STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345262	A. BUILDING: _____ B. WING _____	1/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE	**1300 DON JUAN ROAD HERTFORD, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 568	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview, and staff interviews, the facility failed to provide quarterly statements for a resident's personal funds account for 1 of 1 resident reviewed for personal funds (Resident #20). Findings included: Resident #20 was admitted to the facility on 3/5/21. Review of Resident #20's most recent minimum data set assessment dated 12/1/22 revealed he was assessed as cognitively intact. Review of Resident #20's quarterly statements provided by the facility revealed the last quarterly statement provided to the resident was given to Resident #20 on 4/11/22 and represented his account for the 1st quarter of 2022. Resident #20's quarterly statement for the 4th quarter of 2022 was printed and was scheduled to be given to the resident by 1/16/22. The quarterly statements for the 2nd and 3rd quarter of 2022 were not provided by the facility. During an interview on 1/9/23 at 1:53 PM, Resident #20 stated he used to receive quarterly statements for his personal funds account, but he had not received one for a long time. Instead, he would have to ask the Business Office Manager how much money was in his account. He did not remember the last time he received a quarterly statement. During an interview on 1/11/23 at 1:51 PM, the Business Office Director stated the quarterly statement provided to Resident #20 on 4/11/22 was the last quarterly statement she had provided to Resident #20 according to her records and she did not know why his quarterly statements for the 2nd and 3rd quarter of 2022 were missed. She further stated she did have Resident #20's quarterly statement for the 4th quarter of 2022 to give to Resident #20 this Friday, 1/13/23. She concluded personal fund statements were to be issued to residents quarterly. During an interview on 1/11/23 at 2:06 PM the Administrator stated quarterly statements should be provided

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 568	Continued From Page 1 to residents quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		2/22/23

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

Electronically Signed | 02/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) plan which contained the required information to meet the health, safety, and security needs of the residents and staff. This had the potential to affect all facility residents. The findings included: A review of the facility's Emergency Preparedness plan on 1/12/23 revealed: A. The EP plan had not been updated annually with the last review date of 2020. B. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials. C. The EP plan did not address a communication plan. D. The EP plan did not address subsistence needs for staff and residents. E. The EP plan did not address procedures for tracking of staff and residents. F. The EP plan did not address policies and procedures for medical documents.	E 001	1.Hertford Rehabilitation Emergency Preparedness (EP) Manual updates were initiated 02/08/2023 by the Administrator to ensure the Federal, State and Local emergency preparedness guidelines are met and address: CFR(s): 483.73 403.748, 416.54, 418.113, 441.184, 460.84, 482.15, 483.73, 483.475, 484.102, 485.68, 485.542, 485.625, 485.727, 485.920, 486.360, 491.12. The EP plan is based on and includes facility-based and community-based risk assessments. The EP plan includes collaboration with local, Regional, State and Federal officials. The EP plan includes a communication plan that includes information of staff, residents, physician, other facilities, the State Licensing and Certification Agency and State Long Term Care Ombudsman, to integrate response during a disaster or an emergent situation. The EP plan addresses subsistence needs for staff and residents, to include food, water, medical and pharmaceutical supplies. Alternate sources of energy to maintain, facility temperatures, safe	

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E 001	Continued From page 2 G. The EP plan did not address a means of sharing the EP plan with residents or responsible party (RP). H. The facility failed to develop and put into place EP training and testing plans. I. The EP plan lacked information regarding the emergency generator location. An interview was conducted with the Administrator on 1/12/23 at 1:26 PM. The Administrator stated that this was the only Emergency Preparedness plan he had and that he was unaware of the need to have a comprehensive emergency preparedness plan that was specific to the EP needs of the facility. He verified the facility's EP plan had not been updated in over 2 years.	E 001	storage of provisions and emergency lighting. Fire detection, alarm systems. Sewage and waste disposal. The EP plan addresses procedures for tracking of staff and residents, that shelter in place or are relocated during an emergency. The EP plan addresses policy and procedures for medical documentation, procedures to preserve resident information and protect resident confidentiality, secure, and maintain the resident□s medical record. The EP plan includes procedure for sharing information regarding its emergency plan with residents and/ or responsible party. The EP plan includes EP training and testing plans, based upon the facility and community risk assessment. Initial training in emergency preparedness policy and procedures to all new and existing staff, volunteers, and other individuals providing services to the facility. The plan includes a community-based exercise annually, and when not available, an annual facility based mock emergency exercise. The EP plan includes analyzing the facility□s response and revision to the EP plan, as needed. The EP plan includes the location of the emergency generator and shut off valves.	

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E 001	Continued From page 3	E 001	The EP plan includes generator inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. A map of the generator location and emergency shut off values are included in the EP plan and reviewed during staff training and orientation 2. All residents at the Facility are at risk to be affected by the Emergency Preparedness Plan. 3. An Administrative change became effective at the Facility on January 13, 2023. The updated Emergency Preparedness Plan is in review. Staff will be re-educated on emergency preparedness by the Administrator, Maintenance Director, Director of Nursing, Vice President of Operations and/ or designee, by 02/22/2023. The Administrator educated the Maintenance Director 02/09/2023, on the 2023 Schedule for North Carolina Emergency Management Preparedness Campaigns. 4. The Maintenance Director will conduct quarterly audits to ensure the Emergency Plan has been reviewed with new employees and contractors. The Emergency Plan will be reviewed at least annually to determine if updates or revisions are needed. Results will be reviewed and discussed in the QAPI meetings. The QAPI committee will assess and modify the action plan as	

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E 001	Continued From page 4	E 001	needed to ensure continued compliance.	
F 000	INITIAL COMMENTS The survey team entered the facility on 1/9/23 to conduct a recert and complaint survey and exited on 1/12/23. Additional information was obtained on 1/26/23 through 1/31/23. Therefore, the exit date was changed to 1/31/23. Event ID# U5I411. The following intakes were investigated NC00196567 and NC00194998. 5 of the 8 complaint allegations were substantiated resulting in deficiencies. Intake NC00194998 resulted in immediate jeopardy. Immediate jeopardy was identified at: CFR 483.25 at tag F686 at a scope and severity (K) The tag F686 constituted Substandard Quality of Care. Substandard Quality of Care was also identified at: CFR 483.25 at tag F697 at a scope and severity (H) CFR 483.45 at tag F755 at a scope and severity (H) Immediate Jeopardy began on 11/9/22 and was removed on 1/28/23. An extended survey was conducted.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		2/22/23

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F 561	Continued From page 5 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to honor resident choice to receive a shower for 1 of 1 resident (Resident #14) reviewed for choices. Findings included: Resident #14 was admitted to the facility on 8-18-22 The quarterly Minimum Data Set (MDS) dated 12-1-22 revealed Resident #14 was moderately	F 561	1.Resident #14 was interviewed by the nursing assistants on 01/16/2023 regarding her bathing preferences. Her preferred bathing methods and schedule has been documented on the Kardex. Resident was out of the facility 02/02/2023 - 02/07/2023 for a medical procedure. Her desired shower schedule will resume when she is medically cleared. 2.All residents have the potential to be affected by self-determination, which includes their choice for bathing methods	

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F 561	Continued From page 6 cognitively impaired and required total assistance with one person for bathing. There was no documentation in the MDS of Resident #14 refusing care. Resident #14's care plan dated 12-13-22 revealed a goal that she would maintain current level of function in Activities of Daily Living (ADL). The interventions were Resident #14 required limited assistance with one staff for bathing. During an interview with Resident #14 on 1-9-23 at 10:40am, the resident discussed not receiving showers. She stated she has asked to have a shower but has not received one. Resident #14 stated "I would like to have a shower sometimes instead of taking bird baths." Observation of Resident #14 occurred on 1-9-23 at 10:40am. The resident's hair was noted to be unkempt and matted. Review of the Nursing Assistant (NA) documentation for ADL care on Resident #14 from November 2022 through January 2023 revealed no documentation of Resident #14 receiving a shower. The documentation showed Resident #14 had received a bed bath daily. NA #1 was interviewed on 1-11-23 at 8:30am. The NA stated she had been assigned to Resident #14 on 1-10-23. She explained the resident's shower days were Tuesday and Friday and that the resident had requested a shower. The NA stated she had not provided a shower to Resident #14 yesterday (1-10-23) because "I did not get around to it." NA #1 stated she had provided a bed bath to the resident.	F 561	and schedules. 3.On 02/08/2023, a facility wide interview was conducted by a licensed nurse with each resident regarding their preferred bathing method and schedules. The preference and schedules will be entered into each resident□s Kardex. Education for the Nursing Assistants regarding F561 Self Determination was begun 02/08/23 by the Unit Manager and will continue daily thru 02/22/2023 until all staff are complete. This education will be part of the new employee orientation. 4.The Nurse Management staff will conduct 5 weekly audits and resident interviews to ensure compliance weekly x 4 weeks, 1 x 1 month. Compliance will be reported to the DON. The DON will present compliance and/or corrective actions to the QAPI Committee monthly. Any negative trends will be addressed	

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F 561	Continued From page 7 An interview occurred with NA #2 on 1-11-23 at 9:45am. NA #2 stated she had been assigned to Resident #14 on 12-30-22 and that she had attempted to provide the resident with a shower but explained the resident was already in the bathroom starting to wash and refused the shower. A further interview occurred with NA #1 on 1-11-23 at 10:07am. The NA stated she had been assigned to Resident #14 on 11-15-22, 11-25-22, 12-6-22 and 1-6-23. She said she could not remember if she had provided a shower to Resident #14 on 11-15-22, 11-25-22 and 12-6-22 but stated if she had documented a bed bath than the resident received a bed bath not a shower. NA #1 stated she remembered Resident #14 requesting a shower on 1-6-23 but explained she did not have time to provide a shower to the resident, so the resident received a bed bath. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services discussed the facility having enough staff to provide resident care and showers should be provided to residents on their shower days and at their request. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated request for showers should be followed.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		2/22/23

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F 578	Continued From page 8 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to ensure a resident's	F 578	1.Upon notification of surveyor, an advance directive full code status was	

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F 578	Continued From page 9 advanced directive was documented in the resident's medical record for 1 of 1 resident (Resident #53) reviewed for advance directives. Findings included: Resident #53 was admitted to the facility on 7-23-22 Review of Resident #53's Physician orders from time of admission to 1-11-23 revealed no Physician orders for a code status. Review of Resident #53's electronic medical record from admission to 1-11-23 revealed no documentation for advance directives. The quarterly Minimum Data Set (MDS) dated 12-28-22 revealed Resident #53 was severely cognitively impaired. Resident #53's care plan dated 1-2-23 revealed a goal that he would have his wishes and advance directives honored. The intervention for the goal was to provide cardiopulmonary resuscitation (CPR). The Social Worker (SW) was interviewed on 1-11-23 at 11:50am. The SW stated she was responsible for speaking with the resident/resident representative regarding the advance directives. She reviewed Resident #53's medical record and stated she could not find any documentation that his advance directives had been discussed. The SW explained she was not employed at the facility when Resident #53 was admitted and was unaware the resident did not have any documented advance directives. She further stated she did not know how he had a	F 578	entered as a physician order as per resident #53□s wishes. Upon notification of surveyor, the care plan for advance directives was updated for resident #35 to reflect do not resuscitate. 2.Social Services or Designee will complete an audit of resident orders and care plans by 02/22/2023. 3.The Director of Nursing or Designee will educate the Social Services Director regarding the requirement to obtain advance directive code status as part of the admission process. The DON or Designee will educate the Nursing Administrative and MDS nurses regarding entering MD orders and Care Plan to reflect residents current code status upon admission by 2/22/23. 4.The Director of Nursing or Designee will audit new admission charts for evidence of active code status, physician orders, and care plan weekly x 4 weeks, then monthly x 1 month. Results of audits will be brough to QAPI x 2 months or until compliance is achieved.	

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F 578	Continued From page 10	F 578		

goal and interventions for advance directives when there was no documentation that his wishes were discussed with him or his representative.

Resident #53 was interviewed on 1-11-23 at 3:22pm regarding his advance directives. The resident stated no one had discussed his wishes for his advance directives.

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services discussed advance directives should be addressed upon admission and the Social Worker was responsible for follow up.

The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated each resident should have their advance directives documented so each staff member could be aware of the resident's wishes.

Based on record review and staff interviews, the facility failed to maintain accurate advanced directive (code status) information throughout the medical record for 1 of 1 resident reviewed for advanced directives (Resident #35).

Findings included:

Resident #35 was admitted to the facility on 10/17/22 with diagnoses which included coronary artery disease and hypertension.

Her quarterly Minimum Data Set (MDS) dated 11/10/22 indicated she was moderately cognitively impaired.

Review of Resident #35's physician orders revealed an order dated 11/18/22 for the resident

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F 578	Continued From page 11 to be a Do Not Resuscitate (DNR). Resident #35's care plan last revised on 10/31/22 revealed a focus area that the resident chooses to have CPR (cardiopulmonary resuscitation). The focus intervention was to provide CPR. An interview on 1/11/23 at 9:17 AM with the MDS nurse revealed she had been employed at the facility for about 1 month. She stated the code status on the care plan was in error as the resident had a DNR status and the care plan should have been updated when changes to her advance directives were made. An interview on 1/12/23 at 10:36 AM with the Administrator revealed that he expected care plans to be accurate and updated in a timely manner.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		2/22/23

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F 584	Continued From page 12 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean-living environment and maintain resident furniture in good repair for 5 of 13 rooms (Room 401, 308, 310, 303, 306) reviewed for environment. Findings included: Observation of hall 300 and hall 400 revealed the following. a. Room 401 was observed on 1-9-23 at 3:05pm. The observation showed the residents over the bed table had been broken in one corner allowing	F 584	1.Rooms 401, 308, 310, 303 & 306 have been properly cleaned, with oversight from the new Environmental Services Manager on 02/09/23 and 02/10/23. Bedside tables have been repaired or replaced as needed. 2.The Environmental Services Manager and Purchasing Manager completed a resident room audit on 02/15/2023, to identify rooms that need focused and detailed cleaning and furniture replacement. The Maintenance Director completed a	

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F 584	Continued From page 13 the sharp edge of the plastic cover exposed, the ceiling vent in the bathroom was hanging from the ceiling covered with dust, the windowsill had large areas of a brown substance and there was a brown/orange substance on the floor next to the bed. During a second observation of room 401 occurred on 1-12-23 at 9:09am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director, the observation revealed the residents over the bed table had been broken in one corner allowing the sharp edge of the plastic cover exposed, the ceiling vent in the bathroom was hanging from the ceiling covered with dust, the window sill had large areas of a brown substance and there was a brown/orange substance on the floor next to the bed. The Maintenance Director was interviewed on 1-12-23 at 10:05am. He explained he had ordered new over the bed tables and had replaced some but was not aware of room 401's table. He stated he would have the table replaced. He also stated he was unaware of the bathroom vent dislodging from the ceiling. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the substance on the floor and windowsill was from the resident's tube feeding. He explained he was aware of the cleaning issues but said he felt the changes he had made had not been able to make an impact. b. Room 308 was observed on 1-9-23 at 10:33am. The observation showed a brown and yellow substance on the wall next to the door, the	F 584	resident room audit on 02/08/2023, to ensure that wall heating and air vents are free of dust and debris. In addition, an audit was completed of bed side tables to ensure that the residents have bed side tables that are in good condition. 3.The Administrator reeducated the Maintenance Director and Environmental Services Director on 02/09/2023, on ensuring that the residents room provide a homelike environment. 4.An audit will be completed monthly x 3 months, by the Maintenance Director, Environmental Services Supervisor, or designee of the resident rooms to ensure that the rooms are being properly cleaned, that the heat and air vents are free of debris and properly cleaned, and that the bedside tables are in good condition. Any issues will be reported to the Administrator and addressed through the QAPI meeting.	

