STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING ______ B. WING ______	C 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 2/21/22 through 3/4/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # HGJD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted 2/21/2022 to 3/4/2022. Event ID #HGJD11. 12 of 29 allegations were substantiated. The following intakes were investigated NC00186504, NC00186366, NC00186307, NC00186321, NC00186158, NC00186011, NC00185743, NC00185544, NC00184995 and NC00184782. Substandard Quality of Care was identified at CFR 483.25, F686 and CFR 483.45, F759. An extended survey was conducted.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		4/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/31/2022

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

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F 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide showers to residents twice a week as requested for 1 of 1 resident reviewed for choices. (Resident #8) Findings included: Resident #8 was admitted on 05/31/21. Resident #8's diagnoses included dyskinesia (impairment of voluntary muscles causing jerking movements) and seizures. The care plan revised on 06/09/21 indicated Resident #8 was totally dependent on 1 staff to provide a bath. No rejection of care was noted. Resident #8 was assessed as being cognitively intact on the quarterly Minimum Data Set (MDS) assessment completed on 02/09/22. He had no behaviors and required the assistance of 1 staff with transfers for bathing/showers. Resident #8's shower log and shower sheets indicated he was scheduled to receive a shower	F 561	Resident # 8 received a shower on 3/8/2022 by the certified nursing aide. All residents have the potential to be affected for shower not being given as scheduled. Effective 3/8/2022 current residents were reviewed to ensure showers were given according to the shower schedule and upon request by nurse management. Effective 3/10/2022 Nurse Management will re-educate all nursing staff to include Nurses, certified nursing aides, to include agency staff on ensuring residents receive their showers according to the shower schedule or resident Preference education to be completed by 4/11/2022. Effective 4/11/2022 all new nursing staff to include agency will receive education on ensuring residents receive their showers according to the shower schedule and or resident preference prior to the start of their shift by nurse management.	

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F 561	Continued From page 2 on Tuesdays and Fridays. The shower documentation from 01/01/22 through 02/18/22 indicated Resident #8 received showers on 01/07/22, 01/11/22, 02/08/22, and 02/15/22. There was no documentation of showers being given on 01/04/22, 01/14/22, 01/18/22, 01/21/22, 01/25/22, 01/28/22, 02/01/22, 02/04/22, 02/11/22 or 02/18/22. There was no documentation of shower refusals. An interview was completed on 02/22/22 at 12:00 PM with Resident #8. He stated he was supposed to get showers on Tuesday's and Friday's. He said it was staffing related if he received a shower or not. The resident noted it depended on the number of staff working whether he received a shower or not. He stated he needed minimal assistance with bathing and was able to get his baths completed, as little to no help was required. The resident required the transfer assistance of 1 person with showers. He explained that this had been going on for 2 months. An interview was done with Nurse Aide (NA) #4 on 03/02/22 at 10:54 AM. She stated staffing was "horrible". The NA stated she could not provide showers, baths, or assist residents out of bed when they asked if there were not enough NAs working. She noted she had shared concerns with the Director of Nursing (DON) and the Regional Director of Operations (RDO). The NA stated she would have to go through the building to find someone to help get residents up. She noted the nurses were usually too busy to help. She said if showers were not completed or the resident refused, she let the nurse know. She stated the nurse was supposed to go into the medical record and document refusals. NA #4	F 561	Nurse Management will audit 5 residents to ensure shower was given on shower day and upon request 3 x week x 4 weeks, weekly x 4 weeks and monthly x 1 month. Director of nursing will report findings to Quality Assurance Performance Improvement meeting for any needed improvement monthly x 3 months. Completion date: 4/11/2022	

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F 561	Continued From page 3	F 561		

was assigned to Resident #8 on 02/01/22 and stated she was not able to shower him that day due to staffing.

Attempts to contact NA #11 were made on 02/24/22 regarding showers for Resident #8. She was assigned to Resident #8's hall on 02/04/22 and 02/11/22 when no shower was documented. NA #11 was unable to be reached.

An interview was conducted on 02/25/22 at 4:34 PM with Nurse Aide (NA) #6. She was asked if she was able to provide showers for residents and stated showers were not done if there was not "adequate" staff. The NA added that if there was not enough staff to provide showers, she would "wash them off" in their room instead, since it took less time.

On 02/24/22 at 5:50 PM the Assistant Administrator stated a shower Process Improvement Plan (PIP) was started last Friday 02/18/22 and the Regional Director of Operations (RDO) were meeting tomorrow 02/25/22 about it. He explained the facility identified a concern with showers being provided and they were working on addressing the issue. He said he and the Regional Director of Operations (RDO) were working on it.

The RDO was interviewed on 02/25/22 at 12:25 PM. He confirmed the facility identified a concern with showers being provided and they were implementing a PIP to address the concern. He indicated education was being completed with staff and agency personnel.

An interview was done on 03/01/22 at 4:36 PM with the Director of Nursing. She stated she was

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F 561	Continued From page 4 not aware of issues with showers. The DON noted that staffing was a challenge and explained that would be the cause of showers not being provided as scheduled. Administrator #2 was interviewed via phone on 03/03/22 at 4:20 PM. He was asked about the showers not being provided as scheduled. The Administrator said they needed to honor the preferences of the residents, whether it was a shower or bath and the frequency and shift. He noted the facility should provide showers twice a week as scheduled and document refusals if they occurred.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 565		4/11/22

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F 565	Continued From page 5 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to resolve repeated concerns reported during resident council meetings for two consecutive months reviewed for resident council, November 2021 and December 2021. Findings included: The Resident Council Meeting Minutes were reviewed from October 202 to February 2022. The review revealed the following concerns were voiced during the monthly Resident Council meetings: A. The Resident Council Meeting minutes for 11/5/2021 were reviewed and revealed the residents reported snacks were not being given out at bedtime. A Departmental Response to the issue dated 11/16/2021 stated the snacks not being passed on the 3:00 pm to 11:00 pm shift would be put into a plan of correction and monitored by nurse	F 565	Resident council meeting held on 3/11/2022 by the Activity Director with no resident concerns identified. All residents have the potential to be affected by concerns from resident council meetings. Administrator in-serviced Activity Director, Director of Nursing, and Social Worker as of 3/29/2022 on importance of following up on concerns for resident council and facility policy for grievances. Nurse Management will re-educate the nursing staff on offering residents bedtime snacks education to be completed by 4/11/22. Effective 4/11/22 all new nursing staff to include agency will receive education prior to the start of their shift on importance of following up on concerns for resident council and facility policy for grievances to	

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F 565 Continued From page 6
management.

B. The Resident Council Meeting minutes for 12/15/2021 were reviewed and the documented grievance was snacks were still not being given to residents at bedtime.

A Departmental Response to the issue which was not dated or signed by Director of Nursing #2 stated the staff would be re-educated (nurses and nurse aides) and all snacks are to be offered by 9 pm to all residents and their acceptance or refusal was to be documented in the electronic charting.

During an interview on 2/24/2022 at 11:14 am with the Resident Council President and he stated the Resident Council had a grievance at least twice in the past 6 months that they were not getting their bedtime snacks and it continued to be an issue.

An interview was conducted with Activity Director on 2/24/2022 at 12:18 pm and she stated the previous Director of Nursing would have been responsible for the concerns voiced by the Resident Council on 11/5/2021 and 12/16/2021 for the residents not receiving bedtime snacks.

During an interview with the Director of Nursing #1 on 2/24/2022 at 12:18 pm she stated she remembered the Resident Council concern regarding snacks not being distributed at bedtime that was given to her in November 2021. The Director of Nursing #1 stated she had done an in-service education with the staff that included documenting the snacks either being accepted or refused in the electronic record and also the snacks should be offered to all residents unless

F 565

include the passing of bedtime snacks.

All resident council meeting concerns will be reviewed in the morning meeting following resident council meetings monthly to ensure resolution by the Administrator.

Nurse Management will audit 5 residents 3 x weekly x 4 weeks, then weekly x 1 month and monthly x 1 month to ensure snacks are being offered.

Administrator will report all findings to the Quality Assurance & Performance improvement committee for any needed improvement monthly x 3 months.

Completion Date: 4/11/22

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F 565	Continued From page 7 they were not clinically indicated. Director of Nursing #1 stated the education and the sign in sheet should be located in the Staff Development Coordinator's Office. An interview was conducted with Director of Nursing #2 on 3/2/2022 at 12:21 pm. Director of Nursing #2 stated she was the Assistant Director of Nursing during November 2021 and December 2021 but had not given the in-service education regarding snacks being provided to the residents as bedtime. She stated she did not know where the sign in sheet for the education or monitoring of snacks being provided was located. On 3/3/2022 at 11:57 pm Administrator #2 stated he was not at the facility in November 2021 or December 2021. He stated in general the staff should have offered an evening snack to the residents and snacks should have been accommodated as requested by the residents.	F 565		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.	F 567		4/11/22

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F 567	Continued From page 8 (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to provide same day access to resident fund accounts for residents requesting less than $100 for 2 of 2 residents reviewed for management of personal funds (Resident #39 and Resident #43). Findings Included: 1. Resident # 43 was admitted to the facility on 12/18/19 with a diagnosis of Atrial Fibrillation. Resident #43 most recent Minimum Data Set (MDS) dated 1/4/22 specified the resident's	F 567	Resident #43 and #39 have received any requested funds as of 3/20/2022 by the receptionist. All residents with a resident trust fund have the potential to be affected by funds not being available as requested. Administrator has re-educated the Business Office Manager, receptionist, Director of nursing as of 3/29/2022 on residents right to receive funds when requested seven days a week and after	

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Continued From page 9
cognition as cognitively intact.

An interview was completed with Resident #43 on 2/24/22 at 12:34 PM who stated that she has tried to get money on the weekend and could not and this had been going on since July 2021. Resident #43 stated she only wanted to get a little spending money and was asked if it was under $100.00, and she stated yes, she gets $30.00 a month for spending. Resident #43 stated when she would attempt to get money, she would hear excuses such as there is no one here to give it to you or we cannot get into the safe. Resident #43 stated that it has made her mad.

2. Resident # 39 was admitted to the facility on 6/20/17 with a diagnosis that included Chronic obstructive pulmonary disease. Resident #39 most recent Minimum Data Set (MDS) dated 2/18/22 specified the resident's cognition as cognitively intact.

An observation of a posted sign on the reception desk read; Monday - Friday 8:00 AM - 2:45 PM New Banking Hours.

An interview was completed with Resident #39 on 3/2/22 at 12:14 PM who stated that she has wanted to withdraw on a weekend and sometimes would like to get money for the vending machine or order food, but we cannot because of no banking hours on the weekends. Resident #39 stated that "it feels so institutionalized and almost a dignity thing for me as I like to have a couple dollars on me, I did not want to withdraw a lot of money, maybe $1.00 or $2.00."

An interview was completed with the Business

F 567

normal business hours.

Business Office Manager (BOM) will ensure funds are available at the front desk from 7am until 7pm daily. The Receptionist will ensure funds are available on the 200-hall med cart during afterhours for resident funds. Hours will be posted in the facility for normal banking hours as well as after hour banking.

Administrator will monitor resident trust box and Nursing cart trust box weekly x 4 weeks then monthly x 2 months to ensure funds are available.

Administrator will report any findings to the
Quality Assurance Performance Improvement committee monthly x 3 months for any needed improvement.

Completion Date: 4/11/22

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F 567	Continued From page 10 Manager on 2/23/22 at 4:34 PM who stated she knew the banking hours were Monday through Friday from 8:00 AM to 2:45 PM and was unaware residents could get money on weekends and did not feel comfortable leaving money at the front desk with just anyone on the weekends and there was not a staff that could have access to the resident funds on the weekends. The Business Manager stated she was not sure if the hours would be changed or not. An interview was completed with Receptionist #1 who stated that residents can get their money on Monday through Friday from 8:00 AM to 2:45 PM. Receptionist #1 stated that if they wanted money on weekends there was no one at the facility to give them money. An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that the facility should have funds available for residents 24 hours a day 7 days a week.	F 567		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		4/11/22

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F 580	Continued From page 11 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, physician and resident representative interviews the facility failed to notify the resident	F 580	Effective 3/10/2022 the responsible party for resident #84 was informed of the wander guard placement by nurse	

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representative of a medication error when a medication was administered without an order for 1 of 7 residents reviewed for medication errors; in addition the facility failed to notify the resident representative of an order for a wander guard (a bracelet to alert staff of resident attempts to exit the facility) for 1 of 1 resident reviewed for notification of changes or the physician of a urinalysis and culture that was ordered and not completed. (Resident #10, Resident #84, Resident #237)

1. Resident #10 was admitted on 03/19/20.

The quarterly Minimum Data Set (MDS) assessment completed on 10/28/21 indicated Resident #10 was severely cognitively impaired.

Review of the Physician orders for Resident #10 noted Lorazepam (a sedative) 0.5 milligrams (mg) every 8 hours as needed for anxiety was discontinued on 01/06/22.

Record review of Medical Director #1's progress note dated 02/11/22 revealed Resident #10 was witnessed to be very unsteady and bracing herself against the wall. She appeared to be quite sleepy and even more confused than her typical baseline. Nurse #14 had informed the physician that she had just been given Lorazepam about an hour prior. The Physician stated she requested a wheelchair for the resident and escorted her back to her room after which she fell asleep.
The Physician documented as followed:
Medication administered in error-The Physician discussed with the nurse that the patient did not have orders for Lorazepam and that it was discontinued some time ago by hospice. The

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management Effective 3/11/2022 responsible party for resident #10 was notified of the medication error by nurse management .Effective 3/14/2022 the nurse practitioner was notified of resident #237 urinalysis and culture was not collected. Order was discontinued and no new orders given resident was made aware of no new orders received for collection UACNS by nurse management.
All residents have the potential to be affected by notification of change.
Effective 3/10/2022 current residents with wander guards were reviewed to ensure notification had been given to responsible party by nurse management.
Effective 3/11/2022 current medication carts were reviewed to ensure all discontinued medication had been removed by nurse management.

Effective 3/28/2022 the family was notified of Urinalysis and culture that had not been completed and the provider was notified with no new orders to collect Urinalysis and culture that were identified to have been missed from 3/14/2022 - 3/28/2022 by nurse management.
Effective 3/10/2022 nurse management will educate current licensed nurses and licensed agency nurses on notification of notifying the residents responsible party when placing wander guard, when medication is discontinued to remove it from the cart upon order being received, and if the medication was given after being discontinued to call the physician and responsible party. When a resident's

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Physician requested that the Lorazepam tablets be removed from her supply to prevent further errors in the future.

Review of Resident #10's medical record revealed there was no nursing documentation regarding the medication error or that the resident's representative was notified of the incident on 02/11/22.

A phone interview was conducted with Medical Director #1 on 02/22/22 at 1:58 PM regarding Resident #10. She stated that on 02/11/22 she had observed the resident slurring her words and she was concerned about her. She stated she asked the nurse what medications she had given her. Medical Director #1 stated the nurse told her she had given Resident #10 Lorazepam and Buspar. The Physician stated the resident did not have an order for Lorazepam. The nurse responded that the Lorazepam was in the resident's medication drawer. The Physician stated the medication had been discontinued and the medication cards had not been sent back to the pharmacy.

Nurse #14 was interviewed via phone on 02/27/22 at 5:46 PM regarding Resident #10 about the incident on 02/11/22. She stated she was an agency nurse and had been told earlier in the week if the resident had behaviors, to give her the prn (as needed) medication that was ordered. She said Resident #10 was moving slower, cursing at the staff and the nurse thought she had been up all night. She noted she had given Resident #10 her Lorazepam about 11:00 AM on 02/11/22 that was on the MAR. She said shortly thereafter the Physician commented about the resident's walk. She informed the doctor she had

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urinalysis and culture is not collected the physician and responsible party are to be notified and to notify the responsible party and the physician when a medication error has occurred by nurse management education to be completed by 4/11/22. Effective 4/11/22 all new licensed nursing staff to include agency licensed nurses to receive education prior to the start of their shift regarding

Effective 4/11/2022 nurse management will audit 5 residents with wander guards to ensure notification to the responsible party was completed on any new wander guard orders 3 x a week for 4 weeks, weekly x 4 weeks then monthly x 1 month to ensure responsible party notification.
Nurse management will audit 5 residents to ensure Urinalysis and culture was completed 3 x weekly x 4 weeks, weekly x 2 months to ensure urinalysis and culture were collected as physician order.
Nurse management will review 3 medication carts to ensure discontinued medications were removed from the med cart weekly x 12 weeks.
Director of Nursing will report any findings to the Quality Assurance Improvement committee monthly x 3 months for any needed improvements.

Completion Date: 4/11/22

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given her Lorazepam and the doctor stated it was supposed to have been discontinued. The nurse stated a facility staff nurse was present at the time and told her the discontinued medications were supposed to be taken off the medication cart and sent back to Pharmacy. Nurse #14 was asked about signing out the medication, she stated she always made sure the medication was signed out. Nurse #14 then added that she may have gotten busy and forgot to document it on the MAR or sign it out. She did not contact the resident representative regarding the incident.

An interview with the Regional VP of Clinical Services on 03/01/22 was done and she stated no medication error report was done for Resident #10 regarding the Lorazepam administration without an order on 02/11/22.

A follow up interview was done on 03/02/22 at 9:45 AM with Director of Nursing #2 about the event with Resident #10 and she stated she was out of work, but someone should have notified the resident representative of the medication error.

An interview was done on 03/02/22 at 08:50 AM with Regional VP Nurse Consultant #2 about the Lorazepam given without an order to Resident #10 on 02/11/22. She stated the from what she had investigated, there was no nursing documentation where the resident representative had been notified.

2. Resident #237 was admitted to the facility on 01/26/22.

A physician's order dated 01/31/22 for a urinalysis with culture for Resident #237.

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There were no results in the medical record for Resident #237's urinalysis with culture.

A physician's order dated 2/21/22 specified to follow-up on urinalysis and culture ordered on 01/31/22 for Resident #237.

A phone interview with Medical Director #1 was conducted on 02/27/22 at 4:54 PM regarding Resident #237's labs. She stated she ordered blood work for 02/03/22 and a urinalysis with culture to be done that day. She stated the latest the urine culture should have been done was the following day. She said she would have expected to be notified if the specimen was not done.

A phone interview was conducted with Laboratory Staff #1 was done on 02/28/22 at 11:38 AM regarding Resident #237. She was asked about the lab orders from 01/31/22 for a urinalysis with culture. She stated they had never received a specimen for urinalysis with culture for Resident #237.

An interview with the Director of Nursing #2 was done on 03/01/22 at 4:46 PM regarding laboratory services. She was asked about lab orders not being done. She was asked about a urine C&S from 1/31/22 not being done for Resident #237 and stated it should have been completed.and the physician should be notified if it was not completed.

3. Resident #84 was admitted to the facility on 8/2/21 with a diagnosis of unspecified dementia without behavioral disturbance.

A Quarterly Minimum Data Set (MDS) dated

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2/7/22 specified the resident's cognition was moderately impaired.

A review of Resident #84 medical orders revealed a wander guard bracelet was ordered on 2/10/22 to be placed on Resident #84's left leg.

A review of the electronic health record revealed there was no documentation related to notifying the Resident #84's emergency contact regarding the placement of a wander guard.

An observation of Resident #84 on 2/21/22 at 11:30 AM and 3:45 PM ambulating in his wheelchair in the facility. A second observation on 2/22/22 at 2:30 PM of Resident #84 in his wheelchair in the front office area talking to the receptionist. Resident #84 's elopement bracelet was on his ankle during both observations.

An interview was completed with the MDS Nurse on 2/23/22 at 4:54 PM. The MDS Nurse stated she did put in the order for the wander guard bracelet. The MDS Nurse stated the Director of Nursing (DON) should had contacted the emergency contact regarding the placement of the wander guard bracelet. The MDS Nurse stated that Resident #84 had attempted to open a door.

A phone call was completed with the Resident #84's emergency contact on 2/23/22 at 5:34 PM who stated that he had not received any phone calls or messages regarding a placement of a wander guard bracelet.

A phone interview was completed with the Director of Nursing (DON)on 2/26/22 at 5:26 PM who stated that she was not aware of Resident

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F 580	Continued From page 17 #84's wander guard bracelet and would have notified the family and it would had been discussed at the morning meeting. The DON stated no one had told her about this, and this was the first time she had heard about it. An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that it would be his expectation that for any circumstances that an elopement bracelet is placed on a resident the family or responsible party should be notified as soon as possible.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to protect a resident's right to be free from abuse when another resident (Resident #8) had offered a resident (Resident #30) money in favor of intimate activities and grabbing her jacket almost	F 600	Effective 12/31/2021 facility has ensured resident #55 is safe by removing NA#1 from facility. On 3/8/22 the facility offered a room change to both residents where they declined a room change and no further incidents have been reported.	4/11/22

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causing her to fall. The facility failed to prevent and protect a Resident (Resident #55) from staff to resident abuse when a Nurse Aide (Nurse Aide #1) became too rough while providing resident care by scratching his right wrist and covered his mouth with her hand. This occurred for 2 of 3 residents sampled for resident abuse.

The findings included:

1.Resident #30 was admitted to the facility on 12/1/21 with a diagnosis of cerebral infarction unspecified. Resident #30 is 44 years old. Resident #30's Minimum Data Set (MDS) admission assessment dated 12/13/21 specified the resident's cognition as cognitively intact. Resident #30 was independent with ambulation/walking, eating and personal hygiene.

A review of a form titled Complaint/Grievance Report completed on 2/28/22 by Social Worker (SW) #1 read in part: on 2/28/22 Resident #30 told SW #1 that another resident was asking her to do sexual acts for him for money and this made Resident #30 feel uncomfortable.

An interview was completed with Resident #30 on 3/2/22 at 1:08 PM who stated that Resident #8 had kept coming up to her and asking her to kiss him. Resident #30 stated that back in January 2022, he had offered her $20.00 to kiss him and she had told him no, and he had kept asking Resident #30 and had said things like he was a good kisser and let him kiss her. Resident #30 stated that she told Social Worker (SW) #2 when this happened back in January 2022, and she had done nothing. Resident #30 stated approximately a month ago when she and her roommate were walking to the smoking area,

F 600

Resident # 30 verbalized that she was satisfied with the actions taken by the facility.Administrator/Designee will respond immediately to any further concerns by resident #30.

All residents are at risk for potential Abuse. Nurse management interviewed all alert and oriented female residents for any potential abuse as of 3/2/2022 no residents were found to have been affected.

On 3/28/22 nurse management will re-educate all current staff on the facility abuse and reporting policy to include notification of police, types of abuse to include resident to resident and staff to resident education to be completed by 4/11/2022. Effective 4/11/22 all new staff to include agency staff will be in-serviced on the facility abuse and reporting policy, types of abuse to include resident to resident and staff to resident prior to starting their shift in the facility by nurse management.

Effective 4/11/2022 Nurse management will audit 5 residents weekly to ensure they have no concerns of abuse, 3 x weekly x 4 weeks, weekly x 4 weeks and monthly x 1 month.

Effective 4/11/2022 Nurse management will interview 5 staff members 3 x weekly x 4 weeks, weekly x 4 weeks and then monthly x 1 month to ensure all reported abuse allegations, resident to resident or staff to resident are reported at the time of

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F 600	Continued From page 19 Resident #8 had called her sweetheart and grabbed the back of her jacket and she had almost fallen. Resident #30 stated that it bothered her and terrified her. Resident #30 stated that when he had grabbed her coat a Nurse Aide (NA) had saw this and she just told Resident #8 to stop it. Resident #30 was unable to recall who the NA was. Resident #30 stated that just this past Sunday (2/27/22) she had been out on the smoking patio around 7:00 PM. She had been sitting outside with another male smoker. Resident #30 stated that Resident #8 was inside the television (TV) room and felt that Resident #8 was waiting for her to be alone. Resident #30 took a picture of Resident #8 in the TV room and explained that once the male smoker went inside Resident #8 came out to the smoking patio and Resident #8 was not a smoker. Resident #30 stated that Resident #8 had asked her if he could lick her down there, and Resident #30 was asked to specify where down there meant and she stated her vagina. Resident #30 then hit record on her phone to get a recording of their conversation. Resident #30 played the conversation and stated the first part he said "lick me for 20-30 minutes which was hard to understand. Resident #8 stated he would "20-30 minutes, don't you want to have any fun?" Resident #30 stated "I just do this with my man". Resident #8 "you can't do anything because people are walking in and out." Resident #30 "No". Resident #8 "there is something about you, but I want you, I don't know what it is". Resident #30 "No" Resident #8 "you wouldn't take the $800 in my pocket? Resident #30 "No". Resident #8 "well you are crazy". Resident #30 "I am crazy in love" (with someone else). Resident #8 "(laughed) oh ya. I am going inside I'm cold". Resident #30 explained that another male	F 600	the allegation and who to report too. Administrator will report any findings to the Quality Assurance Performance Improvement for any needed improvement monthly x 3 months. Completion Date: 4/11/22	

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F 600	Continued From page 20 resident came out to the smoking area and Resident #8 stated to the other male smoker how close he came to doing it with a nurse that had worked in the facility. Resident #8 continued to say to the other male smoker "I want Resident #30, but I can't have her." Resident #30 went inside and back to her room and stated that she was afraid and wanted to tell the Activities Director (AD), but she had left. Resident #30 told her roommate and had her listen to the voice recording. Resident #30 stated the following day on Monday 2/28/22 she told the AD in the morning about what happened, and the AD told Social Worker #1 who then came to Resident #30's room and SW #1 listened to the recording. Resident #30 stated that SW #1 stated that she did not know what to do as that had never happened before after SW #1's 22 years of working at the facility and then left Resident #30's room. Resident #30 stated that she went to the SW #1's office a few hours later and another man was in the office who stated to Resident #30 that if she had been a child, she could have pressed charges, but he would speak to Resident #8. Resident #30 stated that the following day on Tuesday 3/1/22 she went to SW #1's office and asked her what they were going to do about the situation regarding Resident #8 and Resident #30. Resident #30 stated that they were going to make room changes and tell the Nurse Aides to keep him away from Resident #30. Resident #30 stated that Resident #8 was still on the same hall as she was. Resident #30 stated that SW #1 stated they did not have a male room available for Resident #8 to move to but may had just found one but would have to ask the Assistant Administrator. Resident #30 stated he (Resident #8) is soliciting me that she was sick of the nursing home not doing anything to stop it.	F 600		

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An interview was completed with SW #1 on 3/2/22 at 2:05 PM who stated that Resident #30 had a concern regarding another resident. SW #1 was asked what type of concern and SW #1 responded stating that Resident #8 was asking Resident #30 to do sexually inappropriate things. SW #1 stated that she then reported it to the Administrator, and we had both been working on it and the Administrator was going to speak to Resident #8. The SW stated that she became aware of the situation on Monday 2/28/22 and she believed the encounter happened on Sunday 2/27/22. SW #1 was asked how Resident #30 was doing and SW#1 stated that when she had talked to Resident #30, Resident #8 had called her sweetheart twice and the Administrator was going to talk to Resident #8 but did not know if that had occurred. SW #1 was asked how Resident #30 was being protected. SW #1 stated "How is she being protected? I check on her, I don't know how to answer that question." SW#1 was asked how she checks on Resident #30, and she responded that she talked to her. SW #1 stated that Resident #8 told Resident #30 something about licking her and that he had licked somebody down there for 30-40 minutes and would pay her $800.00 if he (Resident #8) would sleep with her. SW #1 was asked if Resident #8 was soliciting Resident #30 and SW #1 stated "well I guess that is why I got my administrator as I was not sure how to handle the situation as Resident #8 had a guardian." SW #1 stated that Resident #30 told the SW #1 that the facility was going to move Resident #8 off the hall, and SW #1 stated at no time did we say we would move him off the hall as that is how she (SW #1) remembered it. SW #1 stated that we are working on a plan and that was one idea and

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again discussed it to the Administrator. SW #1 was asked if she reported this to Resident #8's guardian and she responded No, we did not notify the guardian. SW #1 was asked when you have resident to resident abuse what do you do? SW #1 said she would take it to the Administrator, as he is our abuse coordinator. SW #1 stated we would make sure the Resident was safe. SW #1 stated that the Administrator and she were still talking about a plan. SW #1 stated that she had been aware of the incident in January which was handled by SW #2 who is no longer at the facility. SW #2 spoke to Resident #8, and he denied it, and there was no proof of that happening. SW #1 stated she did not know who the Administrator was at that time. SW #1 sated that she felt Ok with Resident #30 as she stated she was not afraid. SW #1 did state that she had the psychologist speak to Resident #30 on Tuesday 3/1/22. SW #1 stated that we did fill out a concern form on Monday 2/28/22 and it goes to our Administrator, and we work through it, it is like a grievance. SW #1 was asked if she had seen Resident #30 today and she responded she had not had time to see her yet today (3/2/22).

