DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Harrison House Senior Living

DATE SURVEY COMPLETED: August 9, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint Survey was conducted at this facility from July 30, 2024 through August 9, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was one hundred fourteen (114). The survey sample totaled twenty-eight (28) residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing 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 August 9, 2024: cross refer: F550, F609, F644, F645, F658, F661, F677, F690, F692, F711, F740, F757, F758, F760, F803, F812, F880, F881 and F908.	

Provider's Signature _____ Title NHA Date 8/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SENIOR LIVING OF GEORGETOWN, LLC	110 W. NORTH STREET GEORGETOWN, DE 19947

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E 000	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from July 30, 2024 through August 9, 2024. The facility census was 114 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Extended Survey was conducted at this facility from July 30, 2024 through August 9, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 114. The investigative sample totaled 28 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; IDT - Inter-disciplinary team; LPN - Licensed Practical Nurse; MD - Medical doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; QA - Quality Assurance;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/07/2024

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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RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
SW - Social Worker;
UAP - Unlicensed assitive personnel.

2/2 - Secondary to;
ABT - Antibiotic;
Activities of daily living (ADLs) - Tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;
Acute - Rapid onset and relatively short duration;
Advance Directive - Written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor;
Afebrile - Free from fever;
Alzheimer's Disease - Degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language;
Antispychotic Medication - Type of psychiatric medication which are available on prescription to treat psychosis;
Aphasis - Language disorder caused by damage to specific brain rgions that affect the ability to comprehend and formulate speech;
Bicep - Large muscle that lies on the front of the upper arm between the shoulder and the elbow;
BID - Twice a day;
Bipolar Disorder - Mood disorder;
Bladder Incontinence - Loss of control of bladder function;
Bladder retraining - A planned program to develop regular voiding times;
BMP - Basic metabolic panel, a lab study that measures various bodily functions;
Brief Interview for Mental Status (BIMS) - Assessment of the resident's mental status. The

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total possible BIMS Score ranges from 0 to 15 with 15 being the best.
0-7: Severe impairment (never/rarely made decisions)
08-12: Moderately impaired (decisions poor; cues/supervision required)
13-15: Cognitively intact (decisions consistent/reasonable);
CBC - Complete blood count; a lab study that counts all the various cells in a patient's blood;
CDC - Centers for Disease Control;
C-diff - Bacterial overgrow that releases toxins that attack the lining of the intestines;
cm - Centimeter;
CMS - Centers for Medicare and Medicaid Services;
Cognition - The process of acquiring knowledge and understanding through thought, experience and the senses;
C&S - Culture and sensitivity;
Delirious/Delirium - Acutely disturbed state of mind;
Delusional disorder - A serious mental illness previously called paranoid disorder, in which a person can't tell real from what is imagined;
Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
dl - Deciliter;
EBP - Enhanced barrier precautions,
EMR - Electronic medical record;
Enterocolitis - Inflammation of the intestines caused by severe infection;
ESBL- Extended-spectrum beta lactamases - An organism that causes infections that is resistant to many antibiotics;

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Foley catheter - A tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder;
g - Gram;
Generalized anxiety disorder (GAD) - A mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things;
HAIs - Healthcare-associated infections;
Hallucinations - Something that seems real but does not really exist;
Incontinence - Loss of control of bladder and/or bowel function;
Insulin - A type of hormone that allows glucose in the blood to enter cells, providing them with the energy to function;
IV - intravenous;
lbs - Pounds;
LOS - Length of stay;
Major Depressive Disorder - Also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause;
MDROs - Multidrug resistant organisms;
MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;
Medication Administration Record (MAR) - List of daily medications to be administered;
Medication Regimen Review (MRR) - Monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist;
mg/dL - Milligram per deciliter;

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mg - Milligram;
mL - Milliliter;
mmol/L - Millimole per liter;
MRSA - Methicillin-resistant Staphylococcus aureus - An infection caused by a type of bacteria that's become resistant to many of the antibiotics;
NPO - Nothing by mouth;
Osteomyelitis - Infection/inflammation of the bone and/or bone marrow;
PASSAR - Preadmission Screening and Resident Review - Screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there;
PCC- Point Click Care, facility's platform for their electronic medical record;
PICC - Peripherally inserted central catheter;
PCM - Protein-calorie malnutrition;
PO - By mouth;
PPE - Personal protective equipment;
PRN - As needed;
Psychotic disorder(s) - Severe mental disorders that cause abnormal thinking and perceptions;
Psychotropic (medication) - Any medication capable of affecting the mind, emotions and behavior;
q - Every;
Quetiapine (also known as Seroquel) - An antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder;
r/t - Related to;
Schizoaffective disorder - Condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, such

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F 000	Continued From page 5 as mania or depression; S/P - Status post; S/S - Signs/symptoms; STAT- Medical term for immediately; Sundowning - State of confiusion, agitation, anxiety or disorientation that occurs int he late afternoon or evening. it is common in people with dementia; Sx - Surgery; T - Temperature; Tachycardia - An abnormally fast heart rate; u - Unit (of insulin); UA - Urinanalysis - A lab study that checks for an infection in a patient's urine; UTI - Urinary tract infection; Wt - Weight.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		10/7/24