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F 584	Continued From page 14 wall heating and cooling unit had white and black particles in the vent and the light fixture above the resident's bed had a reddish/brown substance around the frame of the fixture and the popcorn ceiling was peeling off. A second observation of room 308 occurred on 1-12-23 at 9:00am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The observation showed a brown and yellow substance on the wall next to the door, the wall heating and cooling unit had white and black particles in the vent and the light fixture above the resident's bed had a reddish/brown substance around the frame of the fixture and the popcorn ceiling was peeling off. The Maintenance Director was interviewed on 1-12-23 at 10:05. He stated he was responsible for cleaning the wall heating and air vents. The Maintenance Director stated he tried to do this monthly but said he had been preoccupied with other issues in the facility. He also stated the popcorn ceiling peeling off was a new problem and he would address the issue. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the housekeepers assigned to the room should be cleaning any substances off the walls and light fixtures. c. During an observation of room 310 on 1-9-23 at 10:45am, the observation revealed a brown substance on the light switch by the door, the wall heating and air unit had white, brown and black particles in the vent and the light fixture above the resident bed had a reddish-brown substance around the frame of the fixture.	F 584		

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F 584	Continued From page 15	F 584		

A second observation of room 310 occurred on 1-12-23 at 9:05am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The observation revealed a brown substance on the light switch by the door, the wall heating and air unit had white, brown, and black particles in the vent and the light fixture above the resident bed had a reddish-brown substance around the frame of the fixture.

The Maintenance Director was interviewed on 1-12-23 at 10:05am. He stated he was responsible for cleaning the wall heating and air vents. The Maintenance Director stated he tried to do this monthly but said he had been preoccupied with other issues in the facility.

The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator stated the housekeepers assigned to the room should be cleaning any substances off light switches and light fixtures.

d. Room 303 was observed on 1-9-23 at 3:00pm. The observation revealed a brown substance on the floor next to the bed and the ceiling light cover in the bathroom contained a black residue and the end cap of the cover was coming off.

A second observation was made on 1-12-23 at 8:45am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director. The second observation revealed a brown substance on the floor next to the bed and the ceiling light cover in the bathroom contained a black residue and the end cap of the cover was coming off.

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F 584	Continued From page 16 The Maintenance Director was interviewed on 1-12-23 at 10:05am. The Maintenance Director explained he made room rounds weekly and was not aware of room 303's bathroom light fixture. The Administrator was interviewed on 1-12-23 at 10:11am. The Administrator explained the facility did not have an Environmental Manager because the facility had changed services. He also stated he made room rounds "almost" daily and had been aware of the issue in room 303. e. An observation of room 306 occurred on 1-9-23 at 10:30am. The observation revealed a brown substance smeared on the door frame. During a second observation on 1-12-23 at 8:49am with the Administrator who was also serving as the Environmental Manager and the Maintenance Director, the observation revealed a brown substance smeared on the door frame. An interview with the Administrator occurred on 1-12-23 at 10:11am. The Administrator stated housekeeping was responsible for ensuring resident door frames were clean.	F 584		
F 657 SS=D	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- (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.	F 657		2/22/23

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F 657	Continued From page 17 (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, staff, resident, and resident representative interviews the facility failed to (1) update a resident's individualized care plan related to discharge (Resident #14) and (2) hold a quarterly care plan meeting for (Resident #57) for 2 of 2 residents reviewed for care plans. Findings included: 1. Resident #14 was admitted to the facility on 8-18-22. The quarterly Minimum Data Set (MDS) dated 12-1-22 revealed Resident #14 was moderately cognitively impaired. Resident #14's care plan dated 12-13-22	F 657	1.Upon notification of surveyor, the care plan for resident #14 was updated on 01/11/2023, to reflect the current discharge plan for resident to return home to the community. Upon notification of surveyor, a care plan meeting was held on 02/01/2023 for resident #57. 2.Social Services Director or Designee will audit care plans related to discharge to ensure reflection of current discharge plans of residents by 02/22/2023. Social Services Director or Designee will audit resident charts to ensure care plan meetings were offered and held within the last quarter and after admission.	

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F 657	Continued From page 18 revealed a problem for adjustment issues related to need to remain in the facility long term. The goal documented for the problem was resident would receive daily opportunities for social contact. The interventions for the goal were to encourage family involvement and encourage the resident to participate in activities. Resident #14 was interviewed on 1-9-23 at 10:40am. The resident discussed wanting to be discharged. She stated during her last discussion with the facility Social Worker (SW) the plan was for her to go home but she stated she had not heard anything else from the SW. The MDS nurse was interviewed on 1-11-23 at 11:44am. The MDS nurse stated she wrote the care plan on 12-13-22 for the resident to stay in the facility long term. She said she wrote this care plan based on the length of time Resident #14 had been in the facility and the information on the quarterly MDS of no active discharge planning back to the community. The MDS nurse stated she had not discussed the care plan with the resident, resident representative, or the SW. She also stated she was not aware of the care plan meeting that was held in December 2022 with the goal of active discharge planning back into the community for Resident #14. An interview with the SW occurred on 1-11-23 at 11:50am. The SW stated a care plan meeting was held in December 2022 with the resident and the resident family where it was decided that Resident #14 would be discharged back into the community. The SW explained there were several goals for Resident #14 to complete before discharge into the community could occur. She also explained she had been working with	F 657	3.The Director of Nursing or Designee will educate the Social Services Director regarding updating discharge care plans to reflect current resident discharge plans, and of care plan meeting requirements by 2/22/23. 4.The Social Services Director will audit 10 resident care plans weekly x 4 weeks, then monthly x 1 month, for current discharge care plan. Results will be brought to QAPI x 2 months or until compliance is achieved	

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F 657	Continued From page 19 Resident #14 on the proper after care follow up that will be needed such as home health or a higher level of care to meet her needs. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated there had been some confusion between what Resident #14 wanted and what the family wanted but said the care plan should reflect the resident's intent. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated he expected the care plan process to be followed and timely. 2. Resident #57 was admitted to the facility on 10/04/22 with diagnoses which included traumatic brain dysfunction. Resident #57's admission Minimum Data Set dated 10/11/22 noted she was rarely/never understood and a staff assessment for mental status should be conducted, but it was not completed. It further noted she required total dependence on staff for her care. Review of Resident #57's record did not indicate a care plan meeting had been conducted since admission. During an interview with Resident #57's Responsible Party (RP) on 1/09/23 at 4:20 PM she revealed she had been invited to a care plan meeting and had been in the Resident #57's room, but no one came to find her or let her know where she was supposed to go. She stated she never heard anything else about a care plan meeting.	F 657		

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F 657	Continued From page 20 During an interview with the Social Worker (SW) on 1/11/23 at 8:46 AM she revealed she had been aware of an invitation to Resident #57's care plan meeting had been sent to the RP. She stated the meeting had been scheduled for 11/15/22 but was not held and had not been rescheduled. An interview with the Administrator on 1/12/23 at 10:37 AM revealed the care plan meeting should have been rescheduled if staff were unable to participate. He explained he did not know why that had not been done.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to provide nail care to residents who needed extensive assistance and/or dependent for Activities of Daily Living (ADL) care for 2 of 3 residents (Resident #47 and Resident #27) and failed to rinse soap off a resident's skin during a bed bath for 1 of 3 resident (Resident #67) reviewed for ADL care. Findings included: 1. Resident #47 was admitted to the facility on 10-14-21 with multiple diagnoses that included hemiplegia and hemiparesis affecting right dominant side and diabetes.	F 677	1.Upon notification of surveyor, resident #47□s fingernails were cleaned and trimmed. Upon notification of surveyor, resident #27□s fingernails were cleaned and trimmed The facility is unable to retroactively correct rinse soap from resident #67 2.The Unit Manager completed an audit of resident fingernails on 01/25/2023, to ensure nails are clean and trimmed. 3.The Director of Nursing or Designee will educate nursing staff regarding completion of nail care and bed baths, to	2/22/23

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F 677	Continued From page 21 Resident #47's care plan dated 12-13-22 revealed a goal that Resident #47 would improve current level of functioning in ADLs. The interventions for the goal were check nail length, trim and clean on bath day. The quarterly Minimum Data Set (MDS) dated 12-24-22 revealed Resident #47 was cognitively intact and required total assistance with one person for bathing and personal hygiene. Resident #47 was observed and interviewed on 1-9-23 at 10:55am. Resident #47 was observed to have approximately half inch fingernails that had a black substance caked underneath. The resident stated he did not like having long dirty fingernails and explained he had asked staff to cut them several times but could not remember who he asked. An observation of Resident #47 occurred on 1-11-23 at 8:05am. The observation revealed the resident continued to have long fingernails with a black substance caked underneath. Nursing Assistant (NA) #4 was interviewed on 1-11-23 at 8:20am. The NA stated she had recently been assigned to Resident #47 but could not remember the day. She stated she had observed Resident #47's fingernails being long and dirty and explained she could not cut them because the resident was diabetic and only a nurse could cut his nails. NA #4 stated she did not inform the nurse on duty that Resident #47's nails needed cut. An interview with NA #3 occurred on 1-11-23 at 8:25am. NA #3 stated she was assigned to Resident #47 yesterday (1-10-23). She said the	F 677	include rinsing soap from the body, for residents by 2/22/23. 4.The Director of Nursing or Designee will audit 10 residents a week x 4 weeks, then monthly x 1 month for clean, trimmed fingernails, and will complete 5 bed bath observations per week x4 weeks, then monthly x 1 month to ensure soap is rinsed. Results will be brought to QAPI x 2 months or until compliance is achieved.	

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resident had requested his fingernails be cut and stated she had observed the resident's fingernails to be long and dirty. NA #3 explained she was not allowed to cut Resident #47's fingernails because he was a diabetic and only a nurse could cut them. She stated she did not inform the nurse of Resident #47's request to have his fingernails cut because "I forgot to tell her."

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated the NAs could cut Resident #47's fingernails and should have been cut when he requested.

The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need to be trained and knowledgeable in resident nail care.

2. Resident #27 was admitted to the facility on 9-11-21 with multiple diagnoses that included heart failure, vascular dementia, and chronic obstructive pulmonary disease.

Resident #27's care plan dated 9-12-22 revealed a goal that he would improve his current level of functioning in Activities of Daily Living (ADL). The interventions for the goal were Resident #27 required extensive assistance with one person for bathing.

The quarterly Minimum Data Set (MDS) dated 10-24-22 revealed Resident #27 was moderately cognitively impaired and required extensive assistance with one person for personal hygiene.

Resident #27 was observed and interviewed on 1-9-23 at 11:00am. Resident #27's fingernails

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F 677	Continued From page 23	F 677		

were observed to be approximately half an inch long. The resident stated he did not like to have his fingernails long and had asked staff to cut them but could not remember who he asked.

An observation was made on 1-11-23 at 8:05am of Resident #27. The observation revealed Resident #27's fingernails remained long.

Nursing Assistant (NA) #4 was interviewed on 1-11-23 at 8:20am. NA #4 stated she was assigned to Resident #27 today (1-11-23) and had observed his fingernails to be long. She stated she could not remember if the resident had asked for his fingernails to be cut or if she offered to cut his fingernails but said she had not cut his fingernails.

An interview with NA #3 occurred on 1-11-23 at 8:25am. NA #3 stated she had been assigned to Resident #27 yesterday (1-10-23) and had observed his fingernails being long. She also stated Resident #27 had requested for his fingernails to be cut but said she did not cut them because "I did not have time."

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated the NAs could cut Resident #47's fingernails and should have been cut when he requested.

The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need to be trained and knowledgeable in resident nail care.

3. Resident #67 was admitted to the facility on 7-11-22 with multiple diagnoses that included

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nontraumatic intracranial hemorrhage, locked in state.

The quarterly Minimum Data Set (MDS) dated 12-23-22 revealed Resident #67 was severely cognitively impaired and required total assistance with one person for bathing.

Resident #67's care plan dated 12-30-22 revealed a goal that he would improve his level of functioning in Activity of Daily Living (ADL) care. The intervention for the goal was the resident was totally dependent on staff for bathing.

An observation of ADL care for Resident #67 occurred on 1-10-23 at 11:43am with Nursing Assistant (NA) #3. The NA was observed to use a shampoo and body wash with the directions to rinse the soap off the resident. NA #3 was observed to soap the washcloth, clean the resident, and then take a towel to dry the resident without rinsing the soap off first.

NA #3 was interviewed on 1-10-23 at 11:48am. The NA stated she always used the shampoo and body wash to bath Resident #67 and stated she was unaware the soap she was using needed to be rinsed off Resident #67 before she dried the resident.

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:415pm, the VP of
Clinical Services stated the NA should have read the directions and rinsed the soap off Resident #67 as directed.

The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated the NAs need

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F 677	Continued From page 25 to be trained and knowledgeable in the bathing process.	F 677		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, resident interview, and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional. This deficient practice had the potential to affect all 64 residents in the facility. Findings included: Review of the list of key personal provided by the facility on 1/9/23 revealed there was no staff member identified to be the Activities Director.	F 680	1.The facility hired a full time Activities Director on 01/25/2023, who has enrolled in the required Activity Director course to meet the mandatory qualifications. While the Director is completing the required course the facility has arranged for oversight and direction of the Activities Department from a qualified Activities Professional. 2.No additional identification audit is applicable	2/22/23

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F 680	Continued From page 26 During an interview on 1/10/23 at 10:10 AM Activities Assistant #1 stated he had been working for the facility since July 2021. He stated there was no activities director at that time. He stated he believed they had not had an activities director for about a month prior to his starting his employment and they reached out to him because of his extensive nursing home experience as a dietary manager at a different facility. He stated he did not have the qualifications to be the activities director, so he took an as needed position as an activities assistant and came to the facility about three times a week on average. In September of 2021 the facility promoted a housekeeping staff member to the activity's director position, and she received the activities certificate to be a qualified activities director. This activities director remained in that position from September 2021 through 1/2/23. The activities director quit without notice on that date due to a family emergency. He stated he believed the facility was looking for a new activities director at this time but had not confirmed this. He stated he was continuing in his role as the activities assistant and comes to the facility as needed on days the facility did not have an available staff member to set up and provide activities for the residents. The facility was providing activities to the residents and continuing the activities program, however there was no activities director now. During an interview on 1/10/23 at 10:50 AM the Administrator stated in 2021 a housekeeping staff member was promoted to the position of activities director, and she received her certification as a certified activities director in 2021. She continued in this role until she quite without warning on	F 680	3.The Administrator or designee will provide education to the new Activities Director, along with the qualified Activities Professional who will be providing oversight, to ensure that a proper activities program is in place, and that instruction and direction is being provided by the qualified professional. 4.The Administrator or designee will complete an audit monthly for the next three months to ensure that oversight is being provided by the Qualified Professional to the Activities Department.	

