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E 000	Initial Comments An recertification survey and complaint investigation was conducted on 12/11/23 through 12/14/23. Additional information was provided on 12/21/23 therefore the exit date was 12/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # F1FD11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 12/11/23 through 12/14/23. Additional information was provided on 12/21/23 therefore the exit date was 12/21/23. Event ID # F1FD11. The following intakes were investigated: NC00210257 and NC00210839 . Two of the two complaint allegations did not result in deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F 607		

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

Electronically Signed | 01/17/2024

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F 607	Continued From page 1 QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for facility staff to immediately report an allegation of abuse when two staff members failed to report an allegation of staff (Nurse #12) to resident abuse to the facility management as soon as the incident was observed. This occurred for 1 of 3 residents (Resident #16) reviewed for abuse. Findings included. The facility policy titled; Abuse, Neglect, and Exploitation revised October 2023 revealed in part ; facility staff must immediately report allegations of abuse to the Administrator and or designee. The Administrator or designee will immediately begin an investigation and notify the applicable local and State Agencies in accordance with the procedures in this policy. If the allegation involved abuse it should be reported immediately but not later than 2 hours.	F 607	Past noncompliance: no plan of correction required.	

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A facility investigation report revealed on 11/27/23 the facility received an allegation that Resident #16 pinched a staff member (Nurse #12) on the buttocks and the staff member "slapped" Resident #16 on the hand. The accused staff member reported that Resident #16 rolled up to the nurses station in her wheelchair and stated, "you have a tight butt." The staff member responded that the statement was inappropriate, and Resident #16 responded "the girl had a tight butt and wears tight pants." The staff member reported Resident #16 then grabbed the staff members buttocks twice and the staff member pushed Resident #16's hand away. Resident #16 stated, "I'm not going to talk to you anymore" and wheeled back to her room. Resident #16 reported she touched the staff member at the nurses station to get her attention due to her poor vision related to macular degeneration and the staff member slapped Resident #16's hand, but not hard, and stated "don't touch me again." Resident #16 described the staff member as a white female who was holding a little girls hand, and the staff member told the little girl that she had the right not to be touched. The facility investigation substantiated that the staff member slapped the top of Resident #16's hand. The staff member was terminated following the investigation.

During an interview on 12/13/23 at 11:17 AM Nurse Aide #2 stated on 11/23/23 she was sitting at the nurses station charting and the accused staff member (Nurse #12) was at the nurses station with her daughter, but Nurse #12 was seated behind her. She stated Resident #16 came up in her wheelchair like she always did and tried to hold hands with Nurse #12's daughter. Nurse #12 told Resident #16 that she did not have the right to touch her daughters

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hand and that her daughter had the right not to be touched. She stated Resident #16 rolled away in her wheelchair and stated, "that nurse was not very nice." Nurse Aide #2 stated Nurse #12 told her she "popped" Resident #16's hand but stated she did not see her pop her hand. She stated she did not report any allegation of abuse on that day because she did not witness the abuse. She stated another nurse (Nurse #13) read a note documented in the medical record by Nurse #12 regarding Resident #16 and started questioning what happened. She stated during that time another Nurse Aide (#3) informed Nurse #13 of a second incident that occurred on Sunday 11/26/23. She stated she should have reported the initial incident on 11/23/23 but she didn't. She stated she had received abuse training due to this allegation that included reporting allegations of abuse.

During a phone interview on 12/13/23 at 02:01 PM Nurse Aide #3 stated Nurse #12 was a verbally aggressive person in general. She stated she was working day shift on 11/23/23 and she was walking by and saw Nurse #12 and Nurse Aide #2 at the nurses station when she heard Nurse #12 talking forcefully and aggressively to Resident #16 and stated Nurse #12 was saying, "if she doesn't want to be touched then don't touch her." She stated she caught the end of the incident. She stated Nurse #12 had her daughter there that day and Resident #16 tried to give her daughter a hug, when Nurse #12 told Resident #16 it was her daughters right to not be touched." She stated she heard the pop and saw Resident #16 put her hands down at the same time. She stated she did not report it because she thought Nurse #12 would document the incident. She stated then on Sunday 11/26/23 Resident #16

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came to the nurses station to ask Nurse #12 something and rubbed Nurse #12's leg as she was sitting at the nurses station. Nurse #12 became very agitated and stated," you cannot touch me like that." She stated Resident #16 was legally blind and didn't know what she was touching and would reach out and touch your leg or arm when she talked to you. She also touched you to help her know who she was talking to. She stated Nurse #12 told Resident #16 that she was in her personal space in an aggressive voice and stated Nurse #12 was not happy. She stated she didn't think to report the incident because Nurse #12 was a unit manager and she thought Nurse #12 would report it. She stated she should have reported the incident immediately. She stated she had received abuse training to include reporting allegations of abuse.

During an interview on 12/13/23 at 2:47 PM the Nursing Supervisor (Nurse #13) stated on Monday 11/27/23 around 1:30 PM Nurse Aide #3 pulled her aside and told her that she and Nurse Aide #2 had witnessed Nurse #12 slap Resident #16 on her hand. She stated she immediately reported this to the Assistant Director of Nursing (ADON) and full investigation was conducted.

