DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital f/t Chronically Ill (DHCI) **DATE SURVEY COMPLETED: February 22, 2022**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint survey was conducted at this facility from February 14, 2022 through February 22, 2022. The facility census the first day of the survey was 85. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 22, 2022: F568, F609, F610, F641, F644, F656, F698, F758, and F812.	**3201.1.2** Cross Refer to the CMS 2567-L survey completed February 22, 2022: F568, F609, F610, F641, F644, F656, F698, F758, and F812	3/18/2022

Provider's Signature __Geraldine Stewart _RN________ Title__LTC Section Chief_________ Date _3/11/22 ____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING ______ B. WING ______	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	**100 SUNNYSIDE ROAD SMYRNA, DE 19977**

(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 000	INITIAL COMMENTS	F 000		

An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from February 14, 2022 through February 22, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census on the first day of the survey was 85. The sample size was 25.

Abbreviations and Definitions used in Survey:

NHA - Nursing Home Administrator;
CNA - Certified Nursing Assistant;
DON - Director of Nursing;
RN - Registered Nurse;
LPN - Licensed Practical Nurse;
MD - Medical Doctor;
OSS- Operations Support Specialist;
RD (Registered Dietitian) - A food and nutrition expert who helps individuals make smart dietary and lifestyle choices;
RNAC - Registered Nursing Assessment Coordinator;
UM - Unit Manager;
WCN - Wound Care Nurse;

Definitions:

AIMs Test (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long term treatment with antipsychotic medications;
Dialysis - a process of filtering and removing waste products from the bloodstream;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/18/2022

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 000	Continued From page 1 Eschar - dead skin covering a pressure injury or ulcer; MDS (Minimum Data Set) - standardized assessment forms used in nursing homes; PASARR (Preadmission Screening and Resident Review) - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care; PTSD (Post-traumatic stress disorder) - a mental health condition that's triggered by a terrifying event - either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event; PRN - as needed; Representative payee - appointed to accept disability or Social Security payments on behalf of someone incapable of managing their benefits; Seizure disorder - abnormal electrical activity in the brain causing repetitive muscle jerking; Seroquel - A medication used to control symptoms related to mental disorders; Slough - Dead stringy tissue covering a pressure injury or ulcer; Stages of pressure ulcers - Stage 3 - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; Stage 4 - ulcer that has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Unstageable - tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue in the wound bed); Valium - medication used for anxiety and to stop seizures.	F 000		

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F 568	Continued From page 2	F 568		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide two (R18 and R78) out of four residents reviewed for personal funds with quarterly statements of resident funds. Findings include: September 2013 - The facility policy provided by E9 (Financial Determination Administrator) included that quarterly personal funds statements "Will be sent to a client or their legal or responsible representative." 1. Review of R78's clinical record revealed: 11/17/98 - R78 was originally admitted to the facility. 1/7/22 - An Annual MDS (Minimum Data Set) assessment documented that R78 was moderately cognitively impaired with poor decision-making skills.	F 568	Individual/Resident Impacted A. The facility failed to provide two (R18 and R78) out of four residents reviewed for personal funds with quarterly statements of resident funds. The facility immediately corrected this deficient practice by providing a copy of the quarterly statement of resident funds to the resident representatives for R18 and R78. All staff in the Financial Determination Section will receive a refresher in-service on the requirement to provide quarterly statements of resident funds to the resident or to their legal or responsible representative by the Financial Determination Administrator or designee. B. All residents in the facility have the potential to be affected by this deficient	4/5/22

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F 568	Continued From page 3 2/14/22 3:45 PM - During an interview, R78 stated "No. I don't get statements. They [the facility] robbed me! I went from $3,000 to nothing!" 2/22/22 1:55 PM - During an interview with E9, it was revealed that the facility does not send quarterly personal funds statements to FM2 (resident representative for R78) because the facility is R78's representative payee. E9 stated that she was not aware that a resident representative / guardian needs to receive quarterly statements if the facility was the resident's representative payee. 2. Review of R18's record revealed: 12/3/21 - A quarterly MDS assessment documented that R18 was severely cognitively impaired. 2/14/22 1:30 PM - In an interview, FM1 (POA and resident representative for R18) reported that no financial statements had ever been mailed to her by the facility. 2/17/22 12:07 PM - During an interview, E9 (Financial Determination Administrator) said that FM1(R18's POA) had not been mailed R18's account statement because FM1 was not listed as the financial contact for R18. 2/17/22 2:00 PM - A facility policy provided by E9 stated that R18's financial account statements will be provided to the resident or the resident's representative quarterly. 2/22/22 2:30 PM - Findings were reviewed with	F 568	practice. The Financial Determination Administrator reviewed all residents□ financial records on 02/14/22 to identify residents or their legal or responsible representatives to whom quarterly statements of resident funds are to be provided. Residents or their legal or responsible representatives who were identified will be provided with their quarterly statement of resident funds at the beginning of the next quarter in 04/2022. C. The root cause of this deficient practice was the facility□s failure to follow the facility□s policy related to the requirement of providing quarterly statements of resident funds to the resident or to their legal or responsible representative if the facility was the residents□ representative payee. In response to this citation, the Financial Determination Section has revised their process to ensure that each resident has an individual who has been identified and listed to receive quarterly statements of resident funds using the Quarterly Statement Checklist (See Attachment #1). The Quarterly Statement Checklist will include a listing of all residents and the type, name, and relationship of the identified representative to whom the quarterly statements of resident funds are to be provided. The Quarterly Statement Checklist will be reviewed and signed by Financial Determination Section staff to validate that the quarterly statements of resident funds were provided for each	