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F 680	Continued From page 27 1/2/23. She came to the morning meeting that day and informed them that it was going to be her last day and she would not be returning to work. He stated they immediately advertised a job opening for a qualified activities director. He stated they made some networking inquiries and had researched past applicants and prior activities directors as well. No candidates had surfaced or become available to the facility yet and the search for a qualified activities director was ongoing.	F 680		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Wound Care Physician, and Medical Director interviews, the facility failed to provide ongoing skin assessments, monitor consistently, and ensure treatments and interventions were implemented to prevent pressure ulcer development and worsening for a resident at risk for pressure ulcers who was admitted to the	F 686	1.Upon notification of surveyor, a low air loss mattress was placed on resident #67□s bed, turning and repositioning orders were entered into the Plan of Care, and physician orders for weekly skin assessments and weekly pressure wound assessments were entered. Resident #5 no longer resides at the	2/22/23

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F 686	Continued From page 28 facility without pressure ulcers. On 10/02/22 Resident #67 was identified with a stage 2 pressure ulcer on his sacrum that worsened to a stage 4 pressure ulcer on 11/9/22. On 12/25/22 Resident #67 was diagnosed with osteomyelitis on admission to the hospital. In addition, the facility had a lower level of deficient practice when the facility failed to provide ongoing skin assessments, consistent wound monitoring, and to implement interventions of a low air-loss mattress and turning and repositioning as recommended by the wound care physician for Resident #5. This deficient practice affected 2 of 3 residents reviewed for pressure ulcers (Resident #67 and #5). Immediate Jeopardy began on 11/09/22 when the facility failed to assess and identify a stage 4 sacral pressure ulcer for Resident #67. The immediate jeopardy was removed on 1/28/23 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the education and the monitoring systems put in place are effective and to address deficient practice for Resident #5. Findings included: 1. Resident #67 was admitted to the facility on 7/11/22 with diagnoses which included traumatic brain dysfunction and respiratory failure. The head-to-toe skin assessment dated 7/12/22 at 8:28 AM revealed Resident #67 had no pressure ulcers present on the 7/11/22	F 686	facility. 2.The Unit Managers completed a facility skin sweep for identification of current skin impairments on 02/07/2023. The Director of Nursing entered turning and positioning into the Plan of care, audited and updated pressure wound orders, and entered orders for weekly skin observations and weekly pressure wound observations for all residents with pressure wounds between 1/20/23 and 1/27/23. Braden scales were audited by the Director of Nursing on 1/27/23 and plans of care for those residents at risk for skin impairments were reviewed for appropriate interventions by Nursing Administration and the VP of Clinical Services. A nurse was appointed as a wound care nurse on 1/27/23 and enrolled into a wound certification course. 3.The Director of Nursing or Designee educated nursing staff on 1/27/23 related to the wound management process to include, turning and positioning, intervention implementation, notification of new wounds, assessment completion, and completion of treatments as ordered. 4.The Director of Nursing or Designee will audit 10 resident charts per week, to include new admissions, for completion of Braden scales, care plans with interventions, turning and repositioning,	

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F 686	Continued From page 29 admission. Resident #67's care plan initiated on 7/13/22 had a focus for potential impairment to skin integrity related to fragile skin, immobility, and incontinence. The interventions included weekly skin assessments and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. A pressure sore scale for predicting pressure sore risk dated 7/18/22 at 4:28 PM assessed the resident was at high risk. The admission Minimum Data Set (MDS) dated 7/18/22 revealed Resident #67 had severe cognitive impairment and was totally dependent on staff for all activities of daily living including bed mobility. The assessment noted no pressure ulcers, always incontinent of bowel and bladder, was on a scheduled pain medication regimen, received no as needed pain medication, had no weight gain or loss and received 100% nutrition through a feeding tube. The resident had no behaviors or refusal of care. He was coded to have a pressure reducing device for bed. The weekly skin assessments from 7/11/22 through 8/30/22 revealed no pressure ulcers present. The weekly skin assessment dated 9/06/22 revealed a stage 2 neck pressure ulcer which was treated and resolved on 9/28/22. The weekly skin assessment completed by Nurse #10 dated 9/28/22 revealed moisture associated skin damage to the sacrum.	F 686	physician orders for weekly skin assessments and/or weekly pressure wound observations, and completion of weekly skin assessments and or weekly wound observations weekly x 8 weeks, then monthly x one month. The Director of Nursing or Designee will review the recommendations from the wound physician to ensure implementation of recommendations and new orders, and Treatment Administration Records for residents with pressure ulcers will be reviewed weekly x 8 weeks, then monthly x 1 month.	

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F 686	Continued From page 30 The September 2022 Treatment Administration Record (TAR) revealed the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. The weekly skin assessment completed by Nurse #2 dated 10/02/22 revealed a stage 2 pressure ulcer to the sacrum. An interview on 1/27/23 at 2:04 PM with Nurse #2 revealed she was not currently employed at the facility but had been assigned to provide care for Resident #67 three nights per week for the three months she worked at the facility. She stated that wound care treatments were completed during the day and did not remember completing the weekly skin assessment. The care plan was not updated when the sacral pressure ulcer was identified. The quarterly MDS dated 10/18/22 revealed Resident #67 had severe cognitive impairment and was totally dependent on staff for all activities of daily living including bed mobility. The assessment noted one unstageable pressure ulcer which was not present on admission, always incontinent of bowel and bladder, was not on a scheduled pain medication regimen, received no as needed pain medication, had no weight gain or loss and received 100% nutrition through a feeding tube. The resident had no behaviors or refusal of care. He was coded to have a pressure reducing device for bed, received pressure ulcer/injury care, and application of ointments/medications to other than feet. The October 2022 TAR revealed a continuation of	F 686		

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the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. An additional treatment order dated 10/14/22 read in part for Collagenase (used to remove dead tissue) ointment applied to sacrum every day. This treatment was not signed as completed on 10/19/22 and 10/22/22.

An interview on 1/27/23 at 8:52 AM with Nurse #9 revealed she had obtained the order dated 10/14/22 for Collagenase. She stated she did not remember if the physician assessed the sacral wound or if she called him. She stated she observed the wound when assisting the Nursing Assistant (NA) with resident care on 10/14/22. Nurse #9 also stated she did not complete wound measurements or notify management about this wound. She stated that if she completed the wound care treatments, she signed the TAR.

There were no weekly skin checks or pressure ulcer assessment notes after 10/02/22 until 11/09/22.

Resident #67 was first assessed and treated by the Wound Care Physician for his sacral pressure ulcer on 11/09/22. His wound evaluation and management summary dated 11/09/22 read, in part, that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 6.5 centimeters (cm) by 5.0 cm by 0.1 cm. The ulcer had moderate serous exudate with 80% necrotic tissue and 20% granulation tissue. His ulcer detail note read, in part, that the resident was seen for initial evaluation and management of recent development of unstageable necrosis pressure injury of the sacrum. His plan of care recommendations included to off-load wound, turn side to side and

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front to back in bed every 1-2 hours if able, and a low air-loss mattress. His dressing treatment plan recommendations were for an absorbent, antimicrobial dressing applied daily for 30 days and Collagenase ointment applied daily for 30 days.

Resident #67's wound evaluation and management summary dated 11/16/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.5 cm. The ulcer had moderate serous exudate with 60% necrotic tissue, 30% slough, and 10% granulation tissue.

Resident #67's wound evaluation and management summary dated 11/23/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm. The ulcer had moderate serous exudate with 70% necrotic tissue, and 30% slough.

Resident #67's wound evaluation and management summary dated 11/30/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.8 cm. The ulcer had moderate serous exudate with 20% necrotic tissue, 50% slough, and 30% granulation tissue.

Resident #67's wound evaluation and management summary dated 12/07/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.8 cm. The ulcer had moderate serous exudate with 70% necrotic tissue and 30% slough.

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Resident #67's wound evaluation and management summary dated 12/14/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm. The ulcer had moderate serous exudate with 60% necrotic tissue and 40% slough.

Resident #67's wound evaluation and management summary dated 12/21/22 read, in part that Resident #67 had a stage 4 pressure ulcer to his sacrum. The sacral pressure ulcer measured 7.0 cm by 5.0 cm by 1.9 cm with undermining of 4.3 cm at 3 o'clock. There was a deep tissue injury (DTI) noted within the wound bed area. The ulcer had moderate serous exudate with 60% necrotic tissue, 30% slough, and 10% granulation tissue.

An interview with the Wound Care Physician on 1/11/23 at 3:00 PM revealed he made recommendations in his wound care notes. He stated he had recommended a low air-loss mattress for Resident #67 on his 11/09/22 recommendations. He also stated that a low air-loss mattress and turning and repositioning were vital to wound healing.

Another interview with the Wound Care Physician on 1/27/23 at 11:44 AM revealed he was consulted by the facility to see Resident #67. He stated he could not say how the resident's wound developed, but confirmed it was a stage 4 sacral pressure ulcer when he initially assessed it on 11/09/22. He stated the resident was at high risk for wound development due to his medical comorbidities. The Wound Care Physician stated that he followed the resident weekly and when he saw him on 12/21/22 he noted no signs or

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symptoms of infection, but the resident had a high biofilm (thin, slimy film of bacteria that adheres to a surface) and necrotic burden (dead tissue that is a physical barrier and is a medium for bacterial growth), so he was at high risk of developing an osteomyelitis infection.

The November 2022 TAR revealed a continuation of the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks three times per day. The treatment order dated 10/14/22 for Collagenase to the sacrum was discontinued on 11/09/22. This treatment was not signed as completed on 11/2/22 and 11/4/22.

The November 2022 TAR also had an order dated 11/09/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 11/16/22. This treatment was not signed as completed on 11/11/22.

The November 2022 TAR had an order dated 11/16/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This treatment was not signed as completed on 11/18/22, 11/23/22, and 11/26/22.

Resident #67's care plan was updated on 11/29/22 with an additional focus area notation that the resident had a pressure wound to inner buttocks. The goals and interventions were not updated.

The weekly skin assessment completed by Nurse #11 dated 12/07/22 revealed a stage 4 pressure ulcer to the sacrum. The wound measurements were 7.0 cm x 5.0 cm x 1.8 cm.

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An interview with the Nurse #11 on 1/27/23 at 11:23 AM revealed she was an agency nurse and had worked at the facility for a couple of months mostly as the wound care nurse. She stated she rarely saw the resident in a different position and did not feel he was turned or repositioned as he should have been to prevent his pressure ulcers from getting worse or not healing. She stated the hall nurse was responsible for completing the residents' weekly skin assessments. She also stated that they were responsible for completing the residents' wound care treatments if there was no wound care nurse.

The Wound Care Physician's wound evaluation and management summary dated 12/21/22 did not indicate concerns about infection and noted moderate serous drainage. The wound was debrided to remove necrotic tissue and biofilm and health bleeding tissue was observed. The wound measurements were 7.0 cm x 5.0 cm x 1.9 cm.

The December 2022 TAR revealed a continuation of the 8/16/22 treatment order for skin protectant ointment to be applied to buttocks every shift which was three times per day. This treatment order was discontinued on 12/30/22.

The December 2022 TAR had an order dated 11/16/22 for Collagenase ointment with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 12/20.22. This treatment was not signed as completed on 12/01/22, 12/09/22, 12/13/22, and 12/17/22.

The December 2022 TAR had an order dated 12/20/22 for Collagenase ointment and collagen

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powder with an absorbent, antimicrobial dressing to be applied every day. This order was discontinued on 12/21/22.

The December 2022 TAR had an order dated 12/21/22 for Collagenase ointment and collagen powder and to pack the wound with wound cleanser moistened gauze with an absorbent, antimicrobial dressing every day. This order was discontinued on 12/30/22. This treatment was not signed as completed on 12/23/22.

Review of nurses' progress note completed by Nurse #12 dated 12/22/22 revealed Resident #67 tested positive for COVID.

Review of nurses' progress note completed by Nurse #2 dated 12/25/22 revealed the resident was sent to the hospital for fever and respiratory distress.

Resident #67's care plan initiated on 12/30/22 had a focus for multiple pressure injuries related to incontinence and decreased mobility and was at risk for worsening of wounds and additional breakdown. The interventions included to reposition and/or turn at frequent intervals to provide pressure relief and complete a full body check weekly and document.

Review of Resident #67's hospital discharge summary dated 1/05/23 included admission diagnoses of Covid pneumonia and stage 4 decubitus ulcer with osteomyelitis. He was treated with intravenous (IV) antibiotics with a discharge medication list to continue two antibiotics for 32 days.

Resident #67's admission skin assessment dated

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1/05/23 indicated he had a stage 4 sacrum pressure ulcer which measured 6.4 cm by 4.0 cm by 2.1 cm.

Multiple observations were made on 1/10/23 at 10:00 AM, 11:15 AM, 12:27 PM and 1:09 PM. Resident #67 was observed to lie in the same position with the head of bed at about 45 degrees, face to the right, lying on his back, pillow under left arm, pillow under right side arm/side, feet wearing protective boots, and legs straight. The resident was not observed to make any independent movements and was not interviewable. The resident was observed to be on a low air-loss mattress.

An interview with Nursing Assistant (NA) #3 on 1/10/23 at 2:13 PM revealed she was assigned to provide care for Resident #67. She also revealed she was scheduled to work from 7:00 AM until 3:00 PM. She stated she had turned him one time that day during his bath right before lunch. She stated that the resident did not get turned every 2 hours today because she was trying to give other residents their baths. She stated she was familiar with the resident, and she knew he was supposed to be turned every 2 hours.

An interview with NA #6 on 1/26/23 at 3:11 PM revealed she was regularly assigned to provide care for Resident #67. She stated she did not turn him completely on his side but used pillows or wedges under his buttocks to reposition him. She also stated she turned him as often as possible but was unable to always turn him every 2 hours.

