STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345312	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/21/2022

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THE GREENS AT HENDERSONVILLE	**1870 PISGAH DRIVE HENDERSONVILLE, NC**

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F 573	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party and staff, the facility failed to provide a copy of the resident's medical records after requested for 1 of 1 resident reviewed for access to medical records (Resident #2). The findings included: Resident #2 was admitted to the facility on 09/29/22. Review of the admission Minimum Data Set (MDS) dated 10/03/22 assessed Resident #2 as being cognitively intact and indicated a legal representative participated in the assessment. Review of medical records revealed the Responsible Party (RP) was identified as a healthcare proxy and listed as an emergency contact for Resident #2. During a telephone interview on 11/10/22 at 2:59 PM the RP stated she requested Resident #2's medical records from the Director of Nursing (DON) who emailed her the form the facility required for her to fill out. The RP stated she filled out the form and sent it back to the DON and was told it would be forwarded to the Administrator. The RP stated as of 11/10/22 she hadn't received any more information from the facility about

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F 573	Continued From Page 1 obtaining the medical records. An interview was conducted on 11/16/22 at 1:28 PM with the DON. The DON explained she received an email from the RP on 10/28/22 asking what she needed to do to request the medical records of Resident #2. The RP wanted copies of the physician and wound treatments orders, nursing and wound care progress notes including pictures of the wound, copies of occupational and physical therapies treatment plan, and any activity progress notes. The DON stated she forwarded the email to Administrator on 10/28/22 the same day the RP requested the medical records. The DON revealed she received another email on 11/07/22 from the RP asking again about the medical records and if the Administrator had followed up on it. An interview was conducted on 11/16/22 at 11:15 AM with the Administrator. The Administrator stated he was not aware of anyone requesting Resident #2's medical records and didn't recall getting an email either. The Administrator explained to request medical records the facility would review the records first then send to their corporate office for review and after corporate reviewed, they sent the records back to the facility. The Administrator revealed a form would need to be filled out by the person requesting the medical records and there was a monetary charge and until those were received the facility wouldn't provide the medical records. A second interview was conducted 11/16/22 at 12:13 PM with the Administrator. The Administrator confirmed the RP asked the DON about obtaining Resident #2's medical records. The Administrator stated the facility was moving forward with the request for getting copies of Resident #2's medical records.
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the

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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 of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with the Medical Director and staff, the facility failed to complete a baseline care plan within 48 hours of admission for 1 of 3 residents reviewed for pressure ulcers (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 09/29/22 with diagnoses including an unstageable sacrum pressure ulcer (a wound obscured by non-viable tissue), malnutrition, and two fractured thoracic vertebrae.

Review of Resident #2's medical records revealed there was no completed baseline care plan done within 48 hours of admission.

An interview was conducted on 11/14/22 at 2:27 with the Medical Director. The Medical Director revealed it was his expectation the baseline care plan was done within the timeframe it was due.

A telephone interview was conducted on 11/14/22 at 3:48 PM with Nurse #1. Nurse #1 confirmed she was the admitting nurse on 09/29/22 for Resident #2. Nurse #1 revealed she did the admission assessment but not the baseline care plan and stated she was unsure who was responsible for completing it.

An interview was conducted on 11/16/22 at 2:26 PM with the Unit Manager (UM). The UM stated the admitting nurse was responsible for completing the baseline care plan and was done when a resident was admitted.

F 657

Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-

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(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to update a care plan to reflect a resident's goal for discharge for 1 of 1 sampled resident (Resident #4).

Findings included:

Resident #4 was admitted to the facility on 06/05/22 with diagnoses that included acquired absence of left leg below knee and acquired absence of right leg above knee.

The quarterly Minimum Data Set (MDS) dated 09/08/22 indicated Resident #4 had moderate impairment in cognition. The MDS noted active discharge planning was in place.

A Social Services progress note written by the Social Worker (SW) on 09/08/22 read in part, Resident #4 "hopes to be able to return to her home when she is able to care for herself. SW is in process of making a referral to a home health agency for intensive in-house therapy services."

Review of Resident #4's comprehensive care plans, last reviewed/revised 11/02/22, revealed a discharge care plan that indicated she would require long-term care. Interventions included: encourage Resident #4 to discuss feelings and concerns of being unable to return to her home, observe for and address episodes of anxiety, fear and distress.

During an interview on 11/21/22 at 11:07 AM, Resident #4 stated her goal was to eventually return home.

During a telephone interview on 11/16/22 at 2:05 PM, the SW confirmed she was responsible for developing and revising residents' discharge care plans. The SW explained when Resident #4 was first admitted to the facility, her plans for discharge was uncertain and it was assumed she would be staying at the facility for long-term care. The SW verified when she completed the quarterly MDS assessment dated 09/08/22, Resident #4 stated she would like to return to the community. The SW stated she should have updated Resident #4's care plan when her discharge plans changed and it was something she just missed.

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F 657	Continued From Page 4 During an interview on 11/21/22 at 1:07 PM, the Administrator stated Resident #4's discharge care plan should have been revised when she verbalized her desire to return to the community.

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted 11/09/22 through 11/21/22. Event ID# K2MP11. The following intakes were investigated: NC00194907, NC00191208, NC00193169, NC00194373, NC00194778, NC00194786, and NC00194765. 3 of the 12 allegations were substantiated resulting in deficiencies. Intake NC00193169 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity of J. Tage F 600 consituted Substandard Quality of Care. Immediate Jeopardy began on 08/10/22 and was removed on 11/19/22. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		12/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2022

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff, Responsible Party, Nurse Practitioner and facility Medical Director (MD) interviews, the facility failed to protect a resident from injuries of unknown origin for 1 of 3 residents reviewed for abuse (Resident #1). On the evening of 08/09/22, Resident #1 was observed guarding her right hip and displaying pain during care. On the morning of 08/10/22, Resident #1 hollered out in pain when care was attempted, was sent out to the hospital for evaluation due to increase lethargy, and subsequently admitted for further treatment when diagnosed with the following fractures: 1) an acute (symptoms that are severe and sudden in onset) intertrochanteric fracture (type of hip fracture between the bony points of the top of the bone where the muscles of the thigh and hip attach) of the right proximal (top of the bone, closer to the center of the body) femur (thigh bone) with approximately one shaft width lateral (to the side of, or away from, the middle of the body) displacement (bone snapped in two or more parts and moved so that the two ends are not lined up straight), 3 centimeters (cm) displacement and valgus (occurs when the broken bones are turned outward away from the midline of the body to an abnormal degree) impaction (occurs when the broken ends of the bone are jammed together by the force of the injury), 2) an acute comminuted (the bone has broken into three or more pieces and in most cases, the number of bone fragments corresponds with the amount of force needed to break the bone) fracture of the left proximal femur with subtrochanteric and intertrochanteric components, at least 7 cm proximal displacement	F 600	Criteria 1: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice On 08/9/22 Resident was noted to be guarding her right hip and a note was placed in the MD book. This information was reported to on-coming nurse on 8/10/22, and MD was notified and ordered an x-ray of right femur and right hip. X-ray was completed as ordered at 12:27pm on 08/10/22. On 8/10/22 Resident #1 had x-ray that reported Right side acute transverse displaced comminuted intertrochanteric fracture. On the morning of 8/10/22 Resident #1 was sent out to the hospital secondary to increased lethargy and per family request for further evaluation. It was discovered that Resident #1 sustained the following fractures: 1) an acute intertrochanteric fracture of the right proximal femur with approximately one shaft width lateral displacement, 3cm proximal displacement, and valgus impaction, 2) an acute comminuted fracture of the left proximal femur with likely subtrochanteric and intertrochanteric components, at least 7 cm proximal displacement with varus angulation and 3) acute nondisplaced fractures of the left inferior and superior pubic rami extending into the pubic body.	

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with varus (occurs when the broken bones are turned toward the center of the body) angulation (when the two ends of the broken bone are at an angle to each other), and 3) acute nondisplaced fractures (when the bone breaks or cracks but retains its proper alignment) of the left inferior and superior pubic rami (group of bones that make up part of the pelvis) extending into the pubic body that required surgical repair.

Immediate Jeopardy began on 08/10/22 when Resident #1 was admitted to the hospital and found to have sustained multiple fractures. Immediate Jeopardy was removed on 11/19/22 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure education and monitoring systems put into place are effective.

Findings included:

Resident #1 admitted to the facility on 07/27/22 with diagnoses that included unspecified brain disorder, acute embolism and thrombosis of right tibial vein (blood clot in a vein located deep within the body), and diabetes.

The admission Minimum Data Set (MDS) dated 08/02/22 assessed Resident #1 with severe impairment in cognition. Resident #1 required extensive staff assistance with bed mobility, transfers and toileting and limited staff assistance with walking and locomotion off the unit using a wheelchair for mobility. The MDS further noted she had no impairment of the upper or lower

On 11/17/22 when finding out about the additional fractures, the facility initiated in-house investigation. The investigation did not glean any specific incident that led to the injuries.

Criteria 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice
All residents are at risk from suffering from the deficient practice and residents with a decreased cognitive status have a greater risk for abuse, neglect, and unreported injuries.
" On 11/17/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers or designee to determine if they have experienced any type of resident abuse and injuries that had not been reported. No concerns were found. No injuries or change in resident baseline(s) noted.
" On 11/17/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there was evidence of abuse. No concerns, no injuries of unknown origin, and/or change in resident baseline(s) noted.
" On 11/17/222, all staff in all departments were interviewed (including any agency staff that perform services for the facility), by Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and designees, in person

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extremities and had no falls since admission.

