STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING & REHABILITATION	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/17/24 through 06/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# U8QG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/17/24 through 06/21/24. An extended survey was conducted on 06/21/24. Event ID# U8QG11. The following intakes were investigated: NC00201184, NC00201232, NC00201764, NC00201955, NC00201977, NC00206814, NC00208627, NC00208826, NC00208960, NC00209712, NC00210394, NC00211028, NC00211039, NC00211346, NC00212279, NC00212454, NC00216248, NC00214235, NC00216258, NC00217181, NC00218229, NC00218451 and NC00218514. 11 of the 72 complaint allegations resulted in deficiencies. Substandard Quality of Care was identified at: CFR483.24 at tag F679 at a scope and severity of H. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		7/25/24

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

Electronically Signed | 07/18/2024

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with residents (Resident #88), family (Resident #74 and Resident #16), and staff, the facility failed to provide a dignified dining	F 550	F 550= Resident Rights/Exercise of Rights 1. Resident #88, #74, #6 were provided lunch and appropriate assistance to finish	

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F 550	Continued From page 2 experience when three (3) residents who dined on the south unit did not receive assistance with their meal to allow them to eat with other residents who ate or were assisted to eat by staff. Resident #74 waited for staff to assist him with eating his meal, while his roommate, Resident #55 fed himself. Resident #88 and Resident #16 waited for staff to assist them with their meals while residents dining with them were assisted to eat by staff or fed themselves. This failure occurred for 3 of 3 residents sampled for dignity with dining (Residents #74, #88 and #16). The reasonable person concept was applied as individuals have the expectation of eating and to be served when dining at the same time as others. The findings included: 1. Resident #74 was admitted to the facility on 9/10/22. The electronic medical record (EMR) for Resident #74 recorded a family member as his responsible party (RP). A 5/24/24 quarterly Minimum Data Set assessment, indicated Resident #74 had adequate hearing, rarely/never understood others, rarely/never understood by others, no speech, impaired short-term/long-term memory, severely impaired cognitive skills for daily decision making, and required substantial/maximal staff assistance with eating. On 6/17/24 a continuous observation of the lunch meal dining occurred on the south unit when the meal cart arrived on the unit at 12:08 PM until 12:48 PM.	F 550	their meals. 2. All residents have the potential to be affected. On 6/19/2024 an audit was completed for all residents that require assistance, including setup and meal delivery. No further occurrences were identified. 3. All staff, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on resident rights, including meal service, delivery of trays, setup and assisting all residents at the same table at the same time. This education was completed on 6/20/2024. This education will be added to the facility orientation program for all new staff, to include new agency staff. 4. The Director of Nursing or Designee will audit 3 meals weekly for 12 weeks to ensure residents are served meals appropriately to promote dignity while dining. The Director of Nursing or Assistant Director of Nursing will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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On 6/17/24 at 12:16 PM Resident #74 and Resident #55 were both observed in the same room. Resident #74 was in bed with the head of his bed elevated. The privacy curtain was observed open between the two Residents. Resident #55 was observed seated in his wheelchair with his lunch meal on his overbed table, he fed himself and at the time of the observation, he had eaten approximately 50% of his lunch. Resident #55 continued to feed himself until 12:21 PM and ate a total of approximately 75% of his lunch meal, while Resident #74 waited for staff to bring him lunch and assist him with his meal. The privacy curtain remained open between the two Residents while Resident #55 fed himself. NA #5 brought Resident #74 his lunch tray into his room at 12:25 PM, set up his meal tray, and fed him.

NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #74 required staff assistance with his meals and when she brought him lunch, his roommate, Resident #55 had already eaten. NA #5 stated she was aware that residents should eat together, but further stated that the facility used to offer a feeding program in the dining room where six residents from the south unit who required staff assistance with meals ate together, but she had not seen this done for the last few weeks.

NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #74 was in the room in his bed when she took the lunch meal into the room for his roommate, Resident #55. She stated she set up the tray for Resident #55 and he fed himself. NA #3 stated that she did not take a lunch tray into the room for Resident #74, because he

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required staff assistance with eating, and NA #5 usually fed Resident #74 after all the trays were passed to residents who fed themselves. NA #5 stated Resident #74 only had to wait a few minutes to get his lunch until all the trays were passed. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with eating, but she had not seen that occur in the last week. She stated that she did not recall the exact time she took a lunch tray into the room for Resident #55, but that he was one of the first Residents on the unit to receive his tray. NA #3 stated that she did not consider it a dignity issue that Resident #74 waited in his room to receive his lunch and to be fed by NA #5.

On 6/20/24 at 12:29 PM, a phone interview with the RP for Resident #74, she stated Resident #74 had to be fed in facility #1 where he lived before, he moved to the current facility. The RP stated that while Resident #74 lived at facility #1, he ate at the same time as all the other residents and that he was accustomed to eating with others. The RP stated that Resident #74 should not have to wait a long time to be fed and that she would not want him to wait too long to eat.

The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.

The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that staff should all be available during meals and that nurses needed to

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know that meal trays are on the halls so that "all hands are on deck" to assist residents with their meals and allow residents to eat together.

2. Resident #88 was admitted to the facility on 8/7/23.

A 4/16/24 quarterly Minimum Data Set assessment indicated Resident #88 spoke clearly, was understood by others, able to understand others, her vision was severely impaired, her hearing was adequate, her cognition was intact, and she required substantial to maximal staff assistance with eating.

A care plan revised 4/30/24 indicated Resident #88 had self-care deficits related to poor muscle control and muscle stiffness. Interventions included for staff to set up her meal tray and to assist her with the completion of her meals.

A continuous observation of dining on the South Unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM. Seven residents, which included Resident #88, were observed seated in their wheelchairs in the commons area of the south unit. Five of the seven residents received their lunch meal from 12:08 PM until 12:15 PM and fed themselves while Resident #88 waited for staff to assist her with her lunch meal. While she waited, Resident #88 responded "yes" when asked by the Surveyor if she was hungry, ready to eat and preferred to eat with the other residents who were eating around her. NA #3 brought Resident #88 her lunch meal at 12:20 PM, set up her meal tray and fed Resident #88 lunch.

NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #88 required staff assistance

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with meals. NA #3 stated that all the meal trays were passed first to residents who fed themselves and then staff provided meal trays to the six residents on the south unit who required staff assistance with meals which caused the residents who required staff assistance with eating to wait about 15 minutes to be fed. NA #3 stated that she was trained to feed more than one resident at a time and that she typically did that for breakfast, but that she did not typically do that for the lunch meal. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with meals, but she had not seen that occur for about a week.

The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.

The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that "all hands are on deck" to assist residents with their meals and allow residents to eat together.

3. Resident #16 was admitted to the facility 9/16/18.

The electronic medical record (EMR) for Resident #16 recorded a family member as her responsible

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party (RP).

A care plan, revised May 2024, indicated Resident #16 had self-care deficits related to severe cognitive impairment with interventions that included staff to set up her meal tray and to assist her with the completion of her meals.

A 5/27/24 quarterly Minimum Data Set assessment indicated Resident #16 spoke clearly, usually understood by others, sometimes able to understand others, vision was impaired, had moderate difficulty hearing, her cognition was severely impaired, and she was dependent on staff for assistance with eating.

A continuous observation of dining on the south unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM, seven residents, which included Resident #16, were observed seated in their wheelchairs in the commons area of the south unit. Six of the seven residents received their lunch meal from 12:08 PM until 12:20 PM while Resident #16 waited for staff to assist her with her lunch meal. While she waited, Nurse Aide (NA) #5 brought Resident #16 her lunch at 12:33 PM, placed it covered on the overbed table that was in front of the Resident, and left the Resident to answer another resident's call light. While Resident #16 waited for lunch, she repeated to herself, "I am so sick." When asked by the Surveyor while she waited if she was hungry, Resident #16 replied, "I am so sick and I am so hungry." NA #5 fed Resident #16 her lunch meal at 12:36 PM.

NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #16 required staff assistance with her meals. NA #5 stated she was

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aware that residents should eat together, but further stated that the facility used to offer a focused feeding program in the dining room where residents who required staff assistance with meals ate together. NA #5 stated she did not see the focused feeding program offered for the last few weeks, and there were six residents on the south unit who required staff assistance with eating. NA #5 stated she thought it was against state rules to feed more than one resident at time and so she only fed one resident at a time so that she could give her attention to the resident she was assisting.

On 6/20/24 at 11:47 PM, a phone interview with the RP for Resident #16, she stated Resident #16 had dementia now and would not know about her surroundings but when she was aware of her surroundings, she would not like to wait to be fed while others around her ate. The RP stated that at times when she visited Resident #16 between 1:00 PM to 2:00 PM at the facility, Resident #16 had not yet received assistance with her lunch meal, but other residents were eating or had already eaten.

The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.

The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing

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F 550	Continued From page 9 staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that "all hands are on deck" to assist residents with their meals and to allow residents to eat together.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assess Resident #153 for the ability to self-administer medications. This failure occurred for 1 of 1 sampled resident reviewed for self-administration of medications. The findings included: Resident #153 was readmitted to the facility on 6/3/24 from the hospital. Diagnoses included urea cycle metabolism disorder (a condition that causes elevated ammonia levels in the blood), osteoarthritis, congestive heart failure and chronic pain. Review of the June 2024 physician (MD) orders in the electronic medical record (EMR) for Resident #153 revealed a 6/3/24 MD order for Aspirin Enteric Coated 81 milligrams (MG), with instructions for the nurse to give by mouth once daily, scheduled in the morning and a 6/3/24 MD order for Lactulose 10 grams (GM)/15 milliliter (ML) solution, for the diagnosis of urea cycle metabolism, with instructions for the nurse to give	F 554	F 554 = Resident Self-Admin Meds-Clinically Appropriate. 1. Resident #153 self-administration assessment was completed on 6/19/2024. Resident #153 was assessed to be safe to self-administer medications. Physician Orders were obtained on 6/19/2024 and Resident #153 was provided with a lockbox. 2. All residents have the potential to be affected. On 6/19/2024 an audit was completed on all resident rooms for medications at the bedside. No additional medications at the bedside were identified. 3. All staff, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on the Medication Administration Policy including reporting of any medications at the bedside or residents that request to self-medicate. This education was completed on 7/2/2024. This education will be added to the facility orientation	7/25/24

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F 554	Continued From page 10 45 ML by mouth, twice daily, scheduled in the morning and evening. There was no MD order for Resident #153 to self-administer these medications at the time of this review. Review of a care plan revised 6/5/24 indicated Resident #153 was at risk for skin tears, bruising, bleeding and other medical complications related to the use of Aspirin as an anticoagulant (a medication that thins the blood). The care plan also indicated Resident #153 may experience pain related to her diagnosis of osteoarthritis and pain in her shoulders. Interventions included providing medication therapy as ordered by the MD. There was no care plan for Resident #153 to self-administer medication at the time of this review. A 6/10/24 quarterly Minimum Data Set assessment recorded Resident #153 had adequate hearing, adequate vision, clear speech, understood others, able to understand, intact cognition and no impairment in functional limitation in range of motion. Further review of the EMR on 6/17/24 and 6/18/24 for Resident #153 revealed there was no assessment to self-administer Aspirin or Lactulose. On 6/17/24 at 10:54 AM during an observation and interview with Resident #153 two bottles of medications were observed on her overbed table. The label of one bottle was recorded as a prescription for "Sodium Chloride" tablets, the contents of the bottle were visible, and the bottle included a pale, yellow-colored liquid. The label of the second bottle recorded a store brand for	F 554	program for all new staff, to include new agency staff. 4. The Director of Nursing or designee will conduct random room observations 2 times a week for 12 weeks to ensure residents that may have medications at the bedside are assessed, MD notification, orders obtained, and a lockbox is provided. The Director of Nursing or Assistant Director of Nursing will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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Aspirin Enteric Coated (pain reliever), 81 MG, 300 tablets; the bottle was approximately three fourths full. During the observation, Resident #153 stated that at times, when her nurse brought the "Lactulose", she was not ready to take it, so the nurse left the "Lactulose" in a medicine cup on her overbed table for her to take later when she was ready. Resident #153 said that she poured the "Lactulose" from the medicine cup left by the nurse into the bottle (labeled Sodium Chloride) and took it later. Resident #153 stated she could not recall the name of the nurse(s) who left the "Lactulose" on her overbed table. Resident #153 also stated that she brought the bottle of "Aspirin" with her when she returned to the facility from a recent hospital stay and that she took it for her pain.