An interview with NA #4 on 1/27/23 at 9:51 AM revealed she had been assigned to provide care for Resident #67 occasionally. She stated that

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she tried to turn and reposition the resident every 2 hours but that was not always possible if she got busy.

An interview with Nurse #8 on 1/10/23 at 1:36 PM revealed she was the assigned nurse for Resident #67. She stated she was his assigned nurse frequently but had only been employed at the facility a short time. She did not provide wound care as there was a wound care nurse. She stated she had never seen him fully turned from one side to the other. She stated she saw pillows placed under one hip then the other to offload pressure on the sacral wound. She stated that he coughed more if turned onto his side.

An interview with Nurse #10 on 1/27/23 at 12:02 PM revealed she had been employed at the facility as the wound care nurse for approximately 1 year and no longer worked at the facility. She stated when she first started working at the facility, she often worked 7 days per week, but then worked 3-5 days per week. She stated she completed weekly assessments and provided wound care treatments to Resident #67. She stated that if the TAR wasn't signed, then the treatment had not been done. She stated when she was the wound care nurse, she completed the weekly skin assessments and wound assessments.

A wound care observation was completed with Nurse #11 and the Wound Care Physician on 1/11/23 at 3:17 PM revealed Resident #67's sacrum pressure ulcer was 6.5 cm (centimeters) x 4.4 cm x 1.9 cm with moderate serosanguinous exudate. The wound had 3.4 cm undermining (when the wound edges become eroded and a pocket forms beneath the wound edge) at the 3

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o'clock position and contained 40% slough and 60% granulation.

An interview with the Medical Director on 1/12/23 at 11:11 AM revealed he believed lack of turning and repositioning could contribute to pressure ulcer decline. He also stated he relied on the facility to ensure the wound physician recommendations in their notes were completed.

A further interview with the Medical Director on 1/27/23 at 7:58 PM, he revealed he had seen and assessed Resident #67's sacral wound when it was a stage 2 but did not specify a date. He stated that the resident had multiple comorbidities which included his cerebrovascular disease, chronic respiratory failure, and tube feeding nutrition but that the lack of care he received played a part in his sacral wound development. He specified the lack of care as the resident not being turned or repositioned as frequently as necessary to prevent the sacral pressure ulcer from developing and worsening and noted that the resident did not have a pressure ulcer on admission. He also felt that weekly skin checks were important.

An interview with the Vice President of Clinical Operations on 1/12/23 at 1:45 PM revealed the facility should adhere to the standards of wound management which included turning and repositioning. She also revealed that Resident #67 had significant comorbidities for pressure ulcer development.

The Administrator was notified of the immediate jeopardy on 1/27/23 at 1:10 PM.

The facility provided the following plan for

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F 686	Continued From page 40 immediate jeopardy removal: - Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Inconsistent nursing leadership led to the compliance failure. The Vice President of Quality Assurance completed this root cause analysis on 1/12/2023. Resident #67's skin assessment was completed on 01/27/2023 by the Unit Manager. The braden scale assessment was completed on 01/13/2023 by staff Registered Nurse and scores a 10, which indicates at risk for skin breakdown. Skin assessment shows sacrum stage IV and left heel deep tissue injury. Orders were entered for weekly skin assessments and weekly pressure wound observations, that were not previously in place. Assessments were scheduled for weekly skin and weekly pressure wound observations, that were not previously in place. Turning and repositioning as needed, not previously in place, was added to plan of care tasks, to be signed by Nursing Assistants, indicating the completion of turning and repositioning task occurred each shift. Resident continues on an air mattress. These updates were entered by the Director of Nursing 1/20-1/27/23. Interventions are in place to address pressure ulcers for Resident #67. - Heel protector boots-1/19/23 ordered, Occupational Therapy 1/5/23, turning and positioning, as needed 01/20/23, air mattress- 11/9/22, the facilty's wound care provider's recommendations were reviewed entered as physician's orders on 01/26/23, by the Director of Nursing.	F 686		

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F 686	Continued From page 41 Residents with a high risk braden score, were audited on 01/27/2023 by the Director of Nursing. Interventions will be reviewed and implemented, as appropriate. No new residents were identified. Braden assessments were audited for residents triggering to be at risk for skin breakdown. Plans of care will be reviewed for those residents that trigger at risk, by the Director of Nursing, Unit Manager and MDS nurse on 01/27/23, to ensure interventions are current and appropriate. - 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: Nurses are being educated by the Unit Manager, regarding documentation of skin assessments, and braden assessments upon admission, with ongoing weekly skin assessments, weekly pressure wound observations, and quarterly braden assessments. Nurses not currently available for education, will receive education by the Unit Manager or Wound Care Nurse prior to assuming their next shift assignment. Nursing education was completed on 1/27/23, and included staff nurses and agency nurses, that are on our current schedules. New hires will receive this education by the Nursing Management team, as part of their nursing orientation. The wound nurse is responsible for the wound management, Monday- Friday, and a nurse will be scheduled on the weekends, for wound care continuity. Should the wound nurse be absent, then the Unit Manager will assume responsibility for wound care.	F 686		

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F 686	Continued From page 42 A staff nurse has been identified as the primary wound care nurse effective January 27, 2023 and has been enrolled in a wound care certification program. Date of alleged IJ removal: 01/28/2023 The credible allegation of immediate jeopardy removal was validated by onsite verification on 1/31/23. Interviews conducted with nursing staff revealed they had attended training on Wound Management- Skin and Wound Protocol. The education included Braden scale, weekly skin review which was to be completed by the licensed nurse for each resident weekly. Weekly pressure wound observation tool- to be completed by clinical managers/designee when the weekly assessment is not completed by the Wound NP. Weekly non-pressure wound observation tool -for diabetic ulcers, arterial or vascular ulcers, surgical wound, excoriations, lacerations, abrasions, bruises , or skin tears- to be completed weekly by Clinical Manager/designee if the Wound NP did not access the area. The education also included steps to take if there were changes to the resident's skin integrity or wound outside the scheduled observations. Inservice forms were reviewed and indicated the dates, topics discussed, and the trainer, and included attending staff signatures. A review of the weekly wound observation dated 1/25/23 revealed the resident was seen by the facility's wound clinic and new orders provided. A review of the physician's orders for the month of January 2023 revealed that new orders and recommendations were included on the MAR. A review of the plan of care NA task list report last updated 1/27/23 included skin care, positioning, and skin integrity. A review of the Braden scale	F 686		

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F 686	Continued From page 43 audit and verification log revealed 100 % of the residents were reviewed on 1/27/23. The facility had appointed a nurse as Wound Nurse Monday thru Friday and the individual has been signed up for a 2-part wound care certification program effective 1/27/23. An Interview conducted with new wound nurse on 1/31/23 revealed that his schedule would be from 11AM-7PM Monday through Friday. The wound nurse stated when he was not present, there was a backup nurse or another agency nurse that would complete the treatments/wounds. He stated his job entailed being responsible for all the treatments, weekly skin checks, weekly wound assessments, and Braden scales. An interview was conducted with the Director of Nursing (DON) on 1/31/23 at 3:00 PM. The DON stated that the wound care nurse would be responsible for wound care management documentation and validation. An observation of Resident #67 on 1/31/23 at 12:35 PM revealed that he was wearing heel protector boots and a pressure relieving mattress was in place. The facility's Immediate Jeopardy removal date of 1/28/23 was validated. 2. Resident #5 was admitted to the facility on 8/26/22 with diagnoses which included cerebrovascular accident and seizure disorder. The baseline care plan dated 8/29/22 had a focus for pressure ulcers present upon admission 8/26/22 and is at risk for further pressure injury development. Resident #5 was initially evaluated and treated by the Wound Care Physician on 8/31/22 for three deep tissue injuries (DTI) and one unstageable	F 686		

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sacral pressure ulcer. The Wound Care Physician's evaluation and management summary dated 8/31/22 included recommendations to off-load wound, turn side to side and front to back in bed every 1-2 hours if able, and a low air-loss mattress.

Review of Resident #5's electronic medical record census indicated he was sent to the hospital on 9/01/22 and returned to the facility on 9/14/22.

Review of Resident #5's head to toe skin check dated 9/14/22 revealed the resident returned to the facility with an additional wound and changes to the previous wounds.

The Wound Care Physician's evaluation and management summary dated 9/21/22 had additional wound detail which read in part that the resident returned to the facility after hospitalization for sepsis due to presumed endocarditis complicated by wound infection and strong suspicion for osteomyelitis underlying stage 4 pressure wound of the sacrum. Resident's overall prognosis is poor.

There were no weekly skin checks or pressure ulcer assessment notes from 10/06/22 until 10/26/22.

Resident #5's quarterly MDS dated 12/19/22 revealed he had 1 stage 3 pressure ulcer which was present on admission. He had 3 stage 4 pressure ulcers, 2 of which were present on admission. He had 2 unstageable pressure ulcers, none of which were present on admission. He also had 8 unstageable suspected deep tissue injury pressure ulcers, 1 of which was

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present on admission.

Review of Resident #5's head to toe skin check dated 12/30/22 revealed he had eleven pressure areas.

The Wound Care Physician's Wound Evaluation and Management Summary note dated 1/04/23 for Resident #5 included staging, measurements, notations of exudate, etiology and the treatment plan for each wound. The summary included that the resident returned to the facility after hospitalization for sepsis likely secondary to urinary tract infection/possible aspiration pneumonia complicated by heart attack likely secondary to sepsis/acute on chronic anemia, acute hypoxic respiratory failure likely secondary to aspiration pneumonitis and acute deep vein thrombosis (DVT) of left subclavian vein. As such, resident has returned to facility with deterioration in surface area and/or depth, and/or increase DTI/slough/necrosis in several wound.

Multiple observations were made on 1/10/23 at 10:02 AM, 12:27 PM and 1:09 PM. Resident #5 was observed lying in the same position with the head of bed about 30 degrees, facing upright, lying on his back, arms crossed over lower body, towel under left arm, legs contracted with knees bent. The resident was not interviewable. The was no low air-mattress observed on the resident's bed.

An interview with Nursing Aide (NA) #3 on 1/10/23 at 2:13 PM revealed she was assigned to provide care for Resident #5. She stated she had turned him one time that day during his bath right before lunch. She stated that the resident did not get turned every 2 hours today because she was

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trying to give other residents their baths. She stated she was familiar with the resident, and she knew he was supposed to be turned at least every 2 hours.

An interview with Nurse #8 on 1/10/23 at 1:36 PM revealed she was assigned to the hall for Resident #5. She did not provide wound care as there was a wound care nurse. She stated he did not like to be moved and she did not know if the physician was aware of this. She confirmed that Resident #5 did not have a low air-loss mattress and stated his low air-loss mattress was on order and did not know the status.

An interview with the Supply Clerk on 1/11/23 at 1:59 PM revealed she ordered a low air-loss mattress when she received a physician's order. She stated she had received an order today for a low air-loss mattress.

An interview with the Wound Care Physician on 1/11/23 at 3:00 PM revealed he made recommendations in his wound care notes. He stated he had recommended a low air-loss mattress for Resident #5 and did not know why he did not have one at this time. He also stated that a low air-loss mattress and turning and repositioning were vital to wound healing. He also stated that the resident had multiple medical comorbidities and contractures which contributed to his pressure ulcers.

An interview with the Medical Director on 1/12/23 at 11:11 AM revealed he relied on the staff to obtain the low air-loss mattress. He also revealed that Resident #5 had contractures and general decline which contributed to his pressure ulcers.

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F 686	Continued From page 47 An interview with the Vice President of Clinical Operations on 1/12/23 at 1:45 PM revealed the facility should adhere to the standards of wound management which includes turning and repositioning. She also revealed that Resident #5 had significant comorbidities for pressure ulcer development.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		2/22/23

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F 690	Continued From page 48 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide necessary care and services of a urinary catheter when a Nursing Assistant (NA #3) cleaned a resident's catheter tubing by wiping the tubing towards the insertion site. This occurred for 1 of 1 resident (Resident #67) reviewed for catheter care. Findings included: Resident #67 was admitted to the facility on 7-11-22 with multiple diagnoses that included retention of urine. The quarterly Minimum Data Set (MDS) dated 12-23-22 revealed Resident #67 was severely cognitively intact and required total assistance with two people for toileting. The MDS also documented Resident #67 had an indwelling catheter. Resident #67's care plan dated 12-30-22 revealed a goal to not develop infections or trauma due to having an indwelling catheter. The interventions for the goal were care for catheter as appropriate. Observation of catheter care occurred on 1-10-23 at 11:43am with NA #3. NA #3 was observed to use a soapy washcloth and wipe the catheter tubing up towards the insertion site. The NA was	F 690	1.Upon notification of surveyor, the certified nursing assistant was provided 1:1 education by the Unit Manager, regarding catheter care for resident #67. 2.The Director of Nursing or Designee will complete observations of catheter care for residents who have catheters within the facility by 02/22/23. 3.The Director of Nursing or Designee will educate certified nursing assistants in how to perform proper catheter care by 2/22/23. 4.The Director of Nursing or Designee will observe 5 catheter care observations per week x 4 weeks, monthly x 1 month to ensure proper catheter care is completed. Results will be brought to QAPI x 2 months or until compliance is achieved.	

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F 690	Continued From page 49 observed to do this three times and then used a clean washcloth to rinse the soap off the tubing by wiping the tubing towards the insertion site. An interview with NA #3 occurred on 1-10-23 at 11:48am. The NA explained she usually did not have a resident assignment because she was the transportation driver. She explained she was a certified nursing assistant and had education on catheter care. NA #3 explained she was not aware she should not clean catheter tubing by wiping towards the insertion site and was not aware of the potential of infection when cleaned in that manner. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated staff were educated to clean catheter tubing away from the insertion site and did not know why the NA would have cleaned the tubing towards the insertion site. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated he expected staff to perform catheter care correctly.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		2/22/23

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F 695	Continued From page 50 by: Based on observation, staff and Physician interview the facility failed to ensure emergency equipment was present at the bedside for residents with tracheostomies. This occurred for 2 of 2 residents (Resident #67 and Resident #57) reviewed for tracheostomy care. Findings included: a. Resident #67 was admitted to the facility on 7-11-22 with multiple diagnoses that included tracheostomy status. The quarterly Minimum Data Set (MDS) dated 12-23-22 revealed Resident #67 was severely cognitively impaired and required oxygen, suctioning and tracheostomy. Resident #67's care plan dated 12-20-22 revealed a goal that Resident #67 will not have any signs or symptoms of infection. The interventions for the goal were keep extra tracheostomy tube and obturator (equipment used to insert a tracheostomy tube) at bedside. Observation of Resident #67 occurred on 1-9-23 at 3:00pm. The resident was observed laying in the bed with a tracheostomy. Observation of the resident room revealed there was no emergency equipment in the room to include tracheostomy tube/obturator. Another observation of Resident #67's room on 1-10-23 at 9:15am revealed no emergency equipment in the room to include tracheostomy tube/obturator. The facility's Medical Director was interviewed by	F 695	1.On 01/12/2023, emergency equipment, including tracheostomy tube and obturator, were placed at bedside by nursing management for resident #67 and resident #57. 2.The Director of Nursing or designee audited all current residents on 01/14/2023 with tracheostomies for emergency equipment, including tracheostomy tube and obturator. 3.Director of Nursing or designee will re-educate Licensed Nurses on maintaining emergency equipment, including tracheostomy tubes and obturators, at the bedside for residents that have tracheostomy tubes by 2/22/23. 4.Director of Nursing or designee will audit resident rooms of all residents with tracheostomies for emergency equipment, including tracheostomy tube and obturator, weekly times 4 weeks and monthly x 1 month. Results will be brought to QAPI for review times 2 months or until compliance is achieved.	