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F 568	Continued From page 4 E1 (NHA) and E2 (DON) during the exit conference.	F 568	resident which will be forwarded to the Nursing Home Administrator for review. D. The Financial Determination Administrator or designee will review all Quarterly Statement Checklists for completion for four (4) consecutive quarters to verify that quarterly statements of resident funds were provided for each resident. Any quarterly statements of resident funds not provided for each resident will be communicated to the Nursing Home Administrator (NHA). The (NHA) will immediately address any deficient practices identified with appropriate corrective actions. The (NHA) or designee will meet with the Financial Determination Administrator quarterly to review the completed Quarterly Statement Checklists to ensure that all residents or their legal or responsible representatives have been provided with their quarterly statements of resident funds for 100 percent compliance for three (3) consecutive quarters. The findings will be discussed at the monthly QAPI Committee meetings. When the facility reaches 100 percent compliance for three (3) consecutive quarters, then the facility will conclude that we have successfully addressed this cited deficient practice.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		4/5/22

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F 609	Continued From page 5 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and other facility documentation, it was determined that for two (R31 and R78) out of two residents reviewed for abuse, the facility failed to immediately report allegations of abuse. Findings include: A facility policy entitled "Protection from Abuse and Responding to Reportable Incidents" (last revised 4/1/21) included: c. "Immediately shall mean as soon as the situation is stabilized (e.g., actions have been taken to provide treatment, comfort and safety of residents involved.	F 609	Individual/Resident Impacted Item 1 and 2 A. The facility failed to immediately report an allegation of abuse to the state survey agency for (R31 and R78) out of two residents reviewed. Once this deficient practice was brought to the attention of the facility, the Director of Nursing (DON) immediately reminded all Nursing Supervisors about the importance of timely reporting of incidents to the state survey agency. Additionally, the NHA will	

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F 609

Continued From page 6

1. Not later than 2 hours if the alleged violation involves abuse."

Cross refer F610

1. Review of R31's clinical record revealed:

2/22/05 - R31 was admitted to the facility with a brain injury.

1/30/22 11:15 AM - An incident report submitted to the State Agency documented that on this date and time R31 reported to the facility, "Resident stated that his CNA 'verbally abuses me.' She calls me stupid and that I am full blown schizophrenic and that is in my file. She told me I did this to myself. She was talking about the kidney disease."

1/31/22 1:13 PM - The 1/30/22 incident was reported to the State Agency approximately twenty-six hours later.

2/17/22 11:45 AM - During an interview, E11 (Charge Nurse) confirmed the incident occurred on a weekend and it was reported to the Supervisor. The facility incident report was then prepared by E12 (RN Supervisor) on 1/31/22 at 11:30 AM. E12 reported the incident to the State agency on 1/31/22 at 1:13 PM.

2. Review of R78's clinical record revealed:

11/17/98 - R78 was admitted to the facility with a stroke and dementia.

2/14/22 3:45 PM - During an initial interview, a State Surveyor asked R78 if he has ever been abused and he said two CNAs hit him a couple of

F 609

provide a refresher in-service to the Assistant Hospital Director,(DON), Nursing Supervisors, Hospital Administrator I, Assistant Director of Nursing (ADON) and Quality Assurance staff regarding time frame for reporting allegations of abuse to the state survey agency by 04/05/2022.

B. All residents have the potential to be affected by this deficient practice in which the facility failed to immediately report an allegation of abuse to the state survey agency. All supervisors have been instructed to immediately report any allegation of abuse to the state survey agency. In addition, supervisors will immediately report all allegations of abuse to the NHA, Nursing administration and the Quality Assurance Administrator (QAA) to ensure compliance.

C. The root cause of this deficient practice was the facility□'s failure to follow the Incident report policy and procedures related to timely reporting of allegations of abuse. The NHA, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and the QAA will review the shift reports for all three shifts (24-hour supervisor□s report), to identify any incident reports of abuse and to determine if they were timely reported to the state survey agency. Appropriate corrective action will be taken towards individuals who failed to follow the facility□s policy for timely reporting. All Supervisors, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and