Resident #1's Activities of Daily Living (ADL) care plan, initiated on 08/10/22, revealed she had a self-care performance deficit related to disease process and requiring staff assistance to complete daily ADL tasks. Interventions included: extensive assistance of 1-2 staff members with bed mobility, toileting, and transfers.

An incident/accident report dated 08/03/22 and completed by the Unit Supervisor noted in part, Resident #1 was observed knocking over a bedside table and sitting down on the floor from her wheelchair. Resident #1 was assessed by the Unit Supervisor with no injuries identified or signs/symptoms of pain.

An incident/accident report dated 08/04/22 and completed by the Unit Supervisor noted in part, Resident #1 was seated in her wheelchair out in the hallway, "lurched (make an abrupt unsteady, uncontrolled movement)" out of the wheelchair and landed on her knees on the floor. Resident #1 was assessed by the Unit Supervisor with no injuries identified or signs/symptoms of pain.

An incident/accident report dated 08/05/22 and completed by the Unit Supervisor noted in part, Resident #1 was seated in her wheelchair out in the hallway and "launched" herself out of the wheelchair landing on her bottom on the floor. Resident #1 was assessed by the Unit Supervisor with no injuries identified or signs/symptoms of pain.

During an interview on 11/10/22 at 2:04 PM, the Occupational Therapy (OT) Assistant revealed he often picked up extra shifts working as a hall

or via phone, to determine if any other resident may have been affected and if they had observed and not reported any behaviors or verbalizations that would indicate abuse or neglect, falls accidents, or injuries with no knowledge of anything new. No concerns were reported.

Criteria 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 11/17/22, education was provided to the Administrator, DON, and the ADON by the Corporate Consultant, Regional Director of Clinical Operations, regarding the abuse and neglect policy, the definition of abuse, neglect, and injury of unknown origin as defined in the facility policy and the resident□s right to be free from neglect and injuries of unknown origin, and the requirements to report and investigate injuries of unknown origin

On 11/17/22, after being reeducated as outlined above, education for all staff was completed in person and via phone by Administrator, DON, ADON, and/or Designee. The education consisted of the following:

" The definition of abuse, neglect, unreported injury, or injury of unknown origin, and the need to immediately notify the Administrator or DON of all issues related to these infractions. If Administrator or DON are not present in the facility, supervisors must be notified,

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Nurse Aide (NA) and was assigned to provide Resident #1's care on 08/05/22 and 08/06/22. The OT Assistant explained Resident #1 was unable to ambulate on her own and required extensive staff assistance with ADL tasks. In addition, he stated Resident #1 would try to stand up unassisted by grabbing onto the handrail while out in the hall, unsteady when attempting to stand and wasn't good with verbal commands. He added nursing staff liked for Resident #1 to be up in her wheelchair during the day so that they could keep her out in the hall in visual sight because if left in bed, she had the tendency to "flop" around which he described as moving her legs around and not lying still. The OT Assistant recalled on 08/05/22 Resident #1 was at her normal baseline and he got her up and ready for the day without incident. He could not recall the exact time but stated while he was in another resident's room providing care, she fell out of her wheelchair out in the hallway and when he came out of the resident's room, staff were already assisting her up off the floor, but he could not recall who the staff members were. On 08/06/22, the OT Assistant stated he had noticed Resident #1 wasn't feeling well, so he left her in the bed and told the hall nurse she wasn't acting her normal self. He stated Resident #1 remained in bed the duration of his shift and when he provided her care, she did not cry out in pain or display any facial grimaces of discomfort when turned and repositioned nor did he notice any bruising, deformity or other injuries when care was provided. The OT Assistant stated he didn't feel Resident #1 was a good candidate for OT services because she couldn't retain cues or follow verbal commands. The OT Assistant stated other than 08/05/22, Resident #1 had not fallen when he was assigned to provide her care.

and they must inform the Administrator or DON immediately in person or by phone. The facility also stressed the importance of reporting any incident, injury, or any status that shows a deviation from the patient□s baseline without fear of negative consequences.

" Injury of unknown source is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of: " the extent of the injury; or " the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or " the number of injuries observed at one particular point in time; or " the incidence of injuries over time

" Signs and symptoms of neglect such as loss of interest, change in routine, mood alterations, pain, or difficulty eating. zero tolerance for resident abuse/neglect by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.

" It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source. Our residents have the right to be free from abuse, neglect, corporal punishment, physical or chemical

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During an interview on 11/14/22 at 5:09 PM, the Rehab Manager revealed Resident #1 was discharged from Physical Therapy (PT) and OT services on 08/08/22. The Rehab Manager stated on 08/08/22 Resident #1 received lower extremity exercises focusing on range of motion, flexibility and strengthening. The Rehab Manager added Resident #1 needed 50% verbal cueing along with manual resistance to get her to move a little more and she displayed no pain that was addressed during the therapy sessions. She added if Resident #1 had any signs of fracture on 08/08/22 the PT and/or OT therapists would have noticed when doing her lower extremity exercises and no one knew of Resident #1 having any abnormal injuries. The Rehab Manager explained Resident #1 had times when she would be very volatile with extreme movements and then other times, she would be completely docile. She added Resident #1 needed substantial to maximum assistance to transfer from the bed to wheelchair, her participation with therapy sessions would be "up and down" as she could retain information at times but not consistently, and basically stayed at baseline, not really advancing in therapy goals.

A MD progress note dated 08/08/22 revealed in part, Resident #1 "was seen at the request of family due to concerns of altered mental status, lethargy, confusion, and poor appetite ...she was resting in bed in no obvious distress although she would not keep her eyes open for the family, she's more confused and not acting herself. Concerned she may have a Urinary Tract Infection (UTI) or some other acute issue." The physical exam noted Resident #1 had "no joint deformity or swelling, generalized weakness and

restraints imposed for purposes of discipline or seclusion. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.
Staff not educated before 12-17-22 will be educated prior to their return to work.
New hires/agency staff will be oriented as to the above education outline before beginning work.

Criteria 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

The DON or designee will conduct an audit of 5 random residents by completing a skin assessment and interviewing the resident (if appropriate). This audit will occur weekly for 4 weeks and monthly for 2 months, to ensure that there are no signs of abuse and that there are no injuries that have not been reported. The results of these audits will be reported by the Director of Nursing/Designee at the monthly Quality Assurance Process Improvement (QAPI) meeting until such time that substantial compliance has been achieved and agreed upon by the QAPI committee.

Criteria 5: Include dates when corrective action will be completed.

The facility will be in compliance no later than 12/17/22.

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her skin was warm and dry with very poor skin turgor (ability of the skin to change shape and return to normal)." There was no bruising of the extremities noted. As part of the plan, the MD ordered a Urine Culture and Sensitivity (test that checks for bacteria in the urine that could cause an infection).

A Nurse Practitioner (NP) progress noted dated 08/09/22 revealed in part, Resident #1 was seen to evaluate current diet orders due to nursing concerns she was on a regular texture diet and had no teeth or dentures. The physical exam noted Resident #1 had "no lower extremity edema (swelling)." As part of the plan, the NP ordered a Speech Therapy consult.

During a telephone interview on 11/16/22 at 8:51 AM, Resident #1's Responsible Party (RP) recalled she had been at the facility the evening of 08/09/22 visiting with Resident #1 and was concerned she wasn't acting right and appeared to be in pain. The RP asked Resident #1's nurse if her behavior was normal and the nurse stated it was. The RP added the nurse stated she would continue to monitor her throughout the night and notify her of any changes. The RP stated sometime that evening (08/09/22), she received a call from the nurse who stated she had noticed Resident #1 guarding her hip and displaying pain during care. The RP asked the nurse if she needed to be sent out to the hospital for evaluation and the nurse stated she would have the physician evaluate the next morning and obtain an x-ray. The RP stated on the morning of 08/10/22 when she arrived at the facility, Resident #1 still wasn't acting normal and appeared to be in pain so she requested the facility staff to send her to the hospital for evaluation.

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During telephone interviews on 11/14/22 at 9:20 AM and 3:24 PM, Nurse #4 confirmed she worked 08/06/22 to 08/09/22 during the hours of 7:00 AM to 7:00 PM and was assigned to provide Resident #1's care. Nurse #4 recalled Resident #1 had remained in bed the entire weekend and did not have any falls during her shifts. Nurse #4 explained Resident #1 "moaned" at baseline but did not voice complaints of pain or display any non-verbal indicators of pain. Nurse #4 did not recall observing or being notified from NA staff of any bruising or deformity noticed on Resident #1's lower extremities. Nurse #4 confirmed NA #1 assisted while she inserted a catheter to obtain a urine sample from Resident #1 on 08/09/22. Nurse #4 explained they assisted Resident #1 onto her back and NA #1 held Resident #1's legs open slightly by the knees while she inserted the catheter. Nurse #4 stated during the process, she was focused on getting the urine sample and did not recall noticing any deformities or bruising to Resident #1's pelvic/hip region. Nurse #4 stated Resident #1 didn't try to resist and only cried out when the catheter was inserted but did not attempt to move in an effort to resist or try to push them away with her hands. After the urine sample was collected, Nurse #4 stated she assisted NA #1 with cleaning Resident #1 and placing her in a clean brief. Nurse #4 stated she was never told during shift report on 08/06/22 that Resident #1 had fallen on 08/03/22, 08/04/22 or 08/05/22 and didn't learn of her falls until a week later when asked to fill out some paperwork for the former DON.