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telephone on 1-10-23 at 9:32am. The Medical Director stated Resident #67 should have emergency equipment present in his room that would include an extra tracheostomy tube and obturator. He also stated he was aware Resident #67 did not have any emergency equipment in his room and said he had asked staff to place the emergency equipment in Resident #67's room.

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 9:30am, the VP of Clinical Services stated the facility did not have a policy regarding tracheostomy care. She explained the facility had specific respiratory policies, but they did not include tracheostomy care.

Resident #67's room was observed on 1-11-23 at 10:00am. The observation revealed no emergency equipment in the room to include tracheostomy tube/obturator.

Nurse #1 was interviewed on 1-11-23 at 1:27pm. Nurse #1 stated she has been assigned to Resident #67. She said she had never seen emergency equipment in the resident room and explained if an emergency occurred with Resident #67's tracheostomy she would send the resident to the emergency room.

During an interview with Nurse #5 on 1-11-23 at 1:37pm, the nurse stated she had been assigned to work with Resident #67. She explained she had never seen any emergency equipment in the resident room and was unaware a tracheostomy resident needed to have emergency equipment at their bedside.

An interview occurred with Nurse #6 on 1-11-23

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at 1:41pm. Nurse #6 stated she had been assigned to Resident #67 "a while ago." She said she did not recall the resident having any emergency equipment in his room and was not aware a tracheostomy resident needed emergency equipment at their bed side.

During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated all tracheostomy residents should have emergency equipment at their bed side and said Resident #67 has had his emergency equipment placed at his bed side.

The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated appropriate equipment should be available for the level of care being provided.

b. Resident #57 was admitted to the facility on 10-4-22 with multiple diagnoses that included tracheostomy status.

Resident #57's care plan dated 10-5-22 revealed a goal that she would not develop any signs or symptoms of infection. The interventions for the goal were keep extra tracheostomy tube and obturator at bedside.

The admission Minimum Data Set (MDS) dated 10-11-22 revealed Resident #57 was severely cognitively impaired and required oxygen, suctioning and tracheostomy.

Observation of Resident #57's room on 1-9-23 at 3:10pm revealed no emergency equipment such as a tracheostomy tube or obturator was present in her room.

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Another observation of Resident #57's room 1-10-23 at 8:10am revealed no emergency equipment was present in her room.

The facility's Medical Director was interviewed by telephone on 1-10-23 at 9:32am. The Medical Director stated Resident #57 should have emergency equipment present in her room that would include a n extra tracheostomy tube and obturator. He also stated he was aware Resident #57 did not have any emergency equipment in her room and said he had asked staff to place the emergency equipment in Resident #57's room.

Resident #57's room was observed on 1-11-23 at 10:05am and revealed no emergency equipment was present in her room.

Nurse #1 was interviewed on 1-11-23 at 1:27pm. Nurse #1 stated she has been assigned to Resident #57. She said she had never seen emergency equipment in the resident room and explained if an emergency occurred with Resident #57's tracheostomy she would send the resident to the emergency room.

During an interview with Nurse #5 on 1-11-23 at 1:37pm, the nurse stated she had been assigned to work with Resident #57. She explained she had never seen any emergency equipment in the resident room and was unaware a tracheostomy resident needed to have emergency equipment at their bedside.

An interview occurred with Nurse #6 on 1-11-23 at 1:41pm. Nurse #6 stated she had been assigned to Resident #57 "a while ago." She said she did not recall the resident having any emergency equipment in her room and was not

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F 695	Continued From page 54 aware a tracheostomy resident needed emergency equipment at their bed side. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated all tracheostomy residents should have emergency equipment at their bed side and said Resident #57 has had her emergency equipment placed at her bed side.	F 695		
F 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff, and physician interviews the facility failed to obtain and administer Oxycodone/acetaminophen (a controlled substance medication ordered to treat pain) as ordered for a resident who was newly admitted to the facility with a recent fracture of the upper and lower left humerus (a long bone located in the upper arm between the shoulder joint and elbow joint). The resident was transferred to the Emergency Department (ED) for unmanaged pain on two occasions (12/24/22 and 12/30/22) where he was provided with Oxycodone/acetaminophen as ordered which was effective in relieving the resident's pain. The resident reported a pain level on 12/24/22 at an 8 out of 10 (with 10 representing the worst pain imaginable) and on 12/30/22 a 10 out of 10 and he expressed he felt like he was being "hit with a	F 697	1.Upon notification of surveyors, resident #66 no longer resides at the facility and the facility is unable to retroactively correct the residents pain management. 2.Director of Nursing or designee will audit all current residents receiving Oxycodone/Acetaminophen for pain management to validate the Oxycodone/Acetaminophen is obtained from the pharmacy and administered as ordered by the Provider by 02/22/23. 3.Director of Nursing or designee will re-educate the licensed nurses on obtaining and administering Oxycodone/ Acetaminophen for pain by 2/22/23.	2/22/23

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F 697	Continued From page 55 hammer." This was for 1 of 1 residents reviewed for pain management. Findings included: Resident #66 was admitted to the facility on 12/22/22. His active diagnoses included fracture of the upper and lower left humerus. The hospital discharge summary dated 12/22/22 revealed he was ordered Oxycodone/acetaminophen 5-325 milligrams (a medication which is a combination of oxycodone and acetaminophen) every 4 hours as needed for pain. Resident #66's admission note dated 12/22/22 completed by Nurse #1 revealed he was alert and oriented and admitted for a fracture to the left arm due to a fall. Resident #66 had bruising noted to arms and chest, left flank area. During an interview on 1/10/23 at 2:15 PM Nurse #1 stated Resident #66 was admitted late on 12/22/22 around 7:00 PM. This was when her shift ended and Unit Manager #1 the took over for her when he arrived at the facility. She concluded that all she did was write the admitting note and did not put the resident's orders into their electronic medical records system. She stated this facility did not allow orders to be entered until the resident physically arrived in the facility, so the unit manager put Resident #66's orders in. Resident #66's orders revealed on 12/22/22 he was ordered Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours for pain. Review of a text conversation between Physician	F 697	4.Director of Nursing or designee will audit residents receiving Oxycodone/ Acetaminophen to validate obtained and administered per the Provider orders, weekly times 4 weeks and monthly times 1 month.	

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#1 and Unit Manager #1 on 12/22/22 from 6:06 PM to 6:14 PM revealed the unit manager notified the physician via text message that Resident #66 had admitted from the hospital and the hospital had not sent any hard script for Resident #66's Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as needed. Unit Manager #1 faxed a hard script to be signed to Physician #1 and Physician #1 texted and indicated he would send the hard script to the pharmacy.

During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated when Resident #66 arrived at the facility on 12/22/22 the first question the resident asked was if his pain medication had arrived at the facility yet. Unit Manager #1 explained to him that the medications had not been entered into their system yet, therefore the pharmacy had not filled any of his prescription at that time. He informed the resident that if there was a medication due for him, they had a backup system in the facility to pull the medication for him to cover the break between the hospital and arrival of the medications from the pharmacy to the facility. After speaking with the resident, the Unit Manager began to enter the resident's orders on their electronic records system. He noted Resident #66's order for Oxycodone/acetaminophen 5-325 milligrams required a hard script at their pharmacy since it was a controlled substance, and a hard script was not sent from the hospital. At that point, on 12/22/22, he texted the physician to explain the situation and informed him that they needed the hard script. The doctor sent the order to the pharmacy that evening.

The Medication Administration Record (MAR) indicated no Oxycodone/acetaminophen was

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administered to Resident #66 on 12/22/22.

Resident #66's baseline care plan dated 12/23/22 revealed he was care planned for pain. The interventions included to evaluate the effectiveness of pain interventions, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, and notify physician if interventions are unsuccessful or if current complaint is a change from past experience of pain.

Review of a text conversation between Physician #1 and Unit Manager #1 on 12/23/22 from 4:35 PM to 5:34 PM revealed Unit Manager #1 again texted the physician regarding Resident #66's pain medication not yet being received. The resident was noted to be complaining of pain as well as the family complaining on his behalf.

During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated on 12/23/22 he was made aware by Resident #66 that he had not received his pain medication. He then sent Physician #1 another text requesting the hard script for the pain medication for Resident #66.

Resident #66's MAR for 12/23/22 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on 12/23/22 at 4:51 PM and again at 10:30 PM. These medications were pulled from the facility emergency backup medicine supply machine.

A nursing note dated 12/24/22 at 3:32 AM revealed Nurse #2 documented Resident #66 had complaints of pain in his left shoulder which he rated an 8 out of 10. Nurse #2 called the pharmacy for Oxycodone/acetaminophen 5-325

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milligrams as the medication for Resident #66 from the facility emergency backup medicine supply machine had run out. Physician #1 was messaged for other options. The pharmacy told the nurse that the Oxycodone/acetaminophen was on the way.

A nursing note dated 12/24/22 at 5:00 AM revealed Nurse #2 documented Resident #66 stated he wanted to go to the hospital because he was in pain and couldn't wait for his pain medication to arrive. He was sent to the emergency department.

During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/24/22, Resident #66 requested pain medication and she identified the Oxycodone/acetaminophen 5-325 milligrams had not arrived at the facility yet. She indicated when she informed Resident #66 that his pain medication had not arrived, the resident requested to be sent to the hospital for pain management as his pain level was 8 out of 10. She stated she sent him to the hospital as he requested for pain management.

A nursing note dated 12/24/22 at 10:42 AM revealed Nurse #3 documented Resident #66 returned to facility around 9:15 AM. Resident #66 was alert and oriented with no signs or symptoms of distress and he was ambulatory in his room. The hospital sent 2 Oxycodone/acetaminophen 5-325 milligrams via emergency medical services.

During an interview on 1/11/23 at 9:07 AM Nurse #3 stated Resident #66 had a blister pack of Oxycodone/acetaminophen 5-325 milligrams in the medication cart during her shift when he

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returned from the hospital on 12/24/22. She reported his pain medication was available and provided as needed per orders during her shift and his pain was under control at that time.

During an interview on 1/10/23 at 9:45 AM Physician #1 stated Resident #66 was prescribed Oxycodone/acetaminophen 5-325 milligrams every 4 hours as needed for pain on admission to the facility. He indicated on 12/23/22 he was made aware by a nurse that Resident #66 did not have a hard script, there was no Oxycodone/acetaminophen in the building available for him, and they did not have an emergency kit to pull the medication from. Physician #1 sent the hard script to the pharmacy via fax on 12/23/22 which was a Friday. On the morning of 12/24/22 Physician #1 was notified that Resident #66 had not received his pain medication from the pharmacy and had been in enough pain that he requested to be sent to the hospital due to pain. He indicated the resident received his pain medication at the hospital and returned to the facility the same day.

During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated the resident came to the facility on 12/22/22. She verified there was an issue with obtaining a hard script for Oxycodone/acetaminophen which resulted in this medication not arriving from the pharmacy until 12/24/22. She indicated prior to the arrival of the Oxycodone/acetaminophen 5-325 milligrams from the pharmacy, in the early morning of 12/24/22 Resident #66 requested pain medication and was told the medication was on the way. Resident #66 requested to be sent to the hospital for pain management as his pain level was 8 out of 10. He was sent to the hospital and during the

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time he was at the hospital, a blister pack with 18 Oxycodone/acetaminophen arrived at the facility. When he returned from the hospital his pain was under control.

Resident #66's MAR for December 2022 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on the following dates and times:
- 12/24/22 at 11:42 AM, 3:43 PM, and 9:13 PM
- 12/25/22 at 4:30 AM, 3:55 PM, and 10:04 PM.
- 12/26/22 at 3:03 AM, 8:26 AM, and 6:07 PM
- 12/27/22 at 12:46 AM, 5:09 AM, 3:30 PM, and 8:23 PM
- 12/28/22 at 1:20 AM, 5:30 AM, 9:31 AM, and 2:23 PM
- 12/29/22 at 1:21 AM

A nursing note dated 12/29/22 written at 7:43 PM as late entry for 12/29/22 at 10:00 AM revealed Nurse #4 documented Resident #66 was upset that his Oxycodone/acetaminophen 5-325 milligrams was not available at the time requested. Nurse #4 informed Resident #66 they were waiting on the delivery of medication from the pharmacy. As needed Acetaminophen was offered, however, Resident #66 refused. Resident #66's family member arrived at bedside around 10:00 AM and started demanding medication for the resident related to left shoulder pain.

During an interview on 1/12/23 at 8:56 AM Nurse #4 stated on 12/29/22 she was informed during change of shift when she came to work that Resident #66's pain medication had run out, but the refill was expected that morning. Resident #66 requested pain medication at some point that morning, but she did not know what time it was. It was later in the morning she believed as therapy

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F 697	Continued From page 61	F 697		

was coming to work with the resident, and he stated he would not do therapy without his pain medications. She offered him Acetaminophen which he refused. She indicated he was agitated which she stated was understandable as he indicated his pain was at a 10 out of 10. His medication did not arrive that morning, so the nurse requested the Director of Nursing's assistance to contact the physician and pharmacy.

A nursing note dated 12/29/22 at 12:05 PM revealed the Director of Nursing documented Resident #66 had complaints of pain. Resident #66 was noted with no more narcotics in the medication cart or available in the facility emergency backup medicine supply machine. A phone call was made to Physician #1 with a request for a new order for Oxycodone/acetaminophen 10-325 milligrams as 2 tabs were available in the facility emergency backup medicine supply machine and would be available to dispense until his prescription refill arrived that evening.

An order dated 12/29/22 revealed Resident #66 was ordered Oxycodone/acetaminophen 10-325 milligrams by mouth every 4 hours for pain.

Resident #66's MAR revealed he received Oxycodone/acetaminophen 10-325 milligrams by mouth on 12/29/22 at 12:00 PM and 4:00 PM.