On 6/17/24 at 10:43 AM during an interview with Nurse #8 and observation of Resident #153, the Nurse observed two bottles of medications on the overbed table in Resident #153's room. Nurse #8 asked Resident #153 what were the medications and the Resident responded that one bottle was "Aspirin" that she brought with her when she came back from the hospital on 6/3/24 and the other bottle was" Lactulose" that she poured into a prescription bottle that she took later when she did not want to take the Lactulose at the time the nurses brought her medications. Nurse #8 stated that this was her first time as the Nurse for Resident #153, she was not aware that the Resident administered medications to herself, and she did not see any medications on her overbed table when she administered medications to the Resident that morning around 9:00 AM.

On 6/19/24 at 12:43 PM, Resident #153 was

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SATURN NURSING & REHABILITATION	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 554	Continued From page 12	F 554		

observed in her room. The same bottle that recorded a prescription for "Sodium Chloride" tablets was observed on her overbed table and included a pale, yellow-colored liquid. Resident #153 said it was her "bottle of Lactulose."

A phone interview with Nurse #9 on 6/21/24 at 8:40 AM revealed she was the Nurse for Resident #153 during the week, and weekends and worked all shifts at the facility. Nurse #9 described that Resident #153 did not work well with staff she did not know and refused medications at times from staff if she did not know them. The Nurse stated that she had not observed medications on the overbed table for the Resident. The Nurse stated that at times Resident #153 refused to take Lactulose and would respond "I don't want that now, leave it, I will take it later." Nurse #9 stated that she did not leave medications with residents who did not have a MD order for self-administration and returned later with any medications refused by a resident. Nurse #9 stated, "I watch the residents take their pills."

An interview with Unit Manager (UM) #1 on 6/19/24 at 5:53 PM revealed she was notified on 6/17/24 by Nurse #8 that Resident #153 had Aspirin at the bedside. UM #1 stated she went to the Resident's room, removed the Aspirin, and notified the Director of Nursing (DON) of the Aspirin and that Resident #153 was not assessed for self-administration of medication. UM #1 stated she did not see the prescription bottle with a label for Sodium Chloride and she was not informed that this bottle was at the bedside and contained a liquid medication that was poured into the bottle by the Resident. UM #1 stated Resident #153 did not have an assessment to self-administer medications when these

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F 554	Continued From page 13 medications were noted at her bedside on 6/17/24. During the interview, UM #1 observed the overbed table in the room of Resident #153 and stated the Resident had a 100 ML bottle of a liquid that the Resident called "Lactulose" that should not be there without an assessment. On 6/19/24 at 5:55 PM, the DON was interviewed and stated that she was made aware on Monday, 6/17/24 that Resident #153 had a bottle of Aspirin that the Resident brought with her when she returned from the hospital on 6/3/24. The DON stated Resident #153 had not been assessed to self-administer medications. The DON stated that staff did not see the prescription bottle that contained Lactulose. The DON stated that Residents who self-administer medications, should be assessed to do so and once the assessment is complete, if the resident demonstrates the ability to self-administer medications, the MD is notified, and a MD order is obtained for the specific medication that the resident will self-administer. The DON further stated that the resident is given a locked box to store the medication and that medications should not be stored on the overbed table. The Administrator stated in an interview on 6/20/24 at 2:53 PM that residents who want to self-administer medications, should be assessed to do so, the MD should be notified, an order obtained, and a locked box should be placed in the resident's room for storage of medications.	F 554		
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	F 607		7/18/24

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F 607	Continued From page 14 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 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, resident and staff interviews the facility failed to implement their abuse policy and procedure in the areas of reporting immediately to administration and investigating when Resident #21 reported that a Nurse Aide (NA) intentionally hit her on the hand with a bed remote. This deficient practice occurred for 1 of 5 residents reviewed for abuse.	F 607	F 607 = Develop/Implement Abuse/Neglect Policies 1. Resident #21 on 6/19/2024 was immediately interviewed by the Director of Nursing Resident #21 denied being hit with bed remote and said it was more poor customer service deliverance by staff. A head-to-toe skin assessment was completed on Resident #21 which	

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F 607	Continued From page 15 The findings included: A review of the facility's "North Carolina Resident Abuse Policy" revised 10/3/2022 defined physical abuse as "hitting, slapping, pinching, and kicking". The policy stated "all allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the Department of Health (DOH) immediately, but not later than 2 hours after the allegation is made." The policy further stated "Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted. The investigation must be conducted within five (5) working days from the alleged occurrence." Resident #21 was admitted to the facility on 12/14/22 with a diagnosis of cerebral infarction (stroke). A review of the quarterly Minimum Data Set (MDS) dated 5/6/24 indicated Resident #21's cognition was intact, and she exhibited verbal and physical behaviors and rejections of care. A review of the care plan dated 5/6/24 revealed Resident #21 had a history of making false accusations against other residents and staff. The interventions included encouraging Resident #21 to vent and express her feelings and explaining the seriousness involved of making false accusations.	F 607	indicated no pain, or injuries noted. On 6/20/2024 Resident #21 was assessed by the Psychiatric Nurse Practitioner and was deemed at baseline. On 6/20/2024 a 24-hour report was submitted to NC DHHS per the abuse reporting guidelines. 5-day investigation revealed the allegation was unsubstantiated. The Social Work Assist was immediately re-educated by the Administrator on the reporting process for abuse allegations. 2. All residents have the potential to be affected. On 6/19/2024 all residents that were non-interviewable had head-to-toe observations completed for any indication of abuse. On 6/19/2024 the Social Service Director completed interviews for abuse monitoring for interviewable residents. No additional concerns were identified. 3. All staff, including agency staff, were re-educated by the Administrator, Director of Nursing and/or the Assistant Director of Nursing on the Abuse, including the reporting process. This education was completed on 6/20/2024 and again on 7/17/2024. This education will be added to the facility orientation program for all new staff, to include new agency staff. 4. The Director of Nursing or designee will complete 3 employee interviews weekly for 12 weeks on abuse and reporting abuse. The Administrator or designee will audit the facility Grievance log for abuse	

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F 607	Continued From page 16 An interview with NA #4 on 6/19/24 at 10:50 AM revealed she was unsure of the date, but Resident #21 had reported to her a 3rd shift NA was rough with her during care and had intentionally hit her across the hand with the bed remote. She stated Resident #21 was unable to recall the name of the 3rd shift NA. NA #4 revealed Resident #21 was very upset about the incident and would not allow her to provide morning care. NA #4 indicated she informed Medication Aide #1 and then found the Social Work Assistant and requested she meet with Resident #21 as soon as possible. An interview was conducted with Medication Aide (MA) #1 on 6/19/24 at 11:03 AM. MA #1 stated she was unable to recall the date, but during her morning medication pass she observed the Social Work Assistant interviewing Resident #21 in her room and overheard Resident #21 tell the Social Work Assistant that a Nurse Aide hit her with the bed remote. MA #1 had no other details regarding the incident. A review of the facility reported incidents revealed the facility had not reported or investigated the allegation by Resident #21 that a 3rd shift Nurse Aide intentionally hit her across the hand with a bed remote A review of the Initial Allegation Report submitted by the facility on 6/20/24 at 12:46 PM revealed Resident #21 reported a Nurse Aide had roughly taken a remote out of her hand hitting her hand with the remote. The report further revealed the facility became aware of the incident on 5/28/24 and no employee was named or accused. An interview was conducted with the	F 607	monitoring weekly for 12 weeks. The Director of Nursing or Assistant Director of Nursing and Social Services Director will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 607	Continued From page 17 Administrator on 6/20/24 at 2:18 PM. The Administrator stated he was not employed at the facility on 5/28/24. He stated Resident #21 reporting that a Nurse Aide hit her with a bed remote was an allegation of abuse and the facility's Resident Abuse policy and procedure should have been implemented.	F 607		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626		7/18/24

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F 626	Continued From page 18 § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, Hospital Case Manager, and staff interviews, the facility failed to allow a resident to return to the facility after being sent to the hospital for a medical evaluation using the residents' behaviors prior to discharge as a basis for their decision for 1 of 3 residents reviewed for transfer and discharge (Resident #303). The findings included: Resident #303 was admitted to the facility on 1/30/24 with multiple readmissions and was last discharged on 6/07/24. Diagnosis included dementia with severity and agitation, metabolic and hepatic encephalopathy, and acute metabolic acidosis. Review of nursing progress note dated 6/07/24 written by Unit Manager #1 revealed she went to check on Resident #303 to see if he would take his medications. Resident #303 stated "I just want to die and disappear." Unit Manager #1 notified social worker of Resident #303 statement and his family would be notified. Review of facility Social Work progress note dated 6/07/24 revealed the social worker went to the magistrate to request IVC (involuntary commitment) for Resident #303 due to his verbalization of self-harm and refusal of taking	F 626	F 626 = Permitting Residents to Return to Facility 1. Resident #303 verbalized he did not want to return to the facility and is no longer a resident. 2. All residents have the potential to be affected. On 7/9/2024, the Social Services Director completed an audit of all residents that had been discharged in the last 30 days to ensure all were issued appropriate discharge notices. No additional concerns were identified. 3. On 6/24/2024 the Regional Clinical Director educated the following members of the Interdisciplinary Team: Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Social Service Assistant, Business Office Manager and Unit Manager on the following procedures: Discharge/Transfer, Bed hold and readmission procedures. This education will be added to the facility orientation program for any new staff in these positions, including new agency staff for these positions. 4. The Social Services Director or	

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F 626	Continued From page 19 medications. Social worker reported the magistrate approved for Resident #303 to be picked up from the facility to be transported to hospital by law enforcement. Resident #303 nursing staff and receptionist were notified. An interview with the Admission Director on 6/18/24 at 2:15 PM revealed she had been employed at the facility for 3 years and was familiar with Resident #303. She stated Resident #303 was sent out to the hospital on 6/07/24 as an involuntarily commitment due to behaviors and refusal of medications. She revealed last week on 6/11/24 she received a telephone call from the hospital case manager to discuss Resident #303 discharge back to the facility. She stated after the telephone call with the hospital case manager, she had emailed the facility clinical team about Resident #303 discharge back to the facility, when the Director of Nursing (DON) informed her Resident #303 would not be returning to facility. The Admission Director revealed she then went and spoke with the interim Administrator who stated the facility would not be allowing Resident #303 to transfer back due to the new company admission guidelines, refusing care and medications, on-going behaviors such as being verbally aggressive towards staff, and in his opinion clinically not being appropriate for skilled care. She stated on 6/11/24 she and the interim Administrator contacted the hospital case manager and informed why the facility would not be allowing Resident #303 to return and would need to locate alternative placement. An interview with the Administrator on 6/18/24 at 2:40 PM revealed he had only been employed at the facility since June 1, 2024. He stated he was aware of Resident #303 being sent out to the	F 626	designee will audit all facility discharges to the hospital to ensure Discharge/Transfer instructions with bed hold policy are provided to the resident and/or representative weekly for 12 weeks. The Social Services Director will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 626	Continued From page 20	F 626		

hospital for an IVC on 6/07/24 and after reviewing his medical chart did not feel he was appropriate to return to the facility. He also stated that in his opinion, Resident #303 level of care should be revised, and he was not appropriate for skilled level of care, the facility had no safe way to provide care, due to him being verbally aggressive towards staff, refusing care and medications. The interim Administrator revealed he along with the Admission Director had spoken with the hospital case manager on a few different occasions and informed them why Resident #303 would not be allowed to return to the facility and an alternative placement would need to be located.