An interview was completed with Resident #8 on 3/2/22 at 4:37 PM who stated that Resident #30 continued to tell lies about him. Resident #8 stated the Administrator told him that sometime today (3/2/22) Resident #30 alleged that Resident #8 had stated he would pay $100.00 to have sex with her. Resident #8 stated he did not say that. Resident #8 was asked if he called Resident #30 sweetheart and he responded I might have called her sweetheart. Resident #8 was asked if he offered Resident #30 $800.00 and he stated that he had $800.00 in his pocket but was darn sure he would not offer it to anyone and did not offer

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Resident #30 money to kiss him. Resident #8 was asked if he had ever grabbed Resident #30 and he stated that one time he did grab her coat to pick at her and she turned around and said "hey." Resident #8 stated that he did go into Resident #30's room to offer her a soda the other night. The door was shut, and he knocked on the door and the roommate said to come in. Resident #8 stated he then went in the room and placed a soda on her overbed table and Resident #30 said thank you. The roommate then stated that she was going to report Resident #8. Resident #8 stated the Administrator had told him that Nurse Aides had made complaints that he had made sexual advances to them as well as the receptionist and that was not true. Resident #8 stated yesterday that he was on by the smoking patio and came inside as Resident #30 wanted to come out and smoke. Resident #8 stated the Regional Director of Operations (RDO) told him today (3/2/22) to stay away from Resident #30.

A second interview was completed with Resident #30 at 5:00 PM who stated that Resident #8 started to bother her in January 2022, and it had made her feel uncomfortable in a way like she was a prostitute. Resident #30 told Resident #8 she was married, and he stated her husband would never find out and that she should think about it and would give her $5.00, $10.00, then $20.00 to kiss him. Resident #30 stated that on 2/28/22 was the first time she had been really scared. Resident #30 explained that someone in Administration had spoken to Resident #8 in January 2022, and he had stopped talking to her for about three weeks and then three or four days ago he had started to call her sweetheart again. Resident #30 was asked how she felt when this happened in January 2022, and she stated that it

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made her mad especially the staff had not been doing what they said they would do which was to keep Resident #8 away from Resident #30 and he was not to speak to her. Resident #30 stated it is just not right. Resident #30 stated that she felt cornered back in January 2022 and was scared that she was causing an issue that she would have to stay at the facility and that scared her. Resident #30 explained the type of issue she meant was that Resident #8 would try and corner her and force himself on her. Resident #30 stated he makes sexual remarks to the NA's and one time observed Resident #8 pinch a NA on her butt. Resident #30 stated the NA's laugh and giggle, and it is very unprofessional.

A second interview was completed with SW #1 on 3/2/22 at 5:35 PM who was asked if they had assessed other residents and she stated "No" and stated the only complaint she had ever had from alert and oriented residents was that Resident #8 plays his radio too loud.

An interview was completed with the Administrator on 3/2/22 at 6:03 PM who was asked what protective actions had been taken for Resident #30. The Administrator stated there was a review to move either one of the residents which was directed by our RDO. The Administrator stated what had been concluded was that Resident #30 is willing to move to a different room if her roommate could go with her, however we don't know where we will accommodate that and are currently reviewing. The Administrator stated the SW #1 had been checking on Resident #30 to make sure there were no additional concerns and he believed that yesterday 3/1/22 SW #1 had reviewed with our psych (psychological) services team to work with

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Resident #8. The Administrator stated they had been interviewing residents if they feel safe and if they have had any inappropriate actions from other residents. The Administrator was asked how you will ensure Resident #30's safety and he stated they are still reviewing that and are keeping an extra eye on Resident #8 for now by completing additional monitoring.

A telephone interview was completed with the RDO on 3/2/22 at 8:30 PM who stated that he spoke with Resident #30 on 2/28/22 regarding an issue she had with another resident who had offered her money for sexual favors. The RDO asked Resident #30 who the resident was, and Resident #30 stated it was Resident #8. The RDO asked Resident #30 if she would feel more comfortable if Resident #8 was moved to a different hallway as their rooms were near one another and would have Resident #8 stay away from her. The RDO stated Resident #30 would be fine with that solution. The RDO stated that he had spoken to Resident #8 who stated that he had no money and would not waste it on offering it to someone else and the only time he had been down to Resident #30's room was when he took her a soda. The RDO stated that he thought that had been this past Sunday (2/28). The RDO stated that he had been discussing room changes with Resident #8 however, he really did not want to move except he would move to his own apartment. The RDO did offer for him to move to a different facility, but he did not want to that as he had good friends here at the facility. The RDO was asked if this was their normal process when someone reports something like this? The RDO stated that with this situation we investigated it through the grievance process and that this was more of a proposition as he had

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never been aggressive and was just offering money, so we just took this through the grievance route. The RDO stated that Resident #30 never stated that Resident #8 had tried to touch her of force himself on her he had just propositioned her. The RDO stated that today 3/1/22, "we interviewed every single female resident with a brief mental status of 11 (moderate cognitive impairment) or higher, and no one had voiced any concerns about a resident being threatened."

A phone interview was completed on 3/3/22 at 8:29 AM with the AD who stated that on Monday 2/28/22 Resident #30 had her listen to a recording and it was hard to understand what Resident #8 was offering money for, you could hear Resident #30 say she had a boyfriend. The AD stated that Resident #30 showed her a picture of Resident #8 watching her however how would one know that Resident #8 was watching Resident #30 he had a right to be in the TV room. The AD stated that she felt that Resident #30 and her roommate were trying to set up Resident #8 as a lot of people do not like Resident #8. The AD did not feel like he had been threatening. The AD stated that Resident #30 told her that Resident #8 had been after Resident #30 for a long time, however the AD stated she had never saw the two residents talking or socializing together. The AD was asked if Resident #30 told her that Resident #8 had asked to lick her private area and the AD stated that she did tell her that, but you could not hear that on the recording. The AD stated that Resident #30 never told her that she was afraid or scared.

An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated the communications that had been presented to

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him was that Resident #30 felt uncomfortable and he would not mean that it would rise to the level of abuse if we had one adult to another adult that is making comments that is making one resident feel uncomfortable. The Administrator stated that "there were no signs of mental anguish, it had been obvious that she did not want him to do this, and we had offered to call the police but Resident #30 stated no." The Administrator stated, he "would go back and re-address the situation as the facility had an obligation anytime we identify abuse or an allegation of abuse to begin and investigation and protect the resident."

2. Resident #55 was admitted to the facility on 10/3/21. Diagnoses included cerebral infarction without residual deficits (stroke) and arthritis, among others.

An admission Minimum Data Set (MDS) assessment and Care Area Assessment, both dated 10/15/21, assessed Resident #55 with clear speech, able to understand and be understood, adequate hearing and vision, intact cognition, and required limited staff assistance with toileting from one person. The MDS also assessed Resident #55 with physical behaviors directed towards others (hitting, kicking, pushing, scratching, grabbing), which occurred 1 to 3 days during this assessment and verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) which occurred 4 to 6 days during the assessment.

A care plan, revised 11/22/21 identified Resident #55 was verbally aggressive, had ineffective coping skills, and poor impulse control. Resident

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#55 was witnessed by staff yelling, screaming, and grabbing staff, behaviors which occurred daily. When this behavior occurred, staff were to intervene before the agitation escalated, guide the resident away from the source of distress, and engage calmly in conversation. If the resident's response was aggressive, staff were to walk away calmly and approach later.

Review of nursing progress notes for each shift and skin audits from 12/26/21 - 12/30/21 recorded no new skin concerns for Resident #55.

A Health Care Personnel Investigations (HCPI) Initial Allegation of Abuse Report (Initial Report), dated 12/31/21, completed by the Assistant Administrator, documented an allegation of staff to resident abuse. The Initial Report, documented in part, Resident #55 was alert and oriented and reported to the Assistant Administrator on 12/31/21 at 5:00 PM that during care on 12/30/21 around 9:30 PM, nurse aide (NA) #1 was rough with him. Resident #55 described the abuse occurred when NA #1 attempted to turn him over in bed, she dug her nail into his right wrist and scratched him, then she covered his mouth when he yelled out. The Initial Report documented that on 12/31/21 when Resident #55 reported an allegation of abuse, Nurse #3 completed a head-to-toe skin assessment for Resident #55, NA #1 was interviewed and wrote a statement regarding the events, she was suspended, the allegation of abuse was reported to law enforcement and the physician was notified.

A written statement recorded by NA #1, dated 12/31/21, documented that on 12/30/21 around 9:00 PM, she saw Resident #5's call light on, NA #2 was already in the room and the Resident

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stated he needed to be put on the bedpan. Resident #55 was put on the bedpan by NA #2. While NA #2 was helping to change him, he resisted her help. He kept pushing back and didn't want to roll over far enough for NA #2 to clean him. NA #1 documented that she grabbed under his left leg and grabbed his upper arm to hold him. Resident #55 kept trying to say that we were hurting him. NA #1 asked him to please calm down and explained that we were just trying to get him changed. Resident used "expletives" and continued to yell and scream. NA #1 covered his mouth because he was spitting and yelling in her face. During the care, Resident #55 constantly pushed back and swung his hands and arms. NA #1 grabbed the Resident's arm just above his wrist to keep him steady until NA#2 finished cleaning him. NA #1 placed her hand on top of the Resident's right hand and held onto his left leg. The statement recorded that Resident #55 constantly tried to break his hand away and hit his hand on the rail of the bed. Resident #55 stated "You scratched my hand look what you did." NA #1 documented that she never touched his hands at all with her nails and that she wore gloves the whole time. NA #1 and NA #2 exited the room and NA #1 told Nurse #4 that Resident #55 "was cutting up" and that she was not going to go back in his room.

A written statement, undated, recorded by NA #2 documented that Resident #55 said NA #1 scratched him. NA #2 recorded that she did not see NA #1 do anything unusual because at one point she left the room to empty the bed pan.

A nurse progress note written by Nurse #4 dated 12/31/21 at 5:57 AM recorded in part that Resident #55 yelled at her, talked over the Nurse,

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cursed, called both NA #1 and #2 names and was disrespectful to the Nurse.

A nurse progress note written by Nurse #3 dated 12/31/21 at 7:51 PM documented that Resident #55 was noted with a linear scratch/abrasion on the right hand proximal to the wrist. Nurse #3 documented that the scratch was without erythema, ecchymosis, exudate, or localized edema. His hand was noted without change in any function, sensation, or range of motion.

A nurse progress note dated 1/6/22 recorded Resident #55 had a new area noted as a medium sized scratch to his right hand, posterior to his palm.

The social worker (SW) documented a progress note dated 1/6/22 and recorded she spoke to Resident #55 regarding the incident that occurred on 12/30/21. During the conversation, Resident #55 presented with a pleasant mood, with no signs of distress or psychological effects from the incident of 12/30/21. The SW offered Resident #55 psych services which he declined.

A nurse practitioner progress note, signed 1/12/22, recorded Resident #55 was a very poor historian, with a circular thought pattern, contradicts himself frequently, accuses staff of lying about him and recently made an accusation of resident abuse that was investigated by the facility.

Resident #55 was interviewed and observed on 2/21/22 at 12:48 PM. Resident #55 stated was observed with a scab to his right wrist. When asked how he obtained the scab, he stated that it occurred when NA #1 grabbed his wrist during

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care. Resident #55 stated that he told NA #1 not to jerk him around and she responded that she was trained to do her job and that he didn't need to tell her what to do. Resident #55 stated he told the Assistant Administrator the next day what happened on the evening of 12/30/21 and that the Assistant Administrator took care of it. He further stated that NA #1 no longer worked at the facility. When asked why he waited until the next day to report the abuse, Resident #55 stated that he wanted to talk to the Assistant Administrator about it first.

A phone interview occurred with NA #1 on 2/25/22 at 12:33 PM and revealed NA #1 used to work in the facility through a staffing agency, but that she did not work in the facility after 12/31/21 when she was suspended. NA #1 stated that on 12/30/21 she worked 3 PM - 11 PM and around 9:00 PM, she saw the call light on for Resident #55. NA #1 stated when she walked into his room, NA #2 was already there taking him off the bedpan after a bowel movement. NA #2 was struggling with him trying get to him to turn over and he would not turn, so she put on gloves and helped her. When NA #1 approached his bed, Resident #55 was turned to the right, but he had a hard time lifting his leg and NA #2 could not get into his peri area to clean him. NA #1 stated she wrapped one of her arms under his left leg to lift it up. She then wrapped her other arm around his right arm, but Resident #55 pulled his right arm out, hit his right arm on the bed rail and started screaming "help", saying we were hurting him. NA #1 said he started spitting and foaming at the mouth, so she covered his mouth because he was spitting and told him to calm down. NA #1 stated he would not calm down and accused her of scratching him. NA #1 stated she was wearing

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gloves and that she told Resident #55 that she did not scratch him, but that she was trying to help him. Resident #55 continued yelling and called NA #1 and NA #2 names. NA #1 said she reported what occurred to Nurse #4 and the next day after she came to work, sometime around 5:30 or 6:00 PM, the Assistant Administrator told NA #1 that Resident #55 accused her of abuse. The Assistant Administrator asked NA #1 to write a statement, then he walked her out of the facility and told her that she was suspended.

A phone interview with NA #2 occurred on 3/2/22 at 5:32 PM. She stated she used to work at the facility through a staffing agency, but that she no longer worked at the facility. She confirmed that she was assigned to work at the facility on 12/30/21 on the 7 PM to 7 AM shift and that she was the assigned NA for Resident #55 that shift. NA #2 stated that when she responded to the call light for Resident #55 on 12/30/21, he asked her to put him on the bed pan and said he would put his call light on when he was finished. NA #2 stated she left his room and when she returned to his room after he put his call light back on, she assisted him off the bedpan. NA #2 stated she provided this care alone, but that she needed help to reposition him in the bed. NA #1 came in to help pull Resident #55 up in the bed, but he started using profanity and said that he did not want her to help. NA #2 stated she walked away to let him calm down and went into the bathroom to wash the bed pan while NA #1 continued to care for Resident #55. NA #2 stated that she did not see any interaction between NA #1 and Resident #55 while she was in the bathroom. NA #2 stated when she came out of the bathroom after washing out the bed pan, Resident #55 was still using profanity toward NA #1, but that he did

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F 600	Continued From page 33 not tell NA #2 that anything happened, he did not say anything about being scratched or that his mouth was covered. NA #2 stated that she did not witness NA #1 pull on the arms or legs of Resident #55 during care. NA #2 stated when they left his room, NA #1 told Nurse #4 that Resident #55 was cursing and did not want her to help him. A phone interview with Nurse #4 occurred on 2/28/22 at 10:00 AM. During the interview, Nurse #4 stated that she did not recall the specifics of her interaction with Resident #55 on 12/30/21 but that she had experienced several behavioral issues with this Resident. Nurse #4 stated she worked 2nd shift on 12/30/21 and that she did recall that she went to the Resident's room on 12/30/21 and spoke to him, but during the conversation he did not report to her that he had any concerns with the care he received from NA #1 and NA #2, nor did he mention that he was scratched during care. Nurse #4 stated that she could not recall anything further about that day. A phone interview with Nurse #3 occurred on 2/24/22 at 12:26 PM. Nurse #3 stated that an hour or two after he came to work at 3 PM on 12/31/21, NA #1 told him that Resident #55 accused her of scratching him, an accusation she denied and then NA #1 said that Resident #55 hit his hand on the bed rail. NA #1 told Nurse #3 that she had just been suspended and that she was going home. Nurse #3 described Resident #55 as having a lot of behavior issues lately and said it was not uncommon for him to be difficult to care for. Nurse #3 said that sometime after he arrived to work on 12/31/21, the Assistant Administrator asked him to go and assess Resident #55. Nurse #3 stated when he went to the Resident's room,	F 600		

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Resident #55 immediately showed Nurse #3 his right hand which was observed by Nurse #3 to have a linear scratch that was approximately 1 3/4 inch in length. Resident #55 stated to Nurse #3 that he was scratched by NA #1 during evening care on 12/30/21 when NA #1 dug her nails into his hand. Nurse #3 stated that he asked Resident #55 if the scratch occurred because he hit something, but Resident #55 said "No, she did this to me."

A phone interview with Nurse #2 occurred on 2/24/22 at 03:20 PM. Nurse #2 stated she was the assigned nurse for Resident #55 on the day shift on 12/31/21. Nurse #2 described Resident #55 as alert/oriented, he was monitored for behaviors. Nurse #2 described that Resident #55 refused nursing care, refused treatments, yelled/screamed at staff, made inappropriate remarks to/about staff and was very demanding. Nurse #2 stated she when she cared for Resident #55 on 12/31/21, he did not express concerns with abuse.

A phone interview with SW #2 occurred on 2/24/22 at 11:52 AM. SW #2 stated she was a SW at the facility April 2021 through February 2022. SW #2 stated that she interviewed residents and ensured residents knew who to report abuse to, as part of her role, when an allegation of abuse occurred. SW #2 further stated that she interviewed Resident #55 on 1/6/22 after he alleged that he was abused by NA #1. SW #2 stated that Resident #55 reported to her that he was abused when NA #1 grabbed his wrist during care and covered his mouth. SW #2 stated she offered to refer Resident #55 for psych services, but he declined. She stated that Resident #55 stated to her that his psychosocial

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needs could be met by talking to SW #2. During the interview, SW #2 stated that she continued to monitor Resident #55's psychosocial status after he made an allegation of abuse, but that she did not identify any further need for psych services.

The Assistant Administrator was interviewed on 2/23/22 at 12:12 PM and at 6:14 PM. He stated during the interviews that Resident #55 called the facility on 12/31/21 between 4:30 PM and 5:00 PM and asked to speak to him. The Assistant Administrator stated he spoke to Resident #55 shortly after he called the facility and Resident #55 told him that the night before, on 12/30/21, NA #1 covered his mouth during care when he screamed out because she was hurting him and scratched his wrist with her fingernail when she tried to turn him over. Resident #55 stated that he did not want NA #1 to care for him again. The Assistant Administrator stated he observed a small abrasion to the right wrist of Resident #55. The Assistant Administrator then stated he wrote down the Resident's statement, checked the schedule, saw that NA #1 was working that day so he went to NA #1 and asked her to write a statement, and then suspended her. The Assistant Administrator further stated he completed the Initial Abuse Report on 12/31/21 and that based on the investigation, which was completed on 1/3/22, the allegation of abuse was substantiated.

The Administrator was interviewed on 2/24/22 at 6:00 PM and stated if a Resident became aggressive during care, staff were trained to make sure the resident was safe and then remove themselves from the resident. The Administrator stated regarding the event that occurred with Resident #55 on 12/30/21, if the

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F 600	Continued From page 36 Resident was not agreeable to receiving care, NA #1 should have left Resident #55 in a safe position and walked away, which would have prevented NA #1 from covering his mouth and the Resident from sustaining an injury.	F 600		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility 1) failed to implement their abuse policy in the areas of reporting, protection, and identification from resident-to-resident abuse, 2) failed to immediately assess other residents for signs/symptoms of abuse and 3) failed to conduct a criminal background check for Nurse Aide #1 prior to an allegation of staff to resident abuse. This occurred for 2 of 3 residents sampled for abuse (Residents #30 and #55). 1. A review of the facilities policy titled Abuse, Neglect and Exploitation revised on 10/22/20 read in part; Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and	F 607	Effective 3/1/2022 facility has ensured resident #55 is safe by removing NA#1 from facility. On 3/8/22 the facility offered a room change to both residents where they declined, and no further incidents have been reported. Resident # 30 verbalized that she was satisfied with the actions taken by the facility.NA#1 removed from the facility on 12/31/2022. All residents are at risk for potential Abuse. Nurse management interviewed alert and oriented resident for any potential abuse as of 3/2/2022.	4/11/22

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F 607	Continued From page 37 implementing written policies and procedures that prohibit and prevent abuse, neglect exploitation and misappropriation of resident property. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations. V. Investigation of Alleged Abuse, Neglect and Exploitation; A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 3. Investigating different types of alleged violations. 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred, the extent, and cause. VI. Protection of Resident; The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within	F 607	On 3/28/22 the Nurse management will re-educate all current staff on the facility abuse and reporting policy to include notification of police, types of abuse to include resident to resident and staff to resident education to be completed by 4/11/2022. Effective 4/11/22 any new staff to include agency staff will be in-serviced on the facility abuse and reporting policy, types of abuse to include resident to resident and staff to resident prior to starting their shift by nurse management On 4/6/22 the Regional Clinical Nurse/ Regional Director of Operations educated the Administrator on Abuse policy and reporting and obtaining a background check on a staff member prior to start of first scheduled shift. Nurse management will audit 5 residents weekly to ensure they have no concerns of abuse, 3 x weekly x 4 weeks, weekly x 4 weeks and monthly x 1 month. Nurse management will interview 5 staff members 3 x weekly x 4 weeks, weekly x 4 weeks and then monthly x 1 month to ensure all reported abuse allegations, resident to resident or staff to resident are reported at the time of the allegation and who to report too. Nurse management will audit 5 staff members files to ensure background checks has been completed weekly x 12 weeks. Administrator will monitor all reported abuse allegations for timely reporting and	

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F 607	Continued From page 38 specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. A review of a form titled Complaint/Grievance Report completed on 2/28/22 by Social Worker (SW) #1 read in part: on 2/28/22 Resident #30 told SW #1 that another resident was asking her to do sexual acts for him for money and this made Resident #30 feel uncomfortable. An interview was completed with Resident #30 on 3/2/22 at 1:08 PM who stated that Resident #8 had kept coming up to her and asking her to kiss him. Resident #30 stated that back in January 2022, he had offered her $20.00 to kiss him and she had told him no, and he had kept asking Resident #30 and had said things like he was a good kisser and let him kiss her. Resident #30 stated that she told Social Worker (SW) #2 when this happened back in January 2022, and she had done nothing. Resident #30 stated approximately a month ago when she and her roommate were walking to the smoking area, Resident #8 had called her sweetheart and grabbed the back of her jacket and she had almost fallen. Resident #30 stated that it bothered her and terrified her. Resident #30 stated that when he had grabbed her coat a Nurse Aide (NA) had saw this and she just told Resident #8 to stop it. Resident #30 was unable to recall who the NA was. Resident #30 stated that just this past Sunday (2/27/22) she had been out on the smoking patio around 7:00 PM. She had been	F 607	completion at time of the allegation. Administrator will report any findings to the Quality Assurance Performance Improvement for any needed improvement monthly x 3 months Completion Date: 4/11/22	

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sitting outside with another male smoker. Resident #30 stated that Resident #8 was inside the television (TV) room and felt that Resident #8 was waiting for her to be alone. Resident #30 took a picture of Resident #8 in the TV room and explained that once the male smoker went inside Resident #8 came out to the smoking patio and Resident #8 was not a smoker. Resident #30 stated that Resident #8 had asked her if he could lick her down there, and Resident #30 was asked to specify where down there meant and she stated her vagina.

An interview was completed with SW #1 on 3/2/22 at 2:05 PM who stated that Resident #30 had a concern regarding another resident. SW #1 was asked what type of concern and SW #1 responded stating that Resident #8 was asking Resident #30 to do sexually inappropriate things. SW #1 stated that she then reported it to the Administrator, and we had both been working on it and the Administrator was going to speak to Resident #8. The SW stated that she became aware of the situation on Monday 2/28/22 and she believed the encounter happened on Sunday 2/27/22. SW #1 was asked how Resident #30 was being protected. SW #1 stated "How is she being protected? I check on her, I don't know how to answer that question." SW#1 was asked how she checks on Resident #30, and she responded that she talked to her. SW #1 was asked if Resident #8 was soliciting Resident #30 and SW #1 stated "well I guess that is why I got my administrator as I was not sure how to handle the situation as Resident #8 had a guardian. SW #1 was asked do you report resident to resident abuse to the state and SW #1 responded to her knowledge yes, we would report resident to resident abuse. SW #1 was asked do you report

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this to the police and SW #1 responded she did not know and had taken it to the Administrator. SW #1 was asked if she had seen Resident #30 today and she responded she had not had time to see her yet today (3/2/22).

A second interview was completed with Resident #30 at 5:00 PM who stated that Resident #8 started to bother her in January 2022, and it had made her feel uncomfortable in a way like she was a prostitute. Resident #30 stated that she felt cornered back in January 2022 and was scared that she was causing an issue that she would have to stay at the facility and that scared her. Resident #30 explained the type of issue she meant was that Resident #8 would try and corner her and force himself on her. Resident #30 stated that SW #1 had not been down to speak with her that for the last two days, Resident #30 had gone to her, and SW #1 had not been down today.

A second interview was completed with SW #1 on 3/2/22 at 5:35 PM who was asked if they had assessed other residents and she stated "No" and stated the only complaint she had ever had from alert and oriented residents was that Resident #8 plays his radio too loud.