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F 609	Continued From page 7 weeks ago. 2/14/22 approximately 4:10 PM - A facility internal incident report included: Per survey team member, the resident reported he was abused two weeks ago when she asked him "Have you been abused?" The Surveyor immediately reported the allegation of abuse. 2/16/22 1:39 PM - An email to SS1 (DHCQ - Division of Healthcare Quality Investigator) composed by E13 (Quality Assurance Administrator) included that on 2/14/22 a State Surveyor completed an interview with R78 as part of the annual licensing survey. During the interview, R78 shared that he had been abused. After the interview, the State Surveyor shared the allegation of abuse with the facility Nursing Supervisor. 2/16/22 2:35 PM - An email reply to the facility from SS1 (DHCQ Investigator) included: "I have checked our IRC complaint system and there is no recent facility reported incident for abuse regarding R78 ... However, our office will still need an Incident Report from your facility regarding the initial allegation (of abuse) made on 02/14/22." 2/21/22 1:30 PM - During an interview, E10 (Hospital Administrator) and E1 (Nursing Home Administrator) confirmed that the incident had not yet been formally reported to the State Agency. E1 stated that SS1 (DHCQ Investigator) was emailed regarding the incident. E1 and E10 reported they thought that after the Surveyor reported the incident to the facility, the Surveyor would formally report the allegation of abuse by R78 to the State Agency.	F 609	Quality Assurance staff will receive a refresher in-service regarding timely reporting of incidents to the state agency by the Nursing Home Administrator by 04/05/2022. D. The NHA, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and the QAA will review any incident reports of abuse daily to ensure timely reporting to the state survey agency. The NHA will immediately address any deficient practices identified with appropriate corrective actions. The Continuous Quality Improvement Nurse (CQI RN III) and QAA will generate a comprehensive monthly report to the QAPI Committee to identify any reportable incidents, possible trends, problem areas, and recommended corrective actions. These reports will be reviewed at the monthly QAPI Committee meeting and the quarterly QAPI Steering Committee meetings for 100 percent accuracy for ten (10) consecutive weeks and then monthly for three (3) consecutive months. If 100 percent compliance is achieved after three (3) consecutive months, then the facility will conclude that they have successfully addressed this cited deficient practice.	

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F 609	Continued From page 8 2/22/22 12:01 PM - The facility to immediately report an allegation of abuse. 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R31) out of two residents reviewed for abuse, the facility failed to immediately put measures in place to ensure further potential abuse. In addition, the facility failed to thoroughly investigate R31's allegation of abuse. Findings include:	F 610	Individual/Resident Impacted A. The facility failed to thoroughly investigate an allegation of abuse for one (R31) out of two residents reviewed for abuse. The facility failed to immediately put measures into place to ensure any further potential abuse to any residents.	4/5/22

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F 610

Continued From page 9

A facility policy entitled "Protection from Abuse and Responding to Reportable Incidents" (approved 4/1/21) included: Prevention: "Prevent further potential abuse ...while an investigation is in progress."

Cross refer F609

1. 2/22/05 - R31 was admitted to the facility with a brain injury.

a. 1/30/22 11:15 AM - An incident report submitted to the State Agency documented that on this date and time R31 reported to the facility, "Resident stated that his CNA (E21) 'verbally abuses me.' She calls me stupid and that I am full blown schizophrenic and that is in my file. She told me I did this to myself. She was talking about the kidney disease."

1/30/22 - Review of the facility CNA resident assignment sheet confirmed that E21 (CNA) worked on the 7:00 AM to 3:00 PM shift and was assigned to R31. Review of the electronic employee time stamps for time worked on 1/30/22 revealed that E21 clocked in at 7:00 AM and clocked out at 3:00 PM. The allegation of abuse occurred at 11:15 AM and E21 remained at the facility until 3:00 PM. E21 was removed from R31's care assignment, but remained in the facility caring for other residents.

2/4/22 - A 5 day follow up submitted to the State Agency by the facility included in the root cause analysis that the CNA was immediately reassigned and removed from the resident's care.

2/17/22 10:37 AM - During an interview, E11

F 610

Once this deficient practice was brought to the attention of the facility, the DON immediately reminded all Nursing Supervisors about the importance of thoroughly investigating all allegations of abuse as well as immediately removing the accused staff from all resident care areas to prevent any further potential abuse to any residents. Additionally, the NHA will provide a refresher in-service to the Assistant Hospital Director, DON, Nursing Supervisors, Hospital Administrator I, ADON and Quality Assurance staff regarding the importance of thoroughly investigating all allegations of abuse as well as putting measures into place to prevent any further potential abuse to any residents by 04/05/22.

B. All residents have the potential to be affected by this deficient practice in which the facility failed to thoroughly investigate an allegation of abuse for R31 and failed to immediately put measures into place to ensure any further potential abuse to any residents. All Supervisors have been instructed to immediately investigate allegations of abuse and remove the accused staff from all resident care areas pending the completion of the investigation.

C. The root cause of this deficient practice was the facility□s failure to follow the Protection from Abuse and Responding to Reportable Incidents policy related to thoroughly investigating and removing accused staff from all resident care areas to prevent any further abuse to

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F 610	Continued From page 10 (Charge Nurse) confirmed that E21 (CNA) was reassigned and removed from R31's care after the allegation of abuse, but worked the rest of the shift providing resident care. E11 added that two CNA's just "swapped their assignment" to have someone else care for R31. The facility failed to protect R31 and/or other residents from further potential abuse. b. A facility policy entitled "Protection from Abuse and Responding to Reportable Incidents" (last approved 4/1/21) included: Investigation - Interview all potential witnesses. Review of the facility investigation related to R31's allegation of abuse on 1/30/22 revealed that only E21 (CNA) and E11 (Charge Nurse) provided written statements. No other staff working on R31's unit provided statements. The facility failed to thoroughly investigate R31's allegation of abuse. 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 610	any residents. The NHA, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and the QAA will review the shift reports for all three shifts (24-hour Supervisor□s report), to identify any incident reports of abuse and to determine if they were thoroughly investigated and the accused staff was immediately removed from all resident care areas. Appropriate corrective action will be taken towards individuals who failed to follow the facility□s policy on abuse and neglect. All Supervisors, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and Quality Assurance staff will receive a refresher in-service by the NHA regarding thoroughly investigating incidents of abuse and removing accused staff from all resident care areas by 04/05/2022. D. The NHA, Assistant Hospital Director, DON, ADON, Hospital Administrator I, and the QAA will review any incident reports of abuse daily to ensure they were thoroughly investigated and accused staff were immediately removed from all resident care areas to prevent any potential abuse to any residents. The NHA will immediately address any deficient practices identified with appropriate corrective actions. The CQI RN III and QAA will generate a comprehensive monthly report to the QAPI Committee to identify any reportable incidents, possible trends, problem areas, and recommended corrective actions. These reports will be reviewed at the monthly QAPI Committee meetings and the quarterly QAPI Steering	