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F 550	Continued From page 6 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R27) out of twenty-eight (28) residents reviewed for dignity, the facility failed to promote dignity. Based on a review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 12/14/23. Findings include: The facility policy titled "Resident Dignity," last updated 10/2020, indicated that "... Residents shall always be treated with dignity and respect... means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth... Staff shall promote, maintain, and protect resident privacy...".	F 550	F550 A. The deficiency was determined to be past non-compliance as of 12/14/23. The nurse was contacted to remove video immediately, R27□s family was notified of incident, provider, DHCQ, professional board of regulation, and the nurse□s agency were all also contacted. Nurse was immediately listed as do not return to facility. No residents were adversely affected by this deficient practice. B. All residents have the potential to affected by this deficiency. Resident and staff interviews were conducted and there were no further incidents related to the dignity of residents.	

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F 550	Continued From page 7 The facility policy titled "Cell Phones," last updated 4/2020, indicated that "... At no time is it considered courteous or professional to use your cell phone while you are in the department providing care and/or services to the residents in the facility...". A review of R27's clinical record revealed: 7/4/15 - R27 was admitted to the facility with diagnoses including, but not limited to, Alzheimer's disease. 9/27/23 - A quarterly MDS for R27 documented a BIMS score of 2, which showed severe cognitive impairment. 12/8/23 - A complaint was submitted by the facility to the State Agency that alleged an agency nurse posted a video to a social media website showing the agency nurse with a resident. Review of facility documentation related to the above complaint revealed the video was posted on the social media website for about 20 minutes, received 45 likes and 4 comments to the video. 8/7/24 9:14 AM - A review of the video that was posted to the social media website revealed E10 (RN, former employee) sitting next to R27 in the common area. R27 was leaned her head towards E10's right side of head, placing her forehead against the right side of E10's head. The video is about 4 seconds long and is repeated on a loop 4 times. There is music playing in the background of the video. There is a caption that stated, "When the lazy nurse complains about having to answer your [favorite] resident call bell at night."	F 550	C. All nursing staff received in-service training/education on resident dignity, cell phone use, and social media policy. Education was all completed by 12/14/23. D. Audits of cell phone usage in patient care areas were conducted and completed by 12/14/23. Any future concerns will be addressed at facility□s monthly QAPI meeting and committee will determine if any further action is required.	

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F 550	Continued From page 8 8/7/24 10:05 AM - An interview with E2 (ADON) confirmed the findings and stated staff are not supposed to have their cell phones on the floor and E10 was terminated from the facility. All employees were educated on topics such as HIPAA (Health Insurance Portability and Accountability Act), Cell Phones and Rules for Use of Technology, Treatment of Residents/Resident Rights and Abuse Prevention. The facility had audited all employees to make sure education was completed on the previous topics. Based on the review of the facility's thorough investigation, documented response, completion of in-service training and audits, staff interviews and no further incidents related to the dignity of residents, R27's incident was determined to be past non-compliance. The plan of correction was initiated on 12/8/23 and completed on 12/14/23. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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	F 609		10/7/24

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F 609	Continued From page 9 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 and interview, it was determined that for one (R90) out of fourteen (14) sampled residents reviewed for abuse, it was determined that the facility failed to immediately report an injury of unknown source. Findings include: A review of R90's clinical record revealed: 3/8/23 - R90 was admitted to the facility with diagnoses including but not limited to Alzheimer's disease. 6/8/24 11:57 AM - A nursing note documented by E17 (LPN) stated that R90 had a large bruise on the left inner bicep with measurements of 8.5 cm x 6.4 cm, resident is complaining of pain from the area. The note documented the supervisor was notified and the bruise documented in the	F 609	F609 A. Resident R90 was transferred to hospital for further evaluation/treatment. R90 has since followed-up with orthopedics, physical therapy, and pain management. Both employees responsible for the delay in reporting are no longer employed at facility. B. All residents have the potential to be affected by this deficient practice. DON, or nursing designee, will audit all reports of abuse submitted in the past two weeks for timely reporting of allegations. Audit to be completed by October 7th, 2024. C. Root cause analysis revealed employee responsible for reporting, knowingly submitted late. All staff have	