An interview was completed with the Administrator on 3/2/22 at 6:03 PM who was asked what protective actions had been taken for Resident #30. The Administrator stated there was a review to move either one of the residents which was directed by our RDO. The Administrator stated what had been concluded was that Resident #30 is willing to move to a different room if her roommate could go with her, however we don't know where we will accommodate that and are currently reviewing.

F 607

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The Administrator stated the SW #1 had been checking on Resident #30 to make sure there were no additional concerns and he believed that yesterday 3/1/22 SW #1 had reviewed with our psych (psychological) services team to work with Resident #8. The Administrator stated they had been interviewing residents if they feel safe and if they have had any inappropriate actions from other residents. The Administrator was asked how you will ensure Resident #30's safety and he stated they are still reviewing that and are keeping an extra eye on Resident #8 for now by completing additional monitoring.

A telephone interview was completed with the RDO on 3/2/22 at 8:30 PM who stated that he spoke with Resident #30 on 2/28/22 regarding an issue she had with another resident who had offered her money for sexual favors. The RDO asked Resident #30 who the resident was, and Resident #30 stated it was Resident #8. The RDO stated that with this situation we investigated it through the grievance process and that this was more of a proposition as he had never been aggressive and was just offering money, so we just took this through the grievance route. The RDO explained if this was abuse, we would have reported it and done a 24-hour report. The RDO stated that Resident #30 never stated that Resident #8 had tried to touch her of force himself on her he had just propositioned her.

A phone interview was completed on 3/3/22 at 8:29 AM with the AD who stated that on Monday 2/28/22 Resident #30 had her listen to a recording and it was hard to understand what Resident #8 was offering money for, you could hear Resident #30 say she had a boyfriend. The AD was asked if Resident #30 told her that

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Resident #8 had asked to lick her private area and the AD stated that she did tell her that, but you could not hear that on the recording. The AD stated that she did report it to SW #1.

An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that it was his expectation that "if the facility had identified an abuse situation that we protect the resident involved and assure all other residents are safe and complete the reporting responsibilities and complete our investigation and appropriately address the alleged perpetrator."

A review of a facility reported incident initial allegation report was faxed to the Department of Health and Human Services Complaint Intake and Healthcare Personnell on 3/3/22 at 4:44 PM. The initial allegation report revealed the facility learned of the allegation on 2/28/22 at 10:00 AM.

2. The facility policy, Abuse, Neglect and Exploitation, implemented 11/1/20 recorded in part that each potential employee, to include temporary contracted staff, would be screened for a history of abuse, exploitation, or misappropriation of resident property with a background, reference, and credential's check. The screening would be conducted by the facility or by a third party and the facility would maintain documentation of the screening.

Resident #55 was admitted to the facility on 10/3/21. Diagnoses included cerebral infarction without residual deficits (stroke) and arthritis, among others.

An admission Minimum Data Set assessment

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dated 10/15/21, assessed Resident #55 with clear speech, able to understand and be understood, adequate hearing and vision, intact cognition, and required limited staff assistance with toileting from one person.

A Health Care Personnel Investigations (HCPI) Initial Allegation of Abuse Report (Initial Report), dated 12/31/21, completed by the Assistant Administrator, documented an allegation of staff to resident abuse. The Initial Report, documented in part, Resident #55 was alert and oriented and reported to the Assistant Administrator on 12/31/21 at 5:00 PM that during care on 12/30/21 around 9:30 PM, nurse aide (NA) #1 was rough with him when she attempted to turn him over in bed, she dug her nail into his right wrist and scratched him, then she covered his mouth when he yelled out. A written statement by NA #1 dated 12/31/21 documented that NA #2 was also present on 12/31/21 and provided care to Resident #55 at the time he alleged abuse. Review of the witness statement by NA #2, undated, revealed she was in the bathroom emptying the urinal and did not witness staff to resident abuse. The 5 Day Investigation Report, completed by the Assistant Administrator on 1/3/22 documented that the allegation of staff to resident abuse was substantiated.

Review of employee and time records for NA #2 revealed she worked at the facility from a temporary staffing agency on 12/30/21 - 1/7/22. Further review of employee records revealed there was no documentation of a criminal background check completed for NA #2 prior to 12/30/21.

The Assistant Administrator was interviewed on

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F 607	Continued From page 44 2/23/22 at 12:12 PM. During the interview, he stated that he completed the HCPI Initial Report in which Resident #55 accused NA #1 of abuse while NA #1 and NA #2 provided care, conducted the abuse investigation, and substantiated the allegation of staff to resident abuse. The Assistant Administrator stated NA #2 was not an employee of the facility, but rather worked for a staffing agency who was responsible for screening potential employees prior to hire. He stated that the staffing agency should only provide staff support with staff who had been screened and have a clear background check. He stated that the facility did not screen potential employees who were staffed from a staffing agency. An interview with the Administrator occurred on 2/24/22 at 6:00 PM. The Administrator stated that the facility staffed the facility with contract agency staff and that the facility expected the agency to ensure background checks were completed for all contracted staff prior to being eligible for hire in a nursing home setting and to ensure there were no criminal concerns in their background. The Administrator stated that the facility did not conduct a criminal background check for NA #2, and that he contacted the staffing agency and determined that proof of a criminal background check was not available for NA #2 from the staffing agency.	F 607		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		4/11/22

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this

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F 636	Continued From page 46 chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete comprehensive Minimum Data Set (MDS) assessments for 2 of 2 residents reviewed for admission to the facility (Resident #2 and Resident #66). Findings included: 1. Resident #2 was admitted to the facility on 10/6/2021. A review of Resident #2's Admission MDS Assessment, with an assessment reference date of 10/12/2021 (the last day of the look-back period), revealed the assessment was not completed until 10/22/2021. During an interview with the MDS Nurse on 3/1/2022 at 11:16 am she stated she had been off during the time Resident #2's assessment should have been completed. She explained the Regional Clinical Reimbursement Consultant had been aware she was not in the facility and should	F 636	Facility MDS nurse has completed Comprehensive Assessments for resident #2 was completed on 10/22/2021. Facility MDS Nurse completed comprehensive assessment on resident #66 on 1/28/2021. All residents have the potential to be affected by late assessment completion. Regional Clinical Reimbursement Consultant (RCRC) reviewed all assessments for timely completion as of 3/29/2022. RCRC re-educated the MDS Nurse, Social Worker and Activity Director on facility policy for completing comprehensive assessment timely on 3/29/2022. Nurse management will monitor comprehensive assessments scheduled weekly x 4 weeks then monthly x 3	

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F 636	Continued From page 47 be her back up to ensure assessments were completed. An interview was conducted with the Regional Clinical Reimbursement Consultant on 3/1/2022 at 12:56 pm. He stated he was aware the MDS Nurse had been off when Resident #2's admission Minimum Data Set (MDS) assessment was submitted late. He stated they did not have staff available to complete Resident #2's admission MDS assessment when the MDS Coordinator had been off. During an interview with Administrator #2 on 3/3/2022 at 11:57 am he stated the MDS assessment should have been completed according to the required assessment schedule defined by the Resident Assessment Instrument (RAI). 2. Resident #66 was admitted to the facility on 1/8/2022. A review of Resident #66's Admission Assessment, with an assessment reference date of 1/21/2022 (the last day of the look-back period), revealed it was completed 1/28/2022. On 3/2/2022 at 9:20 am an interview was conducted with the MDS Nurse. She stated Resident #66's Admission MDS Assessment was completed late because she had been off during the time the assessment was due. The MDS Coordinator stated the Regional Clinical Reimbursement Consultant had been aware she would not be able to complete the assessment. An interview was conducted with the Regional Clinical Reimbursement Consultant on 3/1/2022	F 636	months to ensure comprehensive assessments are completed timely. Administrator will report any findings to the Quality Assurance Performance Improvement committee monthly x 3 months for any needed improvements. Completion Date 4/11/22	

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F 636	Continued From page 48 at 12:56 pm. He stated he was aware the MDS Nurse had been off when Resident #66's admission Minimum Data Set (MDS) assessment was submitted late. He stated they did not have staff available to complete Resident #66's admission MDS assessment when the MDS Coordinator had been off. During an interview with Administrator #2 on 3/3/2022 at 11:57 am he stated the MDS assessment should have been completed according to the required assessment schedule defined by the Resident Assessment Instrument (RAI).	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		4/11/22

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F 655	Continued From page 49 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission to address the immediate needs of a resident for wound and diabetic care, anticoagulant therapy, oxygen therapy, hemodialysis and nutrition; or a baseline care plan for the immediate needs of a resident with paraplegia (inability to move from the waist down) with a urinary catheter, antibiotic therapy and pressure ulcer care for 2 of 2 residents reviewed for baseline care plans (Resident #187, #237). The findings included: 1. Resident #187 was admitted to the facility on	F 655	Effective 3/14/2022 residents #187 and #237 baseline Care Plan was completed to show resident care needs by nurse management. All new admissions have the potential to be affected by baseline care plan not being completed. Effective 3/14/2022 all residents admitted 2/22/2022 through 3/14/2022 were reviewed to ensure baseline care plan were completed by nurse management. Effective 3/20/2022 Nurse management will re-educate current license nurses to include agency licensed staff on the	

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F 655	Continued From page 50 02/15/22. Resident #187's diagnoses included recent amputation of toes, hypertension, osteomyelitis, atrial fibrillation, chronic kidney disease requiring hemodialysis, diabetes and stroke. The Admission Minimum Data Set (MDS) assessment for Resident #187 was not completed at the time of the survey. Review of the Nursing Admission Assessment completed on 02/15/22 indicated Resident #187 was alert and oriented to person, place, time and situation. It indicated he had a shunt for dialysis to his right upper arm and 2 incisions on his abdomen and amputation of his left foot to the heel. A review of the physician orders for Resident #187 included Warfarin (blood thinner) 02/15/22, fingerstick blood sugar checks and insulin sliding scale were ordered before meals and at bedtime on 02/15/22, oxygen therapy was ordered on 02/16/22, and wound care of normal saline wet to dry dressing was ordered on 02/17/22. Review of the Hospital Discharge Record dated 02/12/22 indicated Resident #187 was to continue with outpatient hemodialysis. An interview with Social Worker (SW) #1 was done on 02/28/22 at 2:46 PM. She stated Resident #187 had no baseline care plan completed on admission. The SW indicated nursing usually started it and she did not know why it was not done. The Minimum Data Set Coordinator was	F 655	facility policy for admissions to include baseline care plan completion on admission, information to be reviewed with resident and/or responsible party at 72 hour care plan meeting, at time of meeting resident and/or responsible party will be given a copy of baseline care plan education to be completed by 4/11/2022. Effective 4/11/22 all new licensed nurses to include agency licensed nurses will be educated prior to starting their first shift by nurse management Nurse management will audit all new admissions daily in morning meeting Monday through Friday ongoing to ensure baseline care plan has been completed. Any new admits from weekends will be reviewed in morning meeting on the following Monday. Director of Nursing will report any findings to the Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months. Completion date; 4/11/2022	

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interviewed on 02/28/22 at 3:04 PM. She noted Resident #187 did not have a baseline care plan and stated nursing had not completed it. She said normally the MDS nurse or the SW, would review the baseline care plan with the resident/resident's representative. The MDS nurse stated the Director of Nursing (DON) #2 had been made aware it was not completed.

An interview was done with Director of Nursing (DON) #2 on 03/02/22 at 9:45 AM regarding baseline care plans. She said baseline care plans were supposed to be done within 24 hours of the resident coming into the building. The DON stated "in a perfect world and when they had staff, they had completed baseline care plans within 2 hours of a resident coming in." The DON said starting in January 2022 they were getting 2-3 admissions a day and the staff couldn't keep up. She said the baseline care plan not being done was related to staffing, and the majority of staff were agency nurses. She noted there were instructions at the desk and inservices had been done but there was difficulty getting agency staff to complete them.

A phone interview was conducted on 03/03/22 at 4:01 PM with Administrator #2 and he stated baseline care plans should be completed within the designated time frame.

2. Resident #237 was admitted to the facility on 01/26/22.

Resident #237's diagnoses included paraplegia, severe sepsis secondary to a catheter associated urinary tract infection, clostridium difficile colitis and neurogenic bladder.

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The Admission Minimum Data Set (MDS) assessment completed on 02/07/22 indicated Resident #237 was cognitively intact. It indicated he had 2-stage 3 pressure ulcers and 2-unstageable pressure ulcers on admission and an indwelling urinary catheter.

A review of the initial Physician orders for Resident #237 included an antibiotic for clostridium difficile on 01/26/22 and a pressure ulcer redistribution mattress on 01/27/22. There were no urinary catheter orders entered and pressure ulcer wound care orders were not entered until 02/03/22.

The MDS Coordinator was interviewed on 03/01/22 at 6:15 PM regarding the baseline care plan for Resident #237. She stated the baseline care plan was not done. She stated nursing did not initiate it with his admission which was the protocol. The MDS coordinator said once nursing had completed it, the Social Worker or MDS nurse would complete it with the resident/resident representative.

Social Worker #1 was interviewed on 03/02/22 at 9:41 AM regarding the baseline care plan for Resident #237. She stated there was no baseline care plan as nursing had not started it with his admission.

An interview was done with Director of Nursing (DON) #2 on 03/02/22 at 9:45 AM regarding baseline care plans. She said baseline care plans were supposed to be done within 24 hours of the resident coming into the building. The DON stated "in a perfect world and when they had staff, they had completed baseline care plans within 2 hours of a resident coming in." The DON

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F 655	Continued From page 53 said starting in January 2022 they were getting 2-3 admissions a day and the staff couldn't keep up. She said the baseline care plan not being done was related to staffing, and the majority of staff were agency nurses. She noted there were instructions at the desk and inservices had been done but there was difficulty getting agency staff to complete them. A phone interview was conducted on 03/03/22 at 4:01 PM with Administrator #2 and he stated baseline care plans should be completed within the designated time frame.	F 655		
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 record review, observations, staff, and Physician interviews the facility failed to provide surgical wound treatments for 2 of 2 residents (Resident #243) reviewed for surgical wounds. Resident #243 was reviewed for surgical wound care and the facility failed to change the wound vacuum dressing and maintain a wound vacuum device on a leg wound as ordered by the physician upon admission. Resident #54 was reviewed for surgical wound care in which wound vacuum closure was ordered.	F 684	Residents #243 and #54 no longer Resides in the facility, All residents are at risk for surgical wounds and orders not being documented as completed therefore on 3/7/2022 a skin sweep was completed on current residents to ensure residents are receiving treatments for surgical wounds by nurse management and orders documented as completed.	4/11/22

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Findings included:

1. Resident #243 admitted to the facility on 2/9/2022 with diagnoses of diabetes and amputation of his left and right great toes. Resident #243 discharged to the community on 2/25/2022.

A baseline Care Plan dated 2/9/2022 stated Resident #243 was admitted for rehabilitation services and wound management.

During a review of Resident #243's admission physician's orders dated 2/9/2022 there was no order discovered for Resident #243's surgical wound dressing changes for his right and left great toe amputation.

Review of Resident #243's medical record revealed a Minimum Data Set 5 day assessment with an assessment reference date of 2/14/2022. Resident #243 was assessed as mildly cognitively impaired; he required limited assistance with bed mobility and transfers; and he had surgical wounds.

A physician's order dated 2/15/2022 stated Resident #243's left and right foot surgical wound should be cleansed with betadine and covered with a nonadherent dressing and gauze wrap.

Review of Resident #243's Treatment Administration Record revealed there was no dressing changes documented for his right or left great toe surgical amputation site from his admission on 2/9/2022 to 2/15/2022, or for 2/19/2022, 2/20/2022, or 2/21/2022.

F 684

Effective 3/10/2022, the Nurse management will educate current licensed nurses to include agency nurses before there first shift to ensure residents have treatment orders for surgical wounds and if resident presents with surgical wounds upon admission without orders license nurse will call physician for orders education to be completed by 4/11/2022.

Effective 4/11/2022 any new licensed nurses to include agency licensed nurses will receive education prior to the start of their shift on wound care policy by nurse management.

Nurse management will audit 5 residents with surgical wounds to ensure treatment orders are entered into the resident□s electronic medical record and completed as ordered, 3 x a week x 4 weeks, weekly x 8 weeks.

Director of Nursing will report any findings to
Quality Assurance Performance Improvement monthly x 3 months for any needed improvements

Completion date: 4/11/2022

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An interview was conducted with Nurse #2 on 2/24/2022 at 10:56 am and she stated she was assigned to Resident #243 on 2/19/2022, 2/20/2022 and 2/21/2022. She stated if she did not sign off the dressing change on the Treatment Administration Record and she was not able to do them. She stated the patient load when she works at the facility makes it impossible for her to complete the wound dressing changes but she did notify the Regional Director of Clinical Services that she had not been able to complete the dressing changes.

On 2/24/2022 at 3:46 pm an interview was conducted with the Regional Director of Clinical Services. She stated Nurse #2 did not notify her she was unable to complete the dressing changes for Resident #243. She added she was aware since last Wednesday, 2/16/2022 or Thursday, 2/17/2022, that dressing changes were not being done and the facility had started a performance improvement plan for dressing changes.

On 2/23/2022 at 7:30 pm a phone interview was conducted with Resident #243's Family Member and she stated Resident #243's had both of his great toes amputated and had admitted to the facility on 2/9/2022. The Family Member stated the nursing staff did not get an order or changed Resident #243's surgical dressing for several days and there had been several days since they got an order for the dressing changes that it still had not been completed according to the Resident. The Family Member stated Resident #243 was cognitively intact and would let her know when the dressing changes had not been done.

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On 2/25/2022 at 9:22 am an observation and interview was conducted with Resident #243. Resident #243 was up in his wheelchair and stated his dressing came off at 9:00 pm on 2/24/2022. Resident #243's left foot had a gauze dressing and a blue shoe cover over it. His right foot great toe amputation surgical site did not have a dressing and had a blue shoe cover over it. He stated at 9:00 pm last night, 2/24/2022, he asked a staff member, but did not know their name, to tell the Nurse his dressing had come off and needed a bandage. He stated no one came to change his dressing last night, he stated he told the Nurse Aide at 8:00 am that he needed his dressing replaced, and she told him she would tell the Nurse #1. Resident #243 stated he put the blue shoe cover over his right foot for protection but his right foot did not have a dressing over the surgical incision to his right great toe amputation site. The Assistant Administrator was notified of Resident #243's need for assistance with obtaining a dressing to his right great toe amputation site. He responded Nurse #1 stated she could not apply a dressing to his right great toe surgical site because she was completing her morning medication round and did not have time.

Nurse #1 was interviewed on 3/1/2022 at 9:39 am. She stated she was assigned to Resident #243 on 2/25/2022 and had started her shift at 8:30 am because someone had called out. Nurse #1 stated no one told her Resident #243 had asked to have his dressing replaced on 2/25/2022. She stated when the Assistant Administrator notified her of his dressing being off, she had already started her medication round and she was afraid she would be late giving medications if she were to stop to apply a

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dressing. Nurse #1 stated she did not remember being assigned to Resident #243 on 2/15/2022 and she did not remember if she had missed changing his dressing on that day. Nurse #1 stated she does not usually work on the 300 hall where Resident #243 resides, but it is a very challenging assignment, and it would be hard to complete the medication administration pass, and get the wound treatments done on that assignment.

An interview was conducted with the Director of Nursing (DON) #2 on 3/3/2022 at 11:45 am. She stated she was aware Resident #243 did not have a physician's order for his right and left great toe amputation surgical sites until 2/14/2022 and he was admitted on 2/9/2022. The DON #2 stated she was also aware there were missed treatments to Resident #243's right and left great toe amputation surgical sites. The DON #2 stated she was on medical leave when Resident #243 admitted to facility and when his dressing changes were not completed. She stated she was notified by Administrator #1 Resident #243's dressing changes were not ordered on admission and was asked to do education with the nursing staff while she was on medical leave, but it was not completed. DON #2 stated she had worked on a nurse staff assignment so often before she went on medical leave, she was not able to monitor the nursing staff for issues like dressings not being changed or educated them on them not being changed. DON #2 stated nurse staffing had been a problem since she accepted the DON position after DON #1 left on 12/31/2021.

On 3/4/2022 at 1:38 pm an interview was conducted with the Medical Director #1, and she stated Resident #243's right and left great toe

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amputation surgical dressings had not been changed for the first 5 days he was admitted to the facility. She further stated it had put him at risk of developing a surgical wound infection. Medical Director #1 stated she had reported the lack of surgical wound care to the Regional Director of Clinical Operations by email when the pervious administrator left but did not receive a response.

An interview was conducted with Administrator #2 on 3/3/2022 at 11:57 am and he stated there should have been a review of Resident #243's hospital medical record when he admitted to the facility to ensure his needs were met. He stated Resident #243 should have been assessed for all needs and orders obtained and the orders for treatments to his right and left great toe amputations should have been completed as ordered by the physician.
2. Hospital discharge records from 01/03/22 for Resident #54 indicated she was admitted for an infected hematoma of the left leg. Her wound had been managed with a wound vacuum assisted closure (VAC) (or negative pressure dressing) device in the hospital and the plan was to continue that treatment.

Resident #54 was admitted to the facility on 01/03/22 and her diagnoses included atrial fibrillation, hypertension, and a surgical wound on her left leg from a previous injury.

a. A physician order dated 01/03/22 was for a Wound Consult and Treat for left leg cellulitis-wound VAC in place for Resident #54.

An order was written for Resident #54 on 01/03/22 to place black foam, apply dressing,

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make sure the seal was good and start at 125 millimeters of mercury (mmHg) and change the dressing on Monday, Wednesday and Friday and as needed. The order for the wound VAC and dressing changes were discontinued on 02/02/22.

The care plan for Resident #54 was initiated on 01/04/22 with the care area actual impairment to skin integrity of the lower leg related to laceration, surgical wound, deep tissue injury, from hitting leg with transfer board at home. An intervention on 01/04/22 indicated that the resident had been refusing the wound VAC since admission.

A phone interview was done with Resident #54 on 02/25/22 at 7:41AM following her discharge. Resident #54 was asked if she ever refused the wound care and she said the first night she got there from the hospital, it was dark, and they came in asking about the wound VAC and staff did not seem to know what they were doing. She said she did not trust that they knew what they were doing, and they were asking her if she had her own wound VAC. She stated she told them she would wait till the morning when the head nurse was there.

An order for Resident #54 was written on 01/05/22 to place a wound VAC to the left leg and change the dressing on Monday, Wednesday, and Friday, and to monitor to ensure it was properly working (this order was documented as having been placed on hold 02/16/22 due to the resident being placed in the COVID unit).

A note from Wound Physician #1 dated 01/10/22 indicated the plan was to have the wound VAC in place continuously and change the dressing three times per week for 30 days for Resident #54.

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F 684	Continued From page 60 An order to hold the above wound VAC order due to pending equipment delivery was written by the Nurse Practitioner on 01/10/22 for Resident #54. An interview was done with Director of Nursing (DON) #2 on 03/01/22 at 4:36 PM. She stated the facility had 3 wound VAC machines and had 5 days of supplies but the nurses were not trained in how to apply, manage, or chang the wound VAC dressings, or manage the equipment. She stated the Staff Development Coordinator (SDC) was supposed to have helped with the training (Through the investigation it was discovered The SDC was no longer employed the facility as of 01/24/22 and attempts to contact her were unsuccessful). The DON stated it was herself, one staff nurse, and 2 agency nurses (who worked intermittently) who knew how to care for wound VAC's. The January 2022 Treatment Administration Record (TAR) for Resident #54 indicated the wound VAC was ordered to be applied and the dressing were to be changed on Monday, Wednesday and Friday starting 01/05/22. Review of the TAR revealed no documentation for the ordered care being completed on 01/14/22, 01/17/22, 01/21/22, 0/24/22 or 01/31/22. Further review revealed an order to ensure the wound VAC was working properly on Monday, Wednesday, and Friday, starting on 01/10/22, with no documentation as being completed for 01/17/22, 01/21/22, 01/24/22 or 01/31/22. An admission Minimum Data Set (MDS) assessment completed 01/19/22 indicated Resident #54 was cognitively intact, had a wound on admission, and no pressure ulcers.	F 684		

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During an interview conducted with Nurse #15, who was assigned to care for the resident on 01/21/22, she stated she did not recall whether the wound VAC was on the resident that day, or was working properly. She noted some days they had 27 residents, and she could not do blood sugars, medications, dressings, or turn the residents with pressure ulcers every 2 hours.

The Wound Physician progress note dated 02/09/22 by Wound Care MD #2 indicated Resident #54's treating surgeon had resumed all wound care and had prescribed the placement of a wound VAC, and dressing changes three times a week until discharge.

A phone interview was done with Resident #54, who was discharged at the time of the interview, on 02/25/22 at 7:41 AM. She said the staff were not doing her dressings as ordered. She said there were a lot of problems with having staff who knew how the wound VAC machine worked and how to care for the dressings. She explained the machine would act faulty, beep constantly, and the nursing staff would not know what to do. She said that was reason that her dressing was changed to a wet to dry dressing (a dressing which dis not utilize the wound VAC) was because staff did not know how to take care of the wound VAC.

A phone interview with Medical Director #1 was done on 02/22/22 at 12:41 PM. She indicated she had concerns with Resident #54 not receiving the wound VAC care as ordered from the MD on admission and throughout her stay. The physician indicated there were several times treatments for the wound VAC were not done.

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She noted when the resident was on the COVID unit it was frequently staffed by a medication aide, no nurse was available to complete the wound VAC dressing, so wet to dry dressings had to be done.

The Director of Nursing (DON) #2 was interviewed on 03/01/22 at 4:36 PM regarding Resident #54's wound VAC and dressing changes. She stated the wound doctor came on Mondays, would view the wound, the wound VAC dressing was changed that day and the other days as ordered. The DON said she would do rounds on the resident frequently. She stated she felt like the wound VAC and dressings were done more than was documented but staffing was an issue. The DON said the resident would tell her they took the wound VAC, and the dressing, off frequently due to it beeping and would put wet to dry dressings on instead. She said after the resident went to the COVID unit there may not have been a nurse on the COVID unit to care for the wound VAC and the wound VAC dressing changes.

b. The Wound Care Physician note from 02/02/22 indicated Resident #54 did not want to continue with the wound VAC. The Physician ordered calcium alginate dressings to be changed daily for 30 days. He documented the hope was to transition back to three times a week therapy for when the resident was to home.

Review of the February 2022 TAR revealed a physician order written for Resident #54 on 02/02/22 for a treatment of calcium alginate dressing daily was not signed off on 02/05/22, 02/07/22, 02/10/22. The order was discontinued on 02/10/22.