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F 610	Continued From page 11	F 610	Committee meetings for 100 percent accuracy for ten (10) consecutive weeks and then monthly for three (3) consecutive months. If 100 percent compliance is achieved after three (3) consecutive months, then the facility will conclude that they have successfully addressed this cited deficient practice.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R22) out of two residents reviewed for pressure wounds, the facility failed to complete accurate MDS assessments. Findings include: A review of MDS assessments 4/23/21 (annual), 9/17/21 and 12/3/21 (quarterly) documented that R22 had a stage 3 wound and an unstageable wound. 2/14/22 11:12 AM - During an interview, R22 stated she had a wound on her "bottom" that the facility was treating. 2/16/22 10:30 AM - During a wound care observation performed by E5 (WCN), R22 had a wound on the left hip area with depth down to the bone. 2/16/22 11:29 AM - During an interview, E5 (WCN) stated that R22 had the stage 4 left hip	F 641	Individual/Resident Impacted A. The facility failed to complete accurate MDS assessments for one (1) R22 out of two (2) residents reviewed for pressure wounds. The annual and quarterly MDS assessements for R22 were corrected and submitted by the Registered Nurse Assessment Coordinator (RNAC). (See Attachment #2). B. All residents with wounds have the potential to be affected by this deficient practice of failing to complete accurate MDS assessments. A review of section M of the MDS assessments for previously submitted quarterly and annual MDS for all residents with wounds was completed to ensure accuracy. C. The root cause of this deficient	4/5/22

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F 641	Continued From page 12 wound for over a year. E5 said that a wound care company had also been treating the resident for this chronic "Stage 4 wound." 2/16/22 11:56 AM - During an interview, E6 (RNAC) confirmed that she had made "an error" when coding R22's pressure wound and confirmed the three MDS assessments were coded inaccurately. 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 641	practice is knowledge deficit related to coding of section M of the MDS assessments. The RNAC failed to validate the wound care documentation prior to submitting the Quarterly and Annual MDS. The RNAC will be in-serviced by the DON or designee by 04/05/22 on how to validate documentation to assist with accurate assessments and coding of section M of the MDS. D. The RNAC will meet with the Wound Care Nurse (WCN) or designee prior to the weekly Interdisciplinary Team (IDT) meeting to validate wound assessments and documentation. The DON or designee will review section M of the MDS to ensure accurate assessments weekly at the interdisciplinary clinical team meeting for ten (10) consecutive weeks with 100 percent compliance. Additionally, the Continuous Quality Improvement nurse (CQI RN III) or designee will complete 100 percent audits of section M of the MDS using the Nursing Services Audit Tool (See Attachment #3) for residents with wounds to ensure 100% accurate MDS assessments for ten (10) consecutive weeks. Thereafter, audits will continue on a monthly basis for three (3) consecutive months to ensure 100 percent compliance. Any deficient practice found during the audits will be reported to the DON for appropriate corrective action. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will	

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F 641	Continued From page 13	F 641	conclude that we have successfully addressed this cited deficient practice.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R4) out of one resident reviewed for PASARR (Preadmission Screening and Resident Review), the facility failed to refer R4 with newly evident or possible serious mental disorder(s) for a PASARR level II resident review. Findings include: Review of R4's clinical record revealed: 11/6/00 - A PASARR Level I analysis was completed prior to R4's admission to the facility	F 644	Individual/Resident Impacted A. The facility failed to refer one (1) resident (R4) with newly evident or possible serious mental disorder(s) for a PASRR level II resident review. Once the deficient practice was brought to our attention, the Hospital Social Services Administrator II (HSSA II) immediately submitted a PASRR review to the PASRR Unit for R4 on 03/03/22.	4/5/22

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F 644	Continued From page 14 and determined that a nursing home admission was necessary. R4 had PTSD (post-traumatic stress disorder), chronic adjustment disorder and depression. R4 was prescribed medication to treat depression. 6/13/02 - R4 was admitted to the facility. 2/21/22 9:40 AM - During an interview, E26 (SW) confirmed that no PASARR's had been submitted to the State since R4 was admitted to the facility in 2002. 2/21/22 10:00 AM - During an interview, E8 (Pharmacist) confirmed that R4 had three antipsychotic medications since 2016 for bipolar mood disorder and borderline personality disorder, including Seroquel originally ordered 2/21/19, Zyprexa from 2016 - 2019 and Risperidone from January - September 2016. 2/22/22 10:29 AM - SS2 (State PASARR Supervisor) confirmed that the facility should have referred R4 for a PASARR level II resident review when he had new psychiatric diagnoses and antipsychotic medications were prescribed. 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 644	B. Identification of other Residents All residents have the potential to be affected by this deficient practice. A review of all residents□ medical charts was completed on 3/3/22 to verify any significant changes related to any newly evident or possible serious mental disorder(s) that would require a PASRR level II resident review. All residents identified as needing a PASRR review will be referred to the PASRR Unit by 04/05/22. C. System Changes The root cause of this deficient practice is a failure to follow the PASRR program□s procedures for referring all residents with newly evident or possible serious mental health disorder. To address this deficient practice, the facility□s 24-hour Nursing Report will now include notation of any changes in diagnosis and medications. The DON or designee will initiate a weekly clinical team meeting to review residents□ medical records for any changes made to diagnoses and/or medications that could initiate a PASRR level II resident review prior to their next scheduled Interdisciplinary (IDT) meeting. If it is determined that a PASRR level II review is needed, Social Services will initiate a referral to the PASRR Unit. Social Services and Nursing Staff will receive a refresher in-service on PASRR review from the Division of Medicaid and Medicare Unit by 04/05/2022. D. Success Evaluation The Neurobehavioral Health (NBH) Unit	