During an interview on 12/13/23 at 2:39 PM the Assistant Director of Nursing (ADON) stated on Monday 11/27/23 around 1:45 PM the Nursing Supervisor (Nurse #13) reported the incident regarding Resident #16. She stated once it was reported she immediately called the Director of Nursing (DON) who instructed her to pull Nurse #12 from her assignment and get her statement and suspend her pending an investigation. She stated Nurse #12 was terminated following the

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investigation. She stated both nurse aides who witnessed the incident received disciplinary action for not reporting an abuse incident when it occurred.

An interview was conducted on 12/13/23 at 3:30 PM with the Director of Nursing (DON) along with the Administrator. The DON stated she was notified on Monday 11/27/23 around 1:45 PM of the incident regarding Resident #16 and Nurse #12. She stated she was made aware on 11/27/23 that the first incident actually occurred on 11/23/23 when Resident #16 tried to hug Nurse #12's daughter and stated it was reported that Nurse #12 slapped Resident 16's hand and told her not to touch her daughter. She stated then on Sunday 11/26/23 Resident #16 was at the nurses station and touched Nurse #12 on the leg and Nurse #12 pushed her hand away and told her she was being inappropriate. She stated Nurse #12 was immediately suspended on 11/27/23 pending the investigation. She was terminated following the investigation. She stated staff had been trained numerous times to report any incidents of abuse immediately. She stated staff education was initiated on 11/27/23 regarding signs and symptoms of abuse, types of abuse and reporting abuse. She stated the incident on 11/23/23 should have been reported that day but stated that didn't happen. She stated a plan of correction regarding the abuse allegation and not reporting abuse was initiated on 11/27/23.

The corrective action for the noncompliance dated 11/27/23 was as follows:

Following the discovery on 11/27/2023, the facility implemented the following quality assurance

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measures:

On 11/23/2023 an employee slapped a resident's hand who was attempting to touch the employee's daughter. Facility staff failed to report the incident until 11/27/2023.

On 11/27/2023 the employee was suspended pending an investigation.

On 11/27/2023 the resident was interviewed and assessed. No physical or psychological harm were noted.

On 11/27/2023 counseling and education was done with the two employees that failed to report timely.

To identify other residents who may be impacted by the same deficient practice:

On 11/28/2023 the DON/Designee performed head to toe assessments on cognitively impaired residents with no negative findings .

On 11/28/2023 the DON/designee interviewed all alert and oriented residents as it related to abuse. There were no negative findings.

To prevent this reoccurrence the facility completed the following:

On 11/27/2023 the DON/Designee started abuse education with all staff. The training included in part; the facility would not tolerate abuse, neglect, or mistreatment, with emphasis placed on the reporting requirements. Education was completed by 11/28/2023. All staff would be required to complete training prior to their next shift.

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F 607	Continued From page 7 To monitor and maintain ongoing compliance: The DON/designee will conduct 5 skin assessments a week, 5 resident interviews a week and 3 staff interviews a week to monitor for abuse beginning 11/27/23. Audits will be conducted for 12 weeks and reviewed in QAPI (Quality Assurance Performance Improvement) for the duration of the audits including monitoring to ensure staff reported abuse allegations within the required timeframe. The QAPI team may extend the audits or change the plan of correction to ensure ongoing compliance. An ad HOC QAPI meeting was completed on 11/27/23 with the Interdisciplinary team. The Medical Director was notified by the Administrator. Validation of the corrective action was completed on 12/13/23. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. Staff interviews revealed following in-service training they had a better understanding of the reporting requirement related to abuse allegations. The initial audits were verified. There were no concerns identified. The next QAPI meeting was scheduled to be held December 2023 where audit results would be discussed. The facility alleged compliance with the corrective action plan on 12/04/23.	F 607		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		1/15/24

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30

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days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to

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F 623	Continued From page 10 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification of discharge or transfer to the resident and their Responsible Party (RP) of the reason for discharge to the hospital for 1 of 1 sampled resident (Resident #90) reviewed for hospitalization. The findings included: Resident #90 was admitted to the facility on 11/17/22. The admission Minimum Data Set dated 11/23/22 revealed Resident #90 was cognitively impaired. Review of Resident #90's medical record revealed he was transferred to the hospital on 12/08/23 through 12/12/23. No written notice of transfer or discharge was documented to have	F 623	Perpetration and submission of this plan of correction does not constitute an admission, an/or agreement with. It is required by State and Federal law. It is executed and implemented as a means to continuously improver the quality of care to comply with State and Federal requirements. 1. The facility did not send a transfer/discharge notice for resident #90. 2. Residents discharged to the hospital have the potential to be affected by the alleged deficient practice. The social worker(s) will audit facility initiated discharges to the hospital from 12/14/2023 to 1/12/2024 to ensure the discharged/transfer letter was sent from the facility. Transfer/discharge letters will be sent certified to the resident, or	

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F 623	Continued From page 11 been provided to the resident or his RP. An interview was conducted on 12/14/23 at 8:15 AM with Social Worker (SW) #1 and SW #2. Both Social Worker's stated they were not aware that a written hospital notification needed to be provided to the resident or RP as well. An interview was conducted on 12/14/23 at 9:03 AM with the Administrator and Director of Nursing (DON). The Administrator and DON stated that the facility notified the RP by phone and were not aware that a written notification of hospitalization needed to also be sent to the resident or RP.	F 623	residents responsible party within 72 hours of discharge. 3. The Director of Nursing, and or, designee(s) will educate licensed nurses and social worker(s)on the policy in regards to the discharge/transfer letter. 4. To monitor ongoing compliance, the DON, and or, designee(s) will audit facility initiated resident transfers to the hospital 5x a week for 3 months to ensure discharge/transfer letters were sent to the resident, or responsible party. Any missed transfer letters will be sent upon discovery. Audits will be reviewed by the Quality Assurance Performance Improvement (QAPI)Committee monthly for the 3 months. The committee may change or extend the audits to ensure ongoing compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		1/15/24

