialysis. She stated she was not aware of any additional monitoring that was needed for a

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dialysis resident. She stated she thought the nurse sent out a notebook with Resident #33 when she went to dialysis.

An interview was completed on 7/7/22 at 9:20 AM with Nurse #3 working at the split nurses station assigned Resident #33. She stated on Resident #33's dialysis days, the staff got her up, got her dressed and ensured she ate her breakfast. Nurse #3 stated Resident #33 was always tired when she returned from dialysis and the staff just put her to bed. She stated her AV fistula was checked on every shift to a bruit and thrill and that it was her practice to remove the post dialysis AV fistula dressing around 3 or 4 hours after Resident #33's return. Nurse #3 stated normally Resident #33 took a notebook with communication forms inside for the dialysis staff to document any problems or new orders while she was at dialysis. An observation was completed with Nurse #3 to locate Resident #33's dialysis notebook with her dialysis communication forms inside but Nurse #3 was not able to locate Resident #33's dialysis communication notebook. Observations were completed at the rehabilitation nurses station and the long term care nurses station as well. No dialysis communication notebook was located for Resident #33.

An interview was completed on 7/7/22 at 10:07 AM with the interim Director of Nursing (DON). She stated she was under the impression the staff were sending out a notebook with the communication forms inside for the facility and the dialysis clinic staff to document Resident #33's monitoring. The interim DON also stated she was not aware that the facility staff had not obtained Physician orders for the comprehensive care and monitoring of Resident #33.

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A telephone interview was completed on 7/7/22 at 11:06 AM with the dialysis center's Charge Nurse. She recalled Resident #33's dialysis treatment yesterday because she stated it was the first time the facility had sent the communication form with Resident #33. She stated there was a lack of communication between the facility and the dialysis clinic.

An interview was completed on 7/7/22 at 3:05 PM with Nurse #6. She stated when she started working at the facility approximately 3 months ago, she never received any sort of training on the care and monitoring of a dialysis resident. She stated when caring for Resident #33, she only assessed her AV fistula for a bruit and thrill on her shift and did not obtain any vital signs or monitor for bleeding from her AV fistula because there were no orders to do so.

An interview was completed on 7/8/22 at 11:00 AM with the Medical Director. He stated as long as Resident #33 remained a resident at the facility, orders should have been obtained for the monitoring of her vital signs, her AV fistula for signs of bleeding or infection and the removal of the post dialysis treatment dressing to her AV fistula. He also stated there must be ongoing communication between the facility and the dialysis clinic.

An interview was completed on 7/8/22 at 11:42 AM with the Administrator. She was able to provide dialysis communication forms on Resident #33 dated 6/1/22 and another dated 7/6/22. She stated she expected the facility to obtain Physician orders for the care and monitoring of a dialysis resident. She further

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F 698	Continued From page 39 stated she expected the facility to ensure there was written communication between the facility and the dialysis center regarding Resident #33.	F 698		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, Medical Director and staff interviews, the facility failed to hold blood pressure medications as ordered by the physician for 2 of 6 residents whose medications were reviewed (Residents #40 and #18). The findings included:	F 757	F757 CFR(s): 483.45(d)(1)-(6) (1) Resident # 40 and # 18 are receiving medication per order with parameters followed per order. (2) All Residents with orders for medications that have parameters have	8/1/22

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F 757	Continued From page 40 1. Resident #40 was admitted to the facility on 8/24/20 with diagnoses that included hypertension. Review of Resident #40's physician orders included an order dated 4/26/21 for Tenormin (used to treat hypertension) 12.5 milligrams (mg) 1 tablet by mouth once a day. Call physician if systolic blood pressure (SBP) greater than 180 or diastolic blood pressure (DBP) greater than 105. Hold if SBP less than 110. A quarterly Minimum Data Set (MDS) assessment dated 5/16/22 indicated Resident #40 had severe cognitive impairment. The June 2022 and July 2022 Medication Administration Records (MARs) were reviewed and revealed Resident #40 had received Tenormin, despite the SBP below 110 on the following dates: " 6/5/22- SBP was 96 " 6/23/22- SBP was 100 " 6/25/22- SBP was 85 " 6/26/22- SBP was 102 " 6/27/22- SBP was 102 " 6/28/22- SBP was 97 " 6/29/22- SBP was 102 " 7/4/22- SBP was 100 An interview occurred with Nurse #1 on 7/7/22 at 12:01 PM who was assigned to Resident #40 on 6/25/22, 6/27/22, 6/28/22 and 7/4/22. Nurse #1 indicated she was aware the resident had parameters to hold the Tenormin. She reported she took the blood pressure and recorded on the MAR. Nurse #1 reviewed the June 2022 and July 2022 MARs, verified the Tenormin was administered despite the SBP being below 110	F 757	the potential to be affected. Nursing leadership completed an audit of all current residents with orders for BP Parameters on 7/22/22 to determine if orders were followed according, any discrepancy was addressed with the attending physician. (3) Education to be provided by the Director of Nursing or designee for all Licensed Nurses regarding administering medications as ordered within parameters including the 5 rights of medication administration. Education to include that all medications should be administered per MD order. Any staff who has not completed education and/or training prior to or on 8/1/22 will be required to complete education prior to working. Ongoing education to be completed during New Employee Orientation and Annual Education. (4) Nursing Managers to audit blood pressure medications with parameters three times a week for four weeks then weekly for four weeks, for compliance with administration per MD orders. Any discrepancies or issues will be addressed during the audit. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/2022	