Resident #66's Minimum Data Set assessment dated 12/29/22 revealed he was assessed as moderately cognitively impaired. His active diagnoses included unspecified fracture of upper and end of left humerus. He was assessed to have frequent pain that had not disrupted his

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sleep in the past five days but had, over the past 5 days, limited his day-to-day activities because of pain. The worst pain he had experienced in the past 5 days had been a 7 out of 10. He received an opioid 7 of the 7 day look back period.

A progress note dated 12/30/22 at 12:38 AM revealed Nurse #2 documented Resident #66 had complaints of severe pain and he no longer had any Oxycodone/acetaminophen 5-325 milligram or 10-325 milligram tablets available in the facility. Resident #66 reported 10 out of 10 pain in left arm and shoulder and current pain management was insufficient at that time. Resident #66 requested to go to the hospital for pain management.

A nursing note dated 12/30/22 at 3:48 AM revealed Nurse #2 documented Resident #66 arrived back in facility from the hospital with his pain under control.

The medical record indicated Resident #66 discharged home on 12/30/22.

During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/30/22, Resident #66 requested pain medication and she did not have any Oxycodone/acetaminophen 5-325 milligrams or 10-325 milligrams. She stated she informed the resident she had Acetaminophen and was going to seek other options with the physician as well, and the resident requested to be sent to the hospital for pain management again as his pain level was at a 10 out of 10 and he told her it felt like he was being "hit with a hammer." She stated she sent the resident to the hospital and notified the physician.

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F 697	Continued From page 63 During an interview on 1/10/23 at 9:45 AM Physician #1 stated on 12/29/22 he was called by the Director of Nursing, and she informed him that his 18 Oxycodone/acetaminophen pills had run out. She informed him she had two 10-325 milligram Oxycodone/acetaminophen in the facility, and she requested an order to give the resident this dose of the Oxycodone/acetaminophen while waiting for the pharmacy to deliver the medication. He indicated around 3:00 AM on 12/30/22 a nurse called to inform him that Resident #66 was back in the emergency department due to pain because his Oxycodone/acetaminophen still had not arrived at the facility. Physician #1 reported he was working at the hospital that night and called the emergency department to discuss the resident and the emergency department gave the resident pain medication and sent him back to the facility. The resident was scheduled to discharge home that day and he did discharge home as planned. He stated it was not acceptable to let a resident go without his pain medication. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated it was not acceptable for a resident to be in severe pain at the facility due to the lack of ordered pain medication in the facility. She revealed this was why they sent him to the hospital both times as there were no other options and his pain needed to be controlled in that moment.	F 697		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		2/22/23

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F 726	Continued From page 64 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to educate 3 of 3 nurses (Nurse #1, Nurse #5, Nurse #6) to ensure competency and demonstrate skills in providing care to 2 of 2 residents (Resident #67 and Resident #57) reviewed for tracheostomy care. Findings included:	F 726	1.Trach care was added to the new Nurse Orientation Education 02/09/2023. 2.Trach education with competency validation, is scheduled to be provided by an outside vendor on 02/15/2023. The Director of Nursing (DON) or designee will provide any nurse not in attendance, the education and competency validation prior	

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F 726	Continued From page 65 1. Resident #67 was admitted to the facility on 7-11-22 with multiple diagnoses that included tracheostomy status. 2. Resident #57 was admitted to the facility on 10-4-22 with multiple diagnoses that included tracheostomy status. The facility's Medical Director was interviewed by telephone on 1-10-23 at 9:32am. The Medical Director stated the facility nursing staff have not been trained on caring for tracheostomy residents and that he received several calls from staff stating Resident #67 or Resident #57 had a mucous plug in their tracheostomy and they did not know what to do for the resident. An interview with the Vice President (VP) of Operations occurred on 1-11-23 at 12:31pm. The VP of Operations stated the facility did not have any training or skills check off for nursing during orientation on how to care for a resident with a tracheostomy. Nurse #1 was interviewed on 1-11-23 at 1:27pm. Nurse #1 stated she had not received any training or perform skills check off before being assigned residents with a tracheostomy. During an interview with Nurse #5 on 1-11-23 at 1:37pm, the nurse stated he had not received any training or performed skills check off at the facility prior to being assigned residents with a tracheostomy. An interview with Nurse #6 occurred on 1-11-23 at 1:41pm. Nurse #6 stated she had signed a piece of paper today (1-11-23) indicating she had read the procedures on tracheostomy care. The	F 726	to their next schedule shift. 3.The DON or designee will provide trach education to each newly hired nurse or staff nurse not educated, prior to work to ensure trach care competency. 4.The DON or designee will audit monthly, for the next three months, the new hire nurse charts and 25% of the overall nurse charts to ensure that they have been properly educated on trach care and that there are competencies to validate their understanding. . Results will be brought to QAPI for review by the Director of Nursing or designee monthly times 2 months or until compliance is achieved.	

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F 726	Continued From page 66 nurse said prior to today (1-11-23) she had not received any training and had not received skills check off regarding caring for a resident who had a tracheostomy. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Services stated education on tracheostomy care should be provided in orientation along with competency. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated he would have to review the facility's electronic education system to find out why tracheostomy education was not being completed. He also stated nurses needed to have a competency completed prior to working with residents who have tracheostomies.	F 726		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 727	1.The facility is unable to retroactively	2/22/23

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F 727	Continued From page 67 facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 53 days of 135 days (7-1-22, 7-2-22, 7-3-22, 7-6-22, 7-7-22, 7-8-22, 7-11-22, 7-12-22, 7-15-22, 7-16-22, 7-17-22, 7-20-22, 7-21-22, 7-22-22, 7-25-22, 7-26-22, 7-29-22, 7-30-22, 8-13-22, 8-14-22, 8-17-22, 8-18-22, 8-19-22, 8-20-22, 8-21-22, 8-23-22, 8-27-22, 9-1-22, 9-5-22, 9-6-22, 9-9-22, 9-10-22, 9-11-22, 9-12-22, 9-13-22, 9-16-22, 9-21-22, 9-26-22, 9-28-22, 9-30-22, 9-29-22, 12-1-22, 12-6-22, 12-7-22, 12-8-22, 12-9-22, 12-12-22, 12-16-22, 12-20-22, 12-25-22, 12-27-22, 1-11-23) reviewed for staffing. Findings included: Review of the daily staffing sheets for July 2022, August 2022, September 2022, December 2022 and January 2023 revealed there was no RN scheduled on the following days: - July 2022: 7-1-22, 7-2-22, 7-3-22, 7-6-22, 7-7-22, 7-8-22, 7-11-22, 7-12-22, 7-15-22, 7-16-22, 7-17-22, 7-20-22, 7-21-22, 7-22-22, 7-25-22, 7-26-22, 7-29-22, 7-30-22. - August 2022: 8-13-22, 8-14-22, 8-17-22, 8-18-22, 8-19-22, 8-20-22, 8-21-22, 8-23-22, 8-27-22 - September 2022: 9-1-22, 9-5-22, 9-6-22, 9-9-22, 9-10-22, 9-11-22, 9-12-22, 9-13-22, 9-16-22, 9-21-22, 9-26-22, 9-28-22, 9-30-22, 9-29-22 - December 2022: 12-1-22, 12-6-22, 12-7-22, 12-8-22, 12-9-22, 12-12-22, 12-16-22, 12-20-22, 12-25-22, 12-27-22 - January 2023: 1-11-23 During an interview with the facility's scheduler on 1-12-23 at 1:40pm, the scheduler discussed being the staffing coordinator since before July	F 727	correct the previous staffing of the facility. 2.Facility schedules since 1/11/2023 are reviewed for 8 RN hours per day, by the staffing scheduler. 3.The Administrator educated the staff scheduler on 02/09/2023 regarding the requirement for an RN to be staffed at least 8 hours/day 7 days/week. 4.The Administrator or Director of Nursing will review the nursing schedules weekly x 4 weeks, then monthly x 1 for 8 hours of RN coverage per day/ 7 days per week.	

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F 727	Continued From page 68 2022. She explained she did not have any training when she took the position and was unaware there had to be RN coverage for at least 8 consecutive hours a day. The scheduler stated there were times when she was unable to find RN coverage. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated he felt there was a submission error and that there was an RN working in the facility. He said he did not know why the RN would not have been on the schedule.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		2/22/23

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F 732	Continued From page 69 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to post accurate nurse staffing information for Registered Nurses (RN) for 23 of 43 days (12-1-22, 12-6-22, 12-7-22, 12-8-22, 12-9-22, 12-12-22, 12-16-22, 12-20-22, 12-25-22, 12-27-22, 1-1-23 through 1-12-23) reviewed and observed for posted staffing. Findings included: Review of the daily posted staffing sheets for December 2022 and January 2023 revealed there was no Registered Nurse (RN) included on the posting sheets for the following days: - December 2022: 12-1-22, 12-6-22, 12-7-22, 12-8-22, 12-9-22, 12-12-22, 12-16-22, 12-20-22, 12-25-22, 12-27-22. - January 2023: 1-1-23 through 1-8-23. Observation of the daily posted staffing sheets occurred on the following dates and times and the observation revealed there was no RN included on the posted staffing sheets.	F 732	1.The updated staff posting as of 01/13/2023 breaks down the scheduled hours separately for RNs and LPNs 2.No additional identification audit is applicable 3.The Administrator reeducated the Staffing Coordinator on 02/09/2023, on ensuring the daily Staffing Posting sheets break down the hours separately for RNs and LPNs. 4.The Administrator or Director of Nursing will complete a monthly audit for the next three months of at least 25% of the posted staffing sheets to ensure that the sheet breaks down the hours separately for RNs and LPNs	

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F 732	Continued From page 70 - 1-9-23 at 10:15am - 1-10-23 at 7:45am - 1-11-23 at 9:15am - 1-12-23 at 12:30pm The facility scheduler was interviewed on 1-12-23 at 1:40pm. The scheduler stated she was unaware the daily posted staffing sheets had to include an RN. She explained she had not had any training prior to accepting the scheduler position but had been in the scheduler position before July 2022. The Administrator was interviewed on 1-12-22 at 1:57pm. The Administrator stated he had not distinguished between a Licensed Practical Nurse and a Registered Nurse daily but said all disciplines should be included on the daily posted staffing sheets.	F 732		
F 755 SS=H	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		2/22/23

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F 755	Continued From page 71 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, pharmacy, and physician interviews the facility failed to obtain Oxycodone/acetaminophen (a controlled substance medication ordered to treat pain) from their pharmacy for a resident who was newly admitted to the facility with a recent fracture of the upper and lower left humerus (a long bone located in the upper arm between the shoulder joint and elbow joint). The resident was transferred to the Emergency Department (ED) for unmanaged pain on two occasions (12/24/22 and 12/30/22) due to the facility not having Oxycodone/acetaminophen available to the resident in the facility. The resident reported a pain level on 12/24/22 at an 8 out of 10 (with 10 representing the worst pain imaginable) and on 12/30/22 a 10 out of 10 and he expressed he felt like he ~~was~~ being "hit with a hammer." This was for 1 of 1 resident reviewed for pharmacy services. Findings included:	F 755	1.Upon notification of surveyors, resident #66 no longer resides at the facility and the facility is unable to retroactively correct. 2.Director of Nursing or designee will audit all current residents with orders for Oxycodone/Acetaminophen to validate the Oxycodone/Acetaminophen was obtained from the pharmacy by 02/22/23. 3.Director of Nursing or designee will re-educate the licensed nurses on obtaining Oxycodone/Acetaminophen by 2/22/23. 4.Director of Nursing or designee will audit residents with orders for Oxycodone/ Acetaminophen to validate that it was obtained from the pharmacy weekly x 4 weeks and monthly x 2 months. Results will be brought to QAPI for review times 2	

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F 755	Continued From page 72 Resident #66 was admitted to the facility on 12/22/22. His active diagnoses included fracture of the upper and lower left humerus. The hospital discharge summary dated 12/22/22 revealed he was ordered Oxycodone/acetaminophen 5-325 milligrams (a medication which is a combination of oxycodone and acetaminophen) every 4 hours as needed for pain. Resident #66's admission note dated 12/22/22 completed by Nurse #1 revealed he was alert and oriented and admitted for a fracture to the left arm due to a fall. Resident #66 had bruising noted to arms and chest, left flank area. During an interview on 1/10/23 at 2:15 PM Nurse #1 stated Resident #66 was admitted late on 12/22/22 around 7:00 PM. This was when her shift ended and Unit Manager #1 the took over for her when he arrived at the facility. She concluded that all she did was write the admitting note and did not perform any assessments and did not put the resident's orders into their electronic medical records system. She stated this facility did not allow orders to be entered until the resident physically arrived in the facility, so the unit manager put Resident #66's orders in. The unit manager would take the orders and put them in their system to order the medications from their pharmacy which would arrive on the next day, and they would use their backup medication system to bridge the gap. Resident #66's physician orders revealed on 12/22/22 he was ordered Oxycodone/acetaminophen 5-325 milligrams by	F 755	months or until compliance is achieved.	

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F 755	Continued From page 73 mouth every 4 hours for pain. During an interview on 1/10/23 at 2:39 PM Unit Manager #1 stated when a new admission came into the facility, he waited until the resident arrived with his discharge summary from the hospital. He waited for the resident to arrive from the hospital and utilized the physical discharge summary because there was always a chance that the medication was changed last minute by the hospital. He stated he took the physical paperwork including the discharge summary provided by emergency medical services upon the resident's arrival. He further stated once he had the orders in the discharge summary, he entered the orders in and once they are saved the order is automatically sent to the pharmacy. He stated if they had a medication that was due but had not arrived from the pharmacy or if the resident was asking for an as needed medication which they were able to receive at that time, they would go to the facility emergency backup medicine supply machine system which was a large, locked emergency medications kit. He stated when Resident #66 arrived at the facility on 12/22/22 the first question the resident asked was if his pain medication had arrived at the facility yet. Unit Manager #1 explained to him that the medications had not been entered into their system yet, therefore the pharmacy had not filled any of his prescription at that time. He informed the resident that if there was a medication due for him, they had a backup system in the facility to pull the medication for him to cover the break between the hospital and arrival of the medications from the pharmacy to the facility. After speaking with the resident, the Unit Manager began to enter the resident's orders on their electronic records system. He noted	F 755		

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Resident #66's order for Oxycodone/acetaminophen 5-325 milligrams required a hard script at their pharmacy since it was a controlled substance, and a hard script was not sent from the hospital. At that point, on 12/22/22, he texted the physician to explain the situation and informed him that they needed the hard script. The physician sent the order to the pharmacy that evening.

Review of a text conversation between Physician #1 and Unit Manager #1 on 12/22/22 from 6:06 PM to 6:14 PM revealed the unit manager notified the physician via text message that Resident #66 had admitted from the hospital and the hospital had not sent any hard script for Resident #66's Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as needed. Unit Manager #1 faxed a hard script to be signed to Physician #1 and Physician #1 texted and indicated he would send the hard script to the pharmacy.