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F 656	Continued From page 12 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan that addressed Hospice care for 1 of 4 sampled residents reviewed for hospice (Resident #18). Findings included:	F 656	1. The care plan for resident #18 was updated on 12/13/2023. 2. Resident under hospice services have the potential to be affected by the alleged deficient practice. The DON and or, designee(s) will review each resident on	

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F 656	Continued From page 13 Resident #18 was admitted to the facility on 05/03/18 with diagnoses that included dementia and Parkinson's. Review of Resident #18's Significant Change Minimum Data Set (MDS) assessment dated 10/05/23 revealed Resident #18 with moderate cognitive impairment. Resident #18 was coded as receiving Hospice #1 services while a resident; however, Resident #18 had a life expectancy of 6-month or less was not marked as received under special services and treatments. Review of Resident #18's comprehensive care plans, last revised 10/05/23, revealed no care plan for Hospice services. Review of Resident #18's medical record revealed on 10/27/23 the resident was transferred from Hospice #1 services to Hospice #2 services, with resident's Responsible Party (RP) notified. Review of Resident #18's medical record revealed no Hospice Plan of Care. An interview was conducted on interview with MDS Nurse #1 and MDS Nurse #2 on 12/13/23 at 11:40 AM, The two nurses confirmed Resident #18 was under hospice care since 10/05/23. MDS Nurse #1 stated resident's comprehensive care plan that addressed Hospice care plan should have been developed and was overlooked. An interview was conducted with the Director of Nursing (DON) and Administrator on 12/13/23 at 10:15 AM. The DON and Administrator stated Resident #18 was admitted under Hospice care on 10/05/23 and a Hospice specific care plan should have been initiated upon his admission to	F 656	hospice services are care planned accurately. Any inaccuracies will be corrected upon discovery. 3. DON and or designee(s) will educated nursing administration, social worker(s), and MDS nurse(s)on care plan accuracy and update any inaccuracies in the clinical morning meeting. 4. The DON and or, designee(s)will audit the care plan of residents under hospice services weekly for 3 months to ensure accuracy. Any inaccuracies will be corrected upon discovery. Audits will be reviewed by the QAPI committee monthly for 3 months. The QAPI committee may change/extend auditing to ensure ongoing compliance.	

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F 656	Continued From page 14 Hospice as part of the resident's comprehensive care plan and was not.	F 656		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician interviews, the facility failed to administer eye drops as prescribed to a resident (Resident # 35) resulting in 9 extra doses of an eye drop that was prescribed for post cataract surgery care. The deficient practice was found for 1 of 5 residents reviewed for unnecessary medications.	F 757	1. The MD was notified concerning the extra doses of eye drops given to resident #35. A new order was obtained to discontinue the treatment. 2. Residents with eye drop orders have the potential to be affected by the alleged deficient practice.	1/15/24

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F 757	Continued From page 15 Findings included: Resident #35 was admitted to the facility on 4/19/19 with diagnosis which included in part: cataract, stroke, macular degeneration, and glaucoma. Resident #35's 11/25/23 annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact, had adequate vision. A physician order dated 11/26/23 for Easy Cataract eye drops twice per day, apply one drop to the left eye was entered into Resident #35's electronic health record. Review of a post operative progress note dated 12/7/23 written by the eye care provider indicated to change Resident #35's order for Easy Cataract eye drops one time per day every other day to the left eye. The order was entered into the electronic Medication Administration Record (MAR) for Resident #35 for Easy Cataracts drops for 1 drop in left eye every other day once per day for cataract disease. The order was entered by Nurse #1. Medication pass observation was made on 12/13/23 at 9:30 AM with Medication Aide #1 as she administered medication to Resident #35. Interview with Medication Aide #1 on 12/13/23 at 9:30 AM revealed Resident #35 had an entry for Easy Cataract eye drops to be administered every other day at 8:30 AM and twice per day at 9:30 AM and 9:30 PM. Med Aide #1 did not know why there were 2 entries for the eye drops but	F 757	3. The DON and or designee(s) will educate licensed nurses on transcribing/discontinuing medication with a focus on eye drops/dosage. 4. The DON and or designee(s) will audit medication orders for change in eye drop doses/days 5x a week for 3 months. to ensure that "old" doses/times have been removed from the medical record and only the "new" doses/times are entered into the Electronic Medication Administration Record (EMAR) system. Issues will be corrected upon discovery. Audits will be reviewed by the QAPI committee for 3 months. Audits may be changed/extended to ensure ongoing compliance.	

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stated she administered them as written. Medication Aide #1 stated she had administered Resident #35's Easy Cataract eye drops every day as written on the electronic MAR.

During a medication pass reconciliation, a review of the December 2023 Medication Administration Record (MAR) revealed an entry for Easy Cataract eye drops one time a day every other day for cataract disease at 8:30 AM was started on 12/9/23. The December MAR indicated Resident #35 had the following entries completed for Easy Cataract eye drops: on 12/9/23 at 8:30 AM, 9:30 AM and 9:30 PM (2 extra doses administered), on 12/10/23 at 9:30 AM and 9:30 PM (2 extra doses administered), on 12/11/23 at 8:30 AM, 9:30 AM and 9:30 PM (2 extra doses administered),on 12/12/23 at 9:30 AM and 9:30 PM (2 extra doses administered), and 12/13/23 at 8:30 AM and 9:30 AM (1 extra dose administered). The duplicate order on the electronic MAR resulted in 9 extra doses administered from 12/9/23 through 12/13/23.