A telephone interview with the hospital case manager on 6/20/24 at 11:43 AM revealed she was familiar with Resident #303 who had been admitted to the hospital by the facility under an IVC. She stated she had spoken with the Admission Director and the interim Administrator on few different occasions about Resident #303 being ready for discharge back to the facility and was told the facility would not be allowing him back and an alternative placement would need to be located. She revealed when asked why Resident #303 was not allowed to return, she was told that he was verbally aggressive towards staff, and they were not able to provide for his care. The hospital case manager stated Resident #303 was currently still at the hospital and they were continuing to look for placement.

An interview with the Director of Nursing (DON) on 6/20/24 at 11:55 AM revealed she had been employed at the facility since April 2023 and was familiar with Resident #303 and his family. She stated Resident #303 had made statements

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F 626	Continued From page 21 regularly that he "did not want to be at facility" and would then refuse his medications or make statements of harm to get himself to the hospital and his family always wanted him to return. The DON revealed that during Resident #303 last care meeting on 6/06/24 they discussed with Resident #303 and his family about his behaviors, statements towards staff and refusal of medications and that if those things continued the facility would involuntarily commit him and not allow him to return to the facility. She stated a few days after the care plan meeting was when Resident #303 made a statement of harm to himself and refusing medications which led to him being involuntarily committed and sent to the hospital. She revealed that according to the new facility admission guidelines, Resident #303 would not meet criteria for admission, the facility would not be able to continue to provide for his care and felt was best that he did not return. When asked about why Resident #303 had never previously been issued a 30-day discharge notice while having these same behaviors, the DON stated she was not sure why that had not been done previously other than the facility would have still been responsible for finding Resident #303 placement and having him go to the hospital was easier.	F 626		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the minimum data	F 641	F 641 = Accuracy of Assessments 1. Resident # 35 had modifications	7/25/24

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F 641	Continued From page 22 set assessment (MDS) assessment for 1 of 3 (Resident #353) sampled residents reviewed for behaviors and failed to accurately code a significant change MDS assessment for 1 of 1 sampled residents reviewed for hospice care (Resident #35). The findings included: 1. Resident #353 was readmitted to the facility on 7/13/23 with diagnoses that included bipolar disorder, blindness, and conduct disorder. A review of Unit Manager #3's progress note dated 9/10/23 indicated Resident #353 became irate, refused care/ assistance from staff when he shouted at staff, by stating they did not need to tell him how to take care of himself. A review of a Nurse Practitioner (NP) progress note dated 9/8/23 revealed Resident #353 refused to be seen by the facility provider on 9/8/23 and has refused previous psyche consults, refused Zyprexa which previously managed bipolar symptoms, refused diagnoses despite 2021 medical records. A quarterly MDS dated 9/14/23 indicated Resident #353 was cognitively intact, had no behaviors and had not rejected care. An interview on 6/20/24 at 10:42 am with the MDS Coordinator revealed she took over as coordinator in April 2023, was still learning, and that the quarterly MDS should have been coded to reflect Resident #353's on-going behaviors related to refusing care. The MDS Coordinator further revealed behaviors would have been	F 641	completed on 6/20/2024 for MDS for assessment dated 3/11/2024 to reflect Hospice Services. Resident #353 had modification completed on 6/20/2024 for MDS assessment dated 9/14/2023 to reflect Resisting Care. 2. All residents that are on hospice services and residents that resist care have the potential to be affected. On 6/20/2024 the Regional Nurse completed an MDS audit for the last 30 days of current residents receiving Hospice services and residents that resist care. No additional concerns were identified. 3. On 6/24/2024 The Regional Clinical Director re-educated the MDS coordinator on policy and procedures of accuracy of assessments. This education will be provided to any new MDS staff upon hire. 4. The MDS director/designee will review 3 MDS's weekly for 12 weeks to ensure hospice services are coded correctly. The MDS director/designee will review 3 MDS's weekly for 12 weeks to ensure residents that resist care are coded correctly on MDS. The Director of Nursing/designee will review new orders for hospice services in Morning Clinical Meeting 5 times a week for 12 weeks to ensure significant changes are scheduled.	

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F 641	Continued From page 23 discussed during morning meetings or identified through nurse notes, physician orders or nurse NP notes. During an interview on 6/20/24 at 2:50 pm the interim Administrator revealed the MDS should have coded Resident #353's behaviors related to refusing care and was not coded for refusing care. The Administrator further revealed education on coding the MDS accurately and updating the care plan was necessary. 2. Resident #35 admitted to the facility on 2/13/17 with diagnoses that included senile degeneration of the brain and vascular dementia with behavioral disturbance. Review of Resident #35's electronic medical record (EMR) revealed a 2/27/24 physician (MD) order completed by the Director of Nursing (DON) that recorded admit to hospice care for the diagnosis of senile degeneration of the brain. A 3/11/24 significant change MDS assessment for Resident #35, was reviewed. Section O, Special Treatments and Programs did not indicate Resident #35 received hospice care. A 6/18/24 phone interview at 3:35 PM with the Hospice Nurse revealed Resident #35 admitted to hospice care on 2/27/24 and that the Resident currently received hospice care. The MDS Coordinator stated in an interview on 6/18/24 at 4:34 PM that she completed the significant change MDS assessment for Resident #35 on 3/11/24, and that she was not certain why the hospice care was not indicated on the MDS assessment. The MDS Coordinator stated she	F 641	The Director of Nursing/designee will review residents with new behaviors of resisting care in Clinical Morning Meeting 5 times a week for 12 weeks to ensure MDS Coordinator is aware and can accurately capture on assessments as indicated. The Director of Nursing and MDS Director will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 641	Continued From page 24 would review the 3/11/24 significant change MDS for Resident #35 and follow up. During a follow up interview on 6/19/24 at 11:10 AM, the MDS Coordinator stated that it was an oversight that she did not indicate Resident #35 received hospice care on the 3/11/24 significant change MDS. She stated, she was aware of the MD order for hospice care for Resident #35 from a manager's meeting and stated, "I should have marked the MDS for hospice care." The DON stated in an interview on 6/18/24 at 4:59 PM, that she updated the EMR for Resident #35 regarding the MD order for hospice care and that the significant change MDS assessment should have been coded to indicate Resident #35 received hospice care. An interview was conducted with the Administrator on 6/20/24 at 2:46 PM. He stated that the 3/11/24 significant change MDS assessment completed by the MDS Coordinator did not reflect hospice care for Resident #35, but that it should have.	F 641		
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. (B) A registered nurse with responsibility for the resident.	F 657		7/25/24

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F 657	Continued From page 25 (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 and staff interviews, the facility failed to update the care plan to reflect self-administration of all medications and pick up medications from an outside pharmacy for 1 of 3 (Resident #353) sampled residents reviewed for care plans. The findings included: Resident #353 was readmitted to the facility on 7/13/23 with diagnoses that included bipolar disorder, blindness, and conduct disorder. A physician's order dated 5/3/23 indicated Resident #353 could self- administer all medications by mouth, topical and ophthalmic (eye drops) and pick up his own medications from an identified pharmacy. A physician's order dated 7/11/23 indicated all	F 657	F 657 = Care Plan Timing and Revision 1. Resident #353 was discharged on 10/9/2023 and is no longer at the facility. 2. All residents who request for self-administer medications have the potential to be affected. On 6/20/2024 the MDS coordinator completed an audit to ensure that care plans were updated and revised accordingly for self-administration of medications and outside medications were properly obtained in a timely manner for the residents. No additional concerns were identified. 3. On 6/24/2024 the Regional Clinical Director provided education to the MDS coordinator on policy and procedures of Care plan timing and Revisions. On 6/24/2024 the Regional Clinical Director	

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F 657	Continued From page 26 medications by mouth, topical and opthalmic (Tylenol, cetirizine, eye drops, protopic ointment, and topical eyebrow cream) were discontinued. A revised care plan dated 8/24/23 indicated Resident #353 was not care planned for no longer receiving medications from the facility due to refusals and the care plan was not updated to reflect the resident could self-administer "all" medications and pick up his medications from an outside pharmacy provider per physician's order 5/3/24. A quarterly Minimum Data Set assessment dated 9/13/23 indicated Resident #353 was cognitively intact and had not rejected care. A discharge Minimum Data Set (MDS) assessment dated 10/9/23 indicated Resident #353 was cognitively intact and had not rejected care. During an interview on 6/20/24 at 10:00 am the Director of Nursing (DON) indicated Resident #353 would not talk to and refused care from the facility physician or nurse practitioner due to his paranoia. The DON further indicated the resident would schedule his own doctor appointments with outside providers the facility was not aware of, schedule his own transportation, pick up his own medications from a local pharmacy and did not want any care from the facility. The DON stated she was made aware in August or September 2023 who the resident's outside primary care physician was and what pharmacy he was using. The information was not added to the resident's face sheet until 10/2/24. The DON then stated the care plan should have been revised to reflect Resident #353's refusal to utilize the facility	F 657	provided education to the Director of Nursing on how to properly obtain outside pharmacy medications if indicated. This education will be added to the orientation program for new employees in these roles. 4. The MDS Director or designee will randomly audit 5 care plans for self-administration of medications and if a resident uses an outside pharmacy Weekly for 12 weeks. The MDS Director or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 657	Continued From page 27 physician, nurse practitioner and in-house pharmacy. The care plan should have also been revised regarding the use of an outside pharmacy for which he was responsible for picking up and self-administering his medications. The DON also stated the care plan should have been updated to reflect when the self-administered medications were discontinued 7/11/23 during the resident's leave of absence. An interview on 6/20/24 at 10:42 am with the MDS Coordinator revealed she took over as coordinator in April 2023, was still learning, and was responsible for updating/ revising care plans and that Resident # 353's care plan should have been revised to reflect changes and challenges related to self- administration and picking up his own medications from an outside pharmacy. The MDS Coordinator further revealed changes would have been discussed during morning meetings or identified through nurse notes, physician orders or nurse practitioner notes. During an interview on 6/20/24 at 2:50 pm the interim Administrator revealed the care plan should have been updated / revised accordingly for Resident #353 and was not. The interim Administrator further revealed education on updating the care plan accurately was necessary.	F 657		
F 679 SS=H	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		7/18/24

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F 679	Continued From page 28 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 4 residents reviewed for activities (Resident #1, #50, #54, and #85). The residents expressed not being able to leave the facility for over a year made them feel more dependent, less social, sad, and they missed getting out with the group to shop and socialize. The findings included: A review of the June 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility. Observation on 6/17/24 at 9:30 AM revealed the facility was located within a business and residential area that was within driving distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants. a. Resident #1 was admitted to the facility on 11/11/14. An Annual Minimum Data Set (MDS) dated 2/24/24 indicated Resident #1 felt that it was very	F 679	F 679 = Activities Meet Interest/Needs Each Resident 1. Residents #1, #50, #54, #85 were offered first- priority of outing scheduled for 7/12/2024. Residents #1, #54 and #85 attended, Resident #50 declined. 2. All residents have the potential to be affected. On 7/9/2024 – 7/11/2024 the Activities Director reassessed current facility residents on the interest of participating in outside activities. No additional concerns were identified. 3. On 7/9/2024 the Administrator re-educated the Activities Staff on scheduling on monthly calendar, offering to appropriate residents, providing offsite activities/events and transportation to events. This education will be provided to new staff in these rolls. 4. The administrator or designee will audit activities monthly for 3 months to ensure outside activities/events are being scheduled, offered and organized appropriately. The Administrator or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will	

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F 679	Continued From page 29 important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #1 was cognitively intact. An interview was conducted with Resident #1 on 6/19/24 at 10:30 AM during resident council meeting revealed there had not been a scheduled group activity outside of the facility in over two years and the resident council had requested one during their monthly activity meetings, and met with the previous administrator about it and each time was told there was nothing they could do because the van was broken, and they had no other way to transport residents. She stated in her opinion group activities outside of the facility were important to the residents that were able to go and participate because it allowed them some lasting independence, socialization with the group and outside world, and helped with their mental and physical health, it made them feel normal and that they weren't just stuck in a facility. Resident #1 stated not being able to leave the facility in several years and participate in group activities outside the facility had sometimes made her feel as though she had lost some of her own independence and was having to rely on someone else to do her personal shopping instead of on her own. She revealed personally being able to do her own shopping and socializing with other people outside of the facility was very important to her and would make her feel more human and like she still had some independence left. b. Resident #50 was admitted to the facility on 9/17/20. An Annual Minimum Data Set (MDS) dated	F 679	make recommendations and changes as indicated.	