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F 609	Continued From page 10 doctor's book. 6/8/24 10:55 PM - A nursing note documented by E18 (RN former employee) stated that around 7:45 PM the area on R90's left bicep was larger and tight and R90 was guarding her arm. R90 was sent to the emergency room around 8:15 PM. Around 10:40 PM, the emergency room reported R90 had a broken right upper arm. The nursing note documented that a report was given to the DON and the oncoming supervisor. 6/9/24 2:41 PM - A facility reported incident was submitted by the facility to the State Agency that alleged R90 was sent to the emergency room for an evaluation. R90 was observed guarding her left arm. The report stated there was no bruising initially but developed throughout the day and R90 exhibited signs and symptoms of pain. 8/6/24 11:40 AM - An interview with E17 revealed that on 6/8/24 around 7:30 AM, R90 had a discolored area on left upper arm that was not bruised. E17 stated around 10:30 AM, the area on the left upper arm was turning purple in color but not swollen. At approximately 6:30 PM, the area was spreading and remained purple in color. At 8:00 PM, the area was purple in color and spread from the upper arm down to the elbow. 8/7/24 10:05 AM - An interview, E2 (ADON) confirmed that a bruise of unknown origin was a reportable event and she was not sure why there was a delay. E2 stated the DON was on-call that weekend and it should have been reported. 8/0/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 609	previously been educated on this process by Staff Education Coordinator, upon hire, yearly, and as needed, and it was determined to be an isolated incident with that employee. Facility house wide abuse education to be completed by October 7th, 2024. In addition, staffing schedules updated to reflect current DON□s phone number and administrator to be notified immediately by DON for all allegations or suspicions of abuse to verify timely submission. D. DON, or nursing designee, will audit all submitted reports of abuse for timely reporting three times a week until 100% compliance is achieved at three consecutive evaluations; then one time a week until 100% compliance is achieved at three consecutive evaluations and then one month later. If 100% compliance is reached, then it will be concluded the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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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 interview and record review, it was determined that for two (R37 and R47) out of four residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: 1. Review of R37's clinical record revealed: 2/24/17 - A PASARR level I was completed for R37 and determined that no further evaluation was needed. 3/1/17 - R37 was admitted to the facility. 7/30/18 - R37 was diagnosed with the following diagnoses: delusional disorder, bipolar disorder,	F 644	F644 A. Updated PASARR screening referral submitted for R37 and R47 for level II. B. All residents have the potential to be affected by this deficient practice. Facility wide audit to be completed by October 7, 2024 for everyone with a psychiatric diagnosis to determine if PASARR screening is up to date for most recent diagnosis change. C. Social Workers to be educated by Administrator by October 7, 2024 on referring all residents with newly evident or possible serious mental disorders,	10/7/24

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F 644	Continued From page 12 and hallucinations. 3/23/23 - R37 was diagnosed with the following diagnoses: generalized anxiety disorder and dementia with psychotic disturbance. 5/8/24 - An annual MDS assessment revealed that R37 had the following diagnoses: anxiety disorder, depression, manic depression, and psychotic disorder. 8/05/24 12:39 PM - An interview with E8 (SW) revealed that that there was no evidence a level II was submitted when there was evidence of a serious mental disorder. 2. Review of R47's clinical record revealed: 5/16/18 - A PASARR level 1.5 was completed for R47 and indicated R47 has a serious mental illness but did not require a level II at this time. 6/19/18 - R47 was admitted to the facility with the following diagnosis: anxiety disorder. 3/31/20 - A PASARR level I was completed for R47 and indicated R47 has a serious mental illness but did not require a level II at this time. 4/21/24 - R47 was diagnosed with the following diagnoses: schizoaffective disorder, major depressive disorder, and dementia. 5/1/24 - A quarterly MDS assessment revealed that R47 had the following diagnoses: anxiety disorder, depression, manic depression, schizophrenia, and psychotic disorder. 8/05/24 12:39 PM - An interview with E8 (SW)	F 644	intellectual disabilities, or related conditions for level II resident review upon a significant change in status assessment. Root cause analysis revealed social worker knowledge deficit and poor communication process between social work and clinical staff regarding new psychiatric diagnoses. D. Psychiatric Nurse Practitioner to notify in writing Social Workers, in addition to nursing clinical team, of any diagnosis change of residents assessed weekly. Social Work to then submit new PASARR screening referral. SW to audit list of residents assessed by psych NP three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations; then one month later. If 100% compliance is reached, then it will be concluded the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 644	Continued From page 13 revealed that there was no evidence a level II was submitted when there was evidence of a serious mental disorder. The facility lacked evidence of any updates submitted to the State PASARR authority for R37 or R47. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645		10/7/24

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F 645	Continued From page 14 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 645		

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F 645	Continued From page 15 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R104 and R366) of four sampled residents reviewed for Preadmission Screening and Resident Review (PASARR) Level I, the facility failed to have a currently dated PASARR Screening. Findings include: 1. Review of R104's clinical record revealed: 3/1/24 - A level I convalescence categorical admission was submitted for R104 and approved for sixty days. 3/9/24 - R104 was admitted to the facility with the following diagnoses: paranoid schizophrenia and intellectual disability. 4/15/24 - A review of a level I PASARR submitted to the state PASARR authority lacked evidence of R104's current diagnoses and services provided. 5/1/24 - R104's concalescence categorical admission PASARR expired. 8/5/24 1:07 PM - An interview with E8 (SW) confirmed that the PASARR I submitted did not reflect R104's current condition. E8 confirmed that it lacked current diagnoses and services provided. 2. Review of R366's clinical record revealed: Cross refer to F758. 6/24/24 - Notice of PASARR Level I Screen	F 645	F645 A. Updated PASARR screening referral submitted for R104 for level II. Unable to correct R366 as resident no longer resides at facility. B. All residents have the potential to be affected by this deficient practice. Social Workers, or designee, to audit all residents who switched from rehabilitation stay to long term care in the last 30 days to determine if new PASARR screening referrals were completed at time of transition, and if not, submit updated referral. Admissions team, or designee, will audit PASARRs for all admissions in the last 30 days to ensure accuracy based on verification of hospital discharge summary medications and hospital notes/diagnoses. Audits to be completed by October 7, 2024. C. Admissions team to be educated by the Administrator by October 7, 2024 on ensuring PASARR screening sent by hospital is accurate and reflects any use of psychiatric medications, exhibition of symptoms, and/or disorder diagnoses during hospitalization of patient. Social Workers to be educated by October 7, 2024 on ensuring any patient who converts from rehab to long term care gets updated PASARR screening referral submitted upon transition. Root cause analysis revealed hospital was sending	