Interview with Nurse #1 on 12/13/23 at 11:30 AM revealed she entered the new order into the electronic health record for Easy Cataract eye drops on time per day every other day per the physician order on 12/7/23. Nurse #1 stated the previous order for Easy Cataract eye drops twice per day daily should have ended when the new order was started. Nurse #1 stated she thought the previous order would drop off the MAR when the new order was entered and did not realize she needed to discontinue the old order.

Interview on 12/13/23 at 1:25 PM with the Physician revealed not providing the medication according to the physician order was a

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F 757	Continued From page 17 medication error and had the potential for adverse effects. An interview on 12/13/23 at 9:50 AM with the Director of Nursing (DON) revealed she expected that residents received the correct dose of medications and that physician orders were followed as written. The DON stated that when new orders were transcribed in the electronic health record, the previous order was to be discontinued.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		1/15/24

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F 761	Continued From page 18 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and the manufacturer's guidelines, the facility failed to dispose of an expired bottle of insulin in 1 of 2 medication storage rooms observed for medication storage (medication storage room 700-hall). The facility also failed to label with a name and opened date a bottle of nasal spray and failed to discard an expired bottle of eye drops on the 800-hall medication cart for 2 of 4 medication carts reviewed for medication storage. Findings: 1a. Review of the manufacturer's guidelines revealed Humalog Lispro Insulin, a vial of insulin, was to be discarded 28 days after it was opened. An observation was made on 12/12/23 at 2:38 PM of the Medication Room on the 700 Hall with Nurse #1 in attendance. Observation of the refrigerator in the medication room revealed an opened loose vial of Humalog Lispro Insulin 100 units per milliliter for Resident # 60. The label on the vial indicated an opened date of 10/12/23. The expiration date on the label indicated 11/10/23. Interview with Nurse #1 on 12/12/23 at 2:40 PM revealed the vial of Humalog Lispro insulin was expired and should not have been in the refrigerator with the unopened, unexpired medications. 1b. An observation of the 800-hall medication cart on 12/13/23 at 9:30 AM with Medication Aide	F 761	1. The nasal spray was labeled and dated. The expired insulin and eye drops were removed and discarded upon discovery. 2. Resident receiving medication have a potential to be affected by the alleged deficient practice. 3. The DON and or designee(s) will provide education to license nurses on proper medication storage by 1/12/2024. 4. The DON and or designee(s) will audit medication carts and medication rooms for improperly stored/expired medication weekly for 3 months. All improperly stored/expired medication will be corrected upon discovery. Audits will be reviewed by the QAPI committee. Audits may be changed/extended to ensure ongoing compliance.	

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#1 in attendance revealed an opened bottle of Flonase nasal spray with no name, label from the pharmacy or date when opened. A labeled packaging box with the prescribed resident's name and the date when opened was not available on the medication cart.

Interview with Medication Aide #1 revealed the opened bottle of nasal spray with no name or opened date should not be on the medication cart. Medication Aide #1 stated medications on the cart including nasal spray and eye drops should be labeled with a name and date when opened. Medication Aide #1 stated the bottle of nasal spray should have been in a bag labeled with the resident information She further stated the nasal spray may have come from the backup system in the facility until the medication was received from the regular pharmacy.

1c. An observation of the 800 Hall medication cart on 12/13/23 at 9:30 AM with Med Aide #1 present revealed a bottle of Easy Cataract eye drops for Resident #35 with a printed manufacturer label with best use date of 11/15/23.

Interview on 12/13/23 at 9:30 AM with Medication Aide #1indicated she administered Resident #35 the ordered Easy Cataract eye drops from this bottle this morning and each previous morning that she worked. Med Aide #1 indicated the medication was very much expired. Med Aide #1 stated she was supposed to check the dates on medication before she administered them, but she had not noticed these eye drops were expired.

An Interview was conducted with the Director of

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F 761	Continued From page 20 Nursing (DON) on 12/12/23 at 2:50 PM. The DON indicated the nurses should remove medications from the medication cart and the medication rooms that were expired. The DON stated she expected that there would be no expired medications on the medication carts or the medication rooms.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to ensure laboratory services were followed up with when results for a STAT (immediately) urine culture and sensitivity laboratory test was not received resulting in the need for a repeat urine specimen to be collected and a delay in receiving antibiotic treatment for a urinary tract infection. This deficient practice occurred for 1 of 1 resident (Resident #19) reviewed for laboratory services. Findings included. Resident #19 was admitted to the facility on 09/20/19 with diagnoses including benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, retention of urine,	F 770	1. The MD was notified that the lab sent on 12/4/2023 was incomplete and had to be retrieved on 12//2024 for resident #19. The lab was completed and MD was made aware. 2. Resident receiving lab work could be affected from the alleged deficient practice. The DON and or designee(s) will review lab orders from 12/14/2023 - 1/12/2024 to ensure ordered labs have been carried out. Any results that have not been obtained will be reported to the MD and a new order will be obtained. 3. The DON and or designee(s) will educate licensed nursing on entering lab	1/15/24