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An interview was done with Nurse #2 on 02/24/22 at 10:54 AM, who cared for Resident #54 on 02/07/22, and she stated did not recall if Resident #54's dressing was done on 02/07/22. She noted dressings would not always get done due to staffing and the Regional Clinical Nurse #1 had been helping to do some dressings lately as well.

An interview with Nurse #10, who cared for Resident #54 on 02/10/22, was done on 02/27/22 at 5:46 PM via phone and she stated wounds and wound care were not able to be tended to properly. She stated there was not enough time to get wound care done as there was not enough staff. She did not recall doing wound care on 02/10/22.

Director of Nursing (DON) #2 was interviewed on 03/01/22 at 4:36 PM regarding Resident #54's dressing changes. She felt like dressings were done more than was documented but staffing was an issue. She said after the resident went to the COVID unit there may not have been a nurse on the COVID unit to do the dressings.

c. Review of the January 2022 TAR for Resident #54 indicated wet to dry dressing changes were ordered to start 01/11/22 two times a day. The dressings were not documented as being completed on 01/11/22 6:00 AM, 01/11/22 4:00 PM or 01/12/22 at 6:00 AM. The order was discontinued on 01/13/22.

Review of Resident #54's medical record revealed an order dated 02/15/22 for wet to dry dressings, to the left lower extremity, change daily, until the wound VAC can be placed.

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Review of the February 2022 TAR revealed normal saline wet to dry dressing changes to the left lower leg, change daily, were ordered on 02/19/22 for Resident #54, and the dressing was not documented as being changed on 02/20/22. Attempts to obtain contact information for the assigned nurse from 02/20/22, Nurse #17, were unsuccessful.

Resident #54 was discharged home with home health services on 02/22/22 from the COVID unit.

A phone interview with Medical Director #1 on 02/22/22 at 12:41 PM indicated she had concerns with Resident #54 not receiving the wound VAC care as ordered from the MD on admission and throughout her stay. The physician indicated there were several times treatments for the wound VAC were not done. She noted when the resident was on the COVID unit it was frequently staffed by a medication aide, no nurse was available to do the wound VAC dressing, so wet to dry dressings had to be done.

A phone interview was done with Resident #54, who was discharged at the time of the interview, on 02/25/22 at 7:41AM and she said the staff were not doing her dressings as ordered. She said there were a lot of problems with having staff who knew how the wound VAC machine worked and how to do the dressings. She said that was the reason her treatment was changed to a wet to dry dressing was because the nursing staff did not know how to take care of the wound VAC. She stated it was not a good experience at all and they had switched her to a wet to dry dressing, which she would have to make sure herself that they got done, and even then the dressing change did not always get done. She added "I

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was stressed enough having to be there and then to have wounds that weren't being cared for added to it." She said she never refused wound dressings as she wanted to get out of the facility. She said she had a wet to dry dressing on when she left the facility and home health was able to change the treatment to a wound VAC.

A phone interview was done on 02/23/22 at 1:04 PM with the Nurse Practitioner regarding Resident #54's wound care. She stated the wound VAC dressing was supposed to be changed 3 times a week. When the resident became COVID-19 positive on 01/10/22 she spoke with the surgeon and got permission to change it to wet to dry from the surgeon. She noted the resident wanted the wound VAC therapy. The NP was made aware that the dressings were not being changed as ordered. She stated the order for the wound VAC came from the surgeon and she would expect it to be done as ordered. She noted the dressing was done wet to dry also when there were equipment issues with the wound VAC or they did not have supplies. The NP said it was never reported to her that the resident had refused the wound VAC and she did not believe that as she wanted to go home. She stated when the resident was on the COVID unit she would go and change the wet to dry dressing daily Monday-Thursday and on Friday 02/18/22 Nurse #8 stated she had done it. The Nurse Practitioner stated there was not enough staff in the building and she was trying to ensure the dressing was done.

A phone interview was done on 02/27/22 at 4:54 PM with Medical Director #1 regarding Resident #54's wound care. The Physician stated the wound VAC supplies were not there when the

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F 684	Continued From page 66 resident got to the facility. She said she didn't believe that was facility's fault, but it delayed her care with the wound VAC about a week. She stated the wound VAC was supposed to be changed 3 times a week and sometimes it was done once a week. She attributed the concerns she had with wound care to a lack of staffing, wound care in general were an issue, and she was frustrated with the wound care Resident #54 received. She said Resident #54 did not refuse the wound VAC or dressing changes. The Physician stated they should have someone to do wound care at the facility and be there all day for the number of wounds at the facility. Director of Nursing (DON) #2 was interviewed on 03/01/22 at 4:36 PM regarding Resident #54's wound VAC and dressing changes. She felt like the wound VAC and dressings were done more than was documented but staffing was an issue. The DON said the resident would tell her they took the wound VAC off frequently due to it beeping and would put wet to dry dressings on instead. She said after the resident went to the COVID unit there may not have been a nurse on the COVID unit. A phone interview was done with Administrator #2 on 03/03/22 at 4:20 PM. He was informed wound care dressings were not done and documented. The Administrator stated the facility should ensure clinical services were provided and stated they had staff with proven competencies to provide care, and staff available to meet the needs of the residents. The Administrator said once orders were provided by the physician they were to be appropriately placed in the medical record for treatments and interventions to be done. Regarding dressings not being done and	F 684		

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F 684	Continued From page 67 enough competent staff to care for wound VAC devices, he noted all dressings and care was to be provided as written by the physician in the time frame and on time. Regarding adequate staffing, the Administrator said they need to look at competency, efficiency and quantity of staff and it could be a combination of any of these that was related to the wound care not being done.	F 684		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, staff, Wound Physician and Medical Director interviews, the facility failed to provide pressure ulcer dressings ordered by the physician for 1 of 3 residents reviewed for wound care (Resident #83). Resident #83's wounds became infected and he developed further pressure ulcers. Resident #83 was discharged to the hospital with diagnoses of pressure ulcer wound infections and osteomyelitis (bone inflammation caused by infection). The facility	F 686	Effective 3/9/2022 resident #237 recommendation for heel protector boots was discontinued by the physician. Resident #83 no longer reside in the facility. On 3/7/2022 nurse management completed a skin sweep on current residents to ensure residents are receiving treatments for wounds as ordered by the wound medical doctor.	4/11/22

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further failed to follow the wound physician's order for heel protector boots and to float the heels of 1 of 3 residents, Resident #237 reviewed for pressure ulcer prevention (Resident #237).

Findings included:

1. Resident #83 admitted to the facility on 11/4/2021 with diagnoses of paraplegia and four pressure areas including a stage 4 pressure ulcer of the sacrum, a deep tissue injury of the right, posterior heel, a stage 4 pressure ulcer of the left ischium and a stage 3 pressure ulcer of the right ischium.

The Admitting Daily Skin assessment dated 11/4/2021 indicated Resident #83 had a sacral pressure ulcer with tunneling and he was assessed as high risk for predicted pressure ulcer risk.

Review of an initial Wound Evaluation and Management Summary by Wound Physician #1 dated 11/8/2021 indicated Resident #83 had a:

" right, posterior heel deep tissue injury which was unstageable on admission and measured 2.0 length x 2.5 width in centimeters;
" stage 4 sacral pressure ulcer on admission. The sacral pressure ulcer measured 7.8 length x 4.5 width x 1.0 depth in centimeters and had undermining of 0.9 centimeters at 3 o'clock. The Wound Evaluation and Management Summary indicated the sacral wound was surgically debrided at a depth of 1.5 centimeters of devitalized tissue and necrotic periosteum and friable bone;
" stage 4 left ischium pressure ulcer. The stage 4 ischium pressure ulcer measured 2.8

Effective 3/23/2022 current residents electronic record was reviewed to ensure heel protector boots and/or heels are floated as recommended by nurse management.

Effective 3/10/2022, the Nurse management will educate current licensed nurses to include licensed agency nurses on policy and procedure for completing wound care treatments as ordered and transcribing orders for treatment in the electronic medical record education to be completed by 4/11/2022. Effective 4/11/22 any new licensed nurses to include agency will receive education prior to the start of their shift on wound care policy and transcribing orders for treatment in the electronic medical record by the nurse management.

Nurse management will audit 5 residents with wounds to ensure treatment orders are completed as ordered, 3 x a week x 4 weeks, then weekly x 8 weeks.

Director of Nursing will report any findings to
the Quality Assurance Performance Improvement Committee monthly x 3 months for any needed improvement.

Completion date: 4/11/2022

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length x 3.2 width x 2.0 dept in centimeters and had undermining at 1.4 centimeters at 4 o'clock. The Wound Evaluation and Management Summary indicated the stage 4 left ischium pressure ulcer was surgically debrided of devitalized tissue that included nonviable muscle and surrounding fascial fibers to a depth of 2.3 centimeters;
"   right ischium stage 3 pressure ulcer. The Wound Evaluation and Management Summary indicated Resident #83's right ischium pressure ulcer measured 1.9 length x 1.2 width x 1.0 depth in centimeters with 1.8 centimeters of undermining at 2 o'clock.

A Care Plan dated 11/8/2021 stated Resident #83 had right heel deep tissue injury, a sacrum stage 4 with tunneling, left ischium stage 3, right ischium stage 4, left distal heel stage 2 due to history of ulcers and immobility.

A laboratory result dated 11/10/2021 revealed Resident #83's blood albumin level was low at 2.7 grams per deciliter (g/dL). A low albumin level can be an indication of liver or kidney disease and decreased protein intake, which is monitored for wound healing. The reference range for an albumin level is 3.5 to 5.2 g/dL.

A Wound Evaluation and Management Summary written by Wound Physician #1 dated 11/15/2021 indicated Resident #83 continued to have a:

"   right, posterior heel deep tissue injury and was measured in centimeters at 1.4 length x 0.7 width;
"   stage 4 sacral pressure ulcer which measured 8.5 length x 14.0 width x 1.5 depth in centimeters, with undermining of 1.3 centimeters

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at 12 o'clock, and wound progress was deteriorated;
" stage 4 pressure ulcer to the left ischium with measurements of 1.4 length x 2.6 width x 2.2 depth in centimeters and had undermining at 1.2 centimeters at 12 o'clock. It indicated the left ischium stage 4 pressure ulcer was surgically debrided of non-viable muscle and surrounding fascial fibers at a depth of 2.3 centimeter.
" stage 3 pressure ulcer to the right ischium. The Wound Evaluation and Management Summary indicated the stage 3 pressure ulcer to the right ischium measured 1.5 length x 1.4 width x 1.2 depth in centimeters and had undermining at 1.3 centimeters at 2 o'clock.

A Physician's order dated 11/19/2021 at 8:00 pm indicated Resident #83 would receive the protein supplement three times a day for wound healing.

A laboratory result dated 11/22/2021 stated Resident #83's blood hemoglobin level was low at 9.9 grams per deciliter (g/dL). Hemoglobin is the substance that transports oxygen throughout the blood and a low hemoglobin level leads to anemia. The reference range for a healthy hemoglobin level is 13.0 to 16.5 g/dL.

A Care Plan dated 11/22/2021 stated Resident #83 had intravenous antibiotics for increased white blood cell count (which indicated infection) and Vancomycin resistant Enterococcus (VRE), which is a bacteria that is resistant to the antibiotic vancomycin in his wound.

Review of a Wound Evaluation and Management Summary written by Wound Physician #1 dated 11/22/2021 revealed Resident #83 continued to have a:

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" right, posterior heel deep tissue injury that measured 3.4 length x 5.0 width. Review of a Wound Evaluation and Management Summary written by Wound Physician #1 dated 11/22/2021 revealed Resident #83 continued to have a sacral stage 4 pressure ulcer which measured 9.5 length x 13.6 width x 1.1 depth centimeters with undermining of 1.3 centimeters at 12 o'clock. The stage 4 pressure ulcer was surgically debrided of devitalized tissue, necrotic periosteum, and friable bone at a depth of 1.2 centimeters.
" left ischium stage 4 pressure ulcer that measured 2.4 length x 3.2 width x 1.9 depth in centimeters and had undermining at 1.8 centimeters at 12 o'clock. The Wound was surgically debrided of devitalized tissue and non-viable muscle at a depth of 2.0 centimeters.
" right ischium stage 3 pressure ulcer that measured 2.3 length x 1.4 width x 0.9 depth in centimeters and had undermining at 1.8 centimeters at 12 o'clock. The stage 3 pressure ulcer to the right ischium was surgically debrided.

A Wound Evaluation and Management Summary written by Wound Physician #1 dated 11/29/2021 indicated Resident #83 continued to have a:
" right, posterior heel deep tissue injury and was measured at 3.1 length x 3.2 width in centimeters.
" stage 4 sacral pressure ulcer was measured at 9.7 length x 6.7 width x 1.2 depth in centimeters with undermining of 1.4 centimeters at 12 o'clock. The wound was surgically debrided.
" stage 4 left ischium pressure ulcer and the measurements were 2.3 length x 2.5 width x 1.8 depth in centimeters and there was undermining at 2.4 centimeters at 12 o'clock. The wound was

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surgically debrided.
"	stage 3 right ischium pressure ulcer with measurements of 5 length x 1.7 width x 2.5 depth in centimeters with undermining of 2.2 centimeters at 12 o'clock.

A Physician's Order dated 11/30/2021 stated apply skin prep to bilateral heels daily for deep tissue injury.

On 12/5/2021 a left posterior heel stage 2 and right lateral calf deep tissue injury were added to the care plan.

Review of a Wound Evaluation and Management Summary written by Wound Physician #1 dated 12/6/2021 revealed Resident #83 had:
"	right, posterior heel deep tissue injury that measured 5.5 length x 6.4 width. The summary stated the wound was deteriorated.
"	a stage 4 sacral pressure ulcer with measurements of 9.3 length x 11.7 width x 1.4 depth in centimeters with 1.6 centimeters undermining at 9 o'clock. The stage 4 sacral pressure ulcer was surgically debrided at a depth of 1.4 centimeters.
"	left ischium stage 4 pressure ulcer with measurements of 2.5 length x 3.1 width x 2.3 depth in centimeters with undermining of 2.4 centimeters at 1 o'clock.
"	stage 3 pressure ulcer of the right ischium with measurements of 1.8 length x 2.8 width x 1.6 depth in centimeters with undermining of 1.6 centimeters at 11 o'clock. The stage 3 pressure ulcer of the right ischium was surgically debrided to a depth of 1.7 centimeters.
"	developed an unstageable deep tissue injury to his left posterior heel. The unstageable deep tissue injury to Resident #83's left posterior heel

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measured 5.0 length x 2.0 width.

A Wound Evaluation and Management Summary written by Wound Physician #1 dated 12/13/2021 indicated Resident #83 continued to have a:
"   deep tissue injury to his right posterior heel which measured 5.7 length x 4.5 width.
"   stage 4 pressure ulcer to the sacrum that measured 9.6 length x 15.5 width x 1.1 depth in centimeters and had undermining of 2.4 centimeters at 7 o'clock. The sacral pressure ulcer was surgically debrided to a depth of 1.2 centimeters.
"   stage 4 pressure ulcer to the left ischium that measured 2.7 length x 3.3 width x 0.9 depth with undermining of 2.0 centimeters at 1 o'clock. The left ischium pressure ulcer was surgically debrided to a depth of 1.0 centimeters.
"   stage 3 to the right ischium that measured 2.7 length x 3.0 width x 1.1 depth in centimeters and had undermining of 1.9 centimeters at 12 o'clock. The right ischium pressure ulcer was surgically debrided to a depth of 1.2 centimeters.
"   deep tissue injury to the left, posterior heel which measured 4.3 length x 5.5 width.
The Wound Evaluation and Management Summary written by Wound Physician #1 dated 12/20/2021 stated Resident #83 had:
"   an unstageable necrotic pressure ulcer to the right posterior heel that measured 5.7 length x 4.5 width in centimeters. The summary indicated the right posterior heel pressure ulcer was surgically debrided to a depth of 0.1 centimeters.
"   a stage 4 pressure ulcer to the sacrum that measured 9.0 length x 16.0 width x 2.1 depth in centimeters and had 2.2 centimeters of undermining at 10 o'clock. The summary indicated the stage 4 sacral pressure ulcer was debrided to a depth of 2.2 centimeters.

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" stage 4 pressure ulcer to the left ischium with measurements of 1.4 length x 3.7 width x 2.2 depth with undermining of 3.7 centimeters at 1 o'clock. The wound was surgically debrided to a depth of 2.3 centimeters.
" right ischium pressure ulcer that changed from a stage 3 to a stage 4. The right ischium pressure ulcer measured 4.0 length x 3.1 width x 1.7 depth and the summary indicated the wound progress was unchanged.
" a left, posterior heel pressure ulcer which changed from a deep tissue injury to a stage 2 pressure ulcer.
" a left, posterior heel changed from a deep tissue injury to a stage 2 pressure ulcer. The left, posterior heel stage 2 pressure ulcer measured 2.7 length x 4.5 width in centimeters.
" a stage 2 pressure ulcer to the left, distal, lateral foot that measured 8.1 length x 3.1 width.
" developed a stage 2 to the right, distal, lateral foot that measured 5.5 length x 2.3 width.
" developed an unstageable deep tissue injury to the right, posterior, lateral calf that measured 3.8 length x 1.0 width.

A Wound Evaluation and Management Summary written by Wound Physician #1 dated 12/27/2021 indicated Resident #83 had:
" an unstageable necrotic pressure ulcer to his right, posterior heel with measurements of 5.1 length x 5.1 width. The right, posterior heel unstageable necrotic pressure ulcer was surgically debrided to a depth of 0.1 centimeters.
" a stage 4 pressure ulcer to his sacrum with measurements of 9.0 length x 15.2 width x 1.7 depth in centimeters and had 2.4 centimeters of undermining at 9 o'clock. The summary indicated the stage 4 sacral pressure ulcer was surgically debrided to a depth of 1.8 centimeters.

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F 686	Continued From page 75 " a stage 4 pressure ulcer to his left ischium with measurements of 3.0 length x 3.3 width x 2.1 depth in centimeters with 3.2 centimeters of undermining at 1 o'clock. The stage 4 left ischium pressure ulcer was surgically debrided at a depth of 2.2 centimeters. " a stage 4 pressure ulcer to his right ischium measured 4.6 length x 3.1 width x 1.0 depth in centimeters with 2.0 centimeter undermining at 1 o'clock. " a stage 2 pressure ulcer to his left, posterior heel and measured 0.7 length x 1.8 width. " a stage 2 pressure ulcer to his left, distal, lateral foot with measurements of 1.7 length x 0.7 width. " a stage 2 pressure ulcer to his right, distal, lateral foot with measurements of 4.0 length x 1.0 depth. " an unstageable deep tissue injury to his right, posterior, lateral calf with measurements of 4.0 length x 1.0 width. A Minimum Data Set (MDS) quarterly assessment with an assessment reference date of 12/28/2021 indicated resident #83 had two stage 2 pressure ulcer wounds, three stage 4 pressure ulcer wounds, and two deep tissue injury pressure wounds. The assessment further indicated Resident #83 required extensive assistance with bed mobility; and had an indwelling urinary catheter. A Wound Evaluation and Management Summary dated 1/3/2022 written by Wound Physician #3 indicated Resident #83 continued to have: " an unstageable, necrotic pressure ulcer to his right, posterior heel with measurements of 3.0 length x 3.0 width in centimeters. " a stage 4 to his sacrum that measured 7	F 686		

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length x 15 width x 4 depth in centimeters. The Wound Evaluation and Management Summary stated the wound had deteriorated.
" a stage 4 to his left ischium that measured 1.5 length x 2.3 width x 2.5 depth. The Wound Evaluation and Management Summary stated the wound had deteriorated;
" a stage 4 to his left right ischium measured 3.5 length x 3.2 width x 2.3 depth. The Wound Evaluation and Management Summary stated the wound had deteriorated.
" a stage 2 pressure ulcer to his left, posterior heel with measurements of 1.0 length x 0.7 width.
" a stage 2 to the left, distal, lateral foot with measurements of 1.5 length x 0.9 width.
" right, distal, lateral foot stage 2 pressure ulcer had resolved.
" an unstageable deep tissue injury to his right, posterior, lateral calf with measurements of 4.2 length x 0.8 width in centimeters that had deteriorated.

A Wound Evaluation and Management Summary dated 1/10/2022 written by Wound Physician #1 stated Resident #83 had:
" an unstageable necrotic pressure ulcer to his right, posterior heel which measured 3.0 length x 3.2 width x 0.1 depth. The unstageable, necrotic pressure ulcer to Resident #83's right, posterior heel was surgically debrided to a depth of 0.2 centimeters.
" a stage 4 pressure ulcer to his sacrum which measured 10.5 length x 16.7 width x 3.8 depth in centimeters. The wound was surgically debrided to a depth of 4.0 centimeters.
" a stage 4 pressure ulcer to his left ischium with measurements of 1.4 length x 4.5 width x 3.8 depth in centimeters and had 3.9 centimeter undermining at 12 o'clock.

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" a stage 4 to his right ischium which measured 5.9 length x 3.7 width x 1.4 depth in centimeters and had undermining of 1.3 centimeters at 11 o'clock. The Wound Evaluation and Management Summary stated there was thick adherent devitalized necrotic tissue over 20 % of the wound. The right ischium stage 4 pressure ulcer was surgically debrided.
" a stage 2 to his left, posterior heel that measured 0.7 length x 2.0 width in centimeters.
" a left, distal, lateral foot had changed to a stage 3 and measured 1.4 length x 0.7 width x 0.1 depth.
" a left, distal, lateral foot pressure ulcer had changed to a stage 3 from a stage 2.
" unstageable right, posterior, lateral calf pressure ulcer with measurements of 4.2 length x 2.0 width x 0.1 depth.
" developed an unstageable deep tissue injury to the left, anterior ankle that measured 1.0 length x 2.5 width in centimeters.
" developed a right, anterior ankle unstageable deep tissue injury with measurements of 1.3 length x 1.5 width in centimeters.

Laboratory results dated 1/28/2022 revealed resident #83's blood hemoglobin level was low at 7.7 g/dL and his blood albumen level was low at 2.4 g/dL.

A Physician's Order dated 2/3/2022 included:
" left, anterior ankle unstageable pressure ulcer should be cleaned with wound cleanser, calcium alginate with silver applied and wrapped in gauze daily.
" right, posterior heel unstageable necrotic pressure ulcer to have the wounds eschar painted with betadine and alginate calcium with sliver applied once daily and the wound dressed

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with a gauze dressing once daily.
" sacral stage 4 pressure ulcer should be cleansed with wound cleaner, betadine and gauze sponge applied, and covered with a pad dressing and border gauze daily.
" left ischium wound should be cleaned with wound cleanser, apply betadine and gauze sponge, and cover with pad dressing and cover with border gauze daily.
" stage 4 right ischium pressure ulcer should be cleaned with wound cleaner, betadine and gauze sponge applied, and covered with pad dressing and border gauze daily.
" stage 2 left, posterior heel wound should be cleaned with wound cleanser, calcium alginate with silver applied and wrapped in gauze daily.
" distal, lateral foot stage 3 pressure ulcer should be cleaned with wound cleanser, pat dry, apply triple antibiotic ointment, then apply xeroform, and secure with gauze.
" right, posterior, lateral calf stage 4 pressure ulcer should be cleaned wound cleanser, alginate calcium with silver applied, and covered with gauze daily.
" left, anterior ankle unstageable pressure ulcer should be cleaned with wound cleanser, calcium alginate with silver applied and wrapped in gauze daily.
" right, anterior ankle unstageable deep tissue injury should be cleaned with wound cleanser, calcium alginate with silver applied, and wrapped in a gauze dressing daily.

Resident #83's Treatment Administration Record for 2/2022 revealed some or all pressure ulcer treatments were not provided on 2/3/2022, 2/4/2022, 2/5/2022, 2/6/2022, 2/7/2022, 2/10/2022, 2/11/2022, 2/12/2022, 2/13/22, 2/14/2022, 2/15/22, 2/17/2022, 2/18/2022,

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2/19/2022 and 2/20/2022.

A phone interview was conducted with Nurse #6 on 2/23/2022 at 2:58 pm and she stated she worked at the facility on 2/5/2022 and 2/6/2022 on the 300 hall and cared for Resident #83. She stated she refused to return to the facility after that weekend because the staffing was terrible, and it was impossible to get dressing changes done. She stated she had not done the dressing changes for Resident #83 on 2/5/2022 or 2/6/2022 because there was not enough staff. She did not have time to do them.

During a phone interview with Nurse #2 on 2/24/2022 at 10:56 am she stated she was assigned to Resident #83 on 2/7/2022, 2/12/2022, 2/13/2022 and 2/17/2022. Nurse #2 stated if she did not sign off Resident #83's dressing changes then she had not done them because she did not have time. Nurse #2 stated the resident load when she worked at the facility prevented her from being able to complete the wound dressing changes, but she had let the Regional Director of Clinical Services know she was not able to complete the dressing changes.

An interview was conducted with the Regional Director of Clinical Services on 2/24/2022 at 3:46 pm and she stated she was aware Resident #83's left distal, lateral foot had worsened from a stage 2 to a stage 3, but she was not aware his right ischium pressure ulcer had worsened from a stage 3 to a stage 4. The Regional Director of Clinical Services stated they had discovered wound care was not being provided as ordered on 2/16/2022 or 2/17/2022 and they had started writing a performance improvement plan. The Regional Director of Clinical Services stated the

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facility was staffed with agency nurses and sometimes they do not show up when they are scheduled. The Regional Director of Clinical Services stated she was not made aware that Resident #83's dressings had not been changed by Nurse #2.

A Wound Evaluation and Management Summary dated 2/2/2022 written by Wound Physician #1 indicated:
" left, distal, lateral foot stage 3 pressure ulcer measured 2.0 length x 1.5 width x 0.2 depth and had deteriorated. The Wound Evaluation and Management Summary further indicated the left, distal, lateral foot stage 3 pressure ulcer was surgically debrided to a depth of 0.6 centimeters.
" unstageable necrotic pressure ulcer to the right posterior heel which measured 5.0 length x 2.5 depth x 0.1 depth in centimeters. The summary stated Resident #83's unstageable necrotic right, posterior heel pressure ulcer was treated with the eschar being painted with betadine and alginate calcium with sliver applied once daily.
" stage 4 pressure ulcer to the sacrum that measured 10.5 length x 15.0 width x 3.8 depth in centimeters. The stage 4 pressure ulcer was surgically debrided to a depth of 3.8 centimeters.
" stage 4 to the left ischium that measured 4.5 length x 3.0 width x 4.5 depth in centimeters. The Wound Evaluation and Management Summary indicated there was no change to the left ischium pressure ulcer.
" stage 4 to the right ischium with measurements of 7.5 length x 8.0 width x 2.0 depth. The wound progress stated the wound was unchanged and the right ischium stage 4 pressure ulcer was surgically debrided.
" stage 2 to the left, posterior heel with

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measurements of 0.2 length x 1.5 width.
"   stage 3 to the left, distal, lateral foot that had deteriorated.
"   right, posterior, lateral calf pressure ulcer changed from unstageable to a stage 4 pressure ulcer with measurements of 7.5 length x 3.0 width x 0.3 depth.
"   unstageable due to necrosis left, anterior ankle pressure ulcer that measured 1.5 length x 2.5 width x 0.1 depth in centimeters. The wound progress stated the wound had deteriorated and noted there was 40 % thick, adherent devitalized necrotic tissue. The left, anterior ankle pressure ulcer was surgically debrided to a depth of 0.1 centimeters.
"   unstageable deep tissue injury to the right, anterior ankle that measured 1.0 length x 1.0 width.
On 2/9/2022 a Progress Note written by Wound Physician #2 stated Resident #83's wound dressing and treatments had been changed earlier in the day and he had politely declined to have them changed again.