During a telephone interview on 11/15/22 at 1:15 PM, NA #1 confirmed she worked on 08/09/22 during the hours of 7:00 AM to 7:00 PM and was

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assigned to provide Resident #1's care. NA #1 explained it was the first time she had provided care to Resident #1 and recalled she had remained in bed the entire shift and did not fall. NA #1 could not recall the exact time but at one point during the shift she assisted Nurse #4 with obtaining a urine sample from Resident #1. She explained when they went into Resident #1's room, she was in bed lying on her side, they turned her over on her back, and each held her legs open by placing their hands on her inner thighs. NA #1 stated Resident #1 did not complain of any pain or try to push their hands away in an attempt to get them to stop and only "hollered out" when Nurse #4 inserted the catheter. After the urine sample was collected, NA #1 stated she and Nurse #4 cleaned Resident #1, placed her in a clean brief, and repositioned her back onto her side in bed. NA #1 stated Resident #1 did not display any signs of discomfort or distress the remainder of the shift. NA #1 did not recall noticing if Resident #1 had any deformity, bruising or redness when they were collecting the urine sample and stated she didn't really pay attention as she was focused on assisting Nurse #4.

A nurse progress note written by Nurse #3 dated 08/10/22 at 5:41 AM read in part, "Resident #1 holding right hip, grimacing while resting in bed. When ADL/incontinent care was provided, Resident #1 guards right hip/leg, holds right hip, yells out in pain. Note in physician book requesting evaluation and x-ray."

During a telephone interview on 11/10/22 at 12:42 PM, NA #2 confirmed she worked on 08/09/22 during the hours of 7:00 PM to 7:00 AM and was assigned to Resident #1's hall; however, she did

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not specifically recall Resident #1 or care that was provided during her shift. NA #2 did state no residents had fallen during her shift on 08/09/22 and if they had, she would have reported it to the hall Nurse.

During an initial telephone interview on 11/10/22 at 3:56 PM and follow-up telephone interviews on 11/15/22 at 12:00 PM and 11/16/22 at 3:56 PM, Nurse #3 confirmed she worked on 08/09/22 during the hours of 7:00 PM to 7:00 AM and was assigned to provide Resident #1's care. Nurse #3 recalled Resident #1 had poor safety awareness, at times she would sit up on the side of her bed and staff would have to help her turn around to lie back down. Nurse #3 added once in bed, Resident #1 might move her arms around a little but "not in an aggressive kind of way" or attempting to get up out of bed. Nurse #3 explained she kept her medication cart out in the hall outside Resident #1's door so that she could keep an eye on her and another resident across the hall and Resident #1 did not fall during the shift on 08/09/22. Nurse #3 explained staff typically went in pairs to provide Resident #1's care not because she was combative or resistive but more for safety due to her "flailing her arms" a lot during care, which was her baseline behavior. She stated sometime between 8:30 PM and 9:00 PM she assisted the NA (could not recall the name of the staff member) with providing incontinence care to Resident #1 and when she assisted the NA with turning Resident #1 onto her side, she noticed Resident #1 appearing to guard her hip by reaching over and placing her hand to her right hip but she did not wince or display any signs of acute pain. Nurse #3 recalled thinking "is that new" referring to Resident #1's behavior and stated as they provided her care, she did not

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notice deformity, bruising or anything else that appeared acute and Resident #1 did not display any non-verbal indicators of pain. After they had finished providing Resident #1's care, Nurse #3 stated she was repositioned back onto her right side, bed was placed in a low position and she slept "fairly well" the remainder of the shift. Nurse #3 added on that particular night, Resident #1 wouldn't open her eyes when spoken to but she would verbally respond to simple questions. Nurse #3 stated she spoke with Resident #1's RP that evening (08/09/22) about her condition and recalled asking the RP if it was typical behavior for Resident #1 to guard her hip and keep her eyes closed when talking to her. She remembered the RP asking if Resident #1 needed to go out to the hospital and explained she would monitor Resident #1 closely the remainder of the night and notify the physician to examine Resident #1 and order an x-ray as they usually tried to treat in house before sending residents out to the hospital. When asked about the nurse progress note she wrote on 08/10/22, Nurse #3 stated she used the wrong "wording" to describe Resident #1's pain the evening of 08/09/22 and explained Resident #1 was not really yelling, just "moaning." Nurse #3 added at the time, she did not think Resident #1 had any acute issues that needed immediate attention so she did not call the on-call doctor, just put a note in the physician communication book and reported to the Unit Supervisor the next morning during shift report.

During a telephone interview on 11/10/22 at 11:03 AM, NA #3 confirmed she worked on 08/10/22 during the hours of 7:00 AM to 3:00 PM and was assigned to provide Resident #1's care. NA #3 stated it was the first time she had provided care

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to Resident #1 and recalled she had remained in bed that morning until she was sent out to the hospital and did not fall. NA #3 stated she fed Resident #1 her breakfast, changed and repositioned her in bed and she never cried out or displayed any signs of pain or distress. NA #3 added when care was provided, she did not notice Resident #1 having any deformities, bruising, shortening of the legs and if she had noticed anything abnormal, she would have reported it to the hall nurse.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor recalled Resident #1 was a "massive fall risk and impulsive" so staff would keep her in visual sight whenever she was up out of bed in her wheelchair. The Unit Supervisor stated she was the hall nurse assigned to Resident #1's hall on 08/03/22, 08/04/22 and 08/05/22 when she had fallen from her wheelchair. On 08/03/22, the Unit Supervisor stated she was in another resident's room when notified by the Treatment Nurse that Resident #1 had lifted herself up out of the wheelchair and sat down on the floor. The Unit Supervisor stated when she immediately assessed Resident #1, she had no injuries nor displayed any signs of pain. On 08/04/22, the Unit Supervisor stated she was standing at her medication cart when she observed Resident #1 "literally launch herself up out the wheelchair" which she described as Resident #1 putting her hands on the armrests of the wheelchair and pushing herself forward, landing on her knees on the floor. The Unit Supervisor stated Resident #1 had been in close proximity to her medication cart; however, she couldn't reach Resident #1 fast enough to prevent the fall. She stated Resident #1 was immediately assessed with no injury or bruising noted to her

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knees, her functional range of motion in the lower extremities were within normal limits and she had no signs or symptoms of pain. On 08/05/22, the Unit Supervisor stated she witnessed Resident #1 "impulsively" go forward out of her wheelchair landing on her bottom on the floor. She stated Resident #1 was immediately assessed with no injuries or signs of pain and both she and the OT Assistant assisted Resident #1 back into her wheelchair. The Unit Supervisor stated she didn't work again until 08/10/22 and was unaware of Resident #1 having any other falls. The Unit Supervisor recalled on the morning of 08/10/22, she was assigned to provide Resident #1's care and during shift report, Nurse #3 did not report Resident #1 having a fall or any other incident but did state Resident #1 was guarding her hip and suggested they get orders for an x-ray. The Unit Supervisor stated when she went into Resident #1's room the morning of 08/10/22, she was lying in bed, with the bed in a low position, and would not open her eyes but would respond when spoken to. The Unit Supervisor stated when she assessed Resident #1 she did not notice any bruising or other abnormalities, however, she did "holler out in pain" when she assisted NA #3 with turning her over to be changed. She stated Resident #1's legs were drawn up and when they tried to straighten her legs, she cried out in pain, so they stopped and she obtained orders for an x-ray. She stated Resident #1 did not fall during her shift the morning of 08/10/22 and was sent out to the hospital for evaluation due to increased lethargy. The Unit Supervisor stated due to poor safety awareness, Resident #1's bed was kept in a low position and while it was possible Resident #1 could have "physically" pulled herself up back into the bed, given her mentation she would have more likely just crawled or sat on the floor.

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The x-ray report of Resident #1's right femur and hip that was completed at the facility on 08/10/22 revealed in part, "acute transverse displaced comminuted intertrochanteric fracture femur is noted. No other acute fracture or dislocation. Chronic fracture deformity at right inferior pubic ramus is noted ...mineralization is decreased."

A telephone interview was conducted on 11/18/22 at 10:16 AM with the X-Ray Representative of the company who performed Resident #1's x-ray at the facility on 08/10/22. The X-ray Representative explained the Radiologist who read Resident #1's x-ray was not able to give a medical opinion on how a fracture could have occurred. She stated the facility had reached out to request a second opinion and when the x-ray was read by second Radiologist, they had agreed with the original findings noted on the x-ray results.

The Hospital Transfer Form dated 08/10/22 and completed by the Unit Supervisor revealed Resident #1 was sent to the hospital on 08/10/22 at 11:30 AM for evaluation of lethargy (condition marked by drowsiness and an unusual lack of energy and mental alertness).

The Emergency Medical Services (EMS) report dated 08/10/22 noted upon arrival at the skilled nursing facility, Resident #1 was lying in bed with family and facility staff at bedside. The EMS report read in part, "patient had her eyes closed, mumbling incoherently and was positioned oddly in bed with legs turned to the right side. Patient grimaces in pain at any attempt to straighten her extremities and is extremely tender to right hip palpation. Patient left in position of comfort, lifted

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via sheet and transferred to EMS stretcher. Patient remained stable, appeared comfortable and did not require any further intervention. Patient arrived at the Emergency Department (ED) where care was transferred to ED staff with report given."