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F 770	Continued From page 21 obstructive and reflux uropathy (obstructed urinary flow causing a backup of urine into the kidneys), and chronic kidney disease stage III. The Minimum Data Set (MDS) annual assessment dated 12/05/23 revealed Resident #19 was severely cognitively impaired. He required limited one person assistance with activities of daily living (ADLs). Review of Resident #19's medical record revealed a physicians order dated 12/03/23 to collect a urinalysis and send to the laboratory for a urine culture and sensitivity for possible urinary tract infection. The order was signed on 12/04/23 at 12:25 AM. Review of Resident #19's medical record revealed no documentation that the laboratory had called the results, or that the facility had received the results of the urinalysis, or a culture and sensitivity related to the order dated 12/03/23. A physicians order for Resident #19 dated 12/08/23 at 11:00 AM revealed to collect a urinalysis STAT (obtain the specimen immediately) and send to the laboratory for a urine culture and sensitivity for possible urinary tract infection. Review of Resident #19's medical record revealed a laboratory result for the urinalysis that was collected on 12/08/23. The result indicated greater than 100,000 colonies of gram-negative rods (bacteria) which indicated a urinary tract infection.	F 770	orders, ensure labs are completed as ordered. The MD will be notified if there are any delay obtaining an ordered lab. 4. The DON and or designee(s) will audit lab orders 5x a week for 3 months to ensure labs are collected and reported as ordered. If there is an issue the lab will be collected and the MD notified. DON and or designee(s) will educate licensed nurses to ensure labs are collected as ordered. Audits will be reviewed by the QAPI committee monthly for 3 months. Audits may be extended to ensure ongoing compliance.	

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A physicians order dated 12/10/23 for Resident #19 revealed to start Macrobid (antibiotic) 100 milligrams twice a day for urinary tract infection. This order was discontinued on 12/11/23.

A physicians order dated 12/11/23 for Resident #19 revealed to administer Ceftriaxone (antibiotic) 1 gram intramuscularly and administer one dose for urinary tract infection.

During an interview on 12/14/23 at 1:00 PM Nurse #2 stated Resident #19 had sundowning behaviors with increased confusion in the afternoon and evening. Resident #19 had increased agitation on 12/08/23 and a STAT urinalysis was obtained. She stated she received the preliminary result but did not give a date, but she called the results of the urine culture to the provider, and an antibiotic was prescribed. She indicated Resident #19 had a history of urinary tract infections and was prone to them due to his urinary catheter.

During an interview on 12/14/23 at 1:20 PM the Director of Nursing (DON) stated a urine sample was initially collected from Resident #19 and sent to the laboratory on 12/04/23 for a possible urinary tract infection. On the evening of 12/07/23 a member of the nursing staff called the laboratory to be sure they had the specimen. The laboratory informed them at that time that the specimen that was sent on 12/04/23 had Resident #19's name misspelled on the specimen, and they discarded the specimen and did not run the urinalysis. She stated the laboratory did not notify the facility that the specimen was misspelled and thrown away. She

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F 770	Continued From page 23 indicated there was no explanation given by the laboratory as to why the facility was not notified to send a repeat specimen when they discarded the initial specimen. A new urinalysis was ordered STAT on 12/08/23 and sent to the laboratory. She stated they usually expected to see a preliminary urinalysis report from the laboratory on the next day and the final sensitivity report on the third day and they did not receive those results with the initial specimen. She indicated once the preliminary report was obtained an antibiotic was prescribed and administered to Resident #19. During a follow up phone interview on 12/21/23 the Director of Nursing (DON) stated the initial urine specimen was collected and sent on 12/04/23 for Resident #19. She stated the laboratory should have notified the facility to collect another specimen when they discarded the initial specimen and that did not occur. On the evening of 12/07/23 the facility realized the urinalysis result was never received from the laboratory. They sent a new specimen STAT on 12/08/23, and the results were received within the appropriate timeframe and Resident #19 was started on antibiotics. She indicated Resident #19 had received the antibiotic and had no further symptoms. She stated they would have expected notification from the laboratory regarding the discarded specimen and that did not happen. She indicated they would be working with the laboratory to ensure better communication in order to prevent errors like this from occurring.	F 770		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services.	F 776		1/15/24

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F 776	Continued From page 24 §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on observation, Responsible Party and staff interviews, and record review, the facility failed to provide radiology services to meet the resident's needs and to inform the physician when a routine x-ray order for the resident's left hip, left femur (thigh bone), left knee, and left tibia/fibula (the two long bones located in the lower leg) was delayed beyond the expected timeframe for 1 of 1 resident reviewed for radiology services. Findings included: Resident #62 was admitted to the facility on 03/09/22. Review of a Minimum Data Set (MDS) assessment dated 11/03/23 revealed Resident #62 has severely impaired cognition. Review of a nursing progress note completed by Nurse #11 dated 12/07/23 at 11:54 pm documented the resident fell in front of her chair.	F 776	1. Resident #62 did not have an x-ray performed in the expected time frame (STAT within 4 hours, Normal, within 24 hours). The facility also did not notified the MD regarding the delay. X-ray was obtained and MD was notified. 2. The DON and or, designee(s) will review x-ray orders from 12/14/2023-1/12/2024 to ensure all were performed in a timely manner. Any x-rays not performed timely will be communicated to the MD for new orders. 3. The DON and or designee(s) will educate licensed nurses on entering diagnostic orders and time frame of diagnostic services. If testing is not performed within the time frame. the MD is notified for new orders 4. The DON and or designee(s) will review diagnostic orders for 5x a week for	

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There were no abnormal findings within a head to toe observation and no complaints of pain at the immediate time. Pain level 0 out of 10 (indicating no pain).