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F 645	Continued From page 16 documented,"...there are no known mental health symptoms affecting the individual's ability to think through or complete tasks which she/he should be physically capable of completing... Mental Health Medications - no medications ...". 7/8/24 - R366 underwent a psychiatry consult while hospitalized that documented R366 as having hallucinations and behaviors such as pulling out IV's and EKG leads. E29 (psychiatrist) documented, "...87 year old male with formal psychiatric history... developed hospital delirium. He was seen to adjust his medications because of more confusion and restlessness at night suggestive of sundowning... Level of care: Pharmacological: We can increase Seroquel to 50 mg at 6:00 PM to prevent sundowning, we can gradually increase the dose if the 50 mg is not working. Patient psychotic? No...". 7/12/24 - R366's discharge summary from [hospital] documented, "... Hospital Course: ...He [R366] also required a sitter due to "sundowning" episodes... Prescription Medications: Seroquel (Quetiapine) 25 mg oral tablet, 50 mg = 2 tabs...". 7/12/24 - R366's hospital discharge instructions documented, "... Updates to Your Medications... Quetiapine (Seroquel) 25 mg (milligrams) 2 tabs by mouth every 24 hours for delirium...". 7/12/24 - R366 was admitted to the facility. 7/12/24 5:40 PM - E12 (MD) ordered in R366's EMR, "Quetiapine 50 mg - give 1 tablet by mouth one time a day for delirium." 7/14/24 - R366's admission MDS documented in Section N Medications that "antipsychotics were	F 645	incorrect PASARRS by completing them prior to hospital discharge and then medication changes were happening between completion of PASARR and actual discharge. A knowledge deficit was identified in social workers regarding the need to resubmit the PASARR for rehab to long term care transitions. D. Hospital/Referring facility PASARR screenings will be reviewed for accuracy prior to transfer and admission of patient. Admissions to also be reviewed at next scheduled morning meeting by IDT to confirm discharge summary/notes are reflected accurately in hospital PASARR. If any discrepancies are determined, the Admissions team will be responsible for timely resubmission of updated PASARR screening referral for patient. Rehab patients discharge plan to be reviewed weekly at Utilization Review Meeting to ensure any rehab patient transferring to long term care is captured for updated PASARR screening referral to be submitted by Social Worker team. Social Worker, or designee, to audit accuracy of hospital PASARRS three times a week until 100% compliance is achieved at three consecutive evaluations, and then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly	

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F 645	Continued From page 17 received on a routine basis only." 7/15/24 9:47 PM - E13 (PA) documented in R366's progress note, "... History of present illness:... Post-op course was complicated... he was also noted to have sundowning episodes... I spoke with patient son (sic) who stated at home he is AO X 3 (alert and oriented to person, place and time) but became very confused while hospitalized. He also stated that the confusion comes and goes... Diagnosis, Assessment and Plan: ... Delirium 2/2 prolonged hospitalization - continue Seroquel 50 mg daily...". 7/16/24 8:50 PM - E12 (MD) documented in R366's History and Physical progress note, "... Diagnosis, Assessment and Plan:... Delirium - Quetiapine." 8/5/24 8:38 AM - Email correspondence with C1 (State PASRR supervisor), C1 stated, "... He [R366] should have had a resident review submitted when the facility became aware that the PASARR was not an actual reflection of his current condition The PASARR evaluation would determine if further PASARR evaluation or a full level II would be required or not. It is the receiving facility's responsibility to ensure that the PASARR is an accurate reflection of the individual's current condition so they should be reviewing it prior to admitting the individual to their facility. If the PASARR is not accurate, then they should not be admitting the individual and asking the hospital to resubmit. If they do admit, then they must submit the resident review as soon as they are aware of the omissions... In this case, the Level I was not an accurate reflection of his current status at the time of admission."	F 645	QAPI meeting and the committee will decide if further audits will be needed.	