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F 679	Continued From page 30	F 679		

4/04/24 indicated Resident #50 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #50 was cognitively intact.

An interview was conducted with Resident #50 on 6/19/24 at 10:32 AM during resident council meeting revealed she had been at the facility for the past several years and there had not been a scheduled group activity outside of the facility in over two years. She stated they discussed it with the Activities Director and the previous Administrator and was always told they were not able to schedule activities outside of the facility due to the van being broken, not being able to transport residents, and corporate not approving for any alternate transportation. Resident #50 revealed that going out to eat at a restaurant and socializing or going into a store and being able to touch items and shop for your own personal belongings made you feel independent and normal, and she felt that not being able to do those things over the past several years made her sad, become more reliant on staff and not as social as she used to be and she would just like the opportunity to have those things again.

c. Resident #54 was admitted to the facility on 10/18/23.

An Admission Minimum Data Set (MDS) dated 10/27/23 indicated Resident #54 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #54 was cognitively intact.

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An interview was conducted with Resident #54 on 6/19/24 at 10:34 AM during resident council meeting revealed since he had been to the facility there had been no scheduled activities outside of the facility. He stated during the monthly activities meeting, residents had discussed with the Activities Director and the previous Administrator about scheduling activities outside of the facility and were told that was not possible because the facility was not able to provide transportation due to the van being broken. He revealed not having scheduled activities outside of the facility made him feel sad, depressed, and like he was missing out on the world. Resident #54 stated that he felt like he was more reliant on staff to purchase his personal items for him, and he would like the opportunity to go shopping for himself or to eat at a restaurant and socialize with other people.

d. Resident #85 was admitted to the facility on 6/15/23.

An Annual Minimum Data Set (MDS) dated 6/07/24 indicated Resident #85 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #85 was cognitively intact.

An interview was conducted with Resident #85 on 6/19/24 at 10:36 AM during resident council meeting revealed since he had been to the facility there had been no scheduled activities outside of the facility. He stated he participated in a monthly activity meeting, and they had discussed with the Activities Director and the previous Administrator on a regular basis about scheduling activities outside of the facility. He revealed they were

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always told that was not possible because the facility was not able to provide transportation due to the van being broken. Resident #85 stated not having the opportunity to participate in activities outside of the facility made him feel sad, lonely, and like he was losing his independence. He revealed that he felt it was important for residents to have scheduled activities outside of the facility because it allowed them to be able to shop and purchase their own items, maintain their independence, and to be able to socialize with the real world.

A telephone interview was conducted with the previous Administrator on 6/19/24 at 2:25 PM revealed he was employed with the facility for the past 2 ½ years and his last day was on 5/31/24. He stated during the time he worked as the facility Administrator; residents had not been able to participate in scheduled outside of facility activities due to transportation issues. He revealed the facility had two vans but only one of the vans was working, which was used for medical appointments only and corporate would not approve for the other van to be fixed. The previous Administrator stated the Activities Director would speak with him monthly about residents requesting to schedule an activity outside of the facility and he would speak with corporate about fixing the other van or paying for alternate transportation and corporate would not approve for the van to be fixed stating "the van was not worth the cost of the repairs" and alternate transportation was "too expensive". He revealed he did feel that activities outside of the facility were important for residents and allowed them to keep some of their independence and normalcy and he tried to accommodate their requests but without approval from corporate to

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either fix the other van or pay for alternate transportation, his hands were tied.

An interview was conducted with the Activity Director (AD) on 6/20/24 at 9:05 AM revealed she had been working as the AD at the facility for the past 2 years and part of her responsibilities was scheduling and implementing resident activities inside and outside of the facility for each month. She stated since she began working at the facility as the AD, she had not been able to schedule any resident group activities outside of the facility due to transportation issues. She revealed one of the facility vans had been broken since she began working at the facility and she was told by the previous administrator the other facility van could only be used for medical appointments and residents would just have to participate in activities inside of the facility or on facility grounds. The AD stated she had brought the issue to Administration monthly of the residents requesting to schedule activities outside of the facility and each time was told no due to the transportation and alternate transportation for the residents was not available. She revealed she had been doing personal shopping for residents so they could continue to receive their preferences but understood that was not the same as the residents being able to leave the facility and shop for themselves or eat a meal together at a restaurant or watch a movie outside of the facility. She stated she felt like activities outside of the facility for those residents who could participate were important for their overall mental and physical well- being and allowed them some independence.

During an interview conducted with the interim Administrator on 6/20/24 at 10:45 AM revealed he

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F 679	Continued From page 34 began working at the facility on 6/01/24 and was unaware of residents not having been able to participate in activities outside of the facility over the couple of years. He stated he would investigate the issue and see what current and alternative transportation methods were available that could be used to assist the residents being able to participate in activities outside of the facility.	F 679		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide Thrombo-Embolic Deterrent (TED) stockings as ordered by the physician on 11/07/23 and 01/09/24 for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet) (Resident #65) for one of one resident reviewed for quality of care. The findings included: Resident #65 was admitted to the facility on 12/08/22 with diagnoses which included hypertension, lower extremity edema, and	F 684	F684 = Quality of Care 1. Resident #65 was assessed on 6/20/2024. No concerns were identified. MD was notified and the order for TED hose was discontinued. 2. All residents have the potential to be affected. The Director of Nursing and Unit Managers completed a 100% audit of all residents with TED hose orders on 6/26/2024 No additional concerns were identified. 3. All staff, including agency staff, were re-educated by the Administrator, Director	7/25/24

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F 684	Continued From page 35 paraplegia (the inability to voluntarily move the lower parts of the body). Review of a physician's progress note written on 11/07/23 revealed Resident #65 was "being seen for a regulatory visit with three or more chronic health problems and interval concerns were being addressed as in the assessment below." Under assessment and plan the note read in part: "9. Lower extremity edema: Chronic and ongoing. Patient appears to have some baseline lymphedema with no previous diagnosis. Mild 1-2 pitting edema noted. Patient sits in chair majority of the day. Patient states swelling does improve slightly overnight when legs are elevated in bed. Continue to monitor. We are going to place order for TED hose - to place in AM and take off at night and elevated as much as possible since this provides improvement. Review of Resident #65's physician orders revealed an order written on 11/07/23 for TED stockings to bilateral lower legs - apply stockings in the morning when resident gets up and take them off the resident at bedtime before going to bed. Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed. Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on	F 684	of Nursing and/or the Assistant Director of Nursing on the policy of following MD orders for TED hose ordering, application and removal. This education was completed on 7/2/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Director of Nursing or designee will observe residents with MD orders for Ted Hose 5 times a week for 12 weeks to ensure TED Hose are available, applied and removed as ordered. The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime.

Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated 05/13/24 revealed he was cognitively intact and required substantial to maximal assistance with upper body dressing, personal hygiene, and bed mobility. The assessment also revealed Resident #65 was dependent on staff for toileting hygiene, showers/bed baths, lower body dressing, putting on and taking off footwear and transfers. According to the assessment the resident had no behaviors including no rejection of care.

Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. Resident #65 further stated he could not recall if they had ever been in to measure him for TED stockings and said he had not received his stockings. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks.

An interview on 06/20/24 at 11:10 AM with the Director of Nursing and the Central Supply (CS) clerk revealed they were aware Resident #65 had TED stockings ordered for bilateral lower extremity edema. The CS clerk stated she had ordered the stockings in November of 2023 and February of 2024 but had not received them. She

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stated she had not followed up with the company to inquire about the stockings. The DON stated their previous owners would not allow them to use other sources for getting supplies and told them they would have to wait for the contracted company to send them the stockings.

An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had "just assumed" his NA had put them on, so she had checked it off on the MAR.

A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she "just assumed" it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings.

A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00

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F 684	Continued From page 38 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she "marked it off on the MAR and the NA took care of taking them off." Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it. An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room. An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room. NA #1 further stated she had only placed non-skid socks on the resident after washing him up and getting him dressed for the day.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		7/25/24

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F 686	Continued From page 39 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, and interviews with the wound physician and staff, the facility failed to maintain a dressing intact to a stage 3 sacral pressure ulcer for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #35). The findings included: Resident #35 was admitted to the facility 2/13/17. Some of Resident #35's diagnoses included vascular dementia, Alzheimer's disease, mild protein calorie malnutrition (PCM), failure to thrive and stage 3 sacral pressure ulcer. A care plan revised 3/11/24 recorded Resident #35 had self-care deficits, required staff assistance with activities of daily living (ADL) and at increased risk for developing pressure ulcers due to a history of pressure ulcers, a current pressure ulcer, incontinence, and PCM. Interventions included staff assist Resident #35 with turning and positioning, provide incontinence care and wound care per physician (MD) order. Review of Resident #35's MD orders in the	F 686	F 686 = Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. Resident #35 on 6/17/2024 was immediately assessed by Wound Physician, no concerns were identified. 2. All residents with pressure injuries have the potential to be affected. On 6/17/2024 the Unit Manager completed a 100% audit of residents with pressure injuries, no additional concerns were identified. 3. All Licensed Nursing Staff and Certified Nursing Assistants, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on the skin management system, dressing changes, and notifying the nurse of dressings not in place. This education was completed on 6/21/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Director of Nursing or designee	

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F 686	Continued From page 40 electronic medical record (EMR) recorded a 3/11/24 MD order to cleanse sacral pressure ulcer with wound cleanser, pat dry, apply silver calcium alginate (a debridement), cover with a dry dressing daily and as needed (PRN) until healed. A 5/6/24 MD progress note recorded Resident #35 was evaluated for chronic disease management, received hospice services, required total staff assistance with ADL, received treatment for a stage 3 pressure ulcer of the sacrum, and followed by wound care MD. The plan was to continue with current wound treatments. A 6/10/24 quarterly Minimum Data Set (MDS) assessment recorded Resident #5 had adequate hearing, impaired vision, clear speech, usually understood by others, sometimes understood others, always incontinent of bowel and bladder function and rejected care one to three days of the assessment period. The MDS assessment indicated Resident #35 was at risk for developing pressure ulcers and had an unhealed stage 3 pressure ulcer. The June 2024 Treatment Administration Record documented Resident #35 received wound care per MD order on Sunday, 6/16/24 at 2:30 PM. A 6/17/24 MD Wound Evaluation and Management Summary recorded Resident #35 had a current stage 3 sacral pressure ulcer, that measured 2 centimeters (CM) by, 1 cm, by 0.1 cm with moderate serous exudate (bloody discharge). The wound progress was described as not on goal with her behavior as a possible factor. The treatment plan recorded alginate calcium with sliver, apply once daily for 30 days,	F 686	will audit 3 residents with treatment orders for dressing changes weekly for 12 weeks to ensure dressings are intact. The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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apply a gauze island border dressing once daily for 30 days.

A 6/17/24 Wound Assessment Note, recorded by Unit Manager (UM) #4 recorded Resident #35 had a stage 3 pressure ulcer to the sacrum with full thickness that measured 2 cm by 1 cm by 0.1 cm, and moderate serous exudate noted as assessed by the wound MD during wound rounds on 6/17/2024.

On 6/17/24 at 10:39 AM, Resident #35 was observed in her room in bed without a brief on or a dressing in place to her stage 3 sacral pressure ulcer. Nurse Aide (NA) #8 provided peri-care and applied a brief.

On 6/17/24 at 11:00 AM a wound care observation for Resident #35 with the wound MD and UM #4 revealed the stage 3 sacral pressure ulcer was not covered with a dressing prior to the wound care provided by the wound MD.