The Medication Administration Record (MAR) indicated no Oxycodone/acetaminophen was administered to Resident #66 on 12/22/22 or on 12/23/22 until 4:51 PM.

Review of a text conversation between Physician #1 and Unit Manager #1 on 12/23/22 from 4:35 PM to 5:34 PM revealed Unit Manager #1 again texted the physician regarding Resident #66's pain medication not yet being received. The pharmacy had told Unit Manager #1 they had not received the hard script for Oxycodone/acetaminophen, and the resident was complaining of pain. Unit Manager #1 requested the physician send the hard script to a pharmacy nearby for staff to pick up the medication quickly. The physician replied that he would send the

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script directly to the main pharmacy again and that there had not been a hard script on his fax machine that morning (faxed from Unit Manager #1 the evening prior).

During a follow-up interview on 1/10/23 at 2:39 PM Unit Manager #1 stated on 12/23/22 he was made aware by Resident #66 that he had not received his pain medication. He then sent Physician #1 another text requesting the hard script for the pain medication for Resident #66. He asked if this could be sent to a backup local pharmacy nearby to be picked up. Physician #1 asked him where the patient was and if someone had faxed him the hard script. The unit manager told the doctor he had faxed the hard script last night but could fax it to him again. The doctor physician said there wasn't a hard script on his fax machine that morning. Physician #1 sent the script directly to the pharmacy himself.

Resident #66's MAR for 12/23/22 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth on 12/23/22 at 4:51 PM and again at 10:30 PM. These medications were pulled from the emergency backup medicine supply machine.

A nursing note dated 12/24/22 at 3:32 AM revealed Nurse #2 documented Resident #66 had complaints of pain in his left shoulder which he rated an 8 out of 10. Nurse #2 called the pharmacy for Oxycodone/acetaminophen 5-325 milligrams as the medication for Resident #66 from the facility emergency backup medicine supply machine had run out. Physician #1 was messaged for other options. The pharmacy told the nurse that the Oxycodone/acetaminophen was on the way.

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A nursing note dated 12/24/22 at 5:00 AM revealed Nurse #2 documented Resident #66 stated he wanted to go to the hospital because he was in pain and couldn't wait for his pain medication to arrive. He was sent to the emergency department.

During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/24/22, Resident #66 requested pain medication and the nurse identified the Oxycodone/acetaminophen 5-325 milligrams had not arrived at the facility yet and did not know why. She called the pharmacy and was told the medication was on the way and would arrive sometime that morning. She indicated when she informed Resident #66 that his pain medication had not arrived yet, the resident requested to be sent to the hospital for pain management as his pain level was 8 out of 10. She stated she sent him to the hospital as he requested for pain management.

A nursing note dated 12/24/22 at 10:42 AM revealed Nurse #3 documented Resident #66 returned to facility around 9:15 AM. Resident #66 was alert and oriented with no signs or symptoms of distress and he was ambulatory in his room. The hospital sent 2 Oxycodone/acetaminophen 5-325 milligrams via emergency medical services.

During an interview on 1/10/23 at 9:45 AM Physician #1 stated Resident #66 was prescribed Oxycodone/acetaminophen 5-325 milligrams every 4 hours as needed for pain on admission to the facility. He indicated on 12/23/22 he was made aware by a nurse that Resident #66 did not have a hard script, there was no

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Oxycodone/acetaminophen in the building available for him, and they did not have an emergency kit to pull the medication from. Physician #1 sent the hard script to the pharmacy via fax on 12/23/22 which was a Friday. On the morning of 12/24/22 Physician #1 was notified that Resident #66 had not received his pain medication from the pharmacy and had been in enough pain that he requested to be sent to the hospital due to pain. He indicated the resident received his pain medication at the hospital and returned to the facility the same day. He indicated he saw the resident on 12/26/22 and the resident was fine and did not complain of pain.

During an interview on 1/11/23 at 9:40 AM the Director of Client Services for the pharmacy stated the pharmacy received an order for Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as need for pain on 12/23/22 ordered by Physician #1. This order requested 20 pills and two pills had been pulled from the facility emergency backup medicine supply machine so the pharmacy dispensed 18 pills to the facility on 12/23/22 and this order arrived at the facility on 12/24/22 after the resident went to the hospital. On 12/23/22, after they had received the first order, they also received an order for Oxycodone/acetaminophen 5-325 milligrams by mouth every 4 hours as need for pain, but this order requested 180 pills and was ordered by Physician #1. Because the pharmacy could only fill one of the prescriptions as it was a controlled substance, they filled the 20 pills prescription which had arrived first and did not fill the 180 pills prescription. He stated when a nurse requested to refill any prescription through their electron medical records system at the facility, it would send the request to the

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pharmacy. Oxycodone/acetaminophen required a hard script for the prescription to be filled so the Pharmacy would request a new order from the facility and then fill the prescription.

During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated the resident came to the facility on 12/22/22. She verified there was an issue with obtaining a hard script for Oxycodone/acetaminophen which resulted in this medication not arriving from the pharmacy until 12/24/22. She indicated prior to the arrival of the Oxycodone/acetaminophen 5-325 milligrams from the pharmacy, in the early morning of 12/24/22 Resident #66 requested pain medication and was told the medication was on the way. Resident #66 requested to be sent to the hospital for pain management as his pain level was 8 out of 10. He was sent to the hospital and during the time he was at the hospital, a blister pack with 18 Oxycodone/acetaminophen arrived at the facility. When he returned from the hospital his pain was under control.

Resident #66's MAR for December 2022 revealed he received Oxycodone/acetaminophen 5-325 milligrams by mouth in the following dates and times:
- 12/24/22 at 11:42 AM, 3:43 PM, and 9:13 PM
- 12/25/22 at 4:30 AM, 3:55 PM, and 10:04 PM.
- 12/26/22 at 3:03 AM, 8:26 AM, and 6:07 PM
- 12/27/22 at 12:46 AM, 5:09 AM, 3:30 PM, and 8:23 PM
- 12/28/22 at 1:20 AM, 5:30 AM, 9:31 AM, and 2:23 PM
- 12/29/22 at 1:21 AM

A nursing note dated 12/29/22 written at 7:43 PM as late entry for 12/29/22 at 10:00 AM revealed

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Nurse #4 documented Resident #66 was upset that his Oxycodone/acetaminophen 5-milligrams was not available at time requested. Nurse #4 called the Pharmacy to inquire on status of medication delivery. Nurse #4 informed Resident #66 they were waiting on the delivery of medication from the pharmacy. As needed Acetaminophen was offered, however, Resident #66 refused.

During an interview on 1/12/23 at 8:56 AM Nurse #4 stated on 12/29/22 she was informed during change of shift when she came to work that Resident #66's pain medication had run out, but the refill was expected that morning. Resident #66 requested pain medication at some point that morning, but she did not know what time it was. It was later in the morning she believed as therapy was coming to work with the resident, and he stated he would not do therapy without his pain medications. She offered him Acetaminophen which he refused. She indicated he was agitated which she stated was understandable as he indicated his pain was at a 10 out of 10. His medication did not arrive that morning, so the nurse requested the Director of Nursing's assistance to contact the physician and pharmacy.

A nursing note dated 12/29/22 at 12:05 PM revealed the Director of Nursing documented Resident #66 had complaints of pain. Resident #66 was noted with no more narcotics in the medication cart or available in the facility emergency backup medicine supply machine. The Director of Nursing called the pharmacy and discovered the hospital initially sent a prescription for Oxycodone/acetaminophen 5-325 milligrams for a quantity of 20 tablets. Physician #1 also sent

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a prescription for 180 tablets. The pharmacy only sent the 20 tablets as they could not fill both prescriptions. The other prescription was available at the pharmacy and was now filled and will be delivered that evening. A phone call was made to Physician #1 with a request for a new order for Oxycodone/acetaminophen 10-325 milligrams as 2 tabs were available in the facility emergency backup medicine supply machine and would be available to dispense until his prescription refill arrives this evening. Normally an order would be refilled by the nurse when it ran out and she did not have a way to show if a refill was requested or not by the nurse. She stated the only answer she got from the pharmacy of why the refill had not arrived was because they had two orders and only filled one.

An order dated 12/29/22 revealed Resident #66 was ordered Oxycodone/acetaminophen 10-325 milligrams by mouth every 4 hours for pain.

Resident #66's MAR revealed he received Oxycodone/acetaminophen 10-325 milligrams by mouth on 12/29/22 at 12:00 PM and 4:00 PM.

A progress note dated 12/30/22 at 12:38 AM revealed Nurse #2 documented Resident #66 had complaints of severe pain and he no longer had any Oxycodone/acetaminophen 5-325 milligram or 10-325 milligram tablets available in the facility. Resident #66 reported 10 out of 10 pain in left arm and shoulder and current pain management was insufficient at that time. Resident #66 requested to go to the hospital for pain management.

A nursing note dated 12/30/22 at 3:48 AM revealed Nurse #2 documented Resident #66

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arrived back in facility from the hospital with his pain under control.

The medical record indicated Resident #66 discharged home on 12/30/22.

During an interview on 1/11/23 at 8:03 AM Nurse #2 stated in the early morning on 12/30/22, Resident #66 requested pain medication and she did not have any Oxycodone/acetaminophen 5-325 milligrams or 10-325 milligrams. She stated she informed the resident she had Acetaminophen and was going to seek other options with the physician as well, and the resident requested to be sent to the hospital for pain management again as his pain level was at a 10 out of 10 and he told her it felt like he was being "hit with a hammer." She stated she sent the resident to the hospital and notified the physician.

During an interview on 1/10/23 at 9:45 AM Physician #1 stated on 12/29/22 he was called by the Director of Nursing, and she informed him that his 18 Oxycodone/acetaminophen pills had run out. She informed him she had two 10-325 milligram Oxycodone/acetaminophen in the facility, and she requested an order to give the resident this dose of the Oxycodone/acetaminophen while waiting for the pharmacy to deliver the medication. He indicated around 3:00 AM on 12/30/22 a nurse called to inform him that Resident #66 was back in the emergency department due to pain because his Oxycodone/acetaminophen still had not arrived at the facility. Physician #1 reported he was working at the hospital that night and called the emergency department to discuss the resident and the emergency department gave the resident

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F 755	Continued From page 82 pain medication and sent him back to the facility. The resident was scheduled to discharge home that day and he did discharge home as planned. He stated it was not acceptable to let a resident go without his pain medication. During an interview on 1/11/22 at 9:40 AM the Director of Client Services for the pharmacy stated on 12/29/22 the Director of Nursing called the pharmacy to check why the prescription had not been filled. The pharmacy explained that because they had filled the order for the 20 pills, they did not fill the order for 180 pills. The Director of Nursing informed the pharmacy that Resident #66 did not have any Oxycodone/acetaminophen 5-325 milligrams available in the facility and the pharmacy indicated they would fill the 180 pill order at that time. The medication would be on the 9 PM run from the pharmacy which meant it would arrive sometime in the early morning. The order for the 180 pills was dispensed on 12/29/22 and arrived at the facility on the morning of 12/30/22. During an interview on 1/11/23 at 10:32 AM the Director of Nursing stated it was not acceptable for a resident to be in severe pain at the facility due to the lack of ordered pain medication in the facility. She concluded this was why they sent him to the hospital both times as there were no other options and his pain needed to be controlled in that moment.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		2/22/23

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F 761	Continued From page 83 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review observation and staff interviews the facility failed to discard expired medication, date opened insulin and store medication per manufacturers recommendation. This occurred for 3 of 4 medication carts (hall 100, hall 200 and hall 300 carts) reviewed for medication storage. Findings included: 1. Observation of hall 100 medication cart occurred on 1-9-23 at 4:13pm with Nurse #7. The observation revealed a Lantus (insulin) pen that had been opened but not dated. The manufacturers recommendation stated the	F 761	1.Upon notification of surveyor, expired, undated, and not refrigerated insulin pens and vials, as well as the Thiamine OTC, were disposed of. 2.The Medication carts were audited by the Unit Managers on 01/26/2023 for any medications that were expired, undated, or not stored as per manufacturer recommendations. 3.The Director of Nursing or Designee will educate licensed nursing staff regarding medication labeling and storage to include insulins and over the counter medications	

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F 761	Continued From page 84 Lantus would expire 28 days after the pen had been opened. An interview with Nurse #7 occurred on 1-9-23 at 4:14pm. The nurse stated she was unaware the insulin pen had been opened and undated. 2. Hall 200 medication cart was observed with Nurse #1 on 1-9-23 at 4:21pm. The observation revealed the following. - Glargine (insulin) pen that had expired 12-18-22 - Lispro (insulin) pen that expired 12-27-22 - Lispro pen that was unopened and not refrigerated as required by manufacturer - Novolog (insulin) was opened and not dated - Lispro pen was open and not dated and per manufacturer the pen would expire 28 days after being opened. - Novolog (insulin) pen expired 12-7-22 - Glargine pen was unopened and not refrigerated as required by manufacturer. Nurse #1 was interviewed on 1-9-23 at 4:25pm. The nurse stated she had not checked her medication cart for expired, unopened, or undated insulins. She further stated she did not know who was responsible for checking the medication carts. 3. The medication cart for hall 400 was observed with Nurse #7 on 1-9-23 at 4:09pm. The observation revealed Thiamine (vitamin) 100mg bottle had expired on 8-2022. Nurse #7 stated she was not aware the vitamin bottle had expired because of the written date of when the bottle was opened. The Administrator was interviewed on 1-12-23 at	F 761	by 2/22/23. 4.The Director of Nursing or Designee will audit 50% of medication carts for proper labeling and storage weekly x 4 weeks, then monthly x 1 month. Results will be brought to QAPI x 2 months or until compliance is achieved.	