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when it should have been held and responded it was an oversight.

On 7/7/22 at 1:50 PM, an interview occurred with Nurse #3 who was assigned to Resident #40 on 6/5/22 and 6/23/22. The June 2022 MAR was reviewed with her, and she manually checked Resident #40's blood pressure before administering Tenormin due to the hold parameters ordered. She was unable to recall why the Tenormin was administered outside the parameters other than to say it was an error on her part and the medication should have been withheld.

Attempts to contact Nurse #7 were made without success. She was assigned to Resident #40 on 6/26/22 and 6/29/22.

The Medical Director (MD) was interviewed on 7/8/22 at 11:13 AM and stated if Resident #40 had received a few dosages of Tenormin outside the parameters it would not have caused any serious harm. The MD added he would have expected the nurses to follow the orders for Tenormin parameters as written.

The Administrator and Director of Nursing (DON) was interviewed on 7/8/22 at 11:41 AM and stated she expected the nurses to follow doctor's orders including blood pressure medications with parameters to hold.

2. Resident # 18 was admitted to the facility on 5/30/22 with multiple diagnoses including hypertension.

Resident #18 had a doctor's order dated 4/27/21 for Toprol XL (an antihypertensive medication)

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F 757	Continued From page 42 37.5 milligrams (mgs) 1 tablet by mouth daily for hypertension - call the doctor if systolic blood pressure (SBP) is more than 180 or diastolic blood pressure (DBP) is more than 105 and to hold if SBP is less than 110. Review of the May and June 2022 Medication Administration Records (MARs) revealed that Toprol was administered on 5/18/22 with the SBP of 104/68, on 6/5/22 with the SBP of 106/69, on 6/12/22 with the SBP of 108/61, and on 6/13/22 with the SBP of 108/61. Nurse #3, assigned to Resident #58 on 6/13/22, was interviewed on 7/6/22 at 1:40 PM. She stated that she normally checked the BP prior to administering the BP medications. The Nurse added that she was aware that Resident #18 had parameters to hold the BP medication, but she could not remember why the Toprol was not held on 6/13/22 when the SBP was less than 110. Nurse #5, assigned to Resident #18 on 6/5/22 and 6/12/22, was interviewed on 7/6/22 at 2:58 PM. The Nurse stated that she could not remember if Resident #18 had parameters to hold his blood pressure medication. She reported that she normally checked the blood pressure prior to administering the blood pressure medication. Nurse #5 did not have an explanation as to why the Toprol was administered on 6/5/22 and 6/12/22 when the SBP was below 110. The Director of Nursing (DON) and the Administrator were interviewed on 7/8/22 at 11:45 AM. The Administrator stated that the nurses were expected to follow doctor ' s orders.	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More	F 759		8/1/22

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F 759	Continued From page 43 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, review of the medication manufacturer's instruction, observation and staff interview, the facility failed to have a medication error rate of less than 5 % as evidenced by 5 medication errors of 26 opportunities, resulting in a 19 % error rate for 2 of 3 residents observed during medication pass (Residents # 116 & # 56). Findings included: 1 a. Resident #56 was admitted to the facility on 5/18/22. Resident #56 had a doctor's order dated 6/8/22 for Metoprolol extended release (ER) 50 milligrams (mgs) 1 tablet by mouth daily for hypertension. There was no order to crush the medication. The manufacturer's instruction for Metoprolol extended-release tablet indicated "tablet should be swallowed whole and not chewed or crushed". Resident #56 was observed during the medication pass on 7/8/22 at 8:30 AM. Nurse #4 was observed to prepare and to crush the resident's medications including the Metoprolol ER 1 tablet and mixed them with apple sauce. Nurse #4 was observed to administer the crushed medication to the resident.	F 759	F759 CFR(s): 483.45(f)(1) (1) Resident□s # 56 and # 116 are receiving medications per orders. Medication Error Reports were completed on 7/21/22 with physician notification of errors. (2) All Residents with orders for medications have the potential to be affected. 5 Rights of Medication Administration education was completed for these nurses by the RN Manager on 7/7/22. (3) Education to be provided by the Director of Nursing or designee for all Licensed Nurses regarding administering medications as ordered including the 5 rights of medication administration, and transcribing physician admission orders. Medication administration observations will be completed with all Licensed nurses by the Director of Nursing and/or designee. Any staff who has not completed education and medication administration observations prior to or on 8/1/22 will be required to complete education prior to working.	