A Progress Note dated 2/14/2022 written by Wound Physician #2 stated Resident #83 refused to have his wound dressings changed again so soon when she visited since they had been changed the night before. Wound Physician #2 wrote Resident #83 stated the wound dressing changes were uncomfortable and he would like the staff to wait to change them until her visit.

Review of a Wound Evaluation and Management Summary written by Wound Physician #2 dated 2/21/2022 indicated:
"   right, posterior heel unstageable, necrotic pressure ulcer measured 2.0 length x 1.4 width x 0.1 depth.

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F 686	Continued From page 82 " stage 4 sacral wound measured 8.0 length x 16.0 width x 2.7 depth in centimeters and was surgically debrided to a depth of 2.7 centimeters. " stage 4 left ischium pressure ulcer measured 3.5 length x 2.5 width x 4.5 depth in centimeters and was surgically debrided. " right ischium stage 4 pressure ulcer measured 7.0 length x 4.5 width x 1.5 depth in centimeters and was surgically debrided to a depth of 1.5 centimeters. " stage 3 left, distal, lateral foot pressure ulcer measured 1.5 length x 1.0 width x 0.2 depth. " stage 4 right, posterior, lateral calf measured 10.5 length x 4.0 width x 0.6 depth in centimeters and the wound progress was noted as deteriorated. The summary indicated the wound was surgically debrided to a depth of 0.6 centimeters. " left, anterior ankle pressure ulcer that was previously unstageable changed to a stage 3 pressure ulcer and measured 2.5 length x 3.0 width x 0.1 depth and the wound progress indicated the wound had improved. " right, anterior ankle deep tissue injury changed to a stage 3 and measured 0.7 length x 1.2 width x 0.1 depth in centimeters. The Wound Evaluation and Management Summary further indicated the wound had improved. An interview was conducted with Resident #83 on 2/23/2022 at 10:55 am and he stated at times his dressings to his wounds were not changed for 7 days and the wounds would have a bad odor. Observation at this time revealed Resident #83's left foot was not covered with bed linen and the dressing was dated 2/21/2022. Resident #83 stated he had developed several more pressure ulcers on his feet and legs since he had been at the facility. He stated he had been on an air	F 686		

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mattress, but the facility just does not have enough staff to care for him. He stated he is not turned and repositioned and his dressings are not changed daily as ordered. Resident #83 stated he had refused to allow Wound Physician #2 look at his wounds twice because they had just been changed before she came in to look at them and the process was very uncomfortable for him.

An interview was conducted with Nurse Aide #4 on 3/2/2022 at 11:03 am and she stated she would see Resident #83's dressings had not been changed for a week sometimes and she would report it to the nurse, but they would not change them. She stated there was a really bad odor coming from his wounds when she worked with him.

An interview was conducted with Wound Physician #1 on 2/23/2022 at 3:10 pm by phone and he stated Resident #83 had 4 pressure ulcers when he admitted to the facility. He stated Resident #83 had 8 wounds when he saw him on 1/10/2022. He stated he had not seen him since that assessment. Wound Physician #1 stated he did not think the staff were turning and repositioning Resident #83 and he had observed dressings that were 7 days old on Resident #83's wounds and sometimes the dressings would be the dressing that was put on at his last weekly visit. Wound Physician #1 stated he had left the building because there was not enough staff to care for the residents and dressing changes were not being done. Wound Physician #1 stated Resident #83's wounds had worsened as a result of his dressings not being changed and him not being turned and repositioned as he should have been.

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A Progress Note dated 2/28/2022 written by Wound Physician #1 after he no longer worked at the facility stated he did not remember Resident #83's wounds specifically and certainly cannot recreate the thought process that occurred the day of evaluation. The Progress Note dated 2/28/2022 further stated the note he wrote on 12/13/2021 stated the right ischium was a stage three and the note the following week stated it changed to a stage 4 after it was debrided. The Progress Note further stated the note dated 12/13/2021 listed as "no change" because it was not improved, and it was not deteriorated. The Progress Note also stated it was not unusual for a stage 3 to change to a stage 4 with serial debridement without a deterioration. Wound Physician #1 stated in the note that the left, distal, lateral foot wound was described as improved on 1/10/2022 due to the significant improvement of wound surface area and again the wound did not deteriorate therefore it was listed as improved. The Progress Note was obtained and submitted by the Regional Vice President of Clinical Services.

During an interview with Wound Physician #2 on 2/23/2022 at 5:05 pm by phone she stated Resident #83's left, distal, lateral foot pressure wound which changed from a stage 2 to a stage 3 and his right ischium stage 4 and left ischium stage 4 had all deteriorated. Wound Physician #2 also stated the left, distal, lateral foot wound progress was deteriorated as documented. Wound Physician #2 stated when she wrote the Wound Evaluation and Management Summary for the right and left ischium stage 4 pressure ulcers, she meant to document the wound progress as deteriorated. She stated the facility had been short-staffed, but she could not say

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Resident #83's dressings were not being changed or say he was not being turned and repositioned. Wound Physician #2 stated Medical Director #1 had worked on having Resident #83 moved to a facility that was more appropriate for his care because of his paraplegia and wounds.

During review of Resident #83's hospital record a Progress Note by Emergency Department Physician dated 2/26/2022 stated Resident #83's diagnoses included osteomyelitis involving the sacrum and bilateral ischial tuberosity (rounded bone of the ischium), urinary tract infection, and anemia. The Progress Note further indicated Resident #83's hemoglobin was low at 6.7 g/dL and he had a blood transfusion, after the blood transfusion his hemoglobin increased to 8.2 g/dL. The reference range for hemoglobin is 13.5 to 17.5 g/dL.
A Progress Note dated 2/28/2022 from the hospital record written by the attending Physician stated Resident #83 was being treated for infected pressure ulcers and osteomyelitis. A wound culture indicated Resident #83 had methicillin-resistant Staphylococcus aureus (MRSA); extended-spectrum beta Lactamases (ESBL), and Escherichia coli (E. coli) in his sacral and ischial pressure wounds.

During an interview with the Director of Nursing on 3/2/2022 at 11:46 am she stated the intradisciplinary team had talked about Resident #83 every week in the risk management meeting because of his wounds. The Director of Nursing stated she was made aware while she was on medical leave by the previous Administrator of Resident #83's wound dressing changes not being done and was told to educate the Nurses. The DON stated the education had not been

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completed since she was on medical leave. The Director of Nursing stated Wound Physician #1 had complained about the dressings not being done and told her Resident #83's dressings had not been changed for three days. The Director of Nursing stated Medical Director #1 had also verbalized concerns to the previous Administrator and the Regional Director of Operations that Resident #83's dressings were not being changed and his wounds were getting worse and infected.

On 2/24/2022 at 5:29 pm an interview was conducted with the Administrator, and he stated he was aware of the issues the facility had with wound dressing changes not being completed as ordered and they had put together a plan to ensure the wound dressing changes would be completed by obtaining a treatment nurse for every Monday through Friday from an agency. The Administrator stated when there was not a treatment nurse available the nurses would be responsible for completing the dressing changes as they are now. The Administrator stated the facility is obligated to give wound dressing changes and treatments as ordered by the physician.

2. Resident #237 was admitted to the facility on 01/26/22.

Resident #237's diagnoses included paraplegia, sacral and heel pressure ulcers and bilateral heel pressure ulcers, clostridium difficile colitis and neurogenic bladder.

The Admission Minimum Data Set (MDS) assessment completed on 02/07/22 indicated Resident #237 was cognitively intact. It indicated he had 2-stage 3 pressure ulcers and 2-unstageable pressure ulcers on admission.

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A review of the initial Physician orders for Resident #237 included a pressure ulcer redistribution mattress on 01/27/22.

Review of the physician orders for Resident #237 indicated an order on 02/01/22 to consult the Wound Care Physician for a new stage 2 sacral ulcer. No treatment was ordered on 02/01/22.

The care plan for Resident #237 identified the need for pressure ulcer care on 02/04/22 for 2-stage 3 pressure ulcers and 2-deep tissue injuries (DTI) on his heels.

Review of the Wound Physician note from 02/07/22 indicated the resident was to have his heels floated in bed and wear "E-Z boots" (special boots that eliminate pressure) in bed and in the chair to off load wounds, turn side to side and front to back in bed every 1-2 hours if able.

Review of the Physician orders indicated wound physician instructions from 02/07/22 for the special heel boots and instructions to float heels in bed were not ordered for Resident #237.

A phone interview was conducted on 02/27/22 at 12:12 PM with Nurse #18 regarding Resident #237s wound care. She stated she had stayed over on 02/18/22 as there was no staff nurse to relieve her till about 9:00 AM. She stated the resident did not have heel pressure relieving boots on, she did not float the heels or do his sacral dressing. She said she was specific when she agreed to stay over on what she would do. She stated if she had done it, she would have documented it.

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Review of the Wound Physician note from 02/07/22 indicated the resident was to have his heels floated in bed and wear "E-Z boots" (special boots that eliminate pressure) in bed and in the chair to off load wounds, turn side to side and front to back in bed every 1-2 hours if able.

Review of the Physician orders indicated wound physician instructions from 02/07/22 for the special heel boots and instructions to float heels in bed were not ordered for Resident #237.

Review of the Wound Physician note from 02/21/22 indicated the resident was to have his heels floated in bed, wear "E-Z boots" (special boots that eliminate heel pressure) in bed and in the chair to off load wounds, turn side to side and front to back in bed every 1-2 hours if able.

An interview was done with Resident #237 on 03/01/22 at 3:07 PM. He stated he had not received pressure relieving boots for his heels and they were not elevating heels off the bed as ordered by the wound care doctor.

An interview was done on 02/22/22 at 11:40 AM with Resident #237. He stated he had pressure ulcers and staff did not provide care for them as ordered. He stated they don't turn him or elevate his heels. He noted care on second shift was real bad, days and nights were a little better about it.

An interview was done on 02/23/22 at 2:30 PM with Resident #237 when he was up in the wheelchair. He said he did not have heel protector boots when asked and staff did not elevate his heels when he was in bed. He said they rarely ever came in to turn him and he did not get his dressing done when he was supposed

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to. He stated he had complained, but he had gotten tired of nothing being done so he quit saying anything.

An interview was done with Resident #237 on 03/02/22 at 14:30 PM. He stated he had not received any heel protectors and his heels were still not being elevated. His heels were on the bed during visit.

Medical Director #1 was interviewed via phone on 02/27/22 at 4:54 PM about Resident #237's wound care. She noted wounds in general were an issue at the facility and thought it was staffing related. She noted there should be someone at the facility to do wounds and be there all day for the number of wounds at the facility.

An observation was done with the Wound Care Nurse Practitioner on 02/24/22 at 9:20 AM of Resident #237's sacral and buttock wounds. She stated the wounds were healing with pink tissue and would discontinue the dressing and start zinc ointment. She examined his heels, stated they were very dry, discontinued the skin prep as that would dry his heels out and recommended moisturizing lotion instead.

The Nurse Practitioner was interviewed on 03/01/22 at 10:47 AM regarding Resident #237's order for heel pressure relief boots and to elevate the heels off the bed. She stated with heel protectors, she would expect him to receive them as ordered.

The Director of Nursing (DON) #2 was interviewed on 03/01/22 at 4:36 PM regarding the Wound Care Physician's orders from 02/07/22 for heel pressure relief boots and to float the heels

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F 686	Continued From page 90 on Resident #237. The DON stated the nurse that rounded with the Wound MD on 02/07/22 would have heard the order and should have entered the order. She also stated the wound care notes were transcribed and nursing should check the orders in the note and enter the orders if not previously done. She said her expectation was that if it was ordered, an order should have been placed in the electronic medical record and done.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/6/22

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F 690	Continued From page 91 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, resident, laboratory personnel and physician interviews, the facility failed to obtain laboratory work as ordered by the physician for a resident suspected of having a urinary tract infection (UTI) for 1 of 2 residents reviewed for laboratory services (Resident #237). Findings included: Resident #237 was admitted to the facility on 01/26/22 with diagnoses that included paraplegia, severe sepsis secondary to a catheter associated urinary tract infection (CAUTI), clostridium difficile colitis and neurogenic bladder. A physician's order dated 01/31/22 for a urinalysis with culture, basic metabolic panel (BMP) and complete blood count (CBC) to be done on 02/03/22. Further review of the medical record revealed the BMP and CBC were drawn on 02/07/22. Resident #237's hemoglobin was low 11.6 grams per deciliter (gm/dL) with a normal range of 13 - 16.5 gm/dL. There were no results in the medical record for	F 690	Effective 3/14/2022 urinalysis and culture order was discontinued for resident #237. Director of Nursing and/or designee will audit all current resident charts for any pending lab orders by 4/06/2022. Effective 3/28/2022 the nurse practitioner was notified of urinalysis and culture that were not completed from the following dates 3/14/2022 through 3/28/2022. Effective 3/10/2022 the Director of Nursing and or designee will re-educate current license Nurses and agency nurses before their shift on ensuring urinalysis and culture orders are completed as ordered by the physician. Any new hire licensed nurses and agency nurses will be educated on ensuring urinalysis and culture orders followed as ordered by the physician as of 4/01/2022 prior to start of their first shift. Completion date: 4/06/2022 Director of Nursing and/or designee will audit 5 residents with orders for urinalysis and culture orders to ensure completion of order 3 times per week for 4 weeks,	

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F 690	Continued From page 92 Resident #237's urinalysis with culture. The Admission Minimum Data Set (MDS) assessment completed on 02/07/22 indicated Resident #237 was cognitively intact. It indicated he had a urinary catheter. A physician's order dated 2/21/22 specified to follow-up on urinalysis and culture ordered on 01/31/22 for Resident #237. A phone interview with Medical Director #1 was conducted on 02/27/22 at 4:54 PM regarding Resident #237's labs. She stated she ordered blood work for 02/03/22 and a urinalysis with culture to be done that day. She stated the latest the urine culture should have been done was the following day. She noted the resident had a catheter and he thought he had blood in his urine. The Physician noted he had no sensation since he was paralyzed and blood in the urine was a concern for infection. She said paraplegic residents could decline fast and Resident #237 had a history of UTI and sepsis. An interview was done on 02/22/22 at 11:40 AM with Resident #237. He stated lab work had been ordered previously for him and it had not been done. A follow-up interview was conducted with Resident #237 on 02/23/22 at 2:35PM and he reported no one had obtained his lab work. Nurse #1 was asked on 02/22/22 at 11:24 AM about Resident #237's lab work. She looked at the Medication Administration Record (MAR) and said labs were ordered for today. She stated she did not know if they had been done but would check.	F 690	weekly for 4 weeks, and Bi-weekly for 4 weeks. Director of Nursing will report findings to the Quality Assurance Performance Improvement committee for 3 months for needed improvements to current plan.	

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A follow up interview was done with Nurse #1 on 02/23/22 at 2:46 PM about Resident #237's lab work. She stated she had not checked on the labs being drawn as requested and would look in the computer now and check with lab.

Nurse #1 documented in the medical record on 2/23/22 at 4:15 PM that the labs were rescheduled to be drawn on 2/25/2022 and the NP was aware.

A phone interview was conducted with Laboratory Staff #1 was done on 02/28/22 at 11:38 AM regarding Resident #237. She was asked about the lab orders from 01/31/22 for a urinalysis with culture and the CBC and BMP to be done on 02/03/22. She stated the first orders for labs received were for the 02/07/22 CBC and a BMP. She stated they had never received a specimen for urinalysis with culture for Resident #237.

An interview with the Director of Nursing #2 was done on 03/01/22 at 4:46 PM regarding laboratory services. She was asked about lab orders not being done and stated there had been issues on both sides, with the facility and with the laboratory. She said at times lab had changed the phlebotomist schedule due to their staffing and were supposed to fax the schedule if it changed. The DON said it was normally Monday, Wednesday and Thursday and the days had been switched due to staffing and it was not communicated. She was asked about a urine C&S from 1/31/22 not being done for Resident #237 and stated it should have been completed. She noted she would have to investigate it and also looked in the computer and could see it was not done. The DON stated the physician ordered the tests and nurses must confirm it for it to pull

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F 690	Continued From page 94 over in the system. The DON stated it was helpful when lab orders showed up on the Medication Administration Record, but that did not always occur. She noted that was related to how the orders were entered. She stated labs should be completed as ordered by the physician. Need to add who was responsible for obtaining labs? Nurses or the lab? A phone interview with Administrator #2 was done on 03/03/22 at 4:01 PM regarding Laboratory Services. He was asked about the urine specimen not being sent and labs not being done when requested. The Administrator stated staff were to follow the physician orders and there should be a tracking system to ensure all labs are completed timely.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		4/11/22

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F 693	Continued From page 95 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to store a tube feeding syringe with the plunger separated from the syringe, which created the potential for bacterial growth, for 2 of 2 residents (Resident #36 and Resident #47) reviewed for tube feedings. Findings included: 1. Resident #36 admitted to the facility on 10/24/2018 with diagnoses of difficulty swallowing and diabetes. A Physician's Order dated 8/4/2021 stated Resident #36 required 30 milliliters flushes of water in her gastric feeding tube after each medication administration. Resident #36's Physician's Order dated 12/28/2021 stated she received enteral feedings continuously at 60 milliliters per hour. During an observation of Resident #36 on 2/21/2022 at 11:46 am the syringe used to flush her gastric tube was in a plastic bag hanging on the pump stand and the plunger was engaged in the syringe with clear liquid observed in the syringe. A quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 2/14/2022 indicated Resident #36 was mildly cognitively impaired, required total assistance	F 693	Effective 3/04/2022 residents #36 and #47 tube feeding syringes were changed and stored properly by nurse management. Effective 3/10/2022 current tube feeding residents were observed to ensure syringes were stored after use by nurse management. Effective 3/10/2022, the Nurse management will educate current licensed nurses and agency nurses before first assignment on ensuring tube feeding syringe is stored after use. In person and/or via telephone education to be completed by 4/11/2022. Effective 4/11/2022 any new licensed nurses to include agency nurses will be educated prior to the start of their shift on the proper storage of tube feeding syringes by nurse management. Nurse management will audit residents receiving tube feeding to ensure their syringe is stored properly 3 x weekly x 4 weeks and weekly x 8 weeks. Director of Nursing will report all findings to the Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months.	

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with eating, and received 25% or less of her total calories and less than 500 milliliters of fluids by tube feeding per day.

On 3/1/2022 at 2:35 pm an observation of Resident #36 revealed a syringe used to flush her gastric tube was hanging from the pump stand in a plastic bag, the plunger was inside the syringe and there was clear fluid in the tip of the syringe.

2. Resident #47 admitted to the facility on 7/2/2018 with diagnoses of stroke and difficulty swallowing.

Resident #47 had a Physician's Order dated 8/3/2021 for continuous gastric tube feeding at 75 milliliters an hour. The order also instructed Resident #47's gastric tube should be flushed with 30 milliliters of water before and after medications are administered and flushed with 60 milliliters once daily.

A quarterly Minimum Data Set (MDS) assessment with an assessment reference dated of 1/4/2022 indicated Resident #47 was severely cognitively impaired, required extensive assistance with eating, and obtained 51 % or more of her calories and more than 501 milliliters fluids through her gastric tube.

On 2/21/2022 at 11:10 am Resident #47 was observed to have a syringe stored on her feeding pump stand in a plastic bag, the syringe was stored with the plunger in the syringe and there was clear liquid in the tip of the syringe.

During an observation on 2/22/2022 at 9:48 am Resident #47 was noted to have a syringe hanging in a plastic bag from the pump stand, the

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plunger was in the syringe and there was clear liquid in the syringe.

Resident #47 was observed in her room on 3/1/2022 at 2:30 pm and a plastic bag was hanging from her pump stand with a syringe in the bag. The syringe was stored with the plunger in the syringe and clear liquid in the tip of the syringe.

During an interview with Nurse #1 on 3/1/2022 at 5:51 pm she stated she was assigned to the 600 hall today and had placed the syringe in the bag hanging in the plastic bag from Resident #36 and #47's pump stands. She stated the plunger should be stored outside the syringe used to flush the gastric tube and it should be washed and allowed to dry before placing it in the plastic bag. She stated she had placed the plunger in the syringe and placed it in the bag on the feeding pump stand.

An interview was conducted with Director of Nursing (DON) #2 on 3/3/2022 at 11:47 am and she stated they had done education regarding the syringe used for flushing gastric tubes should be washed, allowed to dry and stored with the plunger separate from the syringe to prevent bacteria. She stated Nurse #1 should have followed the proper procedure.

On 3/3/2022 at 11:57 am Administrator #2 was interviewed regarding staff failing to clean and store the syringe used to flush gastric tubes. Administrator #2 stated nursing staff should clean and store the gastric tube flush syringe properly and the issue would be brought up at their quality assurance meeting and education would be done with the nursing staff.

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F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations and physician and staff interviews the facility failed to provide staffing to ensure 1 of 3 residents, Resident #83, received wound care to pressure ulcers and the facility had a full time Director of Nursing (DON) but failed to ensure the DON was not pulled to a staff nurse assignment for 2 of 2 months reviewed due to decreased staff. The	F 725	Effective 2/21/22 the facility has secured a Director of Nursing. Resident # 243 no longer resides in the facility. Resident # 83 is discharged. The facility has onboarded additional	4/11/22

F 725 Continued From page 99

facility failed to administer prescribed antibiotic for 1 of 1 resident and failed to administer insulin and sliding scale insulin within 1 hour of scheduled dose for 1 of 4 residents reviewed, Resident #243, due to decreased staffing.

Findings included:

This tag is cross referenced to:

F686- Based on record review, observation and resident, staff, Wound Physician and Medical Director interviews, the facility failed to provide pressure ulcer dressings ordered by the physician for 1 of 3 residents reviewed for wound care (Resident #83). Resident #83's wounds became infected, and he developed further pressure ulcers. Resident #83 was discharged to the hospital with diagnoses of pressure ulcer wound infections and osteomyelitis (bone inflammation caused by infection). The facility further failed to follow the wound physician's order for heel protector boots and to float the heels of 1 of 3 residents, Resident #237 reviewed for pressure ulcer prevention.

F727- Based on record review and staff interviews the facility failed to provide a full time Director of Nursing for 2 of 2 months reviewed.

F760- Based on observations, record reviews, and staff, Nurse Practitioner, physician, resident and family interviews, the facility administered a sedation medication that had been discontinued for 1 of 6 residents reviewed for unnecessary medications (Resident #10). In addition, the facility failed to administer 3 doses of a prescribed antibiotic (vancomycin for 1 of 1 residents reviewed for antibiotics (Resident #237)

F 725

nursing staffing agencies to secure nursing staff to ensure treatments and medication are administered as prescribed.

All residents are at risk for insufficient nursing staff to administer treatments and medication as prescribed by the physician.

2/14/2021 the regional Director of Operations assisted with staffing of the facility to ensure the Director of Nursing would not be on the medication cart passing meds.
Regional Director of Operations educated the interim Administrator on staffing patterns for the facility to ensure the Director of Nursing does not get pulled to the medication cart as of 2/14/2022.

Regional Director of Operations educated the new Administrator on 3/28/2022 on staffing patterns to ensure the Director of Nursing is not to be pulled to the medication cart.

Effective 3/10/2022 Nurse management will educate the licensed nurses to include agency on ensuring treatments and medication are administered as prescribed education to be completed by 4/11/2022. Effective 4/11/2022 any new licensed nurses to include agency will receive education by the nurse management to ensure treatment and medication are administered as prescribed.

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and failed to administer daily insulin and sliding scale insulin within 1 hour of scheduled dose for 4 of 4 insulin doses reviewed (Resident #243).

On 2/24/2022 at 5:29 pm an interview was conducted with Administrator #2, and he stated the facility had several agency contracts to ensure they had sufficient nurse staffing. He stated they also offered bonuses to the facility staff and agency staff to cover staffing needs. The Administrator stated they had hired a new Director of Nursing and a unit manager recently that would be orienting soon. The Administrator stated they had put together a plan to ensure wound dressing changes and treatments would not be missed because of staffing. He stated they had requested a treatment nurse from their agency contacts for Monday through Friday of each week and they were moving residents to make 4 units with each nurse having more residents, but they would also have a treatment nurse. The Administrator stated on Saturdays and Sundays of each week and when the agency treatment nurse was not available the assigned nurses would be responsible for the dressing changes. The Administrator stated the facility was obligated to give patient care, medication administration, wound dressing changes and treatments as ordered by the physician.
During an interview with the Director of Nursing (DON) #2 on 3/1/2022 at 4:36 pm she stated the previous DON, DON #1, left the facility on 12/31/2021 and they had both worked 12 hour as nurses in an assignment because the staffing was so bad, with DON #1 working 12 hour days and he worked 12 hour nights. DON #2 stated there were no unit managers or an Assistant Director of Nursing since DON #1 left. DON #2 stated she had to stay over at times due to

Administrator and nurse management will review the staffing schedule daily to ensure staffing is adequate to administer treatments and medication as prescribed.

Administrator and nurse management will audit staffing to ensure adequate nursing staff are present to administer treatment and medication as prescribed daily x 4 weeks, then 3 x a week x 4 weeks and weekly x 4 weeks.

Nurse management will audit 5 residents with wounds to ensure treatment orders are completed as prescribed 3 x weekly x 4 weeks, weekly x 4 weeks then monthly x 1 month.

Nurse management will audit 5 residents medication administration to ensure medication are administered as prescribed 3 x weekly x 4 weeks, weekly x 4 weeks then monthly x 1 month.

Administrator will report any findings to the Quality Assurance Performance Improvement for any needed improvement monthly x 3 months.