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F 644	Continued From page 15	F 644	Nurse Manager and Nursing Supervisors or designees will review and monitor residents medical charts for significant changes related to any newly evident or possible serious mental disorder(s) daily. Any findings will be reported to the HSSA II or designee for review and possible referral to the PASRR Unit. The Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random audits on 25 percent of all residents identified as needing a PASRR review weekly using the Nursing Services Audit Tool (See Attachment #3) to ensure 100% compliance for ten (10) consecutive weeks. Thereafter, random audits will continue monthly for three (3) consecutive months to ensure 100 percent compliance. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will conclude that we have successfully addressed this cited deficient practice.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		4/5/22

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F 656	Continued From page 16 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R31) out of 20 sampled residents investigated for comprehensive care plans, the facility failed to initiate a comprehensive care plan to monitor R31's dialysis catheter. Findings include:	F 656	Individual/Resident Impacted A. The facility failed to initiate a comprehensive care plan to monitor R31s dialysis catheter. R31s care plan was immediately updated on 03/03/22 to include interventions to monitor the	

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F 656	Continued From page 17 Cross refer F698 1. Review of R31's clinical record revealed: 2/22/05 - R31 was admitted to the facility with a brain injury and dialysis was initiated related to kidney disease. 8/28/21 - A doctor's order included: I attend dialysis with (said Dialysis Center) on Mondays, Wednesdays and Fridays at 9:40 AM. 2/4/22 - Although R31's care plan included that R31 had a dialysis catheter in his right upper chest, there were no interventions in place to monitor it for an intact dressing or complications. 2/16/22 12:45 PM - During an interview, E14 (Unit Manager) confirmed there was not a comprehensive care plan to monitor R31's dialysis catheter. 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 656	dressing for potential complications. B. All residents that have dialysis catheters have the potential to be affected by this deficient practice of not initiating a comprehensive care plan to include interventions for monitoring. A review of all care plans for residents with dialysis catheters was completed by the Care Plan Coordinator on 03/03/22 to ensure that the care plans included interventions to monitor the dressings for potential complications. C. The root cause of this deficient practice is failure of the nurse to develop a comprehensive care plan to include interventions for monitoring the dressing for potential complications. All licensed nursing staff will receive a refresher in-service by the Director of Nursing (DON) and the Trainer Educator III RN related to the development of a comprehensive care plan to include monitoring dressings for potential complications. D. The Unit Managers or designees will review and update all care plans that are due for each week prior to the weekly clinical team meeting to ensure that care plans are comprehensive to include interventions. The Interdisciplinary Team (IDT) meeting Coordinator or designee will review all care plans after each weekly IDT meeting to ensure that interventions are in place. Any deficient practices identified will be reported to the DON for appropriate corrective action. The	

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F 656	Continued From page 18	F 656	Continuous Quality Improvement Nurse (CQI RN III) will audit 25 percent of the care plans on a rotating schedule of the residents discussed weekly in IDT to determine if the updated interventions have been added to the care plans using the Nursing Services Audit Tool (See Attachment #3). These audits will be completed weekly for ten (10) consecutive weeks, and then monthly for three (3) consecutive months. The results of these audits will be reported at the monthly QAPI committee meetings. If the audits indicate 100 percent compliance after four (4) consecutive monthly reviews, then the facility will conclude that we have successfully addressed this cited deficient practice.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R31) out of one sampled residents reviewed for dialysis, the facility failed to monitor R31's dialysis catheter and failed to consistently monitor R31's before (pre) and after (post) dialysis weights. Findings include: Review of R31's clinical record revealed:	F 698	Individual/Resident Impacted A. The facility failed to monitor R31□s dialysis catheter and to consistently monitor R31□s pre- and post-dialysis weights. A reminder was provided to the Certified Nursing Assistants (CNAs) by the Unit Managers on the importance of completing pre- and post-dialysis weights.	4/5/22

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Continued From page 19

2/22/05 - R31 was admitted to the facility with a brain injury and dialysis was initiated related to kidney disease which required a dialysis catheter.

11/20/20 - A physician's order included: Weights three times per week Monday, Wednesday and Friday morning.

Review of R31's Dialysis Communication forms revealed:

-12/6/21; 1/7/22; 1/19/22; and 1/26/22 - no post dialysis weights.
-12/27/21 - no pre or post dialysis weights.
-2/9/22 - no pre dialysis weight.