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F 645	Continued From page 18 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 645		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for eight (R3, R71, R99, R106, R366, R98, R14 and R47) out of twenty-three residents reviewed for assessments, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete admission assessments and admission progress notes. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 ... Admission Assessments * - RN ...* = Once a care plan is established, the LPN may do assessments ...". 1. Review of R3's clinical record revealed: 1/5/24 - R3 was admitted to the facility. A review of R3's clinical record revealed the following 1/6/24 facility admission forms generated by E14 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and	F 658	F658 A. RN review of Admission/Readmission Assessments with updated progress note by RN for R3, R71, R98, R14, R47, R106. Unable to correct R99 and R366 due to no longer residing at facility. B. All residents have the potential to be affected by this deficient practice. DON, or designee, to audit all admissions in last 2 weeks for Admission/Readmission Assessments and correlating RN Admission progress notes. Audit to be completed by October 7, 2024. If resident admitted by LPN only, RN to provide documented review of Admission/Readmission Assessments with updated correlating progress note. C. All nurses to receive education by Staff Education Coordinator on state regulation scope of practice of RNs only completing admission assessments and admission progress notes by October 7, 2024. Upon root cause analysis,	10/7/24

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F 658	Continued From page 19 Sensory evaluations. 7/1/24 - R3 was re-admitted to the facility after a hospitalization. A review of R3's clinical record revealed the following 7/1/24 facility admission forms generated by E15 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and Sensory evaluations. 2. Review of R71's clinical record revealed: 11/1/23 - R71 was admitted to the facility. A review of R71's clinical record revealed the following 11/2/23 facility admission forms generated by E16 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and Sensory evaluations. 3. Review of R99's clinical record revealed: 2/4/24 - R99 was admitted to the facility. A review of R99's clinical record revealed the following 2/4/24 facility admission forms generated by E16 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and Sensory evaluations.	F 658	knowledge deficit nursing wide identified on assessment requirements of new admissions. D. DON, or designee, to assign each new admission to available RN to complete assessments prior to patient□s arrival. DON, or designee, to audit admission assessments three times a week until 100% compliance is achieved at three consecutive evaluations and then one time a week until 100% compliance is achieved at three consecutive evaluations, and then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 658	Continued From page 20 4. Review of R106's clinical record revealed: 2/27/24 - R106 was admitted to the facility. A review of R106's clinical record revealed the following 2/27/24 facility admission forms generated by E21 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and Sensory evaluations. 5. Review of R366's clinical record revealed: 7/12/24 - R366 was admitted to the facility. A review of R366's clinical record revealed the following 7/12/24 facility admission forms generated by E20 (LPN): Demographics/Orientation to facility, ADLs, Skin Integrity, Oral/Nutrition, Neurological, Respiratory, Cardiovascular, Gastrointestinal, Reproductive, Bladder/Bowel, Sleep, Pain, Mobility/Safety, and Sensory evaluations. 6. Review of R98's clinical record revealed: 9/26/23 - R98 was admitted to the facility. 9/26/23 - E31 (LPN) completed the Prestige Admit/Readmit Screener, Fall Risk, Dehydration Risk, Wander Elopement screener, Assistive Device & Bed Safety Evaluation, and Respiratory Infection screener. 7. Review of R14's clinical record revealed: 7/9/24 - R14 was admitted to the facility.	F 658		

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F 658	Continued From page 21 7/10/24 - E20 (LPN) completed the Prestige Admit/Readmit Screener, Fall Risk, Dehydration Risk, Wander Elopement screener, Assistive Device & Bed Safety Evaluation, Pain Evaluation, Functional Abilities Assessment and Respiratory Infection screener. An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission assessments for R14. 8/1/24 9:55 AM - During an interview, E23 (DON) stated, "The admission paperwork is done by the nurse assigned to the room. Sometimes, the supervisor or charge nurse helps out. Usually they (supervisor/charge nurse) put the orders in. The admission assessments in the Admit/Readmit screener include: demographics/orientation, ALDs, oral/nutrition, neuro, respiratory, cardiovascular, GI (gastrointestinal), reproductive, bladder/bowel, sleep, pain, mobility/safety, dehydration and sensory evaluations. The nurse also does an admission progress note." 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that	F 661		10/7/24

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F 661	Continued From page 22 includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R113) out of one resident reviewed for discharge, the facility failed to ensure that R113 had a discharge summary that included a reaccounting of her stay and a review of her pre-discharge medications. Findings include: 4/14/24 - R113 was admitted to the facility with diagnosis, including but not limited to, broken left arm. 4/26/24 10:12 AM - R113's discharge conference note documented it was attended by E8 (SW),	F 661	F661 A. R113 contacted and updated discharge summary written and signed by facility MD provided to resident and faxed to resident□s primary care provider. B. All residents have the potential to be affected by this deficient practice. DON, or designee, to audit all facility discharges in the last 2 weeks for completion at time of patient discharge by October 7, 2024. Contact to be made with any patient determined to have incomplete MD discharge summaries and preference of	