During a telephone interview on 11/10/22 at 12:25 PM, the EMS Responder recalled when they arrived at the facility on 08/10/22, Resident #1 was lying on the bed in an awkward position with her knees bent and turned to the right side. The EMS Responder could not recall if facility staff reported Resident #1 had fallen that day or within the past few days but stated typically when a hip injury was suspected, they would splint with a pillow placed between the legs; however, Resident #1 would not allow them to do so due to pain so they kept her in position of comfort. The EMS Responder stated with the way Resident #1 was laying, he could not tell if her leg was rotated, deformed or shorter than the other and based on the information provided by facility staff, he just assumed she had a hip fracture and focused on keeping her comfortable during transport to the hospital.

The ED physician progress note dated 08/10/22 at 12:33 PM for Resident #1 read in part, "patient with increasing lethargy and altered mental status currently being treated for UTI. Patient slipped off the front of her chair today and is thought to have right-sided hip fracture per outside facility. Unclear from physical exam. Patient unable to contribute to history." Further review revealed an addendum that read in part, "patient was admitted for severe hypernatremia (high concentration of sodium in the blood) and altered mental status, x-rays of her hips and pelvis were pending. The

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x-rays show bilateral hip fractures and pubic rami fractures. Orthopedic Surgeon will consult on patient in the hospital. Their severity is concerning and this has been noted by the Orthopedic Surgeon as well." There was no notation of any bruising.

The hospital radiology report dated 08/10/22 at 3:26 PM revealed Resident #1 had the following fractures: 1) acute intertrochanteric fracture of the right proximal femur with approximately one shaft width lateral displacement, 3 cm proximal displacement and valgus impaction, 2) acute comminuted fracture of the left proximal femur with likely subtrochanteric and introchanteric components, at least 7 cm proximal displacement with varus angulation, and 3) acute nondisplaced fractures of the left inferior and superior pubic rami extending into the pubic body."

Telephone attempt on 11/16/22 at 12:56 PM for interview with the Hospital Radiologist was unsuccessful.

The hospital history and physical dated 08/10/22 at 4:59 PM read in part, Resident #1 was admitted to the hospital for evaluation of increased lethargy, UTI and right hip fracture that was identified via x-ray at the skilled nursing facility ...she was found on the ground and sent to the emergency room for further evaluation. She was found to have bilateral hip fractures, pelvic fracture and UTI." The physical exam noted Resident #1's "hips are deformed and shortened." There was no notation of any bruising.

The Orthopedic Surgeon consultation progress note dated 08/10/22 for Resident #1 read in part, "admitted for management of altered mental

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status, recent UTI, and new onset of hip discomfort. The records are not completely available and the history was pieced together through combination discussion with the Hospitalist and family ...she has been noted by the family to have a deformity of both lower extremities for at least a few days. Today apparently, she was felt to have had a ground level fall. This was not witnessed. She was transferred to the ED where she was diagnosed with bilateral hip fractures and UTI. Physical Examination: she is lying in the bed with the left lower extremity markedly internally rotated at the hip with the foot lying laterally. She has prominence (projection or protrusion) laterally of her femur, almost tenting (skin maintains a triangular or tentlike appearance when gently pinched) the gluteus maximus. Her right leg has slightly less prominent deformity but there is definite shortening of each extremity ...she is grossly neurovascular intact (relating to or involving both nerves and blood vessels) with a bout of skin changes, but again, her exam was limited by her ability to cooperate. Recommendations: when medically cleared, we will proceed with open reduction and internal fixation of each hip ...she has these significantly shortened and comminuted fractures that appear much older and much more complex than a simple ground level fall would indicate."

During a telephone interview on 11/16/22 at 11:19 PM, the Orthopedic Surgeon declined to have his medical opinion included as part of the investigation regarding Resident #1's fractures.

During a telephone interview on 11/14/22 at 11:05 AM, the former Director of Nursing (DON) recalled on the morning of 08/10/22, Nurse #3

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reported Resident #1 was complaining of hip pain with movement during care the evening of 08/09/22 and an x-ray was obtained on 08/10/22 of her right hip. The former DON stated when she assessed Resident #1 the morning of 08/10/22, Resident #1 was lying on the right side with her knees bent and was not moaning or showing any signs of discomfort. She recalled Resident #1 would not let staff stretch her legs out and she did not try to roll Resident #1 onto her back but did look at her right hip and groin area and did not notice any redness, swelling or deformity. The former DON stated she spoke with Resident #1's RP who insisted they send Resident #1 out to the hospital and orders were obtained. She added prior to Resident #1's transport to the hospital, the x-ray had been completed and the results were forwarded to the hospital when received. The former DON stated she was not notified of Resident #1 falling on 08/09/22 or 08/10/22 prior to her transport to the hospital. The former DON stated the facility's Medical Director (MD) reviewed Resident #1's medical record but could not remember exactly what was determined to be the root cause related to Resident #1's fractures.

During an interview on 11/15/22 at 11:44 AM, the Administrator revealed they had found out about the extent of Resident #1's fractures "indirectly" when the Admissions Director contacted the hospital for an update on her status. He stated they reached out to the hospital for more information and even requested Resident #1's hospital medical records but never received a response. The Administrator explained since the hospital would not provide any additional information related to Resident #1, their investigation of her injury was based on the x-ray

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obtained at the facility that showed a right hip fracture and interviews with staff who provided her care and no one reported any knowledge of Resident #1 having fallen after 08/05/22. In addition, the Administrator stated the MD reviewed Resident #1's medical record and based on her diagnoses and degeneration of the bones, he determined the right hip fracture identified via the x-ray completed at the facility was likely pathological in nature. He stated he wasn't clinical and the MD reviewed Resident #1's medical record in attempt to try and figure out how she sustained the fracture.

During a telephone interview on 11/14/22 at 12:10 PM, the Nurse Practitioner (NP) confirmed Resident #1 was seen by her on 08/09/22 due to poor appetite and concerns from nursing staff that she wasn't eating because she didn't have any dentures or teeth. The NP stated during her exam, Resident #1 was not complaining of or displaying non-verbal indicators of pain, such a guarding a particular area, nor did she observe any deformity or bruising that would have caused her to look into the acute issues further. The NP stated as part of her exams, she always observed a resident's lower legs to see if there was any edema which would indicate possible heart failure and Resident #1 had none. The NP stated she did not examine Resident #1's hip area and did not recall Resident #1's legs appearing shorter than the other during the examination. The NP stated Resident #1 was very tiny and frail and given her condition, she was prone to fractures. The NP was not aware Resident #1's hospital x-ray identified bilateral hip and pelvic fractures and explained they could have been caused due to her bone density being so poor but it was difficult to say for sure what could have caused

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her to sustain those types of fractures.

During an interview on 11/14/22 at 2:05 PM, the facility MD stated he reviewed Resident #1's medical record as part of the facility's investigation but did not have access to her hospital medical records at the time. The MD stated during her stay at the facility, Resident #1 was able to participate with therapy, had no acute pain and would not have sustained the type of fractures indicated on the hospital x-ray due to a fall from the bed or wheelchair. Instead, he stated those types of injuries as indicated on the hospital radiology report would likely be sustained from a trauma related injury such as a motor vehicle accident, blunt force hitting the bone or a fall from a significant height and even then, the chances of bilateral hip fractures would be unlikely and would not have occurred from a single fall. He stated when he examined Resident #1 on 08/08/22, she did not display any significant pain or indicators of a fracture. He added with her fractures identified at the hospital, she would not have been without severe pain or been able to continue participating with therapy. He further stated he did not think it was possible the fractures could have occurred when she fell out of the wheelchair on 08/04/22 or 08/05/22 and not display any pain until 08/10/22. The MD added if she had an unwitnessed fall on 08/09/22 or 08/10/22, Resident #1 would not have been able to pull herself back up off the floor and into bed. The MD stated with her injuries, he would have expected her to have significant pain, bruising and/or hematoma and if there had been that type of evidence, it was not something he, facility staff or EMS would have missed. The MD stated he did not feel Resident #1's fractures, as identified on the hospital radiology report dated

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08/10/22, could have occurred at the facility.

The Administrator and Regional Director of Clinical Operations were notified of Immediate Jeopardy on 11/17/22 at 12:51 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:

*On 08/9/22 Resident was noted to be guarding her right hip and a note was placed in the MD book. This information was reported to on-coming nurse on 8/10/22, and MD was notified and ordered an x-ray of right femur and right hip. X-ray was completed as ordered at 12:27pm on 08/10/22.

*On 8/10/22 Resident #1 had x-ray that reported Right side acute transverse displaced comminuted intertrochanteric fracture.

*On the morning of 8/10/22 Resident #1 was sent out to the hospital secondary to increased lethargy and per family request for further evaluation. It was discovered that Resident #1 sustained the following fractures: 1) an acute intertrochanteric fracture of the right proximal femur with approximately one shaft width lateral displacement, 3cm proximal displacement, and valgus impaction, 2) an acute comminuted fracture of the left proximal femur with likely subtrochanteric and intertrochanteric components, at least 7 cm proximal displacement with varus angulation and 3) acute nondisplaced fractures of the left inferior and superior pubic rami extending into the pubic body.