Review of a progress note completed by the Registered Nurse (RN) Nursing Supervisor dated 12/08/23 at 4:28 pm documented the nurse was called to the Resident #62's room and shown the resident was unable to move her left leg. She was placed in bed with assistance and complained of pain in her left lateral thigh area with range of motion of hip and knee joints. Resident had fallen from the bed to the floor last evening and had no pain today until the last few minutes. The provider was notified, and an x-ray of the leg and hip were ordered. The x-ray provider was notified. No bruising was noted to the leg, hip, or knee.

The routine x-ray order placed on 12/08/23 at 4:30 pm read: X-Ray: left hip, left Femur, left knee, left tibia/fibula. Acute pain due to trauma signs and symptoms increased pain to left hip/leg related to recent fall, one time only for increased pain to left hip and leg related to a fall.

In an interview with the RN Nursing Supervisor on 12/11/23 at 1:50 pm she stated she was the nurse who placed the x-ray order on Friday 12/08/23 at 6:00 pm. She reported she spoke to the facility Nurse Practitioner (NP) who ordered a routine x-ray, not stat (urgent or rush), because the resident had baseline range of motion and no complaints of pain or nonverbal signs of pain.

Review of a progress note completed by Nurse #7 on 12/09/23 at 2:31 pm documented the mobile x-ray company was called and the nurse was left on hold for more than 10 minutes with no

3 months to ensure diagnostic services ordered are completed within the identified time frame. If not performed in the designated time frame, the MD will be notified and a new order will be obtained. Audits will be reviewed monthly by the QAPI committee. Audits may be changed/extended to ensure ongoing compliance.

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customer service answering. Resident denied pain or discomfort.

In an interview with Nurse #7 on 12/12/23 at 4:30 pm she stated she worked on Saturday 12/09/23 and had cared for Resident #62. The Nursing Supervisor instructed her to contact the x-ray company to determine when they would be coming to the facility. Both times she called she was left on hold for 20 minutes and never connected to anyone, so she hung up both times. She reported this to Nurse #9 when he came on shift at 3:00 PM. She had assessed Resident #62 during her shift. At 8:30 AM she applied gel to her knee for pain and assessed her left leg for range of motion at that time and there was no evidence of pain. She stated the resident was up and out of bed self-propelling around the facility. When she went back to bed after lunch, she again assessed her for range of motion and the resident did not complain of hip pain. She reported she had only been told to contact the x-ray company and had not called a physician to report that the x-ray had not been done yet. She left at 3:00 PM when her shift ended.

Review of a progress note completed by Nurse #2 on 12/10/23 at 10:31 am documented the mobile x-ray company was called and reported a radiology technician would call the facility that day to give an estimated time of arrival.

Review of a progress note completed by Nurse #9 on 12/10/23 at 12:56 pm documented the mobile x-ray company called and stated the earliest they could get to the facility would be on 12/11/23.

In an interview with Nurse #9 on 12/11/23 at 1:30

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pm he stated Resident #62 had fallen the previous Thursday (12/07/23) and the facility was waiting for the mobile x-ray technicians to come and x-ray her hip. He stated he had not notified a physician that the x-ray had not been done.

In an interview and observation with the Resident #62 and the resident's Responsible Party on 12/11/23 at 1:30 pm he stated she (Resident #62) had fallen last Thursday (12/7/23) and was supposed to have had an x-ray in the afternoon on Friday (12/8/23) and that it was now Monday and it had not been done. He reported she was having some discomfort in her left hip. Resident #62 also stated she was having pain in her left hip and rubbed the outside of her left leg with her hand. She was lying on her bed and was moving her left leg freely. She was smiling with no facial grimacing or other signs of pain present.

In an interview with the Nurse Practitioner on 12/11/23 at 2:05 PM she stated she had just assessed the resident prior to this interview and the resident had full range of motion according to her baseline. She noted Resident #62 had told her "It hurt a little" and pointed to her left hip. She stated she had offered to send the resident to the hospital for an x-ray, but the family member present told her he did not want to go to the emergency room unless they had to go. She noted she had no control over the mobile x-ray technicians. She reported she had originally ordered the x-ray to be done routinely because the nurse had reported to her the resident was having some pain but that it was not exaggerated pain on Friday (12/08/23). She commented she was not aware the x-ray had not been done when she arrived on Monday and stated if she had known she would have changed the order to stat

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sooner so that it would have been done. She would have expected staff to call her or the on-call physician on Saturday (12/09/23) to report the x-ray had not been done so that the resident could have been sent out for the test or the order could have been changed to stat to ensure the hip was not fractured. She noted that she had only been on-call part of the day that Saturday (12/09/23) but another physician was available.

The following stat x-ray order was placed on 12/11/23 at 2:32 pm: left hip and thigh region x-ray for post fall with pain stat.

Review of a Radiology Results Report for Resident #62 dated 12/11/23 at 4:18 pm documented the left hip joint was intact with no fracture or dislocation seen. The pelvis, left femur, left knee, tibia, and fibula (bones in the lower left leg) were also normal without fracture.