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F 661	Continued From page 23 R113 and her two sons. 5/2/24 10:39 AM - E21 (LPN) completed R113's nursing discharge plan of care instructions. 5/2/24 - R113 was discharged from the facility in the company of her son. 8/1/24 12:11 PM - A review of R113's clinical record revealed two progress notes from the providers dated 4/15/24 and 4/16/24. The surveyor was not able to find evidence of R113's discharge summary in the EMR (electronic medical record). It should be noted that the two provider notes dated 4/15/24 and 4/16/24 (within the first week of R113's admission) are the only provider notes in R113's EMR for her 19 day stay at the facility. 8/5/24 4:06 PM - During a telephone interview, E12 (MD) stated, "Sometimes, the [medical practice] notes don't make it to the chart. I will look for her [R113] discharge summary and send to the facility." 8/6/24 1:36 PM - The surveyor received a copy of R113's discharge summary. The date of service on the discharge summary was 5/2/24. The date the discharge summary document was e-signed in the EMR was 8/5/24 at 5:47 PM. E-signing a note in the EMR marks the time stamp for when a progress note was finalized and made available in the resident's record. Since R113's discharge summary was e-signed on 8/5/24 at 5:47 PM, this discharge summary was not available in the EMR on 5/2/24, the day R113 was discharged from the facility. The discharge	F 661	method of delivery to be obtained to ensure patient and any community providers receive any missing documentation. C. Education by Staff Education Coordinator to be given to facility□s primary medical providers and nurses on ensuring completion of discharge summaries to include a recounting of patient□s stay and a review of pre-discharge medications prior to patient exiting facility, with completion date of October 7, 2024. After weekly Utilization Review meeting, updated list of expected discharge dates to be given to providers to plan accordingly to prepare discharge summaries. Root cause analysis revealed poor communication between nursing staff and providers regarding upcoming discharge dates. Therefore, D/C summary was not completed in timely manner. D. DON, or designee, to audit all facility discharges three times a week until 100% compliance is achieved at three consecutive evaluations and then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed. Discharge checklist sheet to include	

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F 661	Continued From page 24 summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 661	signed MD discharge summary to be created and implemented by DON for use at time of discharge by October 7, 2024.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R37) out of five residents reviewed for ADL's, the facility failed to ensure that residents who are unable to carry out ADL's received the necessary services to maintain good grooming. Findings include: Review of R37's clinical record revealed: 3/1/17 - R37 was admitted to the facility. 5/8/24 - A review of an annual MDS assessment revealed that R37 is dependent for showering and bathing self. June 2024 - A review of the CNA task flow sheet revealed that R37 received thirty two bed baths out of sixty opportunities. July 2024 - A review of the CNA task flow sheet revealed that R37 received twenty nine bed baths out of sixty opportunities.	F 677	F677 A. Bed bath and nail care performed on R37 to address deficient practice for dependent resident. Resident□s preference of time and frequency of bed bath also reassessed. B. All residents have the potential to be affected by this deficient practice. Unit Managers, or designee, will complete an initial audit of all facility residents to determine the need for nail care by October 7, 2024. If indicated, nail care to be performed as designated by nurse supervisor. Unit Managers, or designee, to audit all facility residents for bathing preferences by October 7, 2024 and update charts as indicated. C. All nursing staff will be educated by Staff Education Coordinator as to facility process for expectations for nail care and	10/7/24

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F 677	Continued From page 25 7/30/24 9:55 AM - An observation revealed that R37 had long nails and a black debris noted underneath. 8/1/24 10:34 AM - An observation revealed that R37 had long nails and a black debris noted underneath. 8/2/24 11:36 AM - An observation revealed that R37 had long nails and a black debris noted underneath. 8/7/24 11:55 AM - An interview, E11 (CNA) confirmed that nail care is expected to be completed daily by staff unless physician's orders indicate otherwise or resident refuses. E11 confirmed that R37's nails were long and a black debris noted underneath. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 677	bathing by October 7, 2024. Any resident that refuses nail care and/or regular bathing will be educated as to the risks of refusal and benefits of receiving care. Any preference changes made to bathing or nail care to be communicated on 24 hour report sheet for IDT review. Root cause analysis determined lack of communication between nurse and CNA of changes in resident bathing preferences. CNA knowledge deficit also identified pertaining to nail care being part of patient personal hygiene routine. D. Facility 24 hour report sheets will be audited by Unit Managers, or designee, for changes in nail care and bathing preferences and appropriate follow-up three times a week until 100% compliance is achieved at three consecutive evaluations. Then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	
F 690 SS=E	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	F 690		10/7/24

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F 690	Continued From page 26 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for four (R47, R55, R61 and R100) out of five residents reviewed for bowel and bladder, the facility failed to provide services to restore bladder continence. Findings include:	F 690	F690 A. 3-day voiding trial initiated and evaluated for R47, R55, R61, and R100. R47 determined to not be appropriate for the initiation of toileting program. R55 toileting program updated. R61 and R100	