NA #8 was interviewed on 6/17/24 at 10:39 AM and stated that she had just completed peri care for Resident #35 for bladder incontinence. NA #8 described that she rounded when she came on shift around 7:00 AM on 6/17/24 and checked Resident #35's brief for incontinence, but her brief was dry. She stated that the previous NA did not report to NA #8 that Resident #35 did not have a dressing in place to her sacral pressure ulcer during rounds. NA #8 stated that she did not remove Resident #35's dry brief during rounds and that she could not say if a dressing was in place to the sacral pressure ulcer at the time (7:00 AM) but stated there was no dressing in place or in the brief at 10:30 AM that morning on 6/17/24 when she provided peri care to Resident

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#35 for the first time that shift. NA #8 described Resident #35 was always incontinent of bowel/bladder and that she provided peri care to Resident #35 before and found her a few times without a dressing in place to her wound; when that occurred, she told the nurse. The brief was observed wet without a dressing in the brief.

Multiple attempts to interview the NA assigned to care for Resident #35 on the 11:00 PM to 7:00 AM shift were unsuccessful.

On 6/17/24 at 10:41 AM, Nurse #8, the assigned nurse for Resident #35 on the 7:00 AM to 3:00 PM shift stated in interview that this was her first time as the assigned nurse for Resident #35, she was not aware that a dressing was not in place for Resident #35's sacral pressure ulcer and she had not provided wound care to this Resident before.

During a phone interview on 6/19/24 at 5:01 PM with Nurse #10, she confirmed she was the 7:00 AM to 3:00 PM Nurse on the south unit where Resident #35 resided on Sunday 6/16/24 but stated that she could not continue the interview due to a family emergency. Nurse #10 ended the call. A follow up attempt to interview Nurse #10 was unsuccessful.

A phone interview on 4/21/24 at 4:29 PM, Nurse #11 stated she worked Sunday, 6/16/24 on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts through an agency. Nurse #11 stated she was the assigned nurse for Resident #35 on 6/16/24 but did not recall providing wound care to this Resident on her shift. Nurse #11 stated that when she worked, she provided wound care per MD order for residents assigned but that she did

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not recall being notified that Resident #35's dressing was not in place or asked to reapply a dressing to Resident #35's sacral pressure ulcer.

A 6/21/24 phone interview at 8:40 AM with Nurse #9 revealed she worked at the facility and she was the assigned nurse for Resident #35 two days per week on the 7:00 AM to 3:00 PM and every other weekend. Nurse #9 described Resident #35 as "declining" due to poor nutritional status, received hospice services, incontinence care and wound care for a stage 3 sacral pressure ulcer. Nurse #9 stated that at times during incontinence care, the dressing to Resident #35's sacral pressure ulcer came off and sometimes the NA did not tell the nurse which meant Resident #35 was without a dressing to her pressure ulcer for a while. Nurse #9 stated that if she went to provide Resident #35 with treatment for her sacral pressure ulcer and a dressing was not in place, she asked the NA what happened, and often the response was that the dressing came off during incontinence care. Nurse #9 stated that when this occurred, she reminded the NA to tell the nurse so that the dressing could be reapplied. Nurse #9 stated that if a dressing came off during incontinence care, the NA was supposed to tell the nurse so that the nurse could put another dressing on, but that all the NA did not notify the nurse.

UM #4 was interviewed on 6/18/24 at 4:44 PM and stated that Resident #35 received treatment for a stage 3 sacral pressure ulcer. UM #4 described that the pressure ulcer was taking a while to heal which could be contributed to Resident #35's poor nutritional status. UM #4 stated that she rounded with the wound MD on 6/17/24 and when wound care was provided to

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Resident #35, there was no dressing in place to the pressure ulcer, but a dressing should have been in place. UM #4 stated The MD order was for daily wound treatments changes and PRN, so that in the event the dressing came off the nurse should be notified so that a new dressing could be applied. UM #4 stated that due to the location of Resident #35's pressure ulcer, it was at risk for infection and for getting urine/feces in the pressure ulcer which along with her poor nutritional status, could also inhibit the healing of the pressure ulcer.

A phone interview on 6/18/24 at 3:35 PM with Hospice Nurse revealed Resident #35 admitted to hospice services with a stage 3 pressure ulcer. The Hospice Nurse stated that it would be of concern if Resident #35's stage 3 pressure ulcer was not covered for an extended period which she described as not changed on the same shift of care. The Hospice Nurse described that the concern would be due to the location of the pressure ulcer, the high risk, if left uncovered, of the pressure ulcer encountering fecal/urine material that could inhibit the healing progress and increase the risk of infection.

The Wound Physician (MD) was interviewed on 6/17/24 at 11:00 AM during his evaluation of Resident #35's pressure ulcer. He stated that there was no dressing in place for Resident #35's stage 3 sacral pressure ulcer prior to his evaluation on 6/17/24 during his wound rounds. The Wound MD stated that he would expect Resident #35's stage 3 sacral pressure ulcer to be covered and receive treatment per MD order, which included a MD order for treatment PRN. He further stated that if the dressing came off for any reason, he expected staff to reapply a dressing,

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F 686	Continued From page 45 per the MD order for PRN treatment and that the pressure ulcer should not be "left open like this." A follow up phone interview on 6/19/24 at 4:32 PM, the Wound MD described that Resident #35's stage 3 pressure ulcer had been "stagnant for a while" which he attributed to her end-of-life status. He stated that Resident #35's behaviors of fighting, punching and scratching staff when staff tried to reposition the Resident used to contribute to the slow healing progress, but stated that since her decline she no longer displayed this behavior, and the current concern was her poor nutritional status. The Wound MD stated that when he assessed the pressure ulcer for Resident #35 on 6/17/24 during wound rounds, she did not have a dressing in place to the pressure ulcer. He further stated that he would be concerned if the pressure ulcer was left uncovered for more than an hour or two as stool/urine could get in the pressure ulcer which increased the risk for contamination and could also be a factor to slow down the healing process along with her nutritional status. The Director of Nursing stated in an interview on 6/18/24 at 4:59 PM that residents with treatment orders for wound care should have a dressing in place per MD order to prevent infection or the wound being contaminated with urine/feces.	F 686		
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	F 732		7/25/24

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F 732	Continued From page 46 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. (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 reviews and staff interviews, the facility failed to maintain daily nurse staffing sheets for 244 of 305 days during the period reviewed from August 2023 to May 2024. The facility also failed to ensure the daily nurse staffing sheets were maintained for a minimum of 18 months.	F 732	F 732 = Posted Nursing Staffing Information 1. Facility was unable to locate Daily Nursing Staffing Sheets for October 2023 to May 2024. 2. All residents have the potential to be affected.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 47 The finding included: Review of the daily nurse staffing sheets for October 2023 revealed no information was available for the days of 10/01/2023 through 10/31/2023. Review of the daily nurse staffing sheets for November 2023 revealed no information was available for the days of 11/01/2023 through 11/30/2023. Review of the daily nurse staffing sheets for December 2023 revealed no information was available for the days of 12/01/2023 through 12/31/2023. Review of the daily nurse staffing sheets for January 2024 revealed no information was available for the days of 01/01/2024 through 01/31/2024. Review of the daily nurse staffing sheets for February 2024 revealed no information was available for the days of 02/01/2024 through 02/29/2023. Review of the daily nurse staffing sheets for March 2024 revealed no information was available for the days of 03/01/2024 through 03/31/2024. Review of the daily nurse staffing sheets for April 2024 revealed no information was available for the days of 04/01/2024 through 04/30/2024. Review of the daily nurse staffing sheets for May 2024 revealed no information was available for the days of 05/01/2024 through 05/31/2024.	F 732	3. The Regional Clinical Director re-educated the Staffing Coordinator and the Administrator on the regulatory requirements to maintain daily staffing nursing sheets for 18 months. This education was completed on 6/18/2024. This education will be added to the facility orientation program for new staff in these roles. 4. The Administrator or designee will audit Daily Staffing Nursing Sheets weekly for 12 weeks to ensure the facility is maintaining daily staffing nursing sheets. The Administrator or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 732	Continued From page 48	F 732		

An interview was conducted with the Director of Nursing on 06/19/2024 at 2:43 PM. The Director of Nursing stated that the staffing coordinator was responsible for maintaining the daily nurse staffing sheets.

During an interview on 06/20/2024 at 8:25 AM, the staffing coordinator revealed that she was responsible for the daily nurse staffing sheets, and she did not have any daily staff posting sheets from October 2023 through May 2024. She further revealed that the previous Administrator started collecting the daily nurse staffing sheets in October of 2023 and maintained the sheets in his office. She also stated that she does not know what he did with those sheets.

During an interview with the Administrator on 06/20/2024 at 9:17AM, the Administrator revealed that he was new to the facility as of June 1, 2024. The Administrator also stated that the staffing coordinator was responsible for the daily nurse staffing sheets, and the staffing coordinator had informed him that the previous Administrator collected the daily nurse staffing sheets and maintained them in his office. The Administrator further revealed that he had searched through his entire office and had not found any daily staff posting sheets. The Administrator also confirmed that he was aware of the regulatory requirement to maintain 18 months of daily nurse staffing sheets. The Administrator explained a change in ownership had occurred on June 1st, 2024, and the facility had not been successful in locating the October 2023 to May 2024 daily staff posting sheets.

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F 758	Continued From page 49	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		7/25/24

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F 758	Continued From page 50 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff, physician, and resident responsible party (RP) interviews, the facility failed to discontinue a benzodiazepine medication (Ativan) used for anxiety as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included: Resident #5 was admitted on 05/27/20 to the facility with diagnoses that included anxiety, unspecified dementia with other behaviors. Review of Resident #5's physician orders from October 2023 revealed the following orders: - Ativan 0.5 milligram (mg) tablet - give ½ tablet by mouth twice a day for agitation/anxiety with a start date of 07/05/23 and an end date of 10/10/23. - Clonazepam (benzodiazepine medication) 0.25 mg tablet - give 1 tablet by mouth 3 times daily for anxiety with start date of 10/04/23 and an end date of 10/10/23. Additional review of Resident #5's physician orders revealed the following order written on	F 758	F 758 = Free from Unnecessary Psychotropic Meds/PRN Use 1. Resident #5's Ativan was discontinued on 10/10/2023. 2. All residents that receive psychotropic medications have the potential to be affected. On 7/8/2024 – 7/9/2024 the Pharmacist completed a 100% medication review of all residents that receive psychotropic medications. No additional concerns were identified. 3. All Licensed Nursing Staff, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on properly processing MD orders, including discontinuing psychotropic medications. This education was completed on 7/2/2024. This education will be added to the facility orientation program, to include new Licensed agency staff. 4. The Director of Nursing or designee will audit new psychotropic medication	

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F 758	Continued From page 51 10/04/23: - discontinue Ativan and start clonazepam 0.25mg by mouth three times per day for anxiety with an effective date of 10/04/23. The order was received and transcribed by Former Unit Manager #1. Review of Resident #5's medication administration record revealed Resident #5 received both Ativan 0.5mg and clonazepam 0.25mg from 10/04/23 through 10/10/23. Review of Resident #5's most recent quarterly Minimum Data Set assessment dated 05/30/24 revealed he was severely impaired with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #5 was coded as taking antianxiety and antidepressant medications. An interview with Resident #5's responsible party on 06/18/24 at 2:15 PM via telephone, revealed on 10/10/23, Resident #5 was sent to the hospital. The following day, she was contacted by a physician from the hospital who informed her that Resident #5 had been receiving Ativan and clonazepam. She continued, stating this was concerning since at a care plan meeting conducted on 10/04/23 it was discussed that the facility would discontinue the use of Ativan and start Resident #5 on clonazepam. She stated she contacted the Director of Nursing (DON) on 10/13/23 and discussed the situation with her and was informed that the continuation of Ativan with the dosing of clonazepam was a medication error and that the facility would investigate and re-educate the staff. Resident #5's responsible party reported he was able to return to the facility following a short hospitalization.	F 758	orders 5 times a week for 12 weeks to ensure orders have been processed properly. The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 758	Continued From page 52	F 758		

An interview was completed with Former Unit Manager #1 by telephone on 06/20/24 at 10:07 AM. She reported she remembered Resident #5 and verified she was the staff member that took the physician order to discontinue his Ativan and start clonazepam on 10/04/23. She stated at that the time, she was serving as the unit manager while also working as a hall nurse. Former Unit Manager #1 also verified that Resident #5 received both Ativan and clonazepam from 10/04/23 though 10/10/23 when the facility was contacted by his responsible party, alerting them to the error. She stated she did not know how or why she was able to add and start the clonazepam and did not enter in the discontinue Ativan order into the electronic health record. She reported with her serving as a hall nurse and the unit manager at the time the orders were written, she may have been overwhelmed or had become distracted while entering the orders and had forgotten to enter the discontinue Ativan physician order. She stated Resident #5 was sent out to the hospital on 10/10/23 for heart related issues and the hospital had identified that Resident #5 was prescribed the two medications and reached out to his responsible party who then, in turn, contacted the facility. Former Unit Manager #1 reported during the 7 days that Resident #5 received both the Ativan and clonazepam, she did not note any change in his behaviors or notice him being more lethargic or drowsy.