In an interview with the Director of Nursing (DON) on 12/11/23 at 1:40 pm she stated she had been in the building on the previous Saturday and Sunday (12/09/23 and 12/10/23). She noted staff mentioned the option of going to the hospital for the X-ray on Saturday to the family member of Resident #62 and he refused telling staff it was traumatic for the resident when she had to go out of the facility due to her dementia. She reported that she and the RN Nursing Supervisor went into the resident's room and assessed the resident on Saturday 12/09/23. While they were in the room, she (Resident #62) had tried to get out of bed by herself and they were able to stop her. She stated Nurse #7 had called the on call physician and was told not to send the resident out to the hospital after the nurse reported the resident had stated she was not hurting, had tried to transfer

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herself while staff were in her room, and that she had full range of motion. She noted the mobile x-ray technicians did usually come within 4 hours of placing a routine order but lately it had been a 1 to 2 day wait for a routine exam. She reported she had observed Resident #62 on both Saturday and Sunday (12/09/23 and 12/10/23) self-propelling in her wheelchair around the building with no non-verbal signs of pain (such as facial grimacing) or verbal complaints of pain. She concluded that on both Saturday and Sunday she and the Nursing Supervisor had discussed the situation regarding the mobile x-ray technicians taking so long to come.

During interview with the RN Nursing Supervisor on 12/11/23 at 1:50 pm she noted that Nurse #7 had called the mobile x-ray company on Saturday (12/09/23) and Nurse #9 had called them on Sunday (12/10/23) to determine when they were coming to do the x-ray. She reported she had not notified a physician that the x-ray had not been done. She stated she and the DON discussed the matter on Saturday (12/09/23) trying to decide if Resident #62 should be sent out for the x-ray or to wait for the mobile x-ray company. They decided to wait for the mobile x-ray technicians.

In an interview with the DON on 12/12/23 at 4:45 pm she reported that she had been mistaken and Nurse #7 had not notified the on-call physician on Saturday 12/09/23. She stated when the x-ray technicians did not come, the physician should have been notified of the delay and in fact, she thought a physician had been notified, but she learned during the survey process that a physician was not called on 12/09/23. She noted she herself had not notified a physician that the x-ray had not been done. She stated she had a

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F 776	Continued From page 30 "gut feeling" on Saturday, 12/09/23, that too much time had passed and more should have been done to obtain the x-ray. She stated that in the past the x-ray technicians usually came within 4 hours to do a routine x-ray and sooner when an order was stat. She commented that she had placed a call to the x-ray company requesting to speak to the Director because a delay like this had happened before. In an interview with the physician on 12/13/23 at 11:00 am he stated he would have expected a routine request for an x-ray to be completed within a day and a stat order to be completed immediately or as soon as possible. He stated he would have expected staff to notify a physician when there was a delay in getting the hip x-ray completed by the mobile x-ray company at the facility. He commented he did not want to misuse the stat order option, but in this case, it may have been warranted since the mobile x-ray people did not come within a day's time. He would have expected staff to notify a physician after a day had passed so that the order could have been changed to a stat status. In an interview with Administrator on 12/13/23 at 2:10 pm he stated he would have expected nursing staff to notify a physician if there was a delay in treatment or testing that had been ordered by the physician.	F 776		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849		1/15/24

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through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical,

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mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must

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report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners

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F 849	Continued From page 34 participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain communication and coordination of services provided by Hospice in the medical record complete with Hospice	F 849	1. Resident #18 and #36 did not have hospice admission documentation, hospice plan of care, hospice visit notes, and a physician order for hospice	

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F 849	Continued From page 35 admission documentation, Hospice plan of care, and Hospice visit notes in the facility's electronic medical record and failed to obtain physician orders for Hospice services for 2 of 4 residents reviewed for Hospice, (Resident #18 and #36). The findings included: The Hospice Nursing Home Agreement dated 09/19/17 read in part: "Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and coordination. Each clinical record shall completely, promptly, and accurately document all services provided to, and events concerning, each Hospice patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party." 1. Resident #18 was admitted to the facility on 05/03/18 with diagnoses that included dementia and Parkinson's. Review of Resident #18's Significant Change Minimum Data Set (MDS) assessment dated 10/05/23 revealed Resident #18 with moderate cognitive impairment. Resident #18 was coded as receiving Hospice services while a resident.	F 849	services. All documentation was obtained and entered into the medical record. 2. The DON and or designee(s) will audit all the medical record of all hospice residents to ensure they have hospice admission documentation, hospice plan of care, hospice visit notes, and a physician order for hospice services in their medical record. Any issues identified were corrected 1/12/2024. 3. The DON and or designee(s)will educate licensed nurses on entering hospice orders with the name of the hospice provider and diagnosis by 1/12/2024. The DON and or designee(s)will meet with our hospice providers to provide education on to ensure that hospice admission documentation, hospice plan of care, hospice visit notes, and a physician order for hospice services are present in the medical record. 4. The DON and or designee(s)will audit hospice documentation and orders weekly for 3 months to ensure that they are present in the medical record. Any issues identified will be corrected upon discovery. Audits will be reviewed to the monthly QAPI meeting. Audits may be changed/extended to ensure ongoing compliance.	

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A review of Resident #18's medical record on 12/11/23 revealed no: Physician order for Hospice Services, Hospice Plan of Care, Facility Hospice Care Plan, Hospice Patient Information Form, Hospice Certification Statement, Hospice Visit Record Forms, and no Election of Hospice Form. The only documented Hospice record found for Resident #18 was a Hospice progress note dated 10/13/23; which read, "Resident vital signs take, Resident #18 taken to her room. Incontinent of bowel and bladder, alert and oriented, and denies pain."