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F 690	Continued From page 27 1. Review of R47's clinical record revealed: 6/19/18 - R47 was admitted to the facility. 2/6/24 - A review of a quarterly MDS assessment revealed that R47 is always incontinent of bladder and frequently incontinent of bowel. No toileting program was indicated. 2/2024 - A review of the February CNA task flow sheet revealed that R47 was incontinent of bowel nine out of ninety opportunities. 3/2024 - A review of the March CNA task flow sheet revealed that R47 was incontinent of bowel two out of ninety opportunities. 4/2024 - A review of the March CNA task flow sheet revealed that R47 was incontinent of bowel seven out of ninety opportunities. 5/1/24 - A review of a quarterly MDS assessment revealed that R47 was always incontient of bladder and always incontinent of bowel. No toileting program was indicated. 8/6/24 12:16 PM - An interview with E4 (MDS LPN) revealed that the MDS coordinators are responsible for monitoring residents bowel and bladder continence and establishing toileting programs for the residents who need it. E4 confirmed that R47 was not on a toileting program at this time. 8/7/24 10:50 AM - An interview with E11 (CNA) confirmed that R47 was continent prior to last admission to the hospital and was able to use a bed pain prior. E11 confirmed that R47 is now	F 690	toileting programs initiated. B. All patients have the potential to be affected by this deficient practice. MDS coordinators, or designee, to audit and evaluate all patients currently not on toileting program by October 7, 2024. C. Education by Staff Education Coordinator to be provided by October 7, 2024 to all nursing staff on importance of notifying Unit Managers of decline in continence status. IDT to notify provider for assessment and if appropriate, begin a trial bladder program. Root cause analysis identified knowledge deficit in identifying residents who could benefit from services to help restore and maintain bladder continence. D. MDS coordinators, or designee, will complete audits on any patient that triggers for decline in continence three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 690	Continued From page 28 more incontinent and does not request the bed pan. 2. Review of R55's clinical record revealed: 4/13/22 - R55 was admitted to the facility. 2/28/24 - A review of the annual MDS assessment revealed that R55 was occasionally incontinent of bladder and was always continent of bowel. No toileting program was indicated. 2/2024 - A review of the February CNA task flow sheet revealed that R55 was incontinent of bladder ten out of ninety opportunities. 3/2024 - A review of the March CNA task flow sheet revealed that R55 was incontinent of bladder twenty-seven out of ninety opportunities. 4/2024 - A review of the April CNA task flow sheet revealed that R55 was incontinent of bladder twenty-four out of ninety opportunities. 5/2024 - A review of the May CNA task flow sheet revealed that R55 was incontinent of bladder thirty-three out of ninety opportunities. 5/29/24 - A review of a quaterly MDS assessment revealed that R55 was frequently incontinent of bladder and occasionally incontinent of bowel. No toileting program was indicated. 8/6/24 12:16 PM - An interview with E4 (MDS LPN) revealed that the MDS coordinators are responsible for monitoring residents bowel and bladder continence and establishing toileting programs for the residents who need it. E4 confirmed that R55 was not on a toileting	F 690		

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F 690	Continued From page 29 program at this time. 3. Review of R61's clinical record revealed: 3/12/21 - R61 was admitted to the facility. 12/21/23 - A review of a quarterly MDS assessment revealed that R61 was always incontinent of bladder and frequently incontinent of bowel. No toileting program was indicated. 12/2023 - A review of the December CNA task flow sheet revealed that R61 was incontinent of bowel thirty-nine out of ninety opportunities. 1/2024 - A review of the January CNA task flow sheet revealed that R61 was incontinent of bowel twenty-four out of ninety opportunities. 2/2024 - A review of the February CNA task flow sheet revealed that R61 was incontinent of bowel twelve out of ninety opportunities. 3/2024 - A review of the March CNA task flow sheet revealed that R61 was incontinent of bowel twenty out of ninety opportunities. 3/19/24 - A review of an annual MDS assessment revealed that R61 was always incontient of bladder and always incontinent of bowel. 8/6/24 12:16 PM - An interview with E4 (MDS LPN) revealed that the MDS coordinators are responsible for monitoring residents bowel and bladder continence and establishing toileting programs for the residents who need it. E4 confirmed that R55 was not on a toileting program at this time.	F 690		

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F 690	Continued From page 30 8/7/24 11:04 AM - An interview with E28 (CNA) confirmed that R61 was dependent on staff for toileting and no toileting program was in place. E28 confirmed that R61 was toileted every two hours. 4. Review of R100's clinical record revealed: 10/16/23 - R100 was admitted to the facility. 4/9/24 - A review of a quarterly MDS assessment revealed that R100 was always continent of bladder and always continent of bowel. No toileting program was indicated. 5/2024 - A review of the May CNA task flow sheet revealed that R100 was incontinent of bladder five out of ninety opportunities. 6/2024 - A review of the June CNA task flow sheet revealed that R100 was incontinent of bladder four out of ninety opportunities. 7/2/24 - A review of a quaterly MDS assessment revealed that R100 was occasionally incontinent of bladder and always continent of bowel. No toileting program is indicated at this time. 7/2024 - A review of the July CNA task flow sheet revealed that R100 was incontinent of bladder eight out of ninety opportunities. 8/6/24 12:16 PM - An interview with E4 (MDS LPN) revealed that the MDS coordinators are responsible for monitoring residents bowel and bladder continence and establishing toileting programs for the residents who need it. E4 confirmed that R55 was not on a toileting program at this time.	F 690		