During an interview with the Director of Nursing (DON) on 06/20/24 at 11:59 AM, she reported she remembered the incident and stated it was her understanding that Former Unit Manager #1 had received the telephone order and instead of

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F 758	Continued From page 53 writing two separate orders, one to discontinue Ativan and another to start clonazepam, she wrote both orders on one physician order form. She stated she could only assume that when Former Unit Manager #1 went to enter the order, she somehow overlooked the entry of discontinue Ativan which resulted in Resident #5 receiving both medications until Resident #5 discharged to the hospital on 06/10/23. The DON reported she completed an investigation into the error, re-educated Former Unit Manager #1 and other hall nurses and medication aides. The DON also stated she contacted the hospital and spoke to Resident #5's attending physician and spoke with him about possible side effects and was told there did not appear to be any adverse effects from Resident #5 receiving both medications. The DON reported during the days that Resident #5 received both Ativan and clonazepam, she did not receive one concern regarding excessive drowsiness, or other potential side effects from Resident #5 receiving both medications. The DON reported Resident #5 returned to the facility after a brief hospitalization. During an interview with the Medical Director on 06/20/24 at 11:14 AM, she reported the risks of taking both Ativan and clonazepam would be excessive drowsiness and respiratory depression. She reported she was not at the facility at the time of the investigation and stated it would be almost impossible for her to determine if Resident #5 had an adverse reaction due to receiving both Ativan and clonazepam. The Medical Director stated it was a medication error, but she was unable to state with certainty if it was a significant medication error.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		7/25/24

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F 761	Continued From page 54 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired over the counter medications available for use from a medication storage room in 2 of 2 medication rooms reviewed for medication storage (south side and west side). The findings included: 1a. On 06/19/24 at 10:00 AM during an	F 761	F 761 = Label/Store and Biologicals 1. On 6/19/2024 all expired medications were removed from the medication rooms by the Unit Manager. 2. All residents have the potential to be affected. On 6/27/2024 all medication rooms were audited by the Unit Managers; no additional concerns were identified.	

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F 761	Continued From page 55 observation of the south side medication room with Unit Manager (UM) #1 the observation yielded 1 unopened bottle of Vitamin D 10 micrograms (mcg) with an expiration date of 01/24 (January/2024) and 6 unopened bottles of Vitamin D 10 (mcg) with an expiration date of 05/24 (May/2024). On 06/19/24 at 10:10 AM an interview was conducted with Unit Manger #1. During the interview she stated the medication storage room was checked monthly by the facility staff. She stated she was responsible for checking the medication storage room and had just missed the expiration date by mistake. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the bottle. 1b. On 06/19/24 at 10:45 AM during an observation of the west side medication room with Unit Manager (UM) #2 the observation yielded 4 unopened bottles of Vitamin D 10 (mcg) with an expiration date of 05/24. On 06/19/24 at 11:00 AM an interview was conducted with Unit Manger #2. During the interview she stated the medication storage room was checked monthly by staff. She stated she was responsible for checking the west side medication storage room and had not seen the medication had expired. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the bottle. An interview was conducted with the Director of	F 761	3. All Licensed Nursing Staff, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on the facility Medication Storage policy. This education was completed on 7/2/2024. This education will be added to the facility orientation program, to include new Licensed agency staff. 4. The Director of Nursing or designee will audit medication rooms and medication carts weekly for 12 weeks to ensure there are no expired medications. The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 761	Continued From page 56 Nursing (DON) on 06/19/24 at 11:31 AM. The DON was informed of the findings in the medication storage rooms and the DON stated the facility staff had looked in both rooms a couple of days prior and had not found the expired medication. She stated the facility went by the expiration date listed on the bottle of the medication and the expired medications should have been discarded.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a lunch meal test tray observation, record review and resident interviews (Resident #4, #70, #153 and #65), the facility failed to provide food per resident preference for taste and temperature for 4 of 4 sampled residents on the south unit reviewed for food palatability. This failure had the potential to affect a census of 93 residents who received food in the facility. The findings included: 1a. Resident #4's admission date to the facility was 10/31/20 and included diagnoses of type 2 diabetes mellitus, hypertension, and hyperlipidemia (high blood cholesterol).	F 804	F 804 = Nutritive Value/Appear, Palatable/Prefer Temp 1. Residents #4, #70, #153, and #65 preferences were updated by the Certified Dietary Manager on 6/19/2024. 2. All residents have the potential to be affected. On 7/2/2024 100% audit of residents' meal preferences was completed by the Certified Dietary Manager and meal plan was adjusted as indicated. On 6/18/2024 an audit of food temperatures during dinner meal was completed by the Certified Dietary Manager. No concerns were identified.	7/25/24

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F 804	Continued From page 57 Resident #4's 5/17/24 annual Minimum Data Set (MDS) assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, severely impaired cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray. Resident #4's care plan, revised May 2024 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences. An observation of the lunch meal on 6/17/24 at 12:08 PM, revealed Resident #4's lunch meal tray card recorded a regular diet with no added salt. Resident #4 received ham and macaroni casserole, and spinach for lunch. Resident #4 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, "This macaroni is not good and it's not hot." Resident #4 did not eat the macaroni and ham casserole she received for lunch. 1b. Resident #70's re-admission date to the facility was 9/6/23 with diagnoses that included type 2 diabetes mellitus and hyperlipidemia. Resident #70's 4/26/24 quarterly MDS assessment recorded adequate hearing, impaired vision, spoke clearly, understood, understands, severely impaired cognition, received a mechanically altered, therapeutic diet and fed herself after staff assisted to set up her meal tray. Resident #70's care plan, revised 5/1/24 recorded	F 804	3. All Staff, including dietary and agency staff, were re-educated by the Administrator and/or the Assistant Director of Nursing on the facility policy for resident dietary preferences, meal delivery and food temperatures. This education was completed on 7/17/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Certified Dietary Manager or designee will audit 3 resident food preferences weekly for 12 weeks. The Certified Dietary Manager or designee will audit 3 test trays weekly for 12 weeks to ensure proper food temperatures. The Certified Dietary Manager or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 804	Continued From page 58	F 804		

she was at risk for inadequate nutritional intake due to her receipt of a mechanically altered, therapeutic diet. Interventions included providing foods per her preferences.

An observation of the lunch meal on 6/17/24 at 12:19 PM, revealed Resident #70's lunch meal tray card recorded a mechanical soft textured no concentrated sweets diet. Resident #70 received ham and macaroni casserole, and spinach for lunch. Resident #70 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, "I don't like these greens, they are not hot." Resident #70 did not eat the spinach she received for lunch.

1c. Resident #153 was readmitted to the facility on 6/3/24 and included diagnoses of chronic renal failure and hypertension.

Resident #153's 6/10/24 quarterly MDS assessment recorded adequate hearing, adequate vision, clear speech, understood, understands, intact cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray.

Resident #153's care plan, revised 6/14/24 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences.

An interview with Resident #153 and observation occurred on 6/19/24 at 12:43 PM. Resident #153's lunch meal remained covered and uneaten at the time of the observation. Resident #153 stated that she did not receive salt on her

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F 804	Continued From page 59	F 804		

meal tray with her food, and she did not like the food. Resident #153 stated," They could do better with the food and add more seasonings, it's like they just open a can and pour it in the pot."

1d. The admission date for Resident #65 to the facility was 12/8/22 and included a diagnosis of hypertension.

Resident #65's 5/13/24 quarterly MDS assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, intact cognition, received a therapeutic diet and fed himself after staff assisted to set up his meal tray.

Resident #65's care plan, revised 5/24/24 recorded he was at risk for cardiac complications and altered nutrition regarding his diagnosis of hypertension and receipt of a therapeutic diet. Interventions included providing foods per diet order and preferences.

Resident #65 stated in an interview on 6/17/24 at 4:49 PM that since the fall of 2023, he reported to dietary staff that he did not like the taste of the food and the facility served cold food. He stated that dietary staff advised that the facility served foods per the corporate menus/recipes which was out of the facility's control, so he asked his family to provide him food or he ordered out. Resident #65 provided pictures from his mobile phone for review of foods received at the facility dated October 2023 to May 2024. A follow up phone interview on 6/21/24 at 9:20 AM, Resident #65 stated he received fish cakes for dinner on Wednesday, 6/20/24, and described that the fish cakes were grey on the inside. He stated, "When I bit into it, the fish should have been white, but it

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was grey, so I could not eat it." He further stated that the food at the facility was not the quality of food he should receive, and the food quality was just not good.

1e. A request for a lunch meal test tray from the tray line occurred on 6/17/24 at 11:58 AM. On 6/17/24 at 12:05 PM, 16 trays left the kitchen for delivery to the south unit and the cup of tea placed on the test tray in the kitchen contained ice cubes. The meal cart arrived on the south unit on 6/17/24 at 12:07 PM and two staff delivered meal trays to residents on the south unit until 12:48 PM. A sample of the lunch meal test tray occurred on 6/17/24 at 12:49 PM. The Certified Dietary Manager (CDM) removed the lid from the test tray and stated she did not see any steam coming from the food. The CDM added margarine to the food, which remained congealed and required continuous stirring to melt. The CDM tasted the food on the test tray and stated the macaroni and ham casserole would have been "really good" if it was hot, that it was slightly warm, but not hot. The CDM stated the spinach was not hot like it was when she tasted it in the past "right off the line." An observation of the cup of tea on the test tray revealed the tea was without ice and had a watered appearance.

An interview with the CDM on 6/18/24 at 12:25 PM for follow up she stated that she was aware of resident complaints of cold food on the weekends in September 2023 and since then she and the corporate dietary staff responded by completing test trays on the weekends. The CDM stated that when she conducted a test tray, she sampled food right from the tray line, monitored food temperatures in the kitchen and based on her weekend test tray audits of food right from the

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tray line, she had no current concerns with cold food. The CDM stated that if there were current concerns with cold food, nursing staff would need to increase the availability of staff to distribute meal trays to residents. She stated that there was one resident, she identified as Resident #65 who she stated complained for a while about the food, and that she told Resident #65 that dietary staff followed corporate menus/recipes, complaints were forwarded to the corporate office and that menu changes were out of her control. The CDM stated that the corporate office did not approve all the requested menu changes, but the dietary department changed what they could. The CDM stated she told residents about the alternate menu, but residents preferred to order food for delivery or have family provide them food.

An interview on 6/20/24 at 1:40 PM with the District Training Dietary Manager revealed the facility was a new account for her, the facility was in transition to new management, she was unaware of resident complaints of food quality but that she would discuss that further with the CDM.

The Director of Nursing (DON) interview on 6/19/24 at 6:00 PM revealed that the facility was currently in transition to new management and working through some of the logistics with dining services to provide residents with meals that were not cold, but palatable.

The Administrator interview on 6/20/24 at 2:46 PM revealed that staff should all be available during meals, nurses needed to know that meal trays were on the halls so that "all hands are on deck" to assist residents with their meals and allow residents to receive hot food.