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The Facility Admission Director had received communication that Resident #1 had multiple fractures, the Administrator/management team attempted to obtain more information from the hospital with no results. On 11/17/22 when finding out about the additional fractures, the facility initiated in-house investigation. The investigation details are as follows:
All residents are at risk from suffering from the deficient practice and residents with a decreased cognitive status have a greater risk for abuse, neglect, and unreported injuries.
On 11/17/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers or designee to determine if they have experienced any type of resident abuse and injuries that had not been reported. No concerns were found. No injuries or change in resident baseline(s) noted.
On 11/17/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there was evidence of abuse. No concerns, no injuries of unknown origin, and/or change in resident baseline(s) noted.
On 11/17/222, all staff in all departments were interviewed (including any agency staff that perform services for the facility), by Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and designees, in person or via phone, to determine if any other resident may have been affected and if they had observed and not reported any behaviors or verbalizations that would indicate abuse or neglect, falls, accidents, or injuries with no knowledge of anything new. No concerns were reported.

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Staff who worked with Resident #1 for dates 8/8/22 to 8/10/22 were interviewed specifically about Resident #1. They were questioned about the care they provided, the functional activities they performed with the resident, and what the resident's capacity was during these interactions. This reinvestigation included interviews with nurses, nurse aides, therapists, the radiologist, and the physician. The Radiologist who reviewed the initial x-ray reports states there is not any further means to determine if there were any additional fractures from the original report. The physician continues to report the resident's condition while at the facility does not align with the hospital's report of the extensive fractures. There were no accidents or unusual events that occurred during care episodes or through observation that were reported during these interviews. The Nursing Home Administrator, Director of Nursing or Designee will continue to attempt to reach nurses and nurse aides with whom they were unable to make contact initially. The listing of staff who have been contacted in conjunction with those needing contact will be monitored by the Nursing Home Administrator and Director of Nursing. Maintaining the staff roster was confirmed with the facility leadership upon notification of the IJ by the Regional Director of Operations and Regional Director of Clinical Operations.

Resident #1 did not return to the facility after her discharge on 8/10/2022; current status of her condition is unknown.

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:

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*On 11/17/22, education was provided to the Administrator, DON, and the ADON by the Corporate Consultant, Regional Director of Clinical Operations, regarding the abuse and neglect policy, the definition of abuse, neglect, and injury of unknown origin as defined in the facility policy and the resident's right to be free from neglect and injuries of unknown origin, and the requirements to report and investigate injuries of unknown origin

*On 11/17/22, after being reeducated as outlined above, education for all staff was completed in person and via phone by Administrator, DON, ADON, and/or Designee. The education consisted of the following:

The definition of abuse, neglect, unreported injury, or injury of unknown origin, and the need to immediately notify the Administrator or DON of all issues related to these infractions. If Administrator or DON are not present in the facility, supervisors must be notified, and they must inform the Administrator or DON immediately in person or by phone. The facility also stressed the importance of reporting any incident, injury, or any status that shows a deviation from the patient's baseline without fear of negative consequences.
"Injury of unknown source" is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of: o the extent of the injury; or o the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or o the number of injuries observed at

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one particular point in time; or o the incidence of injuries over time
Signs and symptoms of neglect such as loss of interest, change in routine, mood alterations, pain, or difficulty eating. zero tolerance for resident abuse/neglect by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals.
It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source. Our residents have the right to be free from abuse, neglect, corporal punishment, physical or chemical restraints imposed for purposes of discipline or seclusion. All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.

If staff members are not available on 11/17/22, the education will be delivered prior to their next working shift. This training will be provided by the Administrator or Designee as assigned to all agency staff and new employees during their on-boarding orientation. The Administrator is responsible for tracking who still requires training, and he was notified of this responsibility on 11/17/22.

On 11/18/2022, the facility Administration initiated surveillance of residents during care delivery to observe staff to resident interactions. The surveillance schedule is maintained and communicated to assigned managers by the Director of Nursing. Findings of care audits will be

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F 600	Continued From page 25 reviewed during the Stand-up Meeting with facility administration. The Administrator is responsible for tracking who still requires training and ensuring the care delivery audits are assigned and completed as educated by the Regional Director of Operations on 11/18/2022. The alleged IJ removal date is 11/19/22. On 11/21/22, the facility's credible allegation for Immediate Jeopardy removal effective 11/19/22 was validated by facility documentation and staff interviews. Review of the in-service sign-in sheets revealed all staff received education on the facility's abuse policy and procedure, definition of abuse to include injury of unknown source, resident's right to be free from abuse, and investigating injuries of unknown origins. Staff interviewed all confirmed they received in-service education and were able to verbalize what signs and symptoms to look for when a change in condition was suspected, what to do when an acute change in condition was identified, when to report and who to notify of the acute change. Skin audits completed 11/17/22 on all cognitively impaired residents revealed no signs of injuries or new skin abnormalities. Interviews completed 11/17/22 with all alert and oriented residents revealed no concerns. Staff who provided care to Resident #1 the 3 days prior to her hospitalization were re-interviewed by facility administration and none voiced any knowledge related to Resident #1's injury. Review of the facility's audit tools completed 11/18/22 to 11/20/22 revealed no identified concerns.	F 600		
F 684 SS=D	Quality of Care	F 684		12/17/22

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§ 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 by:
Based on record review and interviews with staff, the Physician Assistant, and Medical Director the facility failed to obtain a venous doppler ultrasound (an evaluation of blood flow in a vein) of the left arm for a resident with a history of deep vein thrombosis (DVT) 1 of 3 residents reviewed for pressure ulcers (Resident #3).

The findings included:

Resident #3 was admitted to the facility on 10/08/22 with diagnoses including a left upper extremity deep vein thrombosis (DVT) (a blood clot that reduces or blocks blood flow in a deep vein) and atrial fibrillation (an irregular heartbeat).

Review of a physician's order written on 10/09/22 was for rivaroxaban (an anticoagulant medication used to prevent blood clots) give 15 milligrams one time a day for blood thinner.

The admission Minimum Data Set (MDS) dated 10/13/22 assessed Resident #3 as being cognitively intact and required extensive assistance with bed mobility and transfers. Resident #3 had received anticoagulant

Resident #3 No longer resides at the facility. On 11/15/2022 the Medical Provider was notified of the Incomplete Ultrasound Diagnostic test that was ordered.

On 12/09/2022, the Director of Nursing (DON) completed an audit for the past 30 days for any Diagnostic orders. All tests completed per order(s).

On 12/09/22 the DON initiated education regarding Diagnostic Orders, which included processing orders, and ensuring tests are completed as ordered, and following up with Diagnostic Company for any tests not completed within 24 hour timeframe(s). Any licensed nurse not receiving the education by 12/16/2022 will receive it prior to their next scheduled shift.

Diagnostic Orders will be reviewed by DON or designee 1x/week for 8 weeks to ensure that all diagnostic procedures were completed as ordered. The results

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medication four days during the lookback period of the MDS assessment.

The care plan initiated on 10/21/22 identified Resident #3 received anticoagulant therapy related to a diagnosis of atrial fibrillation. Interventions included administer anticoagulant medications as ordered by the physician.

Review of the Physician Assistant (PA) progress note written on 10/27/22 revealed Resident #3 was reviewed for left upper extremity edema (increased swelling). The PA noted Resident #3's history of a previous DVT and currently taking the anticoagulant medication rivaroxaban daily and the resident had said her edema had worsened over the past 2 days. The PA's assessment indicated the left upper extremity had no increased redness or warmth, and the plan was to obtain a venous doppler.

A physician's order written on 10/27/22 was to obtain a venous doppler of Resident #3's left upper extremity.

Review of Resident #3's medical records revealed no venous doppler was obtained for the left upper extremity.

During an interview on 11/15/22 at 2:04 PM the PA explained on 10/27/22 she noticed increased edema in Resident #3's left arm but there was no increased redness or pain and she decided to order a venous doppler. After accessing the doppler company's records the PA revealed there were no results for Resident #3 to show it was done. The PA revealed if the results were positive, she would treat using the anticoagulants warfarin and heparin. The PA revealed she saw

of these audits will be reported by the administrator/designee at the monthly by the Quality Assurance Process Improvement (QAPI) meeting until such time that substantial compliance has been achieved and agreed upon by the QAPI committee.

Date of Compliance 12/17/2022

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Resident #3 again on 11/03/22 to follow up on a positive covid-19 test result and the resident wasn't complaining of any edema or pain in the left upper extremity and was asymptomatic. The PA revealed it was her expectation the venous doppler for the left arm was done and if not possibly put Resident #3 at risk for a DVT and reiterated Resident #3 was already taking a blood thinner.

An interview was conducted on 11/15/22 at 3:10 PM with Nurse #5 who initialed Resident #3's Medication Administration Record on 10/28/22 to indicate the left arm venous doppler was done. Nurse #5 revealed she initialed the MAR on 10/28/22 to show the doppler was done but she didn't receive the results. Nurse #5 revealed per the agency she contracted with she didn't receive diagnostic results and indicated the charge nurse would've received the results.

During an interview on 11/16/22 at 9:07 AM the Administrator revealed he contacted the company that would've done the venous doppler for Resident #3 and they did not have results for the left upper extremity to indicate it was done.