02/16/22 12:45 PM - During an interview, E14 (Unit Manager) confirmed there was no physician's order to monitor R31's dialysis catheter.

2/17/22 10:05 AM - During an interview, E14 confirmed there were missing dialysis weights on the aforementioned dates. E14 stated that the facility was responsible for pre dialysis weights and the dialysis center was responsible to record post dialysis weights in R31's dialysis communication book.

2/17/22 10:26 AM - During an interview, E11 (Charge nurse) confirmed that the facility does not weigh R31 after dialysis or contact the dialysis center to follow up on post dialysis weights.

2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

F 698

Additionally, a physician□s order was obtained to monitor the dialysis catheter site each shift, and a treatment administration record was initiated. Licensed nursing staff were reminded by the Unit Managers about the importance of monitoring dialysis catheters and obtaining pre- and post-dialysis weights.

B. All residents have the potential to be affected by this deficient practice regarding not obtaining pre- and post-dialysis weights and not monitoring dialysis catheters for potential complications. A physician□s order was obtained for monitoring the dialysis catheter and a treatment administration record was initiated. CNAs received a reminder to obtain pre- and post-dialysis weights.

C. The root cause of this deficient practice is the facility□s failure to follow our established procedures related to obtaining and documenting pre- and post-dialysis weights and monitoring dialysis catheters. All CNAs will receive an in-service by the Director of Nursing (DON) and the Trainer Educator III RN related to obtaining and documenting pre- and post-dialysis weights. All licensed nursing staff will receive an in-service by the DON and Trainer Educator III RN on monitoring dialysis catheters for possible complications.

D. The Unit Managers or designees will review and monitor pre- and post- dialysis weights weekly to ensure the weights

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F 698	Continued From page 20	F 698	were obtained and documented. Any deficient practices identified will be reported to the Unit Managers for appropriate corrective action. The Continuous Quality Improvement Nurse (CQI RN III) will audit the documentation for all pre- and post-dialysis weights weekly for ten (10) consecutive weeks, and monthly for three (3) consecutive months using the Nursing Services Audit Tool (See Attachment #3). The results of these audits will be reported at the monthly QAPI committee meetings. If the audits indicate 100 percent compliance after four (4) consecutive monthly reviews, then the facility will conclude that we have successfully addressed this cited deficient practice.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		4/5/22

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F 758	Continued From page 21 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R47 and R62) out of five residents reviewed for unnecessary medications, for R62, the facility failed to complete a Gradual Dose Reduction (GDR) and for R47, the facility failed to monitor side effects of psychoactive medication. Additionally, for R47, the facility failed to ensure that PRN psychotropic medication had	F 758	Individual/Resident Impacted Item 1 A. The facility failed to complete a Gradual Dose Reduction (GDR) for one (R62) out of 5 residents sampled for unnecessary medications. R62 was seen	

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F 758	Continued From page 22 a specific duration for continued use. Findings include: The facility policy Psychoactive Medications, dated 11/15/17, documented that an AIM's assessment should be completed quarterly for residents taking psychotropic medication. 1. Review of R62's clinical record revealed: 6/1/04 - R62 was admitted to the facility with major depressive disorder, recurrent, severe with psych symptoms. 10/31/17 (revision date) - The Policy and Procedure for psychoactive medication documented that the Pharmacy Consultant "Will recommend GDR to the primary care physician/NP when appropriate, after each quarterly review. GDR must be attempted quarterly, unless clinically contraindicated." 5/14/21 - An annual MDS assessment documented the use of an antidepressant and a GDR was clinically contraindicated per the Physician, dated 8/29/17. There were no mood symptoms or behaviors. 6/3/21 - Physicians orders revealed an order for Risperdal 12.5 mg to be given by injection into the muscle for one day, then hold 13 days for major depressive disorder and antipsychotic features, then give the next dose. 6/14/21 - A Psychiatric consult signed by E16 (MD) documented R62's mood as "Not too bad and was cooperative, pleasant." 1/14/22 - A quarterly MDS assessment	F 758	by a Psychiatrist on 06/14/21, and it was recommended that a GDR was not appropriate at that time, however this recommendation was not acknowledged by the facility's Medical Director. The facility's Medical Director has reviewed R62's psychiatric consult and concurred with the Psychiatrist's recommendation that a GDR is not appropriate at this time. B. All residents have the potential to be affected by this deficient practice related to GDR. The facility will review all residents who are prescribed psychotropic medications to ensure that an evaluation for the appropriateness of a GDR is completed by 04/05/22. C. The root cause of this deficient practice is failure to follow the facility□s current policy and procedures related to psychotropic medications. The DON or designee will initiate a weekly clinical team meeting to review residents□ care plans related to psychotropic medications prior to their next scheduled Interdisciplinary Meeting (IDT). The facility's Pharmacy Consultants will notify the Unit Managers prior to the weekly clinical meetings of which residents are prescribed psychotropic medications for possible GDR evaluation. All medical providers and licensed nursing staff will be in-serviced on the updated psychotropic medication policy related to GDR (See Attachment #4) by the facility's Pharmacy Consultants and the Director of Nursing by 04/05/22. D. The Neurobehavioral Health (NBH)	