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F 809	Continued From page 62	F 809		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to provide evening snacks to residents when requested for 4 of 4 residents (Resident #1, #50, #54, and #85) reviewed for frequency of snacks. This practice had the potential to affect other residents who requested evening snacks. The findings included: a. Resident #1 was admitted to the facility on 11/11/14 with diagnosis that included type 2 diabetes.	F 809	F 809 = Frequency of Meals/Snacks at Bedtime 1. Residents #1, #50, #54, and #85 were offered bedtime snacks and preferences were updated on 6/21/2024. 2. All residents have the potential to be affected. Beginning 6/21/2024 all residents are offered bedtime snacks. On 6/21/2024 the Certified Dietary Manager implemented a process that snacks and drinks are made readily available. 3. All nursing staff, including agency	7/25/24

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F 809	Continued From page 63 The annual Minimum Data Set (MDS) dated 2/24/24 indicated Resident #1 was cognitively intact. An interview with Resident #1 during resident council meeting on 6/19/24 at 10:30 AM revealed since she had been at the facility she might have received an evening snack maybe once or twice but not on a consistent basis. She stated she did not have the money to be able to purchase her own snacks all of the time and felt the facility should be able to provide her with an evening snack when requested. Resident #1 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available in the nourishment room for them to give to her and they did not have access to get snacks from the kitchen. b. Resident #50 was admitted to the facility on 9/17/20 with diagnosis that included type 2 diabetes. An annual MDS dated 4/04/24 indicated Resident #50 was cognitively intact. An interview with Resident #50 during resident council meeting on 6/19/24 at 10:31 AM revealed during her stay at the facility she might have received an evening snack maybe once or twice but not on a consistent basis. She stated she would have her family bring her snacks or buy them herself. Resident #50 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available for them to give to her.	F 809	staff and dietary staff were educated by the Administrator and/or the Assistant Director of Nursing on the Facility Nourishment Policy and Procedures, including all residents being offered HS snacks. This education was completed on 7/17/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Certified Dietary Manager or designee will audit that snacks are made available 3 times a week for 12 weeks to ensure snacks and drinks are readily available. The Director of Nursing or designee will randomly audit 5 resident charts weekly for 12 weeks to ensure HS snacks are being offered. The Administrator, Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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c. Resident #54 was admitted to the facility on 10/18/23 with diagnosis that included type 2 diabetes.

An admission MDS dated 10/27/23 indicated Resident #54 was cognitively intact.

An interview with Resident #54 during resident council meeting on 6/19/24 at 10:32 AM revealed during her stay at the facility she had never received an evening snack on a consistent basis. He stated he was never made aware that he could request an evening snack and staff have never offered him an evening snack. He revealed he did not have the money to buy snacks and drinks all the time, so having an evening snack and drink offered and available would be nice.

d. Resident #85 was admitted to the facility on 6/15/23 with diagnosis that included type 2 diabetes.

An annual MDS dated 6/07/24 indicated Resident #85 was cognitively intact.

An interview with Resident #85 during resident council meeting on 6/19/24 at 10:33 AM revealed since he had been at the facility he had never received an evening snack or been offered an evening snack consistently. He stated sometimes nursing staff will ask if you want a snack and other times you must request it and when you do the staff will usually come back and say they couldn't find any snacks in the nourishment room and they were not able to access the kitchen for more snacks.

An observation of nourishment rooms on 6/17/24

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and 6/19/24 revealed no snacks, sandwiches, or drinks available for residents.

An interview with Nursing Assistant (NA) #6 on 6/19/24 at 3:05 PM revealed she worked both 1st and 2nd shift and had never seen evening snacks being offered to residents, she had never offered evening snacks to residents, and had never been told to offer evening snacks to residents. She stated if a resident asked for a snack, then staff would get them one, but she wasn't sure if most residents were aware they could request a snack or that snacks were supposed to be offered. She revealed the nourishment rooms did not keep snacks, juices, or sandwiches in them for residents so staff would have to request those from the kitchen, and to her knowledge the kitchen did not order or keep diabetic or sugar free snacks for residents and they did not have pudding or Jello, only applesauce for the medication carts and the only soda available was ginger ale for dialysis residents only. NA #6 stated she felt it was important for residents to be offered snacks but for the facility to have a variety of snacks including diabetic snacks for the residents.

An interview with NA #7 on 6/19/24 at 3:11 PM revealed she worked both 1st and 2nd shift at the facility. She stated to her knowledge staff do not offer residents evening snacks but if a resident requested a snack, they would provide them with one. She stated she was not sure why staff did not offer evening snacks; and had never been told to offer evening snacks to residents and never seen other staff offering evening snacks. She revealed it would make sense to offer residents an evening snack because not all residents are able to request an evening snack,

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and some require certain types of snacks or liquids based on their diets. NA #7 stated she did not recall residents complaining about not receiving an evening snack, but she was also not sure if most residents were aware staff should be offering an evening snack or could request an evening snack. She revealed the nourishment rooms did not keep available snacks or drinks in them for residents so any request for those items staff would get from the kitchen and to her knowledge the facility did not order or have available any sugar-free snacks, puddings, or Jello for residents with diet restrictions.

An interview with the Dietary Manager on 6/20/24 at 9:48 AM revealed every morning and afternoon dietary staff were supposed to provide nursing staff on each hall with a bag of snacks for residents that included some crackers, chips, and snack cakes. She stated nursing staff should be offering snacks to each resident, but she believed they only provided snacks to residents who asked. She revealed dietary did not order or have available sugar-free snacks, puddings, or sodas and they do not stock the nourishment rooms with snacks, sandwiches, juices or milk. The dietary manager stated if a resident or staff let her know about a resident preference for a sandwich or chips, she will make sure to include those items on the resident's lunch or dinner tray but was not sure about snacks for residents who are not able to make requests or needed an alternative snack due to dietary restrictions.

An interview with the interim Administrator on 6/20/24 at 10:45 AM revealed he was not aware of snacks and drinks not being available in the nourishment rooms and residents not being offered or receiving their evening snacks. He

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F 809	Continued From page 67 stated he expected there to always be a variety of snacks available for residents, dietary staff should be ordering a variety of snacks and drinks at least monthly, nourishment rooms should always be stocked, and nursing staff should be offering and assisting with resident snack and drink requests. An interview with the Director of Nursing (DON) on 6/20/24 at 11:55 AM revealed she was not aware there was an issue with residents not receiving or being offered evening snacks. She stated nursing staff should be offering all residents an evening snack and if there was an issue with not having snacks available she would expect administration to be notified immediately so they could correct the issue.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		7/25/24

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F 812	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, manufacturer's recommendations and record review, the facility failed to have a thermometer that registered an accurate temperature in 1 of 1 kitchen reach-in refrigerators and 1 of 4 nourishment room refrigerators on the south unit. The facility failed to use a quaternary ammonia (QUAT) sanitizer (a chemical disinfectant) per manufacturer recommendations of 150 - 400 parts per million for manual dishwashing in the three-compartment sink, use a condiment cart free of food debris, and wear a beard restraint (a facial hair guard) during kitchen tasks. This failure had the potential to affect food served to residents. The findings included: 1a. An observation with the Certified Dietary Manager (CDM) on 6/17/24 at 11:55 AM of the thermometer inside the kitchen reach-in refrigerator revealed a temperature of 28 degrees Fahrenheit (F). The CDM obtained a temperature of 38.5 degrees F for an eight-ounce carton of milk that was stored in the kitchen reach-in refrigerator. The CDM stated she would place a new thermometer in the kitchen reach-in refrigerator to check for accuracy of the temperature. On 6/20/24 at 12:49 PM during a follow up observation of the kitchen reach-in refrigerator, the new thermometer revealed a temperature of 38 degrees F. 1b. An observation on 6/17/24 at 12:30 PM of the south unit nourishment room occurred with the	F 812	F 812 = Food Procurement, Store/Prepare/Serve Sanitary 1. The thermometer was replaced in the reach in refrigerator and the Nutritional Supplements were discarded on 6/18/2024. The nourishment room thermometer was replaced on 6/17/2024. Cook #1 was immediately educated on water requirements for QUAT sanitizer for 3-compartment sink om 6/20/2024. The condiment cart was cleaned on 6/17/2024. Dietary Aide #2 was immediately re-educated on wearing a beard restraint on 6/17/2024. 2. All residents have the potential to be affected. On 6/18/2024 the Certified Dietary Manager completed an audit of all nourishment room refrigerator thermometers. No further concerns were identified. On 6/18/2024 the Certified Dietary Manager completed an audit of all thermometers in the facility kitchen. No further concerns were identified. 3. All dietary staff were reeducated by the Certified Dietary Manager and/or the Assistant Director of Nursing on the policy and procedures for having an accurate thermometer for records temperature in refrigerator in the Nourishment room, to use chemical disinfectants per facility policy, to have carts free of debris and food, and to wear a beard net when working in the kitchen. This education was completed on 7/2/2024. This education will be added to the facility	

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F 812	Continued From page 69 CDM. The thermometer stored inside the nourishment room refrigerator revealed a temperature of 28 degrees. The refrigerator contained multiple unopened containers of high calorie nutritional supplements. The CDM stated she would place a new thermometer in the nourishment room refrigerator to check for accuracy of the temperature. On 6/19/24 at 4:00 PM, during a follow up observation of the south unit nourishment room refrigerator the new thermometer revealed a temperature of 38 degrees F. On 6/20/24 at 12:49 PM, the CDM stated she placed a new thermometer in the kitchen reach-in refrigerator and in the south unit nourishment room refrigerator on 6/17/24 and discarded the thermometers that were in use because the thermometers were not working. The CDM further stated that dietary staff periodically monitored the refrigerator thermometers for accuracy, but that she did not notice that the two thermometers were not working. She could not recall the last time the thermometers were checked for accuracy. An interview with the Administrator on 6/20/24 at 2:50 PM revealed he expected thermometers to provide accurate refrigerator temperatures and that dietary staff would require re-education on monitoring the refrigerator thermometers for accuracy. 2. Review of the QUAT sanitizer manufacture recommendations revealed the acceptable range for concentration of the QUAT sanitizer was 150 - 400 parts per million (PPM).	F 812	orientation program, to include new agency staff. 4. The Certified Dietary Manager or designee will audit nourishment room thermometers 5 times a week for 12 weeks to ensure proper temperatures. The Certified Dietary Manager or designee will audit all thermometers in the kitchen refrigerators 5 times a week for 12 weeks. The Certified Dietary Manager or designee will audit the QUAT Sanitizer for 3-compartment sinks 5 times a week for 12 weeks. The Certified Dietary Manager or designee will audit use of beard restraints 5 times a week for 12 weeks. The Certified Dietary Manager or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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Instructions posted above the three-compartment sink recorded to fill the third sink with water to the fill line, add a chemical sanitizing solution, use a test kit to check the concentration of the sanitizing solution and immerse clean dishes in the solution for 30 seconds.

An observation on 6/20/24 at 1:40 PM of the three-compartment sink while in use by Cook #1 revealed the water level in the sink was approximately six inches below the "water fill line" label on the sink. Cook #1 was observed washing dishes manually at the three-compartment sink. Cook #1 stated that the water in the three-compartment sink was set up by the Training District Dietary Manager (DM) and that Cook #1 did not check the concentration of the QUAT sanitizer in the three-compartment sink before she began to wash dishes manually.

On 6/20/24 at 1:41 PM the Training District DM used a QUAT sanitizer test strip to check the concentration of the QUAT sanitizer in the three-compartment sink and obtained a reading that registered greater than 400 parts PPM, as evidenced by a darker color than the manufacturer recommendation of 400 PPM for maximum concentration. The Training District DM stated that she turned on the water to fill the three-compartment sink and left the water running but Cook #1 turned the water off before the water reached the water fill line. The Training District DM stated that the concentration of the QUAT sanitizer should be checked to ensure the correct concentration.

The Administrator stated in an interview on 6/20/24 at 2:50 PM, that the dietary staff should

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 71	F 812		

check the concentration of the QUAT sanitizer to disinfect dishes per manufacture recommendations. He stated that dietary staff would require re-education on the use of the three-compartment sink.