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F 759	Continued From page 44 b. Resident #56 had a doctor's order dated 6/27/22 for Potassium Chloride (KCL) extended release (ER) 20 milliequivalent (meq) 1 tablet by mouth twice a day for hypokalemia. There was no order to crush the medication. The manufacturer's instruction for KCL ER indicated "swallow the tablets or capsules whole. Do not crush or chew extended-release capsules or tablets. Doing so can release all the drug at once, increasing the risk of side effects". Resident #56 was observed during the medication pass on 7/8/22 at 8:30 AM. Nurse #4 was observed to prepare and to crush the resident's medications including the KCL ER 1 tablet and mixed them with apple sauce. Nurse #4 was observed to administer the crushed medication to the resident. c. Resident #56 had a doctor's order dated 6/8/22 for Pantoprazole delayed release 40 milligrams (mgs) 1 tablet by mouth twice a day for gastroesophageal reflux disease (GERD). There was no order to crush the medication. The manufacturer's instruction for Pantoprazole delayed release indicated "do not split, chew or crush". Resident #56 was observed during the medication pass on 7/8/22 at 8:30 AM. Nurse #4 was observed to prepare and to crush the resident's medications including the Pantoprazole delayed release 1 tablet and mixed them with apple sauce. Nurse #4 was observed to administer the crushed medication to the resident.	F 759	(4) Nursing Managers to randomly audit medication pass twice a week for four weeks then weekly for four weeks, for compliance with administration per MD orders. Nursing management to review new admission orders for accuracy daily for three months. Any discrepancies or issues will be addressed during the audit. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance: 8/1/2022	

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d. Resident #56 had a doctor's order dated 6/8/22 for Cymbalta delayed release 60 milligrams (mgs) 2 capsules by mouth daily for depression. There was no order to crush the medication.

The manufacturer's instruction for Cymbalta delayed release capsule indicated "do not chew or crush and do not open delayed release capsule and sprinkle its contents on food or mix with liquids because these actions might affect the enteric coating".

Resident #56 was observed during the medication pass on 7/8/22 at 8:30 AM. Nurse #4 was observed to prepare and to crush the resident's medications and mixed them with apple sauce. The Nurse was also observed to open the 2 capsules of Cymbalta delayed release and mixed them with the crushed medications. Nurse #4 was observed to administer the crushed medication to the resident.

Nurse #4 was interviewed on 7/8/22 at 9:40 AM. She stated that she was aware that ER medications were not supposed to be crushed but she was trained at this facility that ER medications could be crushed. She could not remember who provided the orientation training.

The Director of Nursing and the Administrator were interviewed on 7/8/22 at 11:45 AM. They both stated that the expectation was ER medications should not be crushed unless there was a doctor's order.

2. Resident # 116 was admitted to the facility on

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6/15/22.

Resident #116 had a doctor's order dated 6/16/22 for Nitroglycerin 0.4 milligrams (mgs)/hour (hr.) 1 patch transdermal daily for angina. Remove at bedtime.

Resident #116 was observed during the medication pass on 7/7/22 at 9:02 AM. Nurse #3 was observed to prepare the resident's medications including the Nitroglycerin patch. Before applying the Nitroglycerin patch, Nurse #3 observed the old Nitroglycerin patch on the resident's chest wall.

Nurse #3 was interviewed on 7/7/22 at 2:15 PM. The Nurse stated that the previous Director of Nursing (DON) had transcribed the Nitroglycerin order on the Medication Administration Record (MAR) to be given at 9:00 AM and to be removed at 8:59 AM the following day (24 hours), instead of at bedtime (12 hours) as ordered.

The Director of Nursing and the Administrator were interviewed on 7/8/22 at 11:45 AM. They both stated that the expectation was for the staff to follow the doctor's order.