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F 761	Continued From page 85 1:57pm. The Administrator stated nursing staff need to follow the guidelines for medications and should not have expired medications in their medication carts.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assurance (QA) process failed to implement, monitor, and revise as needed the action plans developed for the recertification and complaint investigation survey of 10/26/21, the focused infection control and complaint investigation survey of 2/24/22, and the revisit and complaint investigation survey of 4/25/22 in order to achieve and sustain compliance. This was for 3 recited deficiencies on the current recertification survey of 1/31/23. The deficiencies were in the areas of infection control (F880), activities of daily living care (F677), and catheter care (F690). The continued failure during these federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F880 - Based on record review, observation and	F 867	1.The facility's Quality Assurance Performance Improvement (QAPI) process failed to implement, monitor, and revise, as needed, the action plans developed for the recertification and complaint investigation survey of 10/26/21, the focused infection control and complaint investigation survey of 2/24/22, and the revisit and complaint investigation survey of 4/25/22. 2.The Administrator reviewed the previous QAPI minutes 02/07/2023 to establish new monitoring to ensure repeat citation does not occur. 3.The QAPI Committee will meet monthly to identify issues and trends related to QAPI activities. Corrective action to be implemented for identified concerns related to repeat deficiencies as of 02/22/2023.	2/22/23

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F 867	Continued From page 86 staff interviews the facility failed to maintain a sterile field while performing tracheostomy care for 1 of 1 resident (Resident #57) reviewed for tracheostomy care. In addition, the facility failed to develop a policy for tracheostomy care that had the potential to affect 2 residents (Resident #57 and Resident #67) who had tracheostomies. During the recertification and complaint investigation survey of 10/26/21 the facility was cited for failing to use an approved procedure to clean and disinfect a shared glucometer. F677 - Based on observations, record reviews and resident and staff interviews the facility failed to provide nail care to residents who needed extensive assistance and/or dependent for Activities of Daily Living (ADL) care for 2 of 3 residents (Resident #47 and Resident #27) and failed to rinse soap off a resident's skin during a bed bath for 1 of 3 resident (Resident #67) reviewed for ADL care. During the focused infection control and complaint investigation survey of 2/24/22 the facility was cited for failing to provide incontinence care for residents. F690 - Based on observation, record review and staff interviews, the facility failed to provide necessary care and services of a urinary catheter when a Nursing Assistant (NA #3) cleaned a resident's catheter tubing by wiping the tubing towards the insertion site. This occurred for 1 of 1 resident (Resident #67) reviewed for catheter care. During the focused infection control and complaint investigation survey of 2/24/22 the	F 867	To ensure the plan of correction is effective and specific, cited deficiencies will remain corrected and/ or in compliance with regulatory requirements, Corporate oversight from the VP of Operations, VP of Clinical Services or designee, will validate the facility□s progress, review corrective action and dates of completion, quarterly, or more frequently as needed. An Administrative change was effective at the Facility on January 13, 2023. The Administrator will provide the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Unit Nurse Managers, Medical Records, Business Office Director, Minimum Data Set (MDS) Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker and Pharmacy Consultant, on the appropriate functioning of the QAPI Committee. Education to include the purpose of the committee in sustaining corrected deficiencies related to F880, F677, F690, as well as identifying and monitoring other areas of concerns noted from the Quality Improvement process, completing Performance Improvement Plans with systematic analysis and actions. 4. The Administrator will audit Quality Assurance monthly x 3 months to ensure procedures are implemented and monitored to ensure any deficient practice maintains compliance. Monitoring tools will be reviewed by the Corporate VP of	

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F 867	Continued From page 87 facility was cited for failing to remove an indwelling urinary catheter that was not medically justified when ordered. During the revisit and complaint investigation survey of 4/25/22 the facility was cited for failing to secure indwelling urinary catheter tubing to prevent tugging or pulling. During an interview on 1/12/23 at 1:43 PM the Administrator stated staffing turnover was extraordinary. He had never seen the amount of staffing turnover he experienced in the last two years. They recently changed ownership to a different company which brought different processes to review the areas of concern from the previous tags which could contribute to the repeated deficiencies.	F 867	Operations or VP of Clinical Services to ensue any issues identified are corrected.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		2/22/23

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F 880	Continued From page 88 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 89 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to maintain a sterile field while performing tracheostomy care for 1 of 1 resident (Resident #57) reviewed for tracheostomy care. In addition, the facility failed to develop a policy for tracheostomy care that had the potential to affect 2 residents (Resident #57 and Resident #67) who had tracheostomies. Findings included: Observation of tracheostomy care on Resident #57 with Nurse #5 occurred on 1-11-23 at 2:15pm. Nurse #5 was observed to be wearing sterile gloves while suctioning Resident #57. When the nurse finished suctioning, he remained wearing his sterile gloves while moving a plastic bag, picking up the box that contained the inner canula of the trach, opened the box, removed the sterile inner canula by touching the tube and then placing the inner canula into the trach. Nurse #5 was interviewed on 1-11-23 at 2:40pm. The nurse explained the tube for the inner canula was supposed to remain sterile to prevent possible infection. Nurse #5 stated he had contaminated his sterile gloves when moving the plastic bag and touching the inner canula box. He explained he usually did not remove the inner	F 880	1.Upon notification of surveyor, the facility was unable to retroactively correct the tracheostomy care of resident #57 due to discharge. 1:1 education was completed by the Unit Manager on 01/11/2023, with nurse #5 on tracheostomy care including sterile technique and maintaining a sterile field. A policy for tracheostomy care was developed on 01/11/2023. 2.The Unit Manger completed an observation of tracheostomy care, to include sterile technique and maintaining a sterile field, in accordance with the facility tracheostomy care policy, for residents who have tracheostomies in the facility on 02/15/2023. 3.The Director of Nursing and designee educated licensed nurses on 02/15/23 and 02/16/23 on tracheostomy care, including sterile technique and maintaining a sterile field, and the facility tracheostomy care policy. Tracheostomy care was added to the orientation checklist for newly hired licensed staff on 01/11/2023. 4.The Director of Nursing or designee will audit tracheostomy care, including sterile technique and maintaining a sterile field,	

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F 880	Continued From page 90 canula from the box by the tube but rather the button that does not enter the tracheostomy. Nurse #5 stated he was nervous and touched the tubing to the inner canula by mistake contaminating the tubing. During an interview with the Vice President (VP) of Clinical Services on 1-11-23 at 4:15pm, the VP of Clinical Operations stated Nurse #5 should have followed the procedure for tracheostomy care. She said the inner canula was sterile and Nurse #5 should have inserted the inner canula using a sterile procedure. The VP of Clinical Services also stated the facility did not have a policy regarding tracheostomy care. She explained the facility had specific respiratory policies, but they did not include tracheostomy care. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated nurses needed to follow infection control practices when providing care to tracheostomy residents.	F 880	in accordance with the facility tracheostomy care policy, for resident with tracheostomy weekly times 4 weeks and monthly times 2 months. Director of Nursing or designee will audit orientation for licensed agency nurses to validate orientation to tracheostomy care weekly times 4 weeks and monthly times 2 months. Results will be brought to QAPI for review by the Director of Nursing or designee monthly times 2 months or until compliance is achieved.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		2/22/23

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F 883	Continued From page 91 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 92 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess the residents for eligibility and ensure residents were offered the pneumococcal vaccinations upon admittance into the facility and offer annual influenza vaccine for 5 of 5 residents reviewed for immunizations (Residents #19, #52, #53, #57, and #67). Findings included: The facility policy for Pneumococcal Vaccine with the revised date October 2019 read in part "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections." It further read "Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination." The facility policy for Influenza Vaccine with the revised date October 2019 read in part "All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza." It further read in part "Between Oct 1st and March 31st each year, the influenza vaccine shall be offered to residents." 1. Resident #19 was admitted to the facility on 1/30/19 with diagnoses which included hypertension and Diabetes Mellitus. The quarterly Minimum Data Set dated 12/16/22	F 883	1.Residents #19, #52, #53, #57, and #67 were offered pneumococcal immunization, and immunizations were administered as indicated. 2.Residents currently residing in the facility will be offered pneumococcal immunization and immunizations will be administered as indicated. 3.The Director of Nursing or Designee will educate licensed nursing staff regarding the administration of pneumococcal immunizations by 2/22/2023. 4.The Director of Nursing or Designee will audit new admissions for pneumococcal immunizations weekly x 4 weeks, then monthly x 1 month. Results will be brought to QAPI x2 months or until compliance is achieved	

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F 883	Continued From page 93 revealed Resident #19 was cognitively intact. Review of Resident #19's immunization record revealed he had refused the pneumococcal vaccine in 2020. The immunization record revealed he had no other pneumococcal consent forms and no documentation of being offered, given, or refused any other pneumococcal vaccines. An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the pneumococcal or influenza vaccines. She was not sure what the process was for ensuring residents were offered or received immunizations. An interview with the Administrator on 1/12/23 at 10:33 AM revealed that due to staffing turnover, the facility did not have a monitoring and tracking process in place to ensure the residents received the appropriate vaccines. 2. Resident #52 was admitted to the facility on 4/20/22 with diagnoses which included hypertension. The quarterly Minimum Data Set dated 10/14/22 revealed Resident #52 was cognitively intact. Review of Resident #52's immunization record revealed no documentation that he had been offered, given, or refused the pneumococcal vaccine. An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the pneumococcal or influenza vaccines. She was not sure what the process was for ensuring	F 883		

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F 883	Continued From page 94 residents were offered or received immunizations. An interview with the Administrator on 1/12/23 at 10:33 AM revealed that due to staffing turnover, the facility did not have a monitoring and tracking process in place to ensure the residents received the appropriate vaccines. 3. Resident #53 was admitted to the facility on 7/23/22 with diagnoses which included hypertension and Diabetes Mellitus. The quarterly Minimum Data Set dated 12/28/22 revealed Resident #53 had severe cognitive impairment. Review of Resident #53's immunization record revealed no documentation that he or his Responsible Party (RP) had been offered, given, or refused the pneumococcal vaccine. An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the pneumococcal or influenza vaccines. She was not sure what the process was for ensuring residents were offered or received immunizations. An interview with the Administrator on 1/12/23 at 10:33 AM revealed that due to staffing turnover, the facility did not have a monitoring and tracking process in place to ensure the residents received the appropriate vaccines. 4. Resident #57 was admitted to the facility on 10/04/22 with diagnoses which included traumatic brain dysfunction. The admission Minimum Data Set dated 10/11/22	F 883		

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F 883	Continued From page 95	F 883		

revealed Resident #57 had cognitive impairment was undetermined.

Review of Resident #57's immunization record revealed no documentation that she or her RP had been offered, given, or refused the pneumococcal vaccine.

An interview on 1/09/23 at 4:20 PM with Resident #57's RP revealed she had not been asked about the resident's immunization status. She stated she had not been asked about the pneumococcal or influenza vaccines for the resident.

An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the pneumococcal or influenza vaccines. She was not sure what the process was for ensuring residents were offered or received immunizations.

An interview with the Administrator on 1/12/23 at 10:33 AM revealed that due to staffing turnover, the facility did not have a monitoring and tracking process in place to ensure the residents received the appropriate vaccines.

5. Resident #67 was admitted to the facility on 7/11/22 with diagnoses which included traumatic brain dysfunction.

The quarterly Minimum Data Set dated 12/23/22 revealed Resident #67 had severe cognitive impairment.

Review of Resident #67's immunization record revealed no documentation that he or his RP had been offered, given, or refused the pneumococcal

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	345262	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

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F 883	Continued From page 96 vaccine. An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the pneumococcal or influenza vaccines. She was not sure what the process was for ensuring residents were offered or received immunizations. An interview with the Administrator on 1/12/23 at 10:33 AM revealed that due to staffing turnover, the facility did not have a monitoring and tracking process in place to ensure the residents received the appropriate vaccines.	F 883		
F 887 SS=D	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 the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is	F 887		2/22/23

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F 887	Continued From page 97 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 or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (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).	F 887		

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F 887	Continued From page 98 This REQUIREMENT is not met as evidenced by: Based on record review and responsible party (RP) and staff interviews, the facility failed to have systems in place to assess the residents for eligibility for the Covid-19 vaccination, provide education or offer the vaccination upon admittance into the facility for 1 of 5 residents reviewed for immunizations (Residents #57). Findings included: The facility policy on "Vaccination of Residents" dated July 2022 read in part "Covid-19 vaccination will be offered to all residents and administered per physician orders." Resident #57 was admitted to the facility on 10/04/22 and had severe cognitive impairment. Review of Resident #57's vaccination records revealed no documentation of any Covid-19 vaccines. Further review of the medical record revealed there was no documentation of contraindications for Resident #57 to receive the Covid-19 vaccine, education provided to the resident/RP or the facility offering to provide the vaccination to the resident. An interview on 1/09/23 at 4:20 PM with Resident #57's Responsible Party (RP) revealed she had not been asked about the Covid-19 vaccine and the resident had not had any Covid-19 vaccines. The RP stated that she wanted to discuss the resident receiving the Covid-19 vaccine. An interview with the Infection Control Nurse on 1/11/23 at 10:30 AM revealed she was new to the position and had no information about the	F 887	1.Resident #57 has been offered the COVID-19 vaccine. 2.The Infection Preventionist or Designee will audit current residents to determine who is eligible to receive a COVID-19 vaccine and vaccines will be administered accordingly. 3.The Director of Nursing or Designee will educate the Infection Preventionist by 2/22/2023 on a process to track and administer COVID-19 vaccinations of residents. 4.The Infection Preventionist or Designee will audit new admissions for COVID-19 immunizations weekly x 4 weeks then monthly x 1 month. Results will be brought to QAPI x 2 months or until compliance is achieved	

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F 887	Continued From page 99 Covid-19 vaccines. She was unaware of the monitoring or tracking system for residents to receive vaccines. An interview on 1/12/23 at 10:33 AM with the Administrator revealed the facility did not have a monitoring and tracking process in place to ensure the residents receive the appropriate vaccines. The Administrator stated the Infection Control nurse was new to her position and had not been monitoring or tracking the residents to ensure they received the required Covid-19 vaccines.	F 887		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 947		2/22/23

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F 947	Continued From page 100 Based on record review and staff interviews the facility failed to provide required dementia management training for 2 of 5 staff (Nursing Assistant (NA) #3 and NA #5) reviewed for education requirements. Findings included: 1a. NA #3 was hired on 8-26-05. The facility provided NA #3's education for the past year. Review of the NAs education revealed she had not received dementia management training within the last year. b. NA #5 was hired on 5-23-22. The facility provided all the training and education the NA had since her hire date. Review of the education revealed the NA had not completed the dementia management training. A telephone interview occurred with the Director of Nursing (DON) on 1-12-23 at 11:11am. The DON stated she was currently responsible for the training and education of staff at the facility. She stated she had not provided any education on dementia management. She explained the electronic training also covered dementia management, but she had not reviewed what staff had not completed their annual training which would have included dementia management training. The Administrator was interviewed on 1-12-23 at 1:57pm. The Administrator stated he and corporate monitor the electronic training system and he was not aware staff had not completed their required dementia management training.	F 947	1.Dementia training for Nurse Aides was initiated on 02/09/2023 by the Human Resources Director. Staff that were not available, will be educated by the Director of Nursing or designee by 02/22/2023. 2.The Director of Nursing, Human Resources Director or designee, will complete an audit by 02/22/2023 of the Nurse Aide education files to ensure that the nurse aides have completed dementia training in the last 12 months. 3.The Director of Nursing will re-educate the Nurse Aides on the importance of completing their annual training courses and specifically the importance of completing the dementia training education course by 02/22/2023. The Human Resources Director will ensure Dementia training is completed as a part of new hire Nursing Assistant training. 4.The Director of Nursing, or designee will complete a monthly audit for the next three months of Nurse Aides who have been employed for more than one year to ensure that they have completed their Dementia training. Results will be brought to QAPI for review by the Director of Nursing or designee monthly times 2 months or until compliance is achieved.	