An interview was conducted on 11/16/22 at 9:56 AM with the Medical Director. The Medical Director explained Resident #3 was diagnosed with DVT at the hospital and was taking rivaroxaban an anticoagulant medication to help the body absorb the DVT and it could take up to 3 months for that to happen. The Medical Director revealed he would order a doppler if there were symptoms of DVT such as significant edema, increased warmth, and pain. The Medical Director stated it was not good the venous doppler wasn't completed and would expect if the NP ordered it,

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F 684	Continued From page 29 it was done.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff, the Wound Care Nurse Practitioner, and Medical Director the facility failed to initiate new treatments for an unstageable pressure ulcer (Resident #2) and failed to complete thorough skin assessments upon admission and failed to complete weekly skin assessments for 2 of 3 residents reviewed for pressure ulcers (Resident #2 and Resident #3). The findings included: 1. Review of the hospital discharge summary revealed Resident #2 was admitted on 09/10/22 after suffering a fall at home and discharge from the hospital on 09/29/22 with no treatment orders in place or information of an unstageable	F 686	On 11/14/2022 the Director of Nursing (DON) clarified pressure ulcer orders for Resident #2, treatment was completed per orders, and the assigned nurse completed a skin assessment without any further identification of skin breakdown. On 11/14/2022 the DON completed an audit of all residents with pressure ulcers; no further identified issues noted and treatments were in place as ordered. On 11/3/22, an audit was completed by the DON of skin assessment completion for all residents. All residents identified without a current skin assessment received a new skin assessment. Any new admissions will be assessed by the assigned nurse an added to the weekly	12/17/22

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pressure ulcer (a wound obscured by non-viable tissue).

Resident #2 was admitted to the facility on 09/29/22. Resident #2's diagnoses included an unstageable sacrum pressure ulcer, malnutrition, and two fractured thoracic vertebrae.

a. The nursing admission assessment dated 09/29/22 and documented by Nurse #1 included a review of the integrity of Resident #2's skin and identified the sacrum as a site. There was no other information on the assessment and areas left blank included to specify the type of wound (if a pressure ulcer), the length, width, and depth, and if a pressure ulcer the stage.

Review of a progress note written by Nurse #1 on 09/29/22 described Resident #2 had a pressure area on the sacrum with a border foam dressing in place. There was no other information included in the note describing the pressure area.

Review of a physician order written on 10/02/22 revealed Resident #2 was to have weekly skin checks every Sunday.

Review of the TAR for Resident #2 revealed weekly skin checks were initialed as being done on 10/02/22, 10/09/22, and 10/30/22. The TAR did not include an assessment of the integrity of Resident #2's skin.

Review of the weekly skin assessments for Resident #2 revealed none were included in the medical record for 10/02/22, 10/09/22, and 10/16/22.

Review of the admission Minimum Data Set

skin assessment schedule in PCC by the Director of Nursing. New admissions requiring treatment orders will be obtained by the admitting nurse. Any current residents requiring a new treatment will have physician orders obtained and initiated by the assigned nurse.

Regional Clinical Director has educated the DON.

On 12/13/22 the Director of Nursing initiated education regarding assessment and and initiation of treatment of current or new pressure ulcers which included, ensuring accurate documentation of skin assessments based on a weekly schedule for any current resident or new admissions as needed. Any licensed nurse not receiving the education by 12/17/2022 will receive it prior to their next scheduled shift.

Random observations of 1 wound treatment will be completed 2x/week for 8 weeks to ensure correct treatment is in place and matches physician□s order. Random observation of 3 skin assessments will occur 2x/week for 8 weeks to ensure completion and accuracy. The results of these audits will be reported by the administrator/designee at the monthly Quality Assurance Process Improvement (QAPI) meeting until such time that substantial compliance has been achieved and agreed upon by the QAPI committee.

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(MDS) dated 10/03/22 assessed Resident #2 as being cognitively intact and indicated extensive assistance was needed with bed mobility and toilet use and transfers did not occur during the lookback period. The MDS identified an unstageable pressure ulcer and indicated it was present on admission.

The care plan initiated on 10/20/22 indicated Resident #2 had an unstageable pressure ulcer present on admission with the potential for further development of pressure ulcers related to impaired mobility, incontinence, and decreased activity. Interventions included to administer treatments as ordered, Wound NP consults and follow up as indicated.

An interview was conducted on 11/14/22 at 3:48 PM with Nurse #1. Nurse #1 revealed she did not recall much about the area she observed on the sacrum of Resident #2 during her admission skin assessment done on 09/29/22. Nurse #1 stated she did see the area on the sacrum and described the skin appeared pink and red. Nurse #1 revealed she didn't usually stage or measure pressure ulcers that was done by the Wound Care NP.

An interview was conducted on 11/15/22 at 10:59 AM with Nurse #3 who initialed the skin assessment on the TAR as being done on 10/09/22. Nurse #3 revealed the computer system triggered when the weekly skin assessments were due. Nurse #3 explained her process for completing a skin assessment was to check the resident's skin from head to toe and front and back. Nurse #3 revealed skin assessment were kept in the medical record under assessments and she documented her

F 686

The Director of Nursing is responsible for implementing corrective action 12/17/22.

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findings in the note section. Nurse #3 stated if there was no skin assessment in the medical record for Resident #2, it wasn't done. Nurse #3 stated she might have got busy and forgot to go back and complete the skin assessment after she initialed the TAR.

Attempts to interview the Nurses who initialed the TAR on 10/02/22 and 10/30/22 were unsuccessful.

During an interview on 11/10/22 at 3:58 PM the Unit Supervisor revealed the previous system auto populated weekly skin checks but when the new company took over and redid the system, they discovered weekly skin checks were no longer auto populating. The Unit Supervisor explained there was no performance improvement plan in place but when they identified the issue an audit was done of all the residents weekly skin checks and on 11/03/22 the hall nurses were assigned to complete those on all residents.

During an interview on 11/14/22 at 2:27 PM the Medical Director revealed skin assessments should be completed and were used to monitor the integrity of a resident's skin especially if they had an existing pressure ulcer and at risk for developing more.

b. Review of the physician's order written on 09/29/22 for Resident #2's pressure ulcer treatment provided direction to cleanse the sacrum wound with normal saline, dry, and apply a border foam dressing every day and evening shift until a wound consult was completed.

Review of the Treatment Administration Records

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(TAR) for Resident #2 revealed from 09/29/22 through 10/09/22 treatments were done to cleanse the sacrum wound with normal saline, dry, and apply a border foam dressing every day and evening shift until a wound consult was completed.

Review of the Wound Care Nurse Practitioner (NP) consult dated 10/03/22 revealed Resident #2 was seen for an unstageable pressure ulcer on the sacrum and indicated the wound was present on admission. The Wound Care NP noted bilateral wounds on the left and right buttocks connected to a sacrum pressure ulcer that measured 4.03 centimeters (cm) in length and 6.07 cm in width and 0.40 cm in depth with 40% of slough (non-viable tissue). The Wound Care NP recommended daily dressing changes and to cleanse the wound using a sodium hypochlorite antiseptic and apply a medi-honey (a natural debridement) dressing then cover the wound with a foam bordered dressing.

An interview and observation of wound care being provided for Resident #2 were conducted on 11/14/22 at 10:12 AM with the Wound Care NP. The Wound Care NP revealed he first saw Resident #2 on 10/03/22 and observed the pressure ulcer was covered with a significant amount of slough and recommended using a medi-honey dressing as a natural debridement to remove it. The Wound Care NP revealed he was unable to stage the pressure ulcer at this time until he could see the wound bed but indicated it had improved since he first saw it. The Wound Care NP stated he determined the ulcer had improved based on the area on the left buttocks was healed and there was an improvement in the type of tissue and the pressure ulcer had

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decreased in size.

A second interview was conducted with the Wound Care NP on 11/14/22 at 12:24 PM. The Wound Care NP revealed he recommended the treatment for Resident #2's pressure ulcer include a medi-honey dressing used as natural debridement to remove slough from the wound bed. The Wound Care NP stated not using the medi-honey dressing would possibly delay the staging of Resident #2's pressure ulcer and the healing process of the wound.

During an interview on 11/14/22 at 2:27 PM the Medical Director stated a treatment order for the medi-honey dressing should have been in place based on the consult done on 10/03/22 by the Wound Care NP. The Medical Director stated it made sense if the medi-honey dressing was not used that could delay the staging and healing process of Resident #2's pressure ulcer.

2. Review of the hospital discharge summary revealed Resident #3 was discharged on 10/08/22 with a stage 4 sacrum pressure ulcer (tissue loss with exposed bone, muscle, or tendon).

Resident #3 was admitted to the facility on 10/08/22. Resident #3's diagnoses included a stage 4 sacrum pressure ulcer and adult failure to thrive.

Review of the nursing admission assessment dated 10/08/22 revealed no documentation was provided on the skin integrity section of the assessment. The information left blank included to specify the site and type of wound (if a pressure ulcer), the length, width, depth, and if a

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pressure ulcer the stage.

Review of the weekly skin assessments for Resident #3 revealed none were done from 10/08/22 through 10/31/22.

Review of the Wound Care NP progress note dated 10/10/22 indicated Resident #3 was admitted with a stage 4 pressure ulcer on the sacrum. The Wound Care NP described the wound bed had visible bone and measured 8.67 cm in length and 5.43 cm in width and 4.2 cm in depth.