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F 758	Continued From page 23 documented use of an antipsychotic and no mood symptoms or behaviors. 1/20/22 - Review of the Pharmacist Medication Regimen Review revealed "Risperdal consider GDR due on 1/1/22." The facility lacked evidence that the recommendation was considered by the Physician. 2/18/22 12:27 PM - During an interview, E6 (RNAC) confirmed that GDR information for a resident taking an antipsychotic medication was obtained from Behavioral Health Services. 2/21/22 - An email communication with E22 (MD) provided no additional information about a GDR for Risperdal. There was no evidence of a GDR or rationale not to conduct one in the clinical record. 2a. The following was reviewed in R47's clinical record: 6/22/21 - A physician order was written for Valium 5 mg/ml - 5 mg into the muscle PRN (as needed for seizure activity times 6 doses, 5 mg every 5 minutes and may repeat up to 30 mg total dose. The order lacked an end date or rationale for continued use beyond 14 days. 2/21/22 3:00 PM - During an interview, E8 (Pharmacist) said that the prescription for Valium was renewed by the Physician on 12/28/21. E8 confirmed that the order was extended beyond 14 days and did not include a specific duration for use. b. 2/10/20 - A physician order for Seroquel twice	F 758	Nursing Supervisors and Unit Managers or designees will monitor all residents who are prescribed psychotropic medications to ensure any necessary GDR referrals are discussed. If it is found that any GDRs are necessary, the medical provider will be notified. The IDT RN Coordinator or designee will monitor all residents on psychotropic medications. Any deficient practices identified will be reported to the medical provider for appropriate corrective action. Additionally, the Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random audits on 25 percent of all residents prescribed psychotropic medications using the Nursing Services Audit Tool (See Attachment #3) to ensure 100 percent compliance for ten (10) consecutive weeks. Thereafter, random audits will continue monthly for three (3) consecutive months to ensure 100 percent compliance. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will conclude that we have successfully addressed this cited deficient practice. Item 2 A. The facility failed to monitor side effects of psychotropic medications for one (R47) resident out of five sampled residents for unnecessary medications. The facility immediately reviewed (R47) and completed the Abnormal Involuntary Movement Scale (AIMS) assessment on	

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daily was written for R47.

3/23/21 - A review of documentation revealed an AIM's test was completed.

10/26/21 - The pharmacy medication review revealed the last AIM'S test was competed on 3/23/21 (7 months ago).

1/25/22 - A pharmacy medication review incorrectly documented that medication monitoring was adequate, no changes recommended.

2/21/22 9:00 AM - Review of the clinical record lacked evidence of an AIM's assessment after 3/28/21.

2/21/21 1:30 PM - During an interview, E18 (RN) confirmed that AIM's testing was not completed since 3/23/21 for R47. E18 immediately confirmed with E3 (Blossom Unit Manager) that AIM's assessments should be completed every three months for residents on psychotropic medications.

Findings were reviewed with E1 (NHA) and E2 (DON) during exit conference on 2/22/22 at 2:22 PM.

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02/24/22. The Trainer Educator III RN or designee will educate the licensed nursing staff on the need to complete the AIM's assessment for residents who are prescribed antipsychotic medications.

B. All residents have the potential to be affected by this deficient practice in which the facility failed to have psychotropic medication side effect monitoring for (R47). A facility wide sweep was completed on 03/02/22 to ensure that no other residents were affected by this deficient practice.

C. The root cause of this deficient practice is a knowledge deficit related to monitoring side effects of psychotropic medications. The DON or designee will initiate a weekly clinical team meeting to review residents□ care plans related to psychotropic medications prior to their next scheduled Interdisciplinary Meeting (IDT). The facility's Pharmacy Consultants will notify the Unit Managers prior to the weekly clinical meetings of which residents are prescribed antipsychotic medications which requires the completion of an AIMS test. The Director of Nursing (DON) and Trainer Educator III RN or designee will provide a refresher in-service to all licensed staff on the need to complete the AIMS assessment for residents who are prescribed antipsychotic medications by 04/05/22.

D. The Unit Managers or designees will review and update all care plans related to antipsychotic medications prior to the

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F 758	Continued From page 25	F 758	weekly clinical team meeting to ensure that all AIMS tests have been completed. The IDT RN Coordinator or designee will monitor all residents who are prescribed antipsychotic medications to ensure that the AIMS test is completed by the Unit Managers. Any deficient practices identified will be reported to the DON for appropriate corrective action. Additionally, the Continuous Quality Improvement Nurse (CQI RN III) or designee will complete random audits on 25 percent of all residents prescribed antipsychotic medications using the Nursing Services Audit Tool (See attachment) to ensure 100 percent compliance for ten (10) consecutive weeks. Thereafter, random audits will continue monthly for three (3) consecutive months to ensure 100 percent compliance. The results of this audit will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will conclude that we have successfully addressed this cited deficient practice. Item 3 A. The facility failed to ensure that PRN psychotropic medication orders had a specific duration for continued use for one (R47) out of five residents. There was not an end date or documented rationale for the use of PRN psychotropic medication orders beyond the 14-day limit. The facility completed a sweep of all current PRN psychotropic medication orders to ensure documented end dates or documented	

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F 758	Continued From page 26	F 758	rationale for continued use. The Trainer Educator III RN or designee will provide a refresher in-service to the medical providers and licensed nursing staff on the facility□s psychotropic medication policy outlining the regulation on ordering and time limits of PRN psychotropic medication orders. B. All residents prescribed PRN psychotropic medication orders have the potential to be affected by this deficient practice. All residents prescribed PRN psychotropic medication orders will have their medication orders limited to 14 days or the medical provider(s) will document additional rationale to support exceeding this time frame. A sweep of all residents□ PRN psychotropic medication orders was completed on 03/08/22 to ensure they reflect a 14-day limit, or the medical provider(s) has documented additional rationale to support exceeding that time frame. C. The root cause of this deficient practice is a knowledge deficit related to failing to ensure that PRN psychotropic medication orders had a specific duration for continued use. The medical providers and licensed nursing staff will be provided with a refresher in-service by the facility Pharmacy Consultants and the Director of Nursing on the facility□s psychotropic medication policy outlining the regulation on ordering and time limits of PRN psychotropic medication orders by 04/05/22.	