Completion Date: 4/11/2022

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F 725	Continued From page 101 staffing and had to work 22 hours in one day. DON#2 said things fell through the crack and she could not keep up.	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the full-time Director of Nursing worked as a full-time Director of Nursing for 3 of 45 days reviewed of the facility's nursing schedule, 1/22/2022, 2/1/2022, and 2/6/2022. Findings included: A review of the facility's nursing schedules for 1/1/2022 to 2/14/2022 indicated DON #2 was assigned to a nurse assignment on 1/22/2022, 2/1/2022 and 2/6/2022. The census was above 80 residents on 1/22/2022, 2/1/2022, and 2/6/2022. An interview was conducted with Director of	F 727	Facility has secured a fulltime Director of Nursing as of 2/21/2022. All residents are at risk for not having a fulltime Director of Nursing. Effective 2/14/2021 the regional Director of Operations assisted with staffing of the facility to ensure the Director of Nursing would not be used in any position other than the Director of Nursing. Regional Director of Operations educated the interim Administrator on staffing pattern for the facility to ensure the Director of Nursing does not work the	4/11/22

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F 727	Continued From page 102 Nursing (DON) #2 on 3/3/2022 at 11:46 am and she stated she took the Director of Nursing position when DON #1 left the facility on 12/31/2021. DON #2 stated both she and DON #1 worked 12 hour shifts as staff nurses before DON #1 resigned and she continued to work 12 hour shifts as a staff nurse after DON #1 left. DON #2 stated there had not been a Unit Manager or an Assistant Director of Nursing since DON #1 left on 12/31/2021, since she had moved from the Assistant Director of Nursing to the Director of Nursing position when DON #1 left. DON #2 stated she was pulled to a staff nurse assignment so often she was not able to monitor for nursing issues and staffing had been a problem since she began working at the facility. During an interview with Administrator #2 on 3/3/2022at 11:57 am he stated the facility should provide staffing to meet the needs of the residents and the Director of Nursing should not be assigned to a regular staff nurse position since the facility census was greater than 60 residents. An interview was conducted with Administrator #1 on 3/4/2022 at 12:40 pm and he stated he was the administrator for the facility from 1/5/2022 to 2/11/2022. He stated DON #2 worked night shifts as a staff nurse when needed when staffing was an issue.	F 727	medication cart effective 2/14/22. Regional Director of Operations educated the new Administrator on 3/28/2022 on staffing patterns to ensure the Director of Nursing is not to work the medication cart or any other position besides Director of Nursing. Administrator and nurse management will review the staffing schedule daily to ensure staffing is adequate to ensure that the Director of Nursing is not on a medication cart. Nurse management will audit staffing to ensure adequate nursing staff are present in order to not have the Director of Nursing on a medication cart daily x 4 weeks, then 3 x a week x 4 weeks and weekly x 4 weeks. Administrator will report findings to the Quality Assurance Performance Improvement committee for any needed improvements monthly x 3 months. Completion date: 4/11/2022	
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		4/11/22

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F 755	Continued From page 103 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacy interviews, the facility failed to implement a system to consistently and accurately reconcile controlled medications for 3 of 3 medication carts reviewed. Findings included: Review of the policy for 'Controlled Substance Administration and Accountability' provided by the facility with no date implemented or date	F 755	Effective 3/29/2022 Regional Director of Clinical Service and a Licensed Practical Nurse performed a controlled substance count on current medication carts in use to ensure current controlled substance count was accurate. All residents who were prescribed controlled substance were at risk to have been affected.	

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F 755	Continued From page 104 reviewed/revised stated in part: - Areas without an automated dispensing system utilize a paper system for 24 hour recording of controlled substance use. -The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances. Spot checks are performed to verify medication removed from the medication cart/cabinet have a documented physician order. -Two licensed nurses account for all controlled substances and access keys at the end of each shift. 1 a. Review of the 300 hall medication cart revealed the Controlled Substance Shift Count log from 02/14/22 7:00 AM- 02/23/22 7:00 AM indicated: - 10 of 14 controlled substance card counts were not completed -1 of 14 nurse signatures for "coming on duty" were missing - 2 of 14 nurse's signatures for "going off duty" were missing The controlled substance count was not documented as being completed on 02/15/22 or 02/16/22 with shifts, card counts or signatures. b. Review of the 500 hall medication cart Controlled Substance Shift Count log from 02/15/22-02/24/22 indicated: -11 of 24 controlled substance card counts were not completed -2 of 24 nurse signatures for "coming on duty" were missing -6 of 24 nurse's signatures for "going off duty" were missing	F 755	Effective 3/10/2022, the Director of Nursing educated current Licensed nurses, medication aides, on ensuring controlled substance count is performed at the change of shift education to be completed by 4/11/2022. Effective 4/11/22 any new licensed nurses to include agency will receive education prior to the start of their shift on ensuring controlled substance count is performed at the change of the shift by nurse management. Effective 4/11/2022 Nurse management will audit 3 random controlled substance books to ensure license nurse are counting controlled substances and signing count sheets at the change of shift 3 x a week x 4 weeks, weekly x 4 weeks and monthly x 1 month. Director of Nursing will report any findings to Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months. Completion Date: 4/11/2022	

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The controlled substance count was not done from 02/17/22 at 1:50 PM to 02/18/22 at 9:30 AM.

The 500 Hall Shift Count log collected on 02/25/22 at 4:51 PM indicated the Oncoming nurse for 02/24/22 at 7:00 PM had pre-signed the controlled substance count as the "going off duty nurse for the next shift, without the date/time/drug card count or a co-signature for the next day. No count was indicated or nurse "coming on" signature was noted for 7:00 AM 02/25/22.

c. Review of the 600 hall medication cart Controlled Substance Shift Count log from 02/06/22-02/24/22 indicated:
-18 of 36 controlled substance card counts were not completed
-5 of 36 nurse signatures for "coming on duty" were missing
-7 of 36 nurse's signatures for "going off duty" were missing

The controlled substance count was not documented from 02/11/22 at 7:00 PM to 02/13/22 at 7:00 AM.

The controlled substance count was not documented from 02/18/22 at 3:56 PM to 02/20/22 at 7:00 AM. On duty Nurse signing at 7:00 AM on 02/20/22 did not have a second nurse signature.

An interview was conducted with Medication Aide (Med Aide) #3 on 02/23/22 at 8:41 AM regarding the controlled medication sheets. She stated they counted the controlled medications at the change of shift. Upon review of the 600 cart controlled medication count sheets with her there were several medication card counts missing,

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and signatures missing for both the 'coming on nurse's signature' and the 'going off duty nurse's signature.' In addition, there were times with no signatures were present for over 24 hours. She stated she had counted the controlled medications and counted the number of cards per protocol at shift change that morning.

An interview was conducted on 02/25/22 at 4:27 PM interview with Nurse #8. She was on the 200 Hall medication cart giving medications. She was asked to show the controlled medication count sheet for today. It was noted that she had signed as counting controlled medications that morning for 7:00 AM and had already signed as having counted controlled medications for going off shift at 7:00 PM on 02/25/22. She was asked why she had signed the controlled drug shift count early and said, "oh I must have made a mistake, I don't ever do that and today is a day that you would catch me doing that."

A phone interview was conducted with the Director of Pharmacy Services for the facility on 03/01/22 at 01:08 PM. He noted the Pharmacy Clinical Support Representative (CSR) did audits 1-2 times a month and the Pharmacy Nurse Consultant would do spot checks as well. He stated the results of these audits were shared with Administration at the facility.

An interview was conducted with the Pharmacist responsible for the facility on 03/01/22 at 1:10 PM. He stated Pharmacy Nurse consultants were there most months to review medications, carts, etc. He stated the reports were given to the Director of Nursing (DON) for follow up. He stated when controlled medications were sent back the controlled medication sign out sheet was

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also returned. The Pharmacist was asked about all the blank spots on the shift count sheets at change of shift. He stated the Pharmacist Customer Service Representative (CSR) would audit that and bring results or concerns to the DON.

An interview was conducted on 03/01/22 at 2:24 PM with the Pharmacy CSR. She stated she checked the medication carts and medication storage rooms monthly except for December 2021. She stated on 01/12/22 she did audits for the medication carts and medication storage rooms. She checked the front of the book where they sign off on the controlled substance counts at shift change and said there were holes where there were no signatures. She noted she had reviewed her findings with the previous DON in November 2021. She said in January 2022 the interim DON was not available and she left a report with the Minimum Data Set Nurse on 01/12/22. The Pharmacy CSR stated she reviewed the medication rooms on 02/21/22 and reviewed the results with the Regional Clinical Services Nurse #1 that was there on site. The Pharmacy CSR said when she exited with DON #1 in November 2021, she went over these items and it was also on the report in January 2022. She noted it was a very common trend when she exited with DON #1 for her to find some holes in the controlled substance count at shift change. She said controlled substance monitoring was not done with the monthly audit as it was up to the facility to count shift to shift.

An interview with the Regional Nurse Consultant #2 was conducted on 03/02/22 at 08:50 AM and she was asked for the last 4 months of pharmacy audits and the monthly reports. She stated this

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was Quality Assessment and Improvement Plan (QAPI) information. She was to review the last 4 months of QAPI minutes and let the surveyor know if pharmacy audits were discussed.

Attempts to reach the previous Director of Nursing #1 were conducted on 03/02/22 regarding identified pharmacy issues without a response.

An interview was conducted on 03/01/22 at 4:46 PM with the Director of Nursing (DON) #2. She stated when pharmacy checked the carts, they would let them know when the carts were not right. The DON stated she was aware of issues with controlled substance sheets not being signed and holes on the controlled substance count sheet. She was made aware of the observations where there were 24 hours at a time not signed. She stated her expectation was that the staff leaving count off with the person coming on, and if the hall was split and written on the assignment sheet, they needed to show accountability and have nurses assigned to each hall. This would show responsibility for the carts also. She was asked about the nurse signing off at 7:00 PM on the controlled substance count early in shift and said she had seen that done before, it was hard to control with agency staff. The DON stated across the shift count line should be blank until they counted, she said the agency nurses had been doing that. She said this was not an acceptable practice and the last DON would inservice multiple times but when staff changed all the time, and until they were able to have regular staff in the building, she did not see this improving. She said staffing was a critical piece to these issues and it was hard to improve when different nurses were always working, it was hard

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F 755	Continued From page 109 to follow up and improve things.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have a medication error rate less than 5 percent medication rate as evidenced by 3 medication errors out of 26 medication opportunities, resulting in a medication error rate of 11.54 percent for 3 of 3 residents (Resident #19, Resident #82 and Resident #60) observed during a medication pass. The findings included: 1. Resident #19 was admitted to the facility on 10/1/14. Review of the Physician orders indicated on 12/08/21 Resident #19 had Acetaminophen Extra Strength (ED) ordered 500 mg 3 times a day for pain. In addition, Acetaminophen ES 500 mg every 8 hours as needed for pain was previously ordered on 12/07/21. On 02/23/22 at 9:49 AM a continuous observation was done of Nurse #8 as she prepared and administered medications to Resident #19. Acetaminophen ES 500 milligrams(mg) ordered 3 times a day was given. Nurse #8 assessed the resident's pain, and he stated his foot was hurting	F 759	On 4/8/2022, Regional Director of Clinical Services educated Nurse #8 on medication Administration Procedures to include over the counter medication if it is not available nurse #8 will contact the physician to obtain an alternative Effective 3/7/2022 Systane (Polyethyl Glycol-Propyl) was ordered and received on 3/8/2022. As of 4/8/2022, Regional Director of Clinical Services educated Nurse #1 on the medication Administration Procedures to ensure she is administering the appropriate dose that is prescribed by the physician. Effective 3/31/22 nurse management provided medication pass observations to current licensed nurses and medication aides on the medication administration process to be completed by 4/11/2022. Effective 4/8/2022 Nurse management educated current licensed nurses,	4/11/22

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F 759	Continued From page 110 at a level 7 on a 0-10 scale (0=no pain and 10=highest). Nurse #8 returned to the medication cart, reviewed the Medication Administration Record (MAR) and pulled Acetaminophen 325 mg-2 tablets and placed them in a medication cup. She continued into Resident #19's room and she was informed by the surveyor she had just given him Tylenol. Nurse #8 responded "Did I?" She returned to the medication cart and reviewed the MAR. She said, "I didn't give it to him, it is every 8 hours, and then stated, "Oh he just got Tylenol, it is every 8 hours so let me go back and scratch that." She discarded the pills. The Regional Director of Clinical Services was notified on 02/24/22 at 5:33 PM regarding the medication error and Nurse #8 being informed she was giving Acetaminophen twice to Resident #19. An interview was done with Director of Nursing (DON) #2 on 03/01/22 at 04:36 PM. She had not been available to interview prior to this date. She was informed of the medication error rate of 11.54% and the DON stated the nurse should have known not to give the resident more Acetaminophen. She stated the nurse should have reviewed Resident #19's pain orders and notified the Nurse Practitioner if needed for other pain medication. She noted the resident had a stage 4 pressure ulcer and frequently had pain. 2. Resident #60 was admitted on 01/01/17. Review of the Physician orders indicated Systane Solution (Polyethyl Glycol-Propyl) 0.4-0.3% eye drops were ordered on 06/02/2021 for dry eye. Instructions included to instill 1 drop in both eyes three times a day for dry eye.	F 759	medication aides, to include agency on the medication Administration Procedures for all Medications to include over the counter medication. If the medication is not available, the nurse is to notify the physician to obtain an alternative medication. Education to be completed by 4/11/2022. Effective 4/11/2022 any new licensed nurse or medication aides to include agency will receive education on medication administration procedures by nurse management. Effective 3/30/2022, Regional Director of Clinical Services educated Central Supply on ensuring over the counter medications were available and to maintain a Par level in the facility. Nurse management will audit 3 licensed nurses and/or medication aides on medication pass observation on medication administration process weekly x 12 weeks. Director of Nursing will report any findings to the Quality Assurance Performance Improvement committee for any needed improvements monthly x 3 months. Completion Date: 4/11/2022	

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F 759	Continued From page 111 On 2/23/22 at 9:56 AM Nurse #8 was observed continuously as she prepared the medications for Resident #60. The resident was ordered Polyethyl Glycol-Propyl eye drops 0.4-0.3 % 1 drop in both eyes three times a day. No eye drops were available per Nurse #8 in the cart, and she was going to check on them. The resident had multiple vials of Artificial Tears in his drawer. A follow up was done with Nurse #8 on 02/23/22 at 6:30 PM regarding Resident #60's eye drops. She stated someone at the facility was going to purchase them tonight and she had also ordered them through pharmacy, so she would see which came first. A second follow up interview was done on 02/24/22 at 5:18 PM with Nurse #8 regarding the eye drops and she said they had not arrived yet for Resident #60. She stated she had not notified the Nurse Practitioner (NP) until today. The NP had informed her to call if they did not come in by this evening. An interview was done with Director of Nursing (DON) #2 on 03/01/22 at 04:36 PM. She had not been available to interview prior to this date. She was informed of the medication error rate of 11.54% and the Polyethyl Glycol-Propyl eye drops not being available. She stated the nurse should have let the Medical Record manager know as she ordered the Over the Counter (OTC) supplies. An interview was done with the Central Supply/Medical Record Manager on 03/02/22 at 11:18 AM. She stated she ordered for medication house stock every week. She was asked about the Systane (Polyethyl Glycol-Propyl) eye drops	F 759		

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F 759		F 759		

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being ordered. She stated they do not keep those or the substitute in stock. She said she was not told the eye drops were needed prior to 03/01/22 so she did not go to the store and pick them up. She noted she had been told by the company to use lubricant eye drops ulta as a substitute, but those eye drops had not been ordered in months.

3. Resident #82 was admitted on 04/22/19. His diagnoses included coronary artery disease, anemia and hypertension. Review of the physician orders indicated he was ordered ferrous gluconate 240 mg daily with food on 07/22/21.

A continuous observation of the medication administration was completed with Nurse #9 on 02/23/22 at 10:15 AM as she was preparing medications for Resident #82. Nurse #9 opened the top drawer of the medication cart which revealed a plastic medicine cup half full of little green pills. The cup was not covered or marked with the medication or the dose on the cup. Nurse #8 said she was out of iron for her cart, and it was a stock medication. She was asked what the medication and mg was, and she said it was iron she was not sure of the mg. She said she would have to go back and look at the bottle. Nurse #82 said she thought it was 325 mg. She said another nurse gave it to her as she said she had to borrow the pills. Resident #82 was ordered ferrous gluconate 240 mg tablet once daily. The medication that was in the unlabeled medication cup was ferrous sulfate 325 mg as clarified by Nurse #1. The green pills were discarded by the Minimum Data Set (MDS) nurse when she became aware of the incident at 10:28 AM 02/23/22. Nurse #1 had assisted Nurse #9 with

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F 759	Continued From page 113 the iron supplements for the cart, and overheard the conversation about the medication and dose discrepancy, and notified the NP during the medication administration process. The ferrous gluconate was discontinued and Nurse #1 informed Nurse #9 that she had gotten an order for the ferrous sulfate instead. An observation of the Medication Storage room was done on 02/24/22 and revealed ferrous gluconate was available in the surplus supply area. An interview was conducted with the Regional Director of Clinical Services on 02/24/22 at 5:33 PM. She was informed of the medication error rate, details of the medication error with the iron medications and stated there should not be any pills in cups in the medication cart. An interview was done with Director of Nursing (DON) #2 on 03/01/22 at 04:36 PM. She had not been available to interview prior to this date. She was informed of the medication error rate of 11.54%. She stated the nurse should have checked the medication storage room for the iron tablets as more was available and that medication carts should have no medications in cups.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and	F 760	As of 4/8/2022 the medication carts were	4/11/22

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staff, Nurse Practitioner, physician, resident and family interviews, the facility administered a sedation medication that had been discontinued for 1 of 6 residents reviewed for unnecessary medications (Resident #10). In addition, the facility failed to administer 3 doses of a prescribed antibiotic (vancomycin) for 1 of 1 resident reviewed for antibiotics (Resident #237) and failed to administer daily insulin and sliding scale insulin within 1 hour of scheduled dose for 4 of 4 of insulin doses reviewed (Resident #243).

Findings included:

1. Resident #10 was admitted to the facility on 3/19/2020 with diagnoses of Alzheimer's Disease, falls, weakness, and anxiety.

The quarterly Minimum Data Set (MDS) assessment completed on 10/28/21 indicated Resident #10 was severely cognitively impaired.

Ativan (Lorazepam) 0.5 mg every 8 hours for anxiety was listed on the MAR for Resident #10 as discontinued on 02/09/22. There was no documentation of Ativan being given on 02/11/22.

Record review of Medical Director #1's progress note dated 02/11/22 revealed Resident #10 was witnessed to be very unsteady and bracing herself against the wall. She appeared to be quite sleepy and even more confused than her typical baseline. Nurse #14 had informed the physician that she had just been given Lorazepam about an hour prior. The Physician stated she requested a wheelchair for the resident and escorted her back to her room after which she fell asleep.
The Physician's documentation was as followed:

reviewed to ensure sedation medication that was discontinued was removed discarded and/or returned to pharmacy by nurse management.

Effective 3/29/2022 the nurse practitioner was notified of resident #237 missed 3 doses of prescribed antibiotic. No new orders were received. Resident #243 no longer resides in the facility.

All residents have the potential to be affected by medication errors.

On 3/23/022 a reconciliation of the medication carts and medication rooms was completed by nurse management to ensure discontinued medications were removed from the cart.

On 3/23/22 any prescribed antibiotics and or insulins were reviewed by the Regional Director of Clinical Services regarding any missed doses to ensure physician and or responsible party notification.

Effective 4/8/2022 Nurse management educated current licensed nurses, medication aides, to include agency to ensure residents receive prescribed medications as ordered and time of administration by the physician education to be completed by 4/11/2022. Effective 4/11/22 any new licensed nurse or medication aides to include agency will receive education on ensuring residents receive their medication as prescribed by the physician by nurse management.

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- Medication administered in error-The Physician discussed with the nurse that the patient did not have orders for Lorazepam and that it was discontinued some time ago by hospice. The Physician requested that the Lorazepam tablets be removed from her supply to prevent further errors in the future.

A phone interview was conducted with Medical Director #1 on 02/22/22 at 1:58 PM regarding Resident #10. She stated that on 02/11/22 she had observed the resident slurring her words and she was concerned about her. She stated she asked the nurse what medications she had given her. Medical Director #1 stated the nurse told her she had given Resident #10 Lorazepam and Buspar. The Physician stated the resident did not have an order for Lorazepam. The nurse responded that the Lorazepam was in the resident's medication drawer. The Physician stated the medication had been discontinued and the medication cards had not been sent back to the pharmacy.

Nurse #14 was interviewed via phone on 02/27/22 at 5:46 PM regarding Resident #10 about the incident on 02/11/22. She stated she was an agency nurse and had been told earlier in the week if the resident had behaviors, to give her the prn (as needed) medication that was ordered. She said Resident #10 was moving slower, cursing at the staff and the nurse thought she had been up all night. She noted she had given Resident #10 her Lorazepam about 11:00 AM on 02/11/22 that was on the MAR. She said shortly thereafter the Physician commented about the resident's walk. She informed the doctor she had given her Lorazepam and the doctor stated it was supposed to have been discontinued. The nurse

F 760

Nurse management will audit 5 residents medication administration record to ensure medications were administered correctly and timely as ordered 3 x weekly x 4 weeks, then weekly x 8 weeks.

Director of Nursing will report any finding to the Quality Assurance Performance Improvement committee monthly x 3 months for any needed improvements.

Completion Date: 4/11/2022.

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stated a facility staff nurse was present at the time and told her the discontinued medications were supposed to be taken off the medication cart and sent back to Pharmacy. Nurse #14 was asked about signing out the medication, she stated she always made sure the medication was signed out. Nurse #14 then added that she may have gotten busy and forgot to document it on the MAR or sign it out.

2. Resident #237 was admitted to the facility on 01/26/22.

Resident #237's diagnoses included paraplegia, severe sepsis secondary to a catheter associated urinary tract infection, clostridium difficile colitis, pressure ulcers and neurogenic bladder.

The Admission Minimum Data Set (MDS) assessment completed on 02/07/22 indicated Resident #237 was cognitively intact.

A review of the initial Physician orders for Resident #237 included the antibiotic Vancomycin for clostridium difficile on 01/26/22.

Review of the February Medication Administration Record (MAR) for Resident #237 noted the Vancomycin 50 milligrams/milliliter(mg/ml) 2.5 ml four times a day was not documented as given on 02/12/22 at 4:00 PM, or 1/18/22 at 8:00 AM or 12:00 PM.

An interview was done with Nurse #5 regarding the antibiotic dose not documented on 02/12/22 at 4:00 PM for Resident #237. She stated the reason medications were late or missing was staffing, as they were very short. She did not recall the resident or giving him an antibiotic.

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A phone interview was done on 02/27/22 at 12:12 PM to Nurse #18 regarding the antibiotics for Resident #237 for the 02/18/22 8:00 AM dose. She noted she had stayed over from night shift due to no relief and left at 9:00 AM. She stated she had given him medications but did not give him an antibiotic. She said if she had given it, she would have documented it.

An interview was done with Medication Aide (MA) #2 regarding the 01/18/22 12:00 PM dose was done on 02/24/22 at 3:54 PM. She stated on 02/18/22 she was shadowing a nurse on another hall as it was her first day as a MA from 8:00 AM-2:30 PM. She noted she had just received electronic medical access to document after 3:00 PM that day. She stated she did not give the antibiotics that day at 12:00 PM.

The schedule received from the Assistant Administrator on 02/24/22 for 02/18/22 indicated MA #2 was assigned to resident #237 for medications.

An interview was done with Regional Director of Clinical Services #1 on 02/25/22 at 4:10 PM interview. She was asked about 02/18/22 and the medications for Resident #237. She stated the nurse had stayed over that morning and MA #2 showed documentation of some medications on that hall after 11:00 AM. She noted the antibiotics should have been administered and documented on time.

An interview was done on 02/22/22 at 11:21 AM with Resident #237 and he stated some shifts were late with his medications if he got them at all.

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F 760	Continued From page 118	F 760		

A phone interview was done on 02/27/22 at 4:54 PM with Medical Director #1 regarding antibiotic medications not documented as administered. She stated antibiotics should be given on time to maintain the therapeutic blood levels for the infection.

3. Resident #243 was admitted to the facility on 2/9/2022 with diagnoses that included diabetes, absence of right and left great toes, acute kidney failure, hypertension, neuropathy and weakness.

The 5 day Minimum Data Set (MDS) assessment dated 02/14/22 indicated Resident #243 had mild cognitive impairment.

A phone interview with a family member on 02/23/22 indicated Resident #243 was not receiving his insulin as ordered. She stated he was on sliding scale insulin and daily insulin and they had missed doses and given it late. She stated the resident was alert and oriented and would know if they had not given it.
The sliding scale insulin ordered for 02/14/22 at 11:30 AM before meals was administered to Resident #243 at 2:34 PM.

An interview with the MDS Nurse was done on 02/24/22 at 4:52 PM regarding late medication administration for Resident #243. She stated she was asked to cover the morning and afternoon medications on 02/14/22 about 10:00 AM due to a staffing need, and medications had not been started. She said she had given medications until 7:00 PM on 02/14/22 and did the best she could with getting insulin and significant medications prioritized. She said it was just her and 2 medication aides, as there was no other available

F 760

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help.

The Insulin Glargine 20 units once daily for diabetes due on 02/11/22 at 9:00 PM was administered to Resident #243 at 11:44 PM by Nurse #5.

A phone interview with Nurse #5 was done on 02/27/22 at 1:21 PM regarding late medications for Resident #243. She stated the reason for the late medication was staffing was very short. She said she did not notify the physician.

Admelog insulin ordered as sliding scale based on fingerstick blood sugar results was ordered for 9:00 PM 02/13/22 and administered to Resident #243 at 10:32 PM by Nurse #12.

The Insulin Glargine 24 units once daily for diabetes due on 02/13/22 at 9:00 PM was administered to Resident #243 at 10:33 PM by Nurse #12

Admelog insulin ordered as sliding scale based on fingerstick blood sugar results was ordered for 9:00 PM 02/15/22 and administered to Resident #243 on 02/16/22 at 12:22 AM by Nurse #12.

The Insulin Glargine 24 units once daily for diabetes due on 02/13/22 at 9:00 PM was administered to Resident #243 on 12/16/22 at 12:22 AM by Nurse #12

Numerous attempts to reach Nurse #12 that cared for Resident #243 on 02/13/22 was unsuccessful.

A phone interview was done on 02/24/22 at 12:24 PM with Nurse Practitioner (NP) #1 regarding late

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medications for Resident #243. The NP asked about the medications for insulin being given late and she stated she would expect if a medication was late, they should notify the NP or the Physician. She noted with insulin it should be given on time and if late, it could cause hypoglycemia if give too late after a meal. She said when sliding scale insulin was given late at night with no food it was a risk. She noted there was a way to fix it and if given late to give a snack, but the communication needs to occur with the Nurse Practitioner or the Physician. She stated she had been notified on occasion when a medication was late. The NP said medication are all an order and she expected the medications to be given as ordered and notified if it was not.