The admission MDS dated 10/13/22 assessed Resident #3 as being cognitively intact and required extensive assistance with bed mobility, transfers, and toilet use. The MDS indicated Resident #3 was admitted with a stage 4 pressure ulcer.

Review of the care plan initiated on 10/19/22 indicated Resident #3 was admitted with a stage 4 sacrum pressure ulcer and at risk for further development of more related to impaired immobility, decreased activity, and incontinence. Interventions included complete a full body check weekly and document.

Review of a physician's order written on 11/11/22 for Resident #3 to have weekly skin assessments every Friday on night shift.

Attempts to observe wound care were refused by Resident #3.

Attempts to interview the Nurse who documented the nursing admission assessment for Resident #3 were unsuccessful.

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During an interview on 11/10/22 at 3:58 PM the Unit Supervisor revealed the previous system auto populated weekly skin checks but when the new company took over and redid the system, they discovered weekly skin checks no longer auto populated. The Unit Supervisor explained there was no performance improvement plan in place but when they identified the issue an audit was done of all the residents weekly skin checks and on 11/03/22 the hall nurses were assigned to complete skin checks on all residents.

During an interview on 11/14/22 at 2:27 PM the Medical Director revealed skin assessments should be completed to know the integrity of a resident's skin especially if they had an existing pressure ulcer and were at risk for developing more.

F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii)	F 885		12/17/22

§483.80(g) COVID-19 reporting. The facility must—

§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—

(i) Not include personally identifiable information;
(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the

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facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on record review, family and staff interviews, the facility failed to inform residents, resident representatives and families by 5:00 PM the next calendar day following a confirmed COVID-19 infection of a staff member on 10/22/22 for 1 of 1 sampled resident (Resident #2).

Findings included:

Review of the facility's employee COVID-19 documentation provided by the Unit Supervisor revealed one staff member tested positive for COVID-19 on 10/22/22. Further review revealed from 10/26/22 to 11/09/22 12 additional staff members tested positive for COVID-19.

During an interview on 11/14/22 at 4:33 PM, Resident #2's Resident Representative stated she didn't receive notification from the facility regarding confirmed positive COVID-19 cases in the building and wasn't made aware until informed by a nurse while visiting Resident #2 at the facility.

During an interview on 11/10/22 at 5:35 PM, the Administrator stated they called Resident Representatives of the individual residents who

Criteria 1: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice
On 11-11-2022, resident representative for resident #2 was notified of the COVID -19 outbreak by a nurse when visiting the facility. Resident responsible party was made aware of the outbreak by facility administration on 11-11-2022.

Criteria 2: Address how the facility will identify other residents having the potential to be affected by the same deficient practice
All residents are at risk from suffering from the deficient practice. Written notification outlining the facility outbreak was mailed to all resident representatives on 11-14-2022.

Criteria 3: Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 12/12/22, education was provided to

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tested positive for COVID-19 but they did not call when the staff member tested positive for COVID-19 on 10/22/22 or as other cases were identified. The Administrator was unaware that Resident Representatives and families were to be notified by 5:00 PM the next calendar day following a positive COVID-19 case in the facility. The Administrator explained the facility did not have an automated system to send out notifications to families when a new COVID-19 case was identified; however, he did mail weekly letters to the Resident Representatives and families with generic updates on COVID-19 and acknowledged there was no way for the letter to reach the Representatives and families by 5:00 PM the following calendar day.

the Administrator and Director of Nursing (DON) by the Corporate Consultant, Regional Director of Operations, regarding the facility COVID-19 notification policy and their responsibility for the requirement to inform residents, their representatives, and families of those residing in facilities by 5 pm the next calendar day via face to face or telephone call following the occurrence of a single confirmed infection of COVID-19. The administrator/designee will be responsible for providing education to all licensed nurses regarding the facility's responsibility for the requirement to inform residents, their representatives, and families of those residing in facilities by 5 pm the next calendar day via face to face or telephone call following the occurrence of a single confirmed infection of COVID-19. Education was initiated 12-13-22 and was completed by 12-17-22. Staff that have not received this education will receive it before their next shift.

Criteria 4: Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

The Administrator or designee will conduct a weekly audit of facility status regarding the occurrence of a single confirmed infection of COVID-19 placing the facility in a new outbreak. If the facility is found to be in a new outbreak status, 5 random residents/responsible parties will be audited to ensure that notifications were made by 5pm the next calendar day after the positive resident or staff was

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F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms	F 886		12/17/22

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consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state

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and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record review and staff interviews, the facility failed to follow their facility policy by: 1) not testing residents and staff immediately in response to the Wound Nurse Practitioner testing positive for COVID-19 and not documenting the dates and test results that were completed for all residents and 2) not maintaining COVID-19 test results in the residents' medical record for 5 of 5 residents reviewed (Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8).

Findings included:

The facility's policy titled, COVID-19 - Outbreak Precautions last revised June 2022, read in part, "Policy Interpretation and Implementation: Upon identification of a single new case of COVID-19 infection in any staff or residents, outbreak testing for all residents and Healthcare Personnel, regardless of vaccination status, should begin immediately (but not earlier than 24 hours after the exposure, if known) using broad based testing protocols. If no additional cases are identified during broad based testing, no further testing is indicated. If additional cases are identified, testing should be repeated every 3 to 7 days until no new cases are identified for at least 14 days. Documentation: 1. All tests conducted for residents and staff, including results, are documented ...3) For facility outbreak testing, the following is documented: a) the date the case was identified, b) the dates that all other residents were tested, c) the dates that residents who

" On 12/15/22, covid test results were documented in the medical record for residents #4, #5, #6, #7 and #8 by the Director of Nursing (DON).

" All residents may be affected by the deficient practice. On 12/15/22, an audit of all residents who had COVID-19 tests during the outbreak period of 10/22/22-11/14/22 was completed by the DON to ensure that all test results were recorded in the medical record. For any resident who did not have a covid test recorded in the medical record, results were documented in the medical record by the DON or designee. On 12/15/22, the DON completed an audit of the weeks after the last COVID-19 case (on 11/14/22) to ensure there were no new cases where the facility failed to implement immediate testing. No new concerns were identified.

" On 12/14/22, education was provided by DON or designee to licensed nurses regarding the facility policy for testing residents after a new positive case of COVID-19 and ensuring that the results of the testing are documented in the resident medical record. COVID testing is to begin as soon as reasonably possible once there is one COVID positive result or there are 3 or more residents or staff with upper respiratory symptoms within 72 hours of each other. Any staff not

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tested negative were retested, and d) the results of all tests ...4) The resident record includes that testing was offered, testing was completed (as appropriate to the resident's testing status), the results of the test, and specific actions taken with the resident."

1. The facility's resident and staff COVID-19 testing documentation provided by the facility revealed the Wound Nurse Practitioner (NP) tested positive for COVID-19 on 10/22/22.
Further review revealed the following:
Contact tracing was not conducted on the residents or staff potentially exposed when the Wound NP treated residents at the facility on 10/21/22.
Nurse Aide (NA) #4 reported testing positive via a home test on 10/26/22.
Facility wide testing of all residents and staff was conducted on 10/26/22 with no one testing positive.
Facility wide testing of all residents and staff was conducted on 10/30/22 to 10/31/22 with 5 staff members and 14 residents testing positive.
Facility wide testing of residents and staff was conducted on 11/02/22 to 11/03/22 with 2 staff members and 9 residents testing positive.
Facility wide testing of residents and staff was conducted on 11/07/22 to 11/08/22 with 3 staff members and 13 residents testing positive.

During an interview on 11/10/22 at 4:04 PM, the Unit Supervisor confirmed they did not perform contact tracing when the Wound NP reported testing positive on 10/22/22. She added, the 2 residents the Wound NP treated on 10/21/22 had not tested positive for COVID-19 as of 11/09/22. The Unit Supervisor explained she had been helping out with infection control tasks since

educated will receive education before returning for their next shift.

" Monitoring will occur 1x/week for 8 weeks to ensure that testing for COVID-19 is implemented immediately after a new case of COVID-19 is discovered in the facility. Monitoring will also occur for 3 random residents 1x/week for 8 weeks to ensure that any result of COVID-19 testing is documented in the medical record. The results of these audits will be reported by the administrator/designee at the monthly Quality Assurance Process Improvement (QAPI) meeting until such time that substantial compliance has been achieved and agreed upon by the QAPI committee.

" The facility will be in compliance no later than 12/17/22

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September 2022 when the Director of Nursing (DON) left employment and it was her understanding outbreak testing did not need to occur unless there were at least 2 positive cases. The Unit Supervisor explained once notified NA #4 had tested positive on 10/26/22 via a home COVID-19 rapid test, all facility staff and residents were tested with no one testing positive. She added staff and residents were tested again 10/30/22 to 10/31/22 at which time 14 residents tested positive for COVID-19. The Unit Supervisor stated since 10/26/22, residents and staff had been tested twice weekly. The Unit Supervisor stated she currently did not keep a spreadsheet to document COVID-19 surveillance monitoring and spoke with the Corporate Nurse Consultant who would be giving her a spreadsheet to utilize going forward. She also stated she had been in frequent contact with the Local Health Department for guidance and was instructed to keep the residents in their same room for isolation when testing positive for COVID-19.