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F 758	Continued From page 27	F 758	D. The Nursing Supervisors and Unit Managers or designees will review all residents who are prescribed PRN psychotropic medications to ensure an end date of 14 days from the start or continued documented rationale from the medical provider(s). The Continuous Quality Improvement Nurse (CQI RN III) will randomly audit 25 percent of all PRN psychotropic medication orders weekly using the Nursing Services Audit Tool (See Attachment #3) to ensure 100 percent compliance for ten (10) consecutive weeks. Thereafter, random audits will continue monthly for three (3) consecutive months to ensure 100 percent compliance. Any deficient practices identified will be reported to the Director of Nursing for corrective action. The results of these audits will be reviewed at the monthly QAPI Committee meetings. If it is determined that 100 percent compliance is achieved for four (4) consecutive months, then we will conclude that we have successfully addressed this cited deficient practice.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/5/22

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F 812	Continued From page 28 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that food was stored, prepared, and served in a sanitary manner. Findings include: 2/14/22 8:30 - 9:15 AM - During the initial kitchen tour with E25 (Food Service Supervisor), the following were observed: - an upright refrigerator in the food preparation area contained: - 3 unlabeled insulated lunch bags belonging to staff. - an unlabeled zip lock baggie containing fresh broccoli. - an unlabeled plastic container with a lid containing a staff members soup. - 2 opened unlabeled jars of chicken and beef base and a bottle of hot sauce. - an approximately 3 inch by 3 inch piece of butter wrapped in plastic and unlabeled. - a hand sink in the food preparation area did not have a garbage can close by. 2/14/22 9:15 AM - During an interview, the above findings were confirmed with E25.	F 812	Individual/Resident Impacted A. The facility failed to ensure that food was stored, prepared, and served in a sanitary manner. The facility immediately corrected this deficient practice by properly labeling all opened and unlabeled food items in the upright kitchen refrigerator and by placing a garbage can next to the hand sink in the food preparation area. All food service staff were immediately reminded on the need to ensure proper labeling and storage of food items as well as proper sanitary food handling procedures by the Food Service Director. B. All residents in the facility have the potential to be affected by this deficient practice. Corrective actions were taken by the Food Service Director on 02/14/22 by checking all items stored in and nearby the kitchen refrigerators and food preparation areas to ensure proper storage, preparation, and serving of food in a sanitary manner.	

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F 812	Continued From page 29 2/15/22 9:20 AM - During the kitchen inspection an unlabeled open bag of frozen french fries was observed in a freezer. 2/15/22 1:30 PM - During an interview, the above findings were confirmed with E24 (Food Service Director). 2/22/22 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 812	C. The root cause of this deficient practice was a failure to follow the proper procedures for storing, preparing, and serving food in a sanitary manner. The Cook Supervisors or designees will conduct daily environmental kitchen inspections of all refrigerators and food preparation areas using the Kitchen Environmental Checklist (See Attachment #5) to ensure that all food and kitchen items are properly stored, prepared, and served in a sanitary manner. The Food Service Supervisors or designees will conduct weekly environmental kitchen inspections of all kitchen refrigerators and food preparation areas. Any food items found opened and unlabeled in the kitchen refrigerators will be removed and labeled or discarded. Any garbage cans found not placed next to the hand sinks in the food preparation areas will be moved close by. Additionally, the Risk Manager/Safety Officer will conduct monthly environmental kitchen inspections. All environmental findings will be promptly addressed and communicated to the Food Service Director. D. The Cook Supervisors or designees will conduct environmental kitchen inspections of all refrigerators and food preparation areas to ensure that all food and kitchen items are properly stored, prepared, and served in a sanitary manner. The Food Service Supervisors or designees will conduct weekly environmental kitchen inspections of all kitchen refrigerators and food preparation	

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F 812	Continued From page 30	F 812	areas. Additionally, the Risk Manager/Safety Officer will conduct monthly environmental kitchen inspections. The Cook Supervisors, Food Service Supervisors, and Risk Manager/Safety Officer will verify that all environmental concerns identified during the environmental kitchen inspections are addressed promptly. Any environmental concerns that are not addressed will be communicated to the Food Service Director for proper follow-up and to ensure that proper storage, preparation, and serving food in a sanitary manner is sustained. To ensure sustainability, the Continuous Quality Improvement Nurse (CQI RN III) will complete an audit of 25 percent of the environmental checklists weekly for ten (10) consecutive weeks and then monthly for three (3) consecutive months. All audit results will be reviewed at the monthly QAPI committee meetings. When the facility reaches 100 percent compliance for three (3) consecutive months, then the facility will conclude that we have successfully addressed this cited deficient practice.	