3. A lunch meal tray line observation occurred on 6/17/24 from 11:40 AM until 12:07 PM. The condiment cart was observed in use by Dietary Aide (DA) #1. The condiment cart was observed soiled with brown stains and the compartments on the condiment cart were observed with a heavy buildup of white and black granular food debris.

DA #1 stated on 6/17/24 at 11:59 AM that she did not notice the condiment cart was soiled and that the compartments had a heavy buildup of food debris.

On 6/17/24 at 12:00 PM, the Certified Dietary Manager observed the posted cleaning schedule and stated the condiment cart was scheduled for weekly cleaning. She said per the cleaning schedule, the condiment cart was last cleaned on 6/11/24, but that the cleaning schedule would need to be revised to allow for more frequent cleaning of the condiment cart.

The Administrator stated on 6/20/24 at 2:50 PM in an interview that the condiment cart should be maintained clean by dietary staff and that re-education would be provided on maintaining the condiment cart clean.

4. A lunch meal tray line observation occurred on 6/17/24 from 11:40 AM until 12:07 PM. Dietary Aide (DA) #2 was observed assisting on the lunch meal tray line when he took food carts out of the

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	345489	A. BUILDING _____ B. WING _____	C 06/21/2024

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F 812	Continued From page 72 kitchen for delivery of the lunch meal to residents. DA #2 had a full beard but did not wear a beard restraint for his facial hair. On 6/17/24 at 12:07 PM, DA #2 stated he arrived at work that day at 7:00 AM and that he worked in the kitchen for the past nine months as a cook and a dietary aide. He stated that he was aware that he should have a beard restraint in place to cover his facial hair, but that he just forgot to put on a beard restraint to cover his facial hair when he arrived to work that day. On 6/20/24 at 12:49 PM, the Certified Dietary Manager (CDM) stated that all dietary staff should have hair restraints in place and staff with facial hair should have a beard restraint in place while completing tasks in the kitchen. The CDM stated that she did not notice that DA #2 did not have a beard restraint in place while completing kitchen tasks on 6/17/24. The Administrator stated on 6/20/24 at 2:50 PM in an interview that all dietary staff were trained to have hair and beard restraints in place while completing tasks in the kitchen. He stated that re-education would be provided to the dietary department on the use of hair restraints.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to maintain the lid closed for one of two commercial trash dumpsters and the grounds	F 814	F 814 = Dispose Garbage and Refuse Properly 1. On 6/20/2024, the broken equipment	7/25/24

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F 814	Continued From page 73 surrounding the trash dumpster free of broken equipment and bags of odorous trash. This failure attracted pest activity around the exposed trash. The findings included: An observation on 6/20/24 at 9:03 AM revealed the trash dumpster lid was not closed and exposed multiple bags of odorous trash and broken cardboard boxes stored inside the trash dumpster. The grounds around the trash dumpster were observed with multiple items of broken equipment stored on the grounds. The broken items included two broken motorized wheelchairs, one broken bed, one plastic table and two broken wooden pallets. Two large utility trucks were also observed on the grounds near the trash dumpster without lids that exposed multiple bags of odorous trash. Multiple flies were observed around the opened commercial trash dumpster and the utility trucks with bags of exposed trash. A second trash dumpster was observed available for use, and it was observed to be full of trash. A second observation on 6/20/24 at 12:50 PM of the trash dumpster and surrounding grounds occurred with the Certified Dietary Manager (CDM), the Training District Dietary Manager (DM), the Maintenance Director and the Housekeeping District Manager. The lid of the trash dumpster was not closed and the surrounding grounds near the trash dumpster was observed with multiple items of broken equipment stored on the grounds and two large utility trucks without lids that exposed multiple bags of odorous trash. Multiple flies were observed around the opened commercial trash dumpster and the utility trucks with bags of	F 814	was removed from the facility grounds. On 6/20/2024 a third trash dumpster was delivered, and all garbage was disposed of properly with the lids closed. 2. All residents and staff have the potential to be affected. On 6/21/2024 the Maintenance Director completed an audit of the outside area. No further concerns were identified. 3. All staff, including agency staff, were re-educated by the Administrator and/or the Assistant Director of Nursing on proper disposal of garbage, including ensuring the lids are closed and nothing is on the ground. This education was completed on 7/2/2024. This education will be added to the facility orientation program for all new staff, including new agency staff. 4. Maintenance Director/designee will audit exterior garbage disposal areas 5 times a week for 12 weeks to ensure garbage is disposed of properly. The Maintenance Director or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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F 814	Continued From page 74	F 814		

exposed trash.

The CDM stated on 6/20/24 at 12:50 PM that two trash dumpsters were just delivered on 6/18/24 and that the facility was expecting a third trash dumpster as two commercial trash dumpsters were not enough to contain the trash off the grounds.

The Training District DM stated in an interview on 6/20/24 at 1:00 PM that the second commercial trash dumpster used by the dietary department was full of trash and could not be used to store more trash.

The Maintenance Director stated in an interview on 6/20/24 at 1:11 PM that he was the previous Maintenance Director at the facility a few months ago and returned to the facility in his role on Monday, 6/17/24. He stated that when he returned on Monday, 6/17/24, there were no commercial trash dumpsters at the facility. He stated two commercial trash dumpsters were delivered to the facility on Tuesday, 6/18/24. The Maintenance Director stated that the broken equipment was stored on the grounds when he arrived at the facility on Monday, 6/17/24 and that he arranged on Thursday, 6/20/24 for someone in the community to pick up the broken equipment. He stated that he advised staff not to place the two large open utility trucks with bags of exposed trash outside until the third commercial trash dumpster was delivered. However, he stated that staff placed the bags of exposed trash outside anyway in the two large utility trucks without lids and so the exposed trash and broken equipment remained outside on the grounds awaiting delivery of a third commercial trash dumpster.

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F 814	Continued From page 75 The District Housekeeping Manger stated in an interview on 6/20/24 at 1:38 PM that the facility was in transition between ownership and that the facility was waiting delivery of more dumpsters to maintain the trash. The Administrator stated in an interview on 6/20/24 at 2:50 PM, that the commercial trash dumpsters from the prior contract were picked up Monday, 6/17/24 and that the facility did not have commercial trash dumpsters for the new contract until Tuesday, 6/18/24. He stated that a third commercial dumpster would be delivered to the facility so that the exposed trash and broken equipment could be stored inside a closed commercial trash dumpster.	F 814		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		7/25/24

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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F 842	Continued From page 77 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure a resident's medical record accurately reflected that Thrombo-Embolic Deterrent (TED) stockings were not being applied in the morning and removed at night as ordered by the physician for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet). This was for one of one resident (Resident #65) reviewed for accuracy of medical records. The findings included: Resident #65 was admitted to the facility on 12/08/22. Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed. Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime. Review of Resident #65's quarterly Minimum	F 842	F 842 = Resident Records-Identifiable Information 1. Resident #65 was assessed on 6/20/2024. No concerns were identified. MD was notified and the order for TED hose was discontinued. 2. All residents have the potential to be affected. The Director of Nursing and Unit Managers completed a 100% audit of all residents with TED hose orders on 6/26/2024. No additional concerns were identified. 3. All staff, including agency staff, were re-educated by the Administrator, Director of Nursing and/or the Assistant Director of Nursing on the policy of following MD orders for TED hose, documentation, ordering, application and removal. This education was completed on 7/2/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Director of Nursing or designee will audit residents with MD orders for Ted Hose 5 times a week for 12 weeks to ensure TED Hose has appropriate documentation, are available, applied and removed per order.	

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F 842	Continued From page 78 Data Set (MDS) assessment dated 05/13/24 revealed he was cognitively intact. Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks. An interview on 06/20/24 at 11:10 AM with the Director of Nursing revealed she was aware Resident #65 had TED stockings ordered by the physician and said they had not received them from the durable medical equipment company they had ordered them from. She stated she was not aware the Nurses were documenting the TED hose as being put on in the morning and taken off at night. She further stated she would have expected them to have documented on the MAR that the stockings were not available and said the Nurses obviously needed education on accurately documenting in the resident's electronic medical record including the MAR. An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to	F 842	The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

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expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had "just assumed" his NA had put them on, so she had checked it off on the MAR.

A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she "just assumed" it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings.

A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she "marked it off on the MAR and the NA took care of taking them off." Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it.

An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently

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F 842	Continued From page 80 assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room. An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room.	F 842		
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, 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	F 880		7/25/24

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F 880	Continued From page 81 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 82 §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 observations, record review, and staff interviews the facility failed to follow their Enhanced Barrier Precautions (EBP) policy when a nurse failed to wear a gown while providing tracheostomy care for 1 of 6 residents (Resident #62) reviewed for infection control practices. The findings included: A review of the facility's policy entitled "Categories of Transmission Based Precautions" last revised October 2018 stated "Enhanced Barrier Precautions requires the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). The policy further stated "High-contact resident care activities" included "device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing." An observation conducted on 6/17/24 at 12:02 PM revealed Resident #62 had EBP signage on the door to his room and personal protective equipment (PPE) including gloves and gowns beside his door. The EBP signage stated, "All healthcare personnel must: wear gloves and gown for the following high-contact resident care activities" which listed "Device care or use: central line, urinary catheter, feeding tube and tracheostomy." An observation was conducted on 6/19/24 at 2:33	F 880	F880 = Infection Prevention & Control 1. Resident #62 was assessed on 6/20/2024. No concerns were identified. Nurse #1 was educated on 6/20/2024 on Enhanced Barrier Precautions policy and procedure, including wearing an isolation gown while providing tracheostomy care. 2. All residents that have a tracheostomy have the potential to be affected. The Director of Nursing and Unit Managers completed a 100% audit of residents with tracheostomies to ensure staff are donning isolation gowns per Enhanced Barrier Precautions while providing tracheostomy care. No further concerns were identified. 3. All staff, including agency staff, were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on the Policy and Procedure for Enhanced Barrier Precautions for appropriate PPE utilization while providing direct care. This education was completed on 7/2/2024. This education will be added to the facility orientation program, to include new agency staff. 4. The Director of Nursing or designee will audit tracheostomy care 3 times a week for 12 weeks to ensure isolation gowns and all appropriate PPE are being	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 83 PM of Nurse #1 providing tracheostomy care for Resident #62. Nurse #1 performed hand hygiene upon entering the room and donned a clean pair of gloves. She did not don a gown. Nurse #1 removed the cap of the tracheostomy and then doffed her gloves and performed hand hygiene. She donned a clean pair of gloves before cleaning the tracheostomy site but did not don a gown. An interview conducted with Nurse #1 on 6/19/24 at 2:55 PM revealed she received training on the facility's EBP policy and procedure. Nurse #1 stated she was aware Resident #62 was on EBP due to having a catheter and she wore a gown when providing his catheter care. Nurse #1 indicated she did not wear a gown when providing Resident #62's tracheostomy care because it was not high contact care. Nurse #1 reviewed the EBP signage on Resident #62's door and stated according to the signage she should have worn a gown when providing tracheostomy care. An interview was conducted with the Director of Nursing (DON) on 6/20/24 at 11:20 AM. She indicated she was also the facility's Infection Preventionist. She stated the facility's EBP policy required staff to wear gowns and gloves when providing high contact care for any resident with a wound, catheter, tracheostomy, feeding tube, or central line. The DON indicated all staff received EBP training when the policy was implemented 4/1/24. She further indicated newly hired staff receive the training during orientation. The DON revealed when they identify a resident requiring EBP, a sign was placed on the resident's door and PPE was made available outside of their room. The DON stated a nurse providing tracheostomy care should wear a gown and	F 880	worn while providing care. The Director of Nursing or designee will be responsible for reporting the results of these audits in the facility's monthly QAPI for 3 months. The QAPI committee will make recommendations and changes as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 06/21/2024

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F 880	Continued From page 84 gloves An interview was conducted with the Administrator on 6/20/24 at 2:18 PM. He stated his employment at the facility began on 6/1/24 and he was not yet familiar with their EBP policy. The Administrator further stated staff should follow the policy for any infection precautions put in place for a resident and appropriate PPE should be worn.	F 880		