Medical Director #1 was interviewed via phone on 02/27/22 at 4:54 PM. She was asked about Resident #243 and the sliding scale ordered at 9:00 PM being given 3 hours late and stated it was not safe to be given that late. The Physician stated insulin was being given that should be covering for a meal and was not safe to be given that late. She said the physician should have been notified. She said when she was there as the medical director, there was a big issue with medications being super late due to staffing, noon meds would get skipped completely sometimes, morning meds given as late as noon.

A phone interview was done on 03/03/22 at 12:18 PM with Regional Director of Clinical Services #1, that was assigned to the facility since 02/2022 regarding medication concerns. She was asked about medications being given late and stated she was not aware, but she was told by family members of medication concerns. She stated medications should be given 1 hour before or

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F 760	Continued From page 121 after the time due and her understanding was it may have been staffing. An interview was done with Director of Nursing #2 was interviewed on 03/01/22 at 4:12 PM and she was asked about medications being late. She said late medications were due to staffing. She noted the previous DON was working the units on days frequently and she was working nights as the Assistant Director of Nursing to cover staffing. She noted staffing had been a challenge and they had no staff nurses now except their Activity Director who was a nurse that was pulled to the floor frequently. She stated if the medications were late, the protocol was they were supposed to contact the doctor before they gave the next dose. She noted she had only seen 2 nurses do this, one this past weekend and one a week ago which was during the survey. She noted nurses should use their nursing judgement, follow protocol, call the physician and ask questions when medications were late. She stated there had been inservices more than once about the late medications and the importance of documentation. The DON was asked about blood sugars due at 9:00 PM and sliding scale insulin being given late at 12:00-12:30 AM. She stated again the nurse should call the physician, use telehealth and follow the guidelines.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		4/11/22

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F 761	Continued From page 122 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 loose medications from the medication cart drawers for 1 of 3 medication carts reviewed for medication storage (600 Hall Cart) and ensure medication was properly discarded when a medication was found on the floor near the nurse's station. The findings include: 1. A review of the medication cart for the 600 Hall was done on 02/24/22 at 11:40 AM with Nurse #11. Fourteen loose pills were found in the top drawer. There were also several pieces of pills in the drawers. 2. At 5:30 PM on 02/24/22 a loose pill was found by the surveyor in the entrance hall going to the	F 761	Effective 2/24/2022 loose pills on 600 medication cart were removed and disposed of properly by nurse management. Effective 2/24/2022 the loose pill located on the floor was disposed of properly by nurse management. All residents have the potential to be affected with loose pills in the med carts. Effective 4/8/2022 current medications carts in use were reviewed to ensure no loose pills were identified any loose medication identified was discarded properly by nurse management. Effective 4/8/2022 Nurse management	

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F 761	Continued From page 123 200 and 300 hallways. The pill was identified by the code on the pill by Nurse #2 as metoclopramide for high blood pressure. Nurse #2 discarded the pill. An interview was done on 02/24/22 at 11:55 AM with the Pharmacy Nurse consultant that observed the 500 and 600 Hall medication carts being checked. She stated part of her job was to inspect the carts and medications should not be loose in the drawers, nor pieces of pills. An interview was done on 03/01/22 at 2:24 PM with the Pharmacy Customer Service Representative (CSR). She stated she checked the medication carts and medication storage rooms monthly except in December 2021. She stated she was here on 01/12/22 for the medication carts and medication storage rooms audits. The Pharmacy CSR stated she identified medication storage concerns previously and shared this with leadership. She said she did find loose pills in the drawers before, especially when there were a lot of cards packed in the drawers tight, which caused the medications to pop out of the back of the cards. She added there should not be any loose medications in the carts. An interview was done on 02/24/22 at 1:30 PM with the Regional Director of Clinical Services #1 regarding the loose pills and pieces of pills in the medication carts. She stated pharmacy was at the facility on Monday and had cleaned the carts. She noted there should not be any pills loose in the drawers. An interview was done on 03/01/22 at 4:46 PM with the Director of Nursing #2. She was informed about the loose pills in the medication	F 761	educated current licensed nurses, medication aides, to include agency on ensuring loose pills are discarded properly education to be completed by 4/11/2022. Effective 4/11/2022 any new licensed nurses or medication aides to include agency will receive education prior to the start of their shift to ensure loose pills are discarded properly by nurse management. Nurse management will audit 2 medication carts to ensure loose pills are discarded properly 3 x a week x 4 weeks, then weekly x 8 weeks. Director of Nursing will report any findings to the Quality of Assurance Performance Improvement committee monthly x 3 months for any needed improvement. Completion Date: 4/11/2022	

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F 761	Continued From page 124 cart and the blood pressure (BP) medication on the floor. DON #2 said she expected the medication carts would have no loose pills in the drawers or have pills on the floor. She was asked about the blood pressure pill being on the floor and said the nurse should follow the 5 rights and if a pill was dropped, pick it up and discard it in the sharp's container.	F 761		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment,	F 838		4/11/22

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F 838	Continued From page 125 services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the Facility Assessment regarding changes to the administrative personnel and failed to update the Facility Assessment with the number of residents that required wound care and the number of residents	F 838	Administrator updated the facility assessment to reflect current department managers and current wounds and transmission-based precautions as of 3/28/2022.	

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F 838	Continued From page 126 with transmission based precautions. Findings included: 1. a. A review of the facility's Facility Assessment dated 2/1/2022 revealed current administrative staff were not listed. Administrator #1 was listed as the Administrator and Dietary Manager #1 was listed as the Dietary Manager, but no longer worked at the facility. An interview with the Dietary Manager #2 on 2/21/2022 at 11:06 am revealed she had been the facility's Dietary Manager for 9 months. During an interview with Administrator #2 on 3/3/2022 at 11:57 am he stated the Facility Assessment should be updated as the facility's administrative staff change, or positions are empty. He stated he arrived at the facility on 2/14/2022 and the Facility Assessment had not been updated with his or the current Dietary Manager's names. b. A review of the facility's Facility Assessment dated 2/1/2022 revealed there were no residents listed for requiring wound care and no residents requiring transmission based precautions. The facility matrix dated 2/21/2022 indicated 6 residents required wound care and 22 residents required transmission based precautions. During an interview with Administrator #2 on 3/3/2022 at 11:57 am he stated the Facility Assessment was a document that should be updated with changes in the facility.	F 838	All residents have the potential to be affected by the facility assessment not being updated. Regional Director of operations educated the new administrator on facility assessment on 3/28/2022. Effective 4/11/2022 any changes in administration will receive education by the Regional Director of operations on updating the facility assessment. Regional Director of Operation will audit facility assessment for updates weekly x 12 weeks. Administrator will report any findings to the Quality Assurance Performance Improvement committee for any needed changes in improvement monthly x 3 months. Completion Date:4/11/2022	
F 867 SS=H	QAPI/QAA Improvement Activities	F 867		4/11/22

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F 867	Continued From page 127 CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place during the last recertification survey which ended 9/2/2021 for their failure to provide wound care per a physician's orders. During the current recertification survey that ended on 3/4/2022 the facility was recited for failure to provide wound care and treatments as ordered by a physician. The continued failure during two recertification surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referenced to: F686- Based on record review, observation, and staff, Wound Physician and Medical Director interviews the facility failed to provide pressure ulcer dressings and treatments ordered by the physician for 1 of 3 resident, Resident #83, reviewed for wound care which resulted in worsening and infection of a stage 3 and a stage 4 pressure ulcer and development of 8 acquired pressure wounds. The facility further failed to	F 867	Effective 2/24/2022 resident #83 wounds dressings were completed as ordered nursing staff. Effective 3/09/2022 resident #237 heel boots were discontinued by the physician. As of 3/28/2022 resident #237 no longer requires transmission-based precautions. Review of Prior Quality Assurance plan should have been continued longer. Quality Assurance plan will continue for 12 months to ensure continued compliance for infection control and wound care. On 3/29/2022 the Regional Director of Operations educated the administrator on facility policy and procedure in regard to reviewing any improvement plans to ensure procedures and monitoring are in place. Administrator will monitor all active performance improvement plans monthly x3 months to ensure all improvement plans are being implemented and monitored for improvement. Administrator will review Infection control and wound care plans for 12 months for continued compliance.	

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F 867	Continued From page 128 follow the wound physician's order for heel protector boots and to float the heels of 1 of 3 residents, Resident #237 reviewed for pressure ulcer prevention. F880-Based on observations, record review and staff interviews, the facility failed to post the Transmission Based Precautions Enteric/Contact Precaution signage for a resident with Clostridium Difficile infection and staff were not aware of hand hygiene protocols (not to use alcohol-based hand sanitizer but only to use soap and water) when caring for a resident with Clostridium Difficile infection for 1 of 2 residents reviewed for Transmission Based Precautions (Resident #237). The facility failed to investigate in accordance with their Infection Prevention and Control policy, COVID-19 outbreaks beginning on 1/6/22. This occurred during a during a global pandemic. A Performance Improvement Plan with education completed beginning 2/23/2022 and audits beginning 2/24/2022 were provided by Administrator #2. During an interview with Administrator #2 he stated the facility's Quality Assurance and Performance Improvement committee (QAPI) meets at least quarterly but he had not been at the facility long enough to attend one of the QAPI committee meetings. Administrator #2 stated the facility began a Performance Improvement Plan for the recently discovered issue of resident's wound treatments and dressings not being completed.	F 867	Administrator will report findings to Quality Assurance Performance Improvement committee for any needed improvement monthly x 6 months. Infection control and wound plans will be reviewed for 12 months to ensure compliance. Completion date: 4/11/2022	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/11/22

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F 880	Continued From page 129	F 880		

§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 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:

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F 880	Continued From page 130 (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. §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 post the Transmission Based Precautions Enteric/Contact Precaution signage for a resident with Clostridium Difficile infection and staff were not aware of hand hygiene protocols (not to use alcohol-based hand sanitizer but only to use soap and water) when caring for a resident with Clostridium Difficile infection for 1 of 2 residents reviewed for Transmission Based Precautions (Resident #237). The facility failed to investigate in	F 880	Effective 3/22//2022 the Regional Director of Clinical Services educated Nurse #9, Nurse Aide #7, on Transmission Based Precautions sign Enteric Precautions and proper hand hygiene. On 3/29/2022 the Housekeeper # 2 was educated by nurse management on Transmission Based Precautions sign Enteric Precautions and proper hand hygiene.	

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F 880 Continued From page 131

accordance with their Infection Prevention and Control policy, COVID-19 outbreaks beginning on 1/6/22. This occurred during a during a global pandemic.

1. The Facility Policy 'Transmission-Based Precautions' implemented on 11/01/20 indicated Contact Precautions should be implemented for Clostridoides Difficile, formerly Clostridium difficile. Hand hygiene (cleaning hands) should be done with soap and water.

Hospital records dated 01/15/22 prior to admission indicated Resident #237 had been treated for sepsis and a complicated urinary tract infection related to Extended Spectrum Beta-Lactamase (ESBL) in his urine.

Census review indicated Resident #237 was in Room 503. Resident #237 was admitted to the facility on 01/26/22.

Resident #237's diagnoses included clostridium difficile colitis.

Record review indicated Resident #237 was ordered Enteric Precautions on 01/26/22 related to clostridium difficile and ESBL in the urine.

An observation was done on 02/21/22 at 11:53 AM of room 503. There were white drawers outside the room that contained Personal Protective Equipment (PPE), and alcohol based hand sanitizer (ABHS) and red plastic biohazard bags on top. There was no resident name outside the door. It was noted there were other white plastic drawers outside the doors further down the hall and the rooms were not occupied.

F 880

On 3/30/2022 the Regional Director of Clinical Services educated the Director of Nursing on investigating a COVID-19 outbreak in accordance with the Infection Prevention and Control Policy.

All residents have the potential to be affected infection control practices.

An appropriate transmission-based precautions sign was placed on resident # 237 door by nurse management.

On 3/22/2022 Regional Director of Clinical Services reviewed other current resident□s medical records to ensure appropriate Transmission based Precaution signage was implemented no other resident were identified.

Effective 4/10/2022 Nurse management educated current staff members and agency staff on Transmission Based Precautions signage and hand hygiene education to be completed by 4/11/22. Effective 4/11/2022, Nurse management will educate any new staff to include agency prior to the start of their shift staff on Transmission Based Precautions signage and hand hygiene.

Nurse management will audit 5 residents on Transmissions Based Precautions to ensure proper signage is on the door 3 x weekly x 4 weeks, weekly x 4 weeks, and monthly x 1 month.
Nurse management will interview 3 staff

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F 880	Continued From page 132 An interview was conducted on 02/21/22 at 11:54 PM with Nurse #9 that was assigned the 500 Hall. She stated it was her first day at the facility. She was asked about the resident in 503 if he was on isolation due to the isolation cart outside of door and no sign for Transmission Based Precautions (TBP) on the door. She stated she knew he was on vancomycin and looked up the reason in his Medication Administration Record (MAR). She stated he had "colitis" and stated she couldn't say the other word, pointed to the MAR and it revealed "clostridium colitis." She did not understand the purpose of the isolation and was explained it was clostridium difficile or "c diff.". She was asked if she was aware of special hand hygiene for the c diff and had no comment. An interview was done on 02/21/22 at 1:00 PM with Nurse Aide (NA) #7 about the TBP on the 500 hall. She had been passing lunch trays on that hall. The NA was asked about the lack of signs on the door and the carts outside of the rooms and said she was not sure. She noted some residents were new admissions. She said she was told two weeks ago the reason the resident in 503 was in isolation was due to methicillin-resistant staphylococcus aureus (MRSA) but was unsure of the type of isolation. An observation was done on 02/21/22 at 4:30 PM. There was no sign for TBP on the door or resident's name outside the door. An observation was done on 02/22/22 at 10:56 AM of Room 503. The door did not have a TBP sign on the door, the white drawers with ABHS remained outside the door and the resident's name was not outside the door.	F 880	members on Transmissions Based Precautions signage to ensure staff awareness on the signage 3 x weekly x 4 weeks, weekly x 4 weeks, and monthly x 1 month. Nurse management will audit 3 staff members to ensure proper hand hygiene 3 x weekly x 4 weeks, weekly x 4 weeks, and monthly x 1 month. Effective 4/11/2022 Nurse management will audit any staff or resident Covid testing for any positive results in order to initiate contact tracing 2 x weekly x 4 weeks, weekly x 8 weeks. Director of Nursing will report findings to the Quality Assurance Meeting for any needed improvement monthly x 3 months. Regional Director of Clinical Services will audit investigation for COVID-19 outbreak weekly for 12 weeks. Effective 4/11/2022 Regional Director of Clinical Services will ensure contact tracing is completed for any positive Covid 19 cases with staff or residents per current CDC guidelines. Completion Date: 4/11/2022	

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Nurse #11 was interviewed on 02/24/22 at 11:26 AM regarding Resident #237. She stated she had him when he first came in and he was on the 100 hall, and was on TBP for clostridium difficile. She said the Enteric Precaution sign was on his door on the 100 hall and there had been an extra sign not to use the alcohol based hand sanitizer (ABHS). She stated the signs should be on his door for the TBP.

An interview was done on 03/03/22 at 11:30 AM with Housekeeping Staff #2. He stated he cleaned rooms when needed and did the floors on a regular basis as the floor crew staff. He stated when cleaning isolation rooms, he wore gloves, gown and personal protective equipment. He noted he took the items into the rooms and removed them before he came out. He said he used the alcohol based hand sanitizer to clean his hands with all types of isolation. He was asked about a resident on enteric precautions if the protocol for washing hands was the same and he said yes. The surveyor explained there was a resident on enteric precautions on the 100 and 500 hall in the last couple months, and he was asked if he used anything different for hand hygiene with Enteric Precautions and said he "doesn't even know what that means" and he used ABHS always.

A follow-up interview was done with Housekeeping Aide #2 on 03/03/22 at 11:42 AM and he stated he usually cleaned on the 500 and 600 halls and had also cleaned rooms on the 100, 500 and 600 halls since January 2022.

An interview was done on 03/02/22 at 09:45 AM with Director of Nursing #2. She was informed of the concerns with TBP for Resident #237, that no

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sign was outside the door with his name or type of isolation for several days, ABHS on the drawers outside the room and staff not aware of the reason for the TBP. She stated the ABHS should have been covered and a "do not use" sign on it. DON #2 said Resident #237 was admitted with ESBL and Clostridium Difficile (C. Diff) from the hospital. She said upon his admission on the 100 hall, the correct signs had been placed and a sign to wash hands and not to use the ABHS. She noted she had completed inservices regarding all of this upon his admission. She said all the TBP signs should have been moved from the 100 hall with him.

Administrator #2 was interviewed on 03/03/22 at 4:20 PM regarding the TBP signage, staff awareness and hand hygiene. He stated the staff should properly identify and provide signage posted at the resident's room. In addition, the facility should assure staff were competent in these precautions, not use ABHS with Enteric Precautions and know to wash their hands.

2. A review of the facilities policy titled Infection Prevention and Control Program revised on 10/1/21 read in part; 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposure, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: b. The Infection Preventionist serves as the lead in surveillance activities, maintains documentation of incident, findings, and any corrective actions made by the

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facility and reports surveillance findings to the facility Quality Assessment and Assurance Committee.

A review of the facilities policy titled Infection Surveillance revised on 10/1/21 read in part; 6. All residents infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated.

Upon entrance on 2/21/22 the acting Director of Nursing (DON #2) was assuming the role of the infection preventionist.

A review of the Facilities long term care COVID-19 surveillance line list (a table that contains key information about each case in an outbreak with each row representing a case and each column representing a variable such as name, symptoms, date of test) revealed that a COVID-19 outbreak began when a staff tested positive for COVID-19 on 1/6/22. Upon entrance to the facility on 2/21/22 the last staff to have COVID-19 was on 2/17/22. A second review of the COVID-19 surveillance line list for staff dated 2/28/22 did not have any additional positive staff from 2/17/22.

A review of the Facilities long term care COVID-19 surveillance line list for residents revealed that a COVID-19 outbreak began with a resident testing positive for COVID-19 on 1/16/22. Upon entrance to the facility on 2/21/22, 24 residents had COVID-19. A second review of the COVID-19 surveillance line list for residents dated 2/28/22 revealed 21 residents had recovered from COVID -19, six new cases were confirmed between 2/22/22 and 2/28/22 for a total of 9

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F 880	Continued From page 136 COVID-19 cases. A telephone interview was completed with the DON #2 on 2/26/22 at 4:46 PM who stated that a root cause analysis should be completed as to why the outbreak had happened. The DON #2 stated that she would have DON #2e a printout and tried to find where and why cases were going up. The DON #2 stated that the first staff to test positive on 1/6/22 came in and had no symptoms and tested positive. A request was made to review the COVID-19 outbreak investigations for the recent outbreaks beginning in January 2022 however there had been no documented review of the investigations of the recent outbreaks. An interview was completed with the Vice President of Clinical Operations, (VPCO) the Regional Director of Operations (RDO) and the Administrator on 2/28/22 at 4:16 PM. The VPCO stated that she had begun calling the previous COVID-19 positive staff on 2/27/22 to get a clearer picture of the outbreak. The VPCO stated that Nurse #11 had been doing the contract tracing however her last day was 1/16/22. The VPCO stated that she was unsure who had been doing the tracing but would say that the current DON #2 would be doing investigations. The VPCO stated that the Infection Preventionist was at the facility until 1/26/22 and she should have been doing contact tracing but there was no documentation or book on contract tracing as to why the outbreak happened. The VPCO stated that based on her conversations with staff that had been positive they did not appear to have any community exposure but could not say specifically as to why the outbreak happened.	F 880		

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F 880	Continued From page 137 A second interview was completed with the DON #2 on 3/1/22 at 2:58 PM who stated that she had not overseen Infection control and contract tracing in January 2022. The DON #2 stated that after the Infection Preventionist left on 1/26/22 she had assumed that role of the Infection Preventionist. The DON #2 stated "Yes, I should had been doing the investigations/tracing but had to be on the medication cart and did not have time." The DON #2 explained that she was on the medication cart 8-12 hours a day. The DON #2 stated that "Nothing had been written down regarding investigations/tracing and had not seen anything except for the infection line listing." An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that it was his expectation that the facility would make all attempts to conduct a root cause analysis for any outbreak.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883		4/11/22

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has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

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

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F 883	Continued From page 139 This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to failed to include the immunization status for influenza and pneumococcal vaccine in the electronic health record for 5 of 5 sampled residents (Resident #34, Resident # 55, Resident # 62, Resident #66, Resident #68), failed to include education regarding the influenza and pneumococcal vaccine in the electronic health record for 4 of 5 sampled residents (Resident # 55, Resident # 62, Resident #66, Resident # 68), failed to document vaccination declinations for 2 of 5 sampled residents (Resident #55, Resident #66) and failed to administer and offer the pneumococcal and influenza vaccine to 1of 5 sampled residents (Resident #34), Findings Included: 1. A review of the facilities policy titled Pneumococcal Vaccine Series revised on 10/28/20 read in part; 1. Each resident will be assessed for pneumococcal immunization upon admission. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated. 4. The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. 8. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal.	F 883	Effective 4/8/2022 residents #34, #55, #62, #66 and #68 were offered the influenza and pneumococcal vaccine and responses were recorded in the electronic medical record by nurse management. Effective 4/08/2022 residents #55, #62, #66, 34 and #68 were educated on influenza and pneumococcal vaccine and recorded in the electronic medical record by nurse management. On 4/8/2022 residents #55, #66 , # 62, # 68 and # 34 influenza and pneumococcal vaccine declinations were signed and recorded in the electronic medical record by nurse management. On 4/8/2022 current residents were reviewed by nurse management to ensure the influenza and pneumococcal vaccine was offered and response documented in electronic medical record accurately and if a refusal was noted a declination was signed and uploaded in resident□s electronic medical record. An influenza and pneumococcal vaccine clinic will be initiated on 4/11/2022. Effective 3/10/2022, the Nurse management will educate current licensed nurses and agency on offering residents the influenza and pneumococcal vaccine to include documentation education to be completed by 4/11/2022. Effective 4/11/2022 any new License Nurses to include agency nurses will receive education on offering residents	

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A review of the facilities policy titled Influenza Vaccination revised on 10/27/20 read in part; 4. Prior to administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provide with a copy of Center for Disease Control's current vaccine information statement relative to the influenza vaccination. 6. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual' medical record. 8. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal.

a. Resident # 34 was admitted to the facility on 12/7/21 with a diagnosis that included cerebral infarction. Resident #34's Minimum Data Set (MDS) dated 2/14/22 specified the resident's cognition as cognitively intact. A review of the resident's electronic health record showed no influenza and pneumococcal vaccine status in the resident record.

b. Resident # 55 was admitted to the facility on 10/3/21 with a diagnosis that included non-pressure chronic ulcer. Resident #55's Minimum Data Set (MDS) dated 1/27/22 specified the resident's cognition as cognitively intact. A review of the resident's electronic health record showed no influenza and pneumococcal vaccine status in the resident record.

F 883

the influenza and pneumococcal vaccine to include documentation prior to the start of their shift by nurse management.

Effective 4/11/2022 Nurse management will audit 5 residents influenza and pneumococcal vaccine weekly x 12 weeks to ensure the vaccination was offered and documented in the electronic properly in the electronic medical record.

Director of Nursing will report findings to the Quality Assurance Improvement committee monthly x 3 months for any needed improvements.

Completion date: 4/11/2022

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c. Resident # 62 was admitted to the facility on 1/10/22 with a diagnosis that included cardiorespiratory conditions. Resident #62's Minimum Data Set (MDS) assessment dated 12/13/21 specified the resident's cognition as cognitively intact. A review of the resident's electronic health record showed no influenza and pneumococcal vaccine status in the resident record.

d. Resident # 66 was admitted to the facility on 1/8/22 with a diagnosis that included fibromyalgia. Resident #66's Minimum Data Set (MDS) assessment dated 1/21/22 specified the resident's cognition as cognitively intact. A review of the resident's electronic health record showed no influenza and pneumococcal vaccine status in the resident record.

e. Resident # 68 was admitted to the facility on 5/20/19 with a diagnosis that included chronic respiratory failure. Resident #68's Minimum Data Set (MDS) assessment dated 1/24/22 specified the resident's cognition as cognitively intact. A review of the resident's electronic health record showed no influenza and pneumococcal vaccine status in the resident record.

A request was made to the Vice President of Clinical Operations (VPCO) on Monday 2/28/22 at 9:30 AM requesting immunization status for the five sampled residents due to no information included in the EHR.
An interview was completed with the Vice President of Clinical Operations, (VPCO) the Regional Director of Operations (RDO) and the Administrator on 2/28/22 at 4:16 PM who stated

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that the MDS Nurse had met with all the sampled residents and provided the surveyor with a list of the status of each resident. The VPCO stated that there were no declinations in the resident EHR records and was asked as to why they were not there. The VPCO stated she could not answer as to why they were not in the EHR. The VPCO stated that typically it is part of the admission process but there is a follow-up by the MDS Nurse, and they can also review the vaccines. The VPCO stated typically the Infection Preventionist would assume responsiblity for the immunization and we can order any of the vaccines and they can be here within the day.

An interview was completed with the MDS Nurse on 3/1/22 at 10:07 AM to review the status of the five sampled residents. The MDS Nurse stated that she had met with all residents on 2/28/22 regarding the Influenza and pneumococcal immunizations and provided the following information: Resident #34 would like all immunizations, Resident # 55 declined all immunizations, Resident #62 had the immunizations prior, Resident #66 declined all immunizations, Resident #68 had the immunizations prior. The MDS Nurse stated that for those residents declined she entered refused in the resident's electronic health record under immunizations. The MDS Nurse was asked if the residents signed a declination form and the MDS Nurse stated she was not aware of a declination form. The MDS Nurse stated that if the Resident stated they had it she had entered historical. The MDS Nurse stated that when the immunizations came out the facility did provide education to the residents.

An interview was completed with the Director of

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Nursing (DON) on 3/1/22 at 2:58 PM who stated that she and the previous DON had completed consent forms for residents on 12/15/21 when we issued the immunizations. Resident #34 admitted after the clinic. The DON stated that another clinic was to take place the first part of February for Covid-19 Boosters and Influenza and Pneumonia and the Infection Preventionist had been working on that before she left as this would fall under the Infection Preventionist duties.

f. A review of Resident # 55, Resident # 62, Resident #66, Resident # 68 revealed no education was included in the Residents EHR for the pneumococcal and influenza vaccines.

g. A review of Resident #55, Resident #66 EHR revealed there were no declinations included in the Residents EHR.

h. Resident #34's MDS dated 2/14/22 indicated he had received the influenza outside of the facility and for Pneumococcal immunization revealed it was offered and declined. A review of EHR revealed no immunizations found under immunizations in the EHR. An Interview was completed with Resident #34 on 3/1/22 at 4:44 PM who stated that he had told someone that he is willing and able to have all the immunizations. Resident #34 could not remember who he had told but remember he had asked quite some time ago.