During interviews on 11/09/22 at 1:05 PM and 11/10/22 at 5:35 PM, the Administrator confirmed the facility was in COVID outbreak status and there had been no resident hospitalizations or deaths related to COVID-19 infection. He explained the Unit Supervisor and current Interim DON had not attended a state approved training program for infection control and Corporate Consultants who had attended the training were currently filling in as the facility's Infection Preventionist until the position could be filled. He added both he and the Unit Supervisor currently kept up with the facility's infection surveillance but was not sure what criteria they used. The Administrator reported they currently did not keep

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a spreadsheet that documented the dates and results of COVID-19 testing conducted on residents but could access the test results from the laboratory computer system.

During an interview on 11/14/22 at 8 5:30 PM, the Corporate Nurse Consultant stated this was her first day back at the facility filling in as the Interim Infection Preventionist and was not sure what was reported to the other Corporate Consultants who had been filling prior to her return. The Corporate Nurse Consultant explained when the Wound NP notified the facility he had tested positive for COVID-19 on 10/22/22, they should have done contact tracing and tested the residents he treated while at the facility on 10/21/22 and was not sure why it was not done.

During a follow-up interview on 11/21/22 at 1:07 PM, the Administrator stated they had communicated with the Corporate Consultants filling in as their Infection Preventionist throughout the process but could not explain why residents and staff were not immediately tested following notification the Wound NP had tested positive for COVID-19 on 10/22/22.

2. The facility's recent COVID-19 testing documentation provided by the Unit Supervisor revealed samples were collected on all residents and sent to an outside laboratory for processing on 10/31/22, 11/03/22 and 11/08/22.

a. Resident #4 was admitted to the facility on 06/05/22.

Review of Resident #4's medical record on 11/11/22 at 7:15 PM revealed no documentation of COVID test results since her admission in June

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2022.

b. Resident #5 was admitted to the facility on 07/15/22.

Review of Resident #5's medical record on 11/11/22 at 8:35 PM revealed no documentation of COVID test results since January 2022.

c. Resident #6 was admitted to the facility on 07/20/20.

Review of Resident #6's medical record on 11/11/22 at 6:35 PM revealed no documentation of COVID test results since January 2022.

d. Resident #7 was admitted to the facility on 12/10/20.

Review of Resident #7's medical record on 11/11/22 at 9:30 PM revealed no documentation of COVID test results since January 2022.

e. Resident #8 was admitted to the facility on 12/14/21.

Review of Resident #8's medical record on 11/11/22 at 9:06 PM revealed no documentation of COVID test results since January 2022.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor explained she had been helping out with infection control tasks since September 2022 when the Director of Nursing left employment. The Unit Supervisor stated they had only been documenting positive test results in the resident's medical record via a staff progress note and was not aware that negative test results needed to be documented as well. The Unit

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F 886	Continued From page 46 Supervisor added the facility was currently without a Medical Record Clerk which was why the laboratory test results had not been scanned into the residents' medical record. During an interview on 11/10/22 at 5:35 PM, the Administrator stated he was aware COVID-19 test results should be maintained in the resident's medical record and explained they were behind on getting documents scanned into the residents' medical records because the facility currently did not have a Medical Record staff member. The Administrator stated they just started utilizing a new laboratory who sends staff to the facility to conduct all resident COVID testing and he was working with the laboratory for them to enter the test results into the resident's medical records when completed.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with	F 887		12/17/22

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the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:

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Based on record reviews and staff interviews, the facility failed to include documentation in the resident's medical record of education provided regarding the benefits and potential side effects of the COVID-19 vaccine for 4 of 5 residents reviewed for infection control (Resident #4, Resident #5, Resident #6, and Resident #7).

The findings included:

1. Resident #4 was admitted to the facility on 06/05/22.

The quarterly Minimum Data Set (MDS) assessment dated 09/08/22 indicated Resident #4 had moderate impairment in cognition.

A review of Resident #4's medical record revealed her immunization status for the COVID-19 vaccine was noted as "consent refused" with no date of refusal listed. Further review revealed no documentation was included in the medical record to reflect Resident #4 or her Power of Attorney were provided education on the benefits and potential side effects of administering the COVID-19 vaccine.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor explained she had been helping out with infection control tasks since September 2022 when the Director of Nursing left employment. The Unit Supervisor confirmed residents or their Responsible Party were educated on the benefits and potential side effects of the COVID vaccine; however, the facility was currently without a Medical Record Clerk which was why the information had not been scanned into the residents' medical record.

" On 12/9/22, residents #4, #5, #6 and #7 were educated by a licensed nurse on the benefits and potential side effects of administering the COVID-19 vaccine. This education was placed in the resident□s medical record.

" All residents have the potential of being affected by the deficient practice. On 12/15/22, all resident medical records were reviewed for this education on the benefits and potential side effects of the COVID-19 vaccine. All residents or responsible parties of residents who are not cognitively intact and did not have evidence of this education in the medical record were informed of the benefits and potential side effects of the COVID-19 vaccine on 12/15/22 by a licensed nurse.

" On 12/14/22, nursing staff was educated by the DON or designee regarding the requirement for resident education on the benefits and potential side effects of the COVID-19 vaccine and the additional requirement that this education be evident in the resident□s medical record. New admission residents will be educated on the benefits and potential side effects of the COVID-19 vaccine upon admission, and the education will be documented in the medical record. New hires/agency will be educated before they work their next shift.

" Audits will be completed on new admissions to ensure that appropriate patient education regarding the benefits and potential side effects of COVID-19

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During an interview on 11/10/22 at 5:35 PM, the Administrator stated he was aware COVID-19 vaccination information should be maintained in the resident's medical record and explained they were behind on getting documents scanned into the residents' medical records because the facility currently did not have a Medical Record staff member.

2. Resident #5 was admitted to the facility on 07/15/22.

The quarterly Minimum Data Set (MDS) assessment dated 10/31/22 indicated Resident #5 had intact cognition.

A review of Resident #5's medical record revealed her immunization status for the COVID-19 vaccine was noted as "consent refused" with no date of refusal listed. Further review revealed no documentation was included in the medical record to reflect Resident #5 was provided education on the benefits and potential side effects of administering the COVID-19 vaccine.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor explained she had been helping out with infection control tasks since September 2022 when the Director of Nursing left employment. The Unit Supervisor confirmed residents or their Responsible Party were educated on the benefits and potential side effects of the COVID vaccine; however, the facility was currently without a Medical Record Clerk which was why the information had not been scanned into the residents' medical record.

During an interview on 11/10/22 at 5:35 PM, the

vaccine has been completed and that this education is documented in the resident□s medical record. The audits will be completed weekly for two months. The results of these audits will be reported by the administrator/designee at the monthly Quality Assurance Process Improvement (QAPI) meeting until such time that substantial compliance has been achieved and agreed upon by the QAPI committee.

" The facility will be in compliance no later than 12/17/22.

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Administrator stated he was aware COVID-19 vaccination information should be maintained in the resident's medical record and explained they were behind on getting documents scanned into the residents' medical records because the facility currently did not have a Medical Record staff member.

3. Resident #6 was admitted to the facility on 07/20/20.

The quarterly Minimum Data Set (MDS) assessment dated 09/29/22 indicated Resident #6 had moderate impairment in cognition.

A review of Resident #6's medical record revealed she received both doses of the COVID-19 primary vaccination series on 01/05/21 and 02/02/21, respectively, and received a booster dose of the COVID-19 vaccine on 11/02/21. Further review revealed no documentation was included in the medical record to reflect Resident #6 or her Responsible Party (RP) were provided education on the benefits and potential side effects of administering the COVID-19 vaccine.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor explained she had been helping out with infection control tasks since September 2022 when the Director of Nursing left employment. The Unit Supervisor confirmed residents or their Responsible Party were educated on the benefits and potential side effects of the COVID vaccine; however, the facility was currently without a Medical Record Clerk which was why the information had not been scanned into the residents' medical record.

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During an interview on 11/10/22 at 5:35 PM, the Administrator stated he was aware COVID-19 vaccination information should be maintained in the resident's medical record and explained they were behind on getting documents scanned into the residents' medical records because the facility currently did not have a Medical Record staff member.

4. Resident #7 was admitted to the facility on 12/10/20.

The annual Minimum Data Set (MDS) assessment dated 10/26/22 indicated Resident #7 had severe impairment in cognition.

A review of Resident #7's medical record revealed she received both doses of the COVID-19 primary vaccination series on 02/02/21 and 03/02/21, respectively, and received a booster dose of the COVID-19 vaccine on 02/24/22. Further review revealed no documentation was included in the medical record to reflect Resident #7's Responsible Party (RP) was provided education on the benefits and potential side effects of administering the COVID-19 vaccine.

During an interview on 11/10/22 at 2:42 PM, the Unit Supervisor explained she had been helping out with infection control tasks since September 2022 when the Director of Nursing left employment. The Unit Supervisor confirmed residents or their Responsible Party were educated on the benefits and potential side effects of the COVID vaccine; however, the facility was currently without a Medical Record Clerk which was why the information had not been scanned into the residents' medical record.

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During an interview on 11/10/22 at 5:35 PM, the Administrator stated he was aware COVID-19 vaccination information should be maintained in the resident's medical record and explained they were behind on getting documents scanned into the residents' medical records because the facility currently did not have a Medical Record staff member.