An interview on 12/13/23 at 10:15 AM with the Director of Nursing (DON) revealed that it was her expectation that Hospice should have communicated more fully to facility staff as well as provided Hospice Nurse's complete visit documentation prior to leaving the facility and did not. She said Hospice failed to provide them with Resident #18's complete Hospice record complete with Hospice admission documentation, Hospice plan of care, Hospice visit notes, and documented Hospice physician order. The DON said it was her expectation that there be a complete verbal and paper communication process between Hospice and her nursing staff, and there was not. The DON then said she was ultimately responsible for not following up with Hospice as she should have, and for the facility not having a clear process in place to obtain and scan residents Hospice medical records timely into their electronic medical records.

An interview was conducted on 12/13/23 at 11:09 AM with Hospice Nurse #1. She stated the resident was visited weekly by her and 3-times per week by a Hospice Aide. She stated the resident was being well cared for by her and the

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facility's nursing staff. And if further assistance was needed, the facility could reach her 24/7 by phone. The Hospice nurse revealed that not all Hospice documentation had been provided to the facility to scan into their electronic medical record. She said it was her expectation that Resident's #18 complete Hospice medical records be available to facility staff, per facility agreement, and were not. The Hospice nurse agreed that a complete communication structure should have been set up (verbal and written form) between the facility and Hospice staff, and be present at the facility, and was not. She said she and their NA kept most of the resident's orders, assessments, and notes on their computer's. It was her expectation, that from now on, she would print off resident #18's complete visit notes, assessments, updated orders, timely for medical records to scan them into the facility's electronic medical record system. The Hospice nurse agreed that a complete communication structure should have been set up (verbal and written form) between the facility and Hospice staff and was not.

An interview was conducted on 12/13/23 at 11:21 AM with the Hospice Nurse Aide (NA) #1. She stated Resident #18 was visited weekly by her weekly. She stated the resident was being well cared for by her and the facility's nursing staff. The NA #1 revealed that she had been busy and had not completed her Hospice visits documentation or provided them to the facility to scan into their electronic medical record.

An interview was conducted on interview with MDS Nurse #1 and MDS Nurse #2 on 12/13/23 at 11:40 AM, The MDS nurses confirmed Resident #18 was under Hospice care since 10/05/23. The MDS Nurse #1 stated resident's comprehensive

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care plan that addressed Hospice care plan, Hospice admission documentation, and Hospice Physician's order for Hospice services should have been provided by Hospice and were not.

A follow-up interview was conducted on 12/14/23 at 9:03 AM with the facility Administrator revealed that it was his expectation that the Hospice Nurse follow the Nursing Facility Hospice Services Agreement dated 09/19/17 to provide timely all residents clinical documentation, which was not being done per Hospice agreement.

2. Resident #36 was admitted to the facility on 03/09/22 with diagnoses that included, in part: Adult failure to thrive and Alzheimer's Disease early onset.

A significant change Minimum Data Set (MDS) assessment dated 09/29/23 documented Resident #36 was receiving Hospice services while a resident.

Resident #36 had an order to admit to Hospice service on 09/27/23 that was discontinued on 10/27/23.

The facility census on 12/11/23 for Resident #36 documented she was private pay Hospice since 09/27/23 with an admitting diagnosis of Alzheimer's Dementia.

In an interview with the Hospice RN (Registered Nurse) on 12/13/23 at 10:32 am she stated the Responsible Party (RP) for Resident #36 had not revoked services either by telephone or in writing.

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F 849	Continued From page 39 The Hospice RN stated that Hospice services for Resident #36 had not been discontinued. In an interview with the DON on 12/13/23 at 9:00 am she stated Resident #36 had been receiving Hospice services beginning 09/27/23 and on 10/27/23 the order for Hospice services was discontinued. She noted Resident #36 remained a full code with full services provided by the facility in addition to Hospice services being provided since 09/27/23. She concluded the order for Hospice services written on 09/27/23 should not have been discontinued until services were actually revoked. In an interview with the facility Administrator on 12/13/23 at 2:30 pm he stated he would expect there to be a physician order for anyone receiving Hospice Services.	F 849		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		1/15/24

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F 867	Continued From page 40 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

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level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 42 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 09/02/22. This was for a deficiency cited in the area of Developing and Implementing Comprehensive Care Plans (F656) that was subsequently recited during the recertification and complaint investigation survey of 12/21/23. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This tag is cross-referenced to: F656: Based on record review and staff interviews, the facility failed to develop a	F 867	1. The facility failed to maintain an effective QAPI process to implement systemic changes to: Developing and implementing a comprehensive care plan. 2. Based on a previous citation in regards to F 656, the facility failed to develop a comprehensive care plan that address hospice care for 1 out of 4 residents reviewed. A care plan was developed for the resident omitted upon discovery. 3. The DON/Administrator were educated of F 867 to ensure that audits are changed/extended to ensure ongoing compliance. 4. The Regional Director of Clinical Services (RDCS) and or designee(s) will review monthly QAPI committee meetings for 3 months to ensure pertinent items are reviewed and appropriate action is	

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F 867	Continued From page 43 comprehensive care plan that addressed Hospice care for 1 of 4 sampled residents reviewed for hospice (Resident #18). During the recertification and complaint investigation survey completed on 09/02/22 the facility was cited for failure to develop, update, and follow person-centered care plans.	F 867	implemented to maintain ongoing compliance. Audits may be changed/extended based on audit results.	