An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that upon admission Residents should be offered the opportunity to receive the immunization, offered education and have the right to sign a declination. The facility should make

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F 883	Continued From page 144 arrangements for the immunization to be administered within 24 - 48 hours.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		4/11/22

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F 886	Continued From page 145 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to document COVID-19 testing that was completed and the results of each staff test for 3 of 3 sampled staff (Activities Director (AD), Housekeeping Aide #1(HA), Rehabilitation Staff #1 (RS) reviewed for COVID-19 testing, failed to document results in the resident record for 3 of 3 sampled residents (Resident #39, Resident #62, Resident #237).The failure occurred during a COVID-19 pandemic.	F 886	Effective 2/15/2022 Covid 19 test results have been recorded in resident # 62 medical record by nurse staff. Effective 3/28/22 resident # 237 Covid 19 test have been recorded in the resident medical record by nursing staff. Resident # 39 no longer resides at the facility. All residents are at risk to be affected by	

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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 886	Continued From page 146 Findings included: 1. A review of the facilities policy titled Coronavirus Testing revised on 2/2/22 read in part; Documentation of Testing; 1. b. Upon identification of a new COVID-19 case in the facility (i.e., Outbreak), document: ii. Date other staff and residents are tested, iii. Dates that staff and residents who tested negative are retested, iv. Results of all tests. g. The facility will document resident test results in the medical record in accordance with standard for protected health information. A review of the Centers for Disease Control (CDC) COVID-19 Tracker for Rowan County on 2/21/22 transmission rate, revealed a high transmission rate. A review of the facilities COVID- 19 Surveillance line list revealed the facility was in a COVID-19 outbreak since January 6, 2022. The line list documented positive staff from January 6th to February 28th with the last staff being positive on 2/15/22. A review of the testing log for staff revealed a documented testing log from January 7, 2022, which identified the staff name, dated tested positive or negative result and the test type. The facility was unable to locate additional testing logs for staff after January 8, 2022, but did have the February 2022 testing logs which revealed staff were tested two times a week. A review of the COVID-19 testing for the AD revealed she was tested on January 7, 2022 and tested positive for COVID-19 on January 18, 2022. The additional testing logs for January	F 886	lack of Covid 19 reporting. Effective 3/28/2022 the Regional Director of Operations re-educated the Director of Nursing, Administrator and Medical Records on Covid 19 test results being entered into the resident electronic medical record. As of 4/11/2022 nurse management will monitor Covid 19 test results for residents and staff based on current testing requirements to include current resident roster, current staff roster, agency staff and contracted staff the nurse management will monitor 5 tested residents and 5 tested staff weekly x 12 weeks. Administrator will report any findings to Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months. Completion Date: 4/11/2022	

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2022 were unable to be located.
An interview with the AD on 2/25/22 at 12:17 PM stated that residents and staff had been tested two times a week on Tuesday and Fridays since the outbreak in January and she had been sent home immediately upon testing positive for COVID-19.

A review of the COVID-19 testing for the HA revealed she had been tested on 2/1/22, 2/4/22, 2/8/22 and on 2/11/22 had a positive COVID-19 result. The additional testing logs for January 2022 were unable to be located.
An interview with the Housekeeping Aide on 3/2/22 at 12:08 PM who stated that she had been tested two times a week since the outbreak in January and was sent home immediately upon a positive COVID-19 test.

A review of the COVID-19 testing for a RS #1 revealed she had been tested on 2/1/22, 2/4/22 and on 2/8/22 had a positive COVID-19 result. The additional testing logs for January 2022 were unable to be located.
An interview was not able to be conducted with the RA as she had retired.

A review of the facilities COVID- 19 Surveillance line list revealed the facility was in a COVID-19 outbreak since January 6, 2022, due to staff testing positive as of 1/6/22. The line list documented positive resident test results from 1/16/22 to 2/24/22.

A review of the COVID-19 testing logs for residents revealed there were no COVID-19 testing logs for January 2022 however COVID-19 testing logs were present for February 2022.

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a. Resident # 39 was admitted to the facility on 6/20/17 with a diagnosis that included Chronic obstructive pulmonary disease. A review of the resident's electronic health record showed no COVID-19 testing results in the resident record. Resident #39 was tested on 2/4/22, 2/8/22, 2/11/22 and tested positive on 2/15/22.
An interview was completed with Resident #39 on 3/2/22 at 12:14 PM who stated that she had been tested two times a week since January 2022 prior to getting COVID-19.

b. Resident # 62 was admitted to the facility on 1/10/22 with a diagnosis that included cardiorespiratory conditions. A review of the resident's electronic health record showed no COVID-19 testing results in the resident record. Resident # 62 was tested on 2/4/22, 2/8/22, 2/11/22, 2/15/22.

c. Resident #237 was admitted to the facility on 1/26/22 with a diagnosis that included paraplegia. A review of the resident's electronic health record showed no COVID-19 testing results in the resident record. Resident #237 was tested on 2/4/22, 2/8/22, 2/11/22, 2/18/22

An interview was completed with the Assistant Administrator (AA) on 2/25/22 at 8:44 AM who stated that testing is completed every Tuesdays and Fridays for residents and staff since the Outbreak in January 2022. The AA stated the results come back digitally and are kept in a log but were behind with uploading to the electronic health record.

An interview was completed with the Medical Records (MR) on 2/25/22 at 2:55 PM who stated

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that she had never seen a residents COVID-19 testing result and have never uploaded the results to the EHR and had not been instructed to do that.

An interview was completed with the Director of Nursing (DON) on 2/26/22 at 4:46 PM who stated that testing is completed in-house for all residents and staff on Tuesdays and Fridays by a company that comes in and completes a polymerase chain reaction (PCR) test. The DON stated that once the testing is complete the results come in by an email and the Assistant Administrator or the Administrator logs into the testing lab and can see the results. The results are kept in a book and should be uploaded to the electronic health record for all residents.

An interview was completed with the Vice President of Clinical Operations, (VPCO) the Regional Director of Operations (RDO) and the Administrator on 2/28/22 at 4:16 PM. The VPCO stated that she was unable to locate the January testing logs and was certain that testing was done as there was evidence in the resident's electronic health record that families were called regarding results of positive cases in the facility of staff or residents. The VPCO stated that the emails from the Assistant Administrator were sent out that testing was completed. The VPCO stated that staff are tested in house on Tuesdays and Fridays and the process for agency staff should be providing evidence of testing results and giving it to the receptionist if they are not part of the routine testing cycle and all results should be in the book. If a staff does not have proof of a negative COVID-19 test it can be completed by any of the nurses at the facility.

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An interview and observation were completed with receptionist #1 on 3/1/22 at 2:30 PM who sated she works on Monday through Friday from 6:15 PM to 3:15 PM. She stated that she does not put any copy of COVID-19 test results into the binder and had not been instructed to ask for the COVID-19 results nor had any agency staff handed me a result or showed the results to me on the phone. Receptionist #1 stated that she screens all persons walking in the door and asked them if they are waiting on any COVID-19 results. An observation of the staff testing binder did not have COVID-19 results in the binder.

An interview was completed with receptionist #2 on 3/1/22 at 2:31 PM who sated she works nights on Monday through Friday from 2:45 PM to 11 PM and on Saturday and Sunday from 7:00 AM to 11 PM. Receptionist #2 stated that if facility staff she screens them but know they are tested in-house. For agency staff we would ask for their COVID-19 results and if they have been tested. Receptionist #2 stated she was unclear of the frequency of how often they are required to test but did ask to see their results and they usually have it on their phone. Receptionist #2 stated she had not written any results down nor was told to write any results down.

A second interview was completed with the DON on 3/1/22 at 2:58 PM who stated that agency staff are to show us a current COVID-19 test result and we would prefer that they bring in a copy. The DON was asked if these are given to the receptionist, and she stated that it really depends on the receptionist as some are non-confrontational. The DON stated that the facility is almost 98% agency staff so if a staff came in and did not show a recent COVID-19 test

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F 886	Continued From page 151 and the DON or other facility Nurses were not working on a particular weekend we would not know if they gave their information to the front desk. An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that once COVID-19 testing within 72 hours or as soon as possible would be scanned into a resident's electronic health record.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before	F 887		4/11/22

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F 887	Continued From page 152 requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to include the status for COVID-19 vaccination in the electronic health	F 887	On 3/20/2022 residents #34 covid vaccination status was updated in his electronic medical record by nursing	

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record (EHR) for 5 of 5 sampled residents (Resident #34, Resident # 55, Resident # 62, Resident #66, Resident #68), failed to include education regarding the COVID-19 vaccination in the EHR for 3 of 5 sampled residents (Resident # 55, Resident #66, Resident # 68), failed to document COVID-19 vaccination declinations for 3 of 5 sampled residents (Resident #55, Resident #66 Resident #68) and failed to administer and offer the COVID-19 vaccination to 1of 5 sampled residents (Resident #34).

Findings Included:

A review of the facilities policy titled COVID-19 Vaccination - Resident revised on 2/28/22 read in part; 12. COVID-19 vaccinations will be offered to residents when supplies are available, as per Center for Disease Control (CDC) and/or Federal Drug Administration (FDA) guideline unless such immunization is medically Contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. 15. The Facility may administer the vaccine directly or the vaccine may be administered indirectly through an arrangement with a pharmacy partner or local health department. 16. Prior to offering the COVID-19 vaccine, staff, residents, or the resident's representative, will be educated regarding the risks, benefits, and potential side effects associates with the vaccine in a form and manner that can be accessed and understood. 18. Resident or their representative and staff will sing the consent form prior to administration of the COVID-19 vaccine. This information will be retained in the resident's medical record or the staff's medical file. 20. Residents or resident representative retain the right to accept, refuse or change their decision about COVID-19

F 887

management

On 4/8/2022 resident # 55 covid vaccination status was updated in his electronic medical record by nursing management.

On 2/28/2022 resident # 66 covid vaccination status was updated in her electronic medical record by nursing management.

On 2/28/2022 resident # 62 and resident # 68 covid vaccination status was updated in their electronic medical record by nursing management.

Effective 4/9/2022 residents #55, #66, #68, #62 and # 34 received education on the Covid-19 vaccination and recorded into the electronic medical record by nursing management
Effective 4/8/2022 resident #55, #66, and #68 Covid vaccine declinations were signed and uploaded into electronic medical record by nursing management.

As of 4/11/2022 current residents were reviewed to ensure COVID-19 vaccine was documented in electronical record accurately and if a refusal was noted a declination was signed uploaded by nursing management Residents were offered the COVID-19 vaccine and a clinic is to be initiated on 4/11/2022.

On 3/10/2022, the nurse management educated current licensed nurses and agency nurses on offering covid-19

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immunization. If refused, the residents will adhere to the protocols set forth by specific facility policy. 22. The resident's medical record will include documentation of the following: a. Education to the resident or representative regarding the risks, benefits, and potential side effects of the COVID -19 vaccine; b. Each dose of the vaccine administered to the resident, or c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.

A review of the facilities resident's COVID-19 vaccinations was reviewed which included the date in which residents received the first dose, second dose, booster, and the provider of the COVID-19 vaccination. The spreadsheet revealed that out of 94 residents 27 had declined the vaccination. A sample list of five Residents were reviewed for COVID-19 vaccinations:

a. Resident # 34 was admitted to the facility on 12/7/21 with a diagnosis that included cerebral infarction. Resident #34's Minimum Data Set (MDS) dated 2/14/22 specified the resident's cognition as cognitively intact. The facilities vaccine spreadsheet indicated declined for Resident #34. A review of the resident's electronic health record (EHR) showed no COVID-19 vaccine status in the resident record.

b. Resident # 55 was admitted to the facility on 10/3/21 with a diagnosis that included non-pressure chronic ulcer. Resident #55's Minimum Data Set (MDS) dated 1/27/22 specified the resident's cognition as cognitively intact. The vaccine spreadsheet indicated declined for Resident #55. A review of the resident's (EHR) showed no COVID-19 vaccine status in the resident record.

F 887

vaccination to the resident to include documentation in the electronic medical record education to be completed by 4/11/2022.

Effective 4/11/2022 any new licensed nurses to include agency nurses will receive education on offering covid-19 vaccination to the residents to include documentation in the electronic medical record by nursing management.

As of 4/11/2022 Nurse management will audit 5 residents to ensure COVID-19 vaccine was offered with education and the response documented properly in the electronical record weekly x 12 weeks.

Director of Nursing will report findings to the Quality Assurance Improvement committee monthly x 3 months for any needed improvement.

Completion Date: 4/11/2022

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c. Resident # 62 was admitted to the facility on 1/10/22 with a diagnosis that included cardiorespiratory conditions. Resident #62's Minimum Data Set (MDS) assessment dated 12/13/21 specified the resident's cognition as cognitively intact. The vaccine spreadsheet indicated declined for Resident #62. A review of the resident's EHR showed no COVID-19 vaccine status in the resident record.
d. Resident # 66 was admitted to the facility on 1/8/22 with a diagnosis that included fibromyalgia. Resident #66's Minimum Data Set (MDS) assessment dated 1/21/22 specified the resident's cognition as cognitively intact. The vaccine spreadsheet indicated declined for Resident #66. A review of the resident's EHR showed no COVID-19 vaccine status in the resident record.
e. Resident # 68 was admitted to the facility on 5/20/19 with a diagnosis that included chronic respiratory failure. Resident #68's Minimum Data Set (MDS) assessment dated 1/24/22 specified the resident's cognition as cognitively intact. The vaccine spreadsheet indicated declined for Resident #68. A review of the resident's EHR showed no COVID-19 vaccine status in the resident record.

An interview was completed with the Assistant Administrator on 2/25/22 at 8:44 AM who stated that when a Resident is admitted to the facility the Admission Coordinator ensures a Residents vaccination status.
An interview was completed with the Director of Nursing (DON) on 2/26/22 at 4:46 PM who stated to her knowledge there were two residents who had declined the COVID-19 vaccine and that all the declinations should have been uploaded to

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the Residents EHR. The DON was told there were more that two residents who had declined and she stated that she was not aware of more than two Residents.

A request was made to the Vice President of Clinical Operations (VPCO) on Monday 2/28/22 at 9:30 AM requesting COVID-19 vaccine status for the five sampled residents due to no information included in the EHR.

An interview was completed with the Vice President of Clinical Operations, (VPCO) the Regional Director of Operations (RDO) and the Administrator on 2/28/22 at 4:16 PM who stated that the MDS Nurse had met with all the sampled residents and provided the surveyor with a list of the status of each resident. The VPCO stated that there were no declinations in the resident EHR records and was asked as to why they were not there. The VPCO stated she could not answer as to why they were not in the EHR. The VPCO stated that typically it is part of the admission process but there is a follow-up by the MDS Nurse, and they can also review the vaccines. The VPCO stated typically the Infection Preventionist would have been responsible for immunizations, and we can order any of the vaccines and have them here within the day.

An interview was completed with the MDS Nurse on 3/1/22 at 10:07 AM to review the status of the five sampled residents. The MDS Nurse stated that she had met with all residents on 2/28/22 regarding the COVID-19 vaccination and provided the following information: Resident #34 would like the COVID-19 vaccination, Resident # 55 declined the COVID-19 vaccination, Resident #62 had the immunizations prior, the MDS Nurse

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stated she was not able to locate the vaccination status and will have the Admission Coordinator (AC) to obtain the information from the hospital for Resident #62. Resident #66 declined the COVID-19 vaccination, Resident #68 had one dose of a multi dose series of the COVID-19 vaccination. The MDS Nurse stated that for those residents declined she entered consent refused in the resident's EHR under immunizations. The MDS Nurse was asked if the residents signed a declination form and the MDS Nurse stated she was not aware of a declination form. The MDS Nurse stated that when the immunizations came out the facility did provide education to the residents.

An interview was completed with the Admission Coordinator on 3/1/22 at 5:34 PM who was asked how she knows if a Resident has had a COVID-19 vaccination. The Admission Coordinator stated that she does have access to the hospital record for the Resident and will look it up that way and will document this under miscellaneous in the EHR and then send an admission email to nursing. The Admission Coordinator stated that if she would not have proof of vaccination the Resident would have to quarantine upon admission, and I reach out to the families to obtain a copy and bring it to the facility. The Admission Coordinator stated that the nurses will do the admission paperwork and she just get proof of the vaccination and would upload it to miscellaneous in the Residents EHR.

f. A review of Resident # 55, Resident #66, Resident # 68 revealed no education was included in the Residents EHR for the COVID-19 Vaccine.

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F 887		F 887		

Continued From page 158

g. A review of Resident #55, Resident #66, and Resident #68 (who declined the second dose of a multi dose series) EHR revealed there were no declinations included in the Residents EHR for the COVID-19 vaccine.

h. A review Resident #34's EHR revealed no immunizations found under immunizations in the EHR and was listed as declined on the facilities vaccine spreadsheet.

An interview was completed with the Director of Nursing (DON) on 2/24/22 at 1:58 PM. The DON stated that if a resident is alert and oriented, they are provided education and a consent form for the COVID-19 Vaccination. The pharmacy would come to the facility once we have 10 residents. If there are fewer than 10 residents, we would look into other options such as another pharmacy that would not require 10 people for the vaccine. The DON stated that she was not aware that residents wanted the vaccines and were not getting them.

An Interview was completed with Resident #34 on 3/1/22 at 4:44 PM who stated that he had told someone that he is willing and able to have all the vaccinations. Resident #34 stated that when he inquired about the COVID-19 vaccination he had been told he had to get on a list as they needed so many people to do the COVID-19 vaccine. Resident #34 could not remember who he had told but remembered he had asked quite some time ago. Resident #34 stated that since his admission he had been quarantined three times, the first time when I was admitted, the second time I was exposed by someone who had been COVID-19 positive and then he had COVID-19.

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F 887	Continued From page 159 An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that all staff is to be fully vaccinated but for Residents upon admission they would have the opportunity to decline or accept and we would want to provide the Vaccine as soon as possible.	F 887		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting	F 888		4/11/22

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F 888	Continued From page 160	F 888		

and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an

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F 888	Continued From page 161 exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and	F 888		

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F 888	Continued From page 162 (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccinations status of 5 of 9 staff reviewed for COVID-19 Vaccination Status. (Nurse#2, Nurse #12, Nurse #13, Nurse Aide #7, and Nurse Aide #8) Findings Included: A review of the facilities policy titled Employee COVID-19 Vaccination Mandate Policy, revised on 12/28/21 read in part; 14. Accordius Health will track and securely document the vaccination status of each staff member (current and as new employees are onboarded), to include copies of vaccination records. A review of the facilities staff vaccination spreadsheet was reviewed. The spreadsheet included in-house staff, staff exemptions, and contract/agency staff. A review of the facilities employee list with phone numbers and employee title revealed that not all employees on the phone	F 888	There was no affected resident for this citation. All residents have the potential to be affected by this citation. All NHSN information has been completed by the Administrator and updated as of 4/11/2022 Administrator will update the NHSH weekly to ensure updated reporting beginning 3/28/2022. On 3/28/2022 the Regional Director of Operations educated Administrator on covid 19 reporting on NHSH report for Covid 19 reporting of vaccination and tracking. On 3/10/2022 receptionist staff were educated by the Regional Director of Operations on Covid 19 vaccination tracking to ensure all staff entering the facility must have proof of vaccination	

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F 888	Continued From page 163 list were on the COVID-19 vaccination list for staff. A review on 2/27/22 of the National Healthcare Safety Network (NHSN) data week ending on 2/13/22 revealed the following staff vaccination information: Recent Percentage of Staff who are Fully or Partially Vaccinated = 98.7% Recent Percentage of Staff who are Fully Vaccinated = 83.5% Recent Percentage of Fully Vaccinated Staff Who Received a Booster Dose = 6.1% An interview was completed with the Assistant Administrator (AA) who was asked how he ensures that HCP who are working are vaccinated. The AA stated that for HCP we ask that they bring in a copy of their card and each receptionist (screener) has access to the vaccination spreadsheet and well as the binder where the copies of the COVID-19 vaccination cards are kept for all staff. The AA was asked who had access to the binder and the AA stated that the two screeners, the AA, the business office manager, and the Administrator had access to the binder. A request was made to review the binder of the COVID-19 vaccination cards. The AA brought in the binder on 2/25/21 at 9:18 AM and stated that there were a lot of miscellaneous copies of vaccination records that have not been sorted into the binder. An observation of the binder had several copies of vaccination records inside of an inner pocket in the binder and had different sections for in-house staff and agency. The AA was asked who was responsible for reporting to National Healthcare Safety Network (NHSN) and he stated that he was but had not	F 888	status prior to starting their first shift. Effective 4/11/2022 Nurse management will audit 5 staff members 3 x weekly x 4 weeks and weekly x 8 weeks to validate covid-19 vaccine status and NHSN reporting accuracy. Administrator will report findings to the Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months. Completion date: 4/11/2022	

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F 888	Continued From page 164	F 888		

been at the facility for three to four weeks as he was at a sister facility. The AA was asked who had been reporting to NHSN for the facility during his absence and he stated that he had been but had not had any updates in the 3-4 weeks from the vaccination spreadsheet/log but he knew periodically there were COVID-19 vaccination records that were added as when he came back to the facility, he had done a quick audit of the binder and the binder was thicker. The AA stated that the last 3-4 weeks he had been reporting the same data to NHSN. The AA was asked if the receptionist would let him know if she was adding a new HCP COVID-19 vaccination records in the binder and he stated that it is part of her job to add them to the binder and she has access to the spreadsheet which is used to report to NHSN but some receptionist are on second and third shift and may not have access to the spreadsheet but they are putting it into the binder. The AA stated that ultimately, he takes charge of the spreadsheet.

An interview was completed with Receptionist #1 on 2/25/22 at 3:13 PM who stated that when a new HCP member would come in from an agency, they are asked for their vaccination card, if they don't have one, she would ask if they had a picture on their phone and then they could email to the receptionist at the facility, and it would get printed off. Receptionist #1 stated they cannot work on the floor until we have proof of COVID-19 vaccination. Receptionist #1 stated that once she had a copy it goes in the binder. Receptionist #1 stated that she does have access to the COVID-19 spreadsheet but since the AA had been at another facility, she had not had training on how to update the spreadsheet and had not put any of the new HCP on the spreadsheet.

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Receptionist #1 stated that she had not been instructed to tell anyone when a new HCP is added and had not been instructed to update the spreadsheet, but just to make sure a copy of the vaccination status is in the binder.

A phone interview was completed with Nurse Aide (NA) #7 on 2/27/22 at 4:11 PM who had worked for the facility for the last 20 years. During the phone interview it was observed NA #7 was not on the vaccination spreadsheet. NA#7 was asked if she had submitted her vaccination status to the facility and she sated yes, she had and that the previous Director of Nursing (DON #1) had asked her for her vaccination card, and she gave it to her. NA #7 was on the employee phone list.

A further review of staff schedules and the staff vaccination spreadsheet revealed four staff (Nurse#2, Nurse #12, Nurse #13, and NA#8) who had worked had not been included on the staff vaccination spreadsheet. A request was made to the Vice President of Clinical Operations, (VPCO) to inquire of the vaccination status for the following HCP (Nurse#2, Nurse #12, Nurse #13, and NA#8).

An interview was completed with the Vice President of Clinical Operations, (VPCO) on 2/28/22 at 11:10 AM who stated that she had called out to the staff that were not on the vaccination spreadsheet to obtain their vaccination cards.

An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that it would be his expectation that the facility maintain a copy of their current card that reflects the most current vaccination and maintain that

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F 888	Continued From page 166 and available for review.	F 888		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interviews, the facility failed to maintain an orderly environment by having cigarette butts scattered throughout the outdoor patio area in the smoking area and failed to keep an outdoor canopy tent (used for shelter) functional that was torn and is disrepair observed in the smoking area for residents. This had the potential to affect residents that smoke. Findings included: A review of a list of smokers revealed the facility had 9 unsupervised smokers. An observation of the smoking area on 2/21/22 at 12:46 PM revealed over 100 cigarette butts scattered on the outdoor patio and on the wet pine needles. The patio had two outdoor plastic receptacle ashtrays located on the patio. The patio had an outdoor canopy tent (approximately 10X 10 feet) that was on the patio that had a large tear, had come unattached from one of the posts and no longer useable as a canopy. An observation of the smoking area on 2/24/22 at 12:24 PM revealed over 100 cigarette butts scattered on the outdoor patio and on the wet	F 921	The facility had no affected resident identified for this citation. All residents have the potential to be affected by this citation. Facility Maintenance Director removed the canopy tent and cigarette butts from the resident smoking area as of 3/21/2022. 4/7/2022 Administrator re-educated the Maintenance Director and maintenance assistant on keeping the smoking area free of cigarette butts and any broken equipment. Effective 4/06/2022 Maintenance Director will monitor the smoking area 3 x weekly x 4 weeks and weekly x 8 weeks for any equipment that is in need of repairs and for cigarette butts in the smoking area. Maintenance Director will report findings to the Quality Assurance Performance Improvement committee for any needed improvement monthly x 3 months. Completion date: 4/11/2022	4/11/22

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pine needles. The patio had two outdoor plastic receptacle ashtrays located on the patio. The patio had an outdoor canopy tent (approximately 10X10 feet) that was on the patio that had a larger tear, had come unattached from one of the posts and no longer useable as a canopy.

An interview was completed with Resident #30 who was a smoker on 2/24/22 at 12:47 PM who reported she used the designated smoking receptacles for discarding cigarette butts. She added that not all residents used the designated smoking receptacles when discarding cigarette butts.

An observation and interview with the Maintenance Director on 2/25/22 at 10:25 AM was completed of the smoking area for residents. Several cigarette butts were scattered on the patio and on the pine needles. The Maintenance Director was asked how he thought it looked and he stated that it looked awful and had just picked up the butts a few days ago and was not sure what to do about it. The Maintenance Director Maintenance Director stated that canopy had been ripped since it had snowed, and he believed the snow cause the canopy to rip. The Maintenance Director stated that as soon as the weather gets nice, he would be throwing it away.

An observation and interview with the Administrator were completed on 2/25/22 at 10:58 PM of the smoking area for residents. The Administrator stated that he had been made aware of the cigarette butts on the patio. During the observation with the Administrator of the smoking area the MD and his assistant had removed all the cigarette butts and the Administrator stated he would be having the pine

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F 921	Continued From page 168 needles removed and replaced with red rock to avoid a fire hazard. An interview was completed with the Administrator on 3/3/22 at 2:16 PM who stated that the smoking area should be maintained and kept clean and orderly. The cigarette butts should be disposed of properly and provide and adequate number of ashtrays for residents to use.	F 921		