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F 690	Continued From page 31 8/7/24 10:50 AM - An interview with E19 (CNA) confirmed that R100 was not on a toileting program. E19 stated R100 was always continent and does not require staff assistance for toileting. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R47, R55, R61, and R100. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		10/7/24

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F 692	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R366) out of nine residents reviewed for nutrition, the facility failed to recognize and address R366's significant weight loss. Findings include: Cross refer to F711. 7/12/24 - R366 was admitted to the facility with diagnoses including, but not limited to, enterocolitis due to c-diff infection and protein-calorie malnutrition. 7/12/24 10:43 PM - R366's weight was documented in the EMR as 182.5 pounds. 7/12/24 - E12 (MD) ordered in R366's EMR, "Regular diet, mechanical soft with ground meats texture." 7/12/24 - E12 ordered in R366's EMR, "Weight - daily one time a day." 7/15/24 9:47 PM - E13 (PA) documented in R366's progress notes, "... Vital signs: weight 181.2 lbs (pounds)... Patient also does receive TPN (total parental nutrition) due to poor nutritional intake. Diagnosis, Assessment and Plan: Unspecified severe protein-calorie malnutrition - present on admission, Nutrition consult...". 7/15/24 - E13 (PA) ordered in R366's EMR, "Boost one time a day for PCM (protein-calorie malnutrition) risk. Offer 240 ml Boost q day - prefers chocolate."	F 692	F692 A. Unable to correct/verify original weight assessment discrepancies due to R366 no longer residing at facility. All facility weight scales were calibrated on 8/28/24. B. All patients have the potential to be affected by this deficient practice. A facility wide audit of daily weights to be completed by Dietitian, or designee, to identify potential weight loss from previously obtained weight and appropriate course of action. This audit will be completed by October 7, 2024. C. Root cause analysis performed identified a nursing knowledge deficit as to resident weight discrepancies and appropriate course of action. When a resident□s weight is obtained and noted to differ from the previous weight +/- 3lbs in one day, the resident is to have a reweigh immediately, if possible, and if not, then the following day- and if the noted change is confirmed, the nurse will make note on the 24-hour-report sheet and the appropriate health care professional or committee will be notified (i.e., attending physician, dietitian, RNAC, etc.). All nurses, CNAS, and dietician are to have education by Staff Education Coordinator regarding this process to be completed by October 7, 2024. New admissions will be reviewed during daily morning IDT meetings to identify anyone at an increased risk for weight loss to encourage increased monitoring.	

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F 692	Continued From page 33 7/15/24 11:35 AM - R366's lab work documented an albumin level of 2.9 g/dl, with a normal albumin range as 3.5 to 5.0 g/dl, and a total protein level of 6.3g/dl, with a normal total protein level of 6.3 to 8.2 g/dl. 7/15/24 2:06 PM - E7 (Dietician) documented in R366's progress notes that R366 was "seen to review nutrition interventions and collect food/fluid preferences." 7/15/24 4:37 PM - E7 documented in R366's Nutrition Admission assessment,"... Res (resident) is at nutritional risk r/t (related to) use of TPN during hospitalization for hydration and nutritional needs; use of mechanically altered texture diet; physical s/s (signs and symptoms) of malnutrition visible- fat loss + muscle wasting; recent Sx + c-diff infection w/increased metabolic stress/increased needs; advanced age... Res w/noted varied % po intakes since admit... No significant weight changes known from hospital wt 6/18 187 lbs to admit weight to facility... Recent labs 7/15/24... Alb 2.9...Total pro (protein) 6.3... Plan:... Goal is for stable weights despite BMI in elevated range given PCM risk... Macronutritient supplementation for therapeutic diet for PCM risk/ skin integrity/increased needs... Monitor PRN and quarterly during LOS. Update interventions and care plan as needed w/ changes." These two nutritional notes were the only nutritional notes in R366's EMR until the surveyor notified the facility of R366's significant weight loss. 7/16/24 - E7 initiated a nutritional risk focus on R366's care plan with interventions that included:	F 692	D. The dietitian, or designee, will audit daily weights three times a week until 100% compliance is achieved at three consecutive evaluations to identify weight changes or discrepancies and ensure proper course of action is implemented, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 692	Continued From page 34 "Monitor/record/report to MD PRN s/sx of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, > 7.5 % in 3 months, >10% in 6 months." The weight difference from the admission weight on 7/12/24 of 182 pounds to the 7/22/24 weight of 167.4 pounds was a 14.6 pounds weight loss, which represented 8.1 % loss calculated. 7/24/24 1:02 PM - R366's weight was documented in the EMR by E24 (LPN) as 167.0 pounds. 7/30/24 9:35 AM- R366's weight was documented in the EMR by E24 (LPN) as 167.7 pounds. 8/2/24 3:10 PM - During a telephone interview, the surveyor notified E7(Dietician) of R366's 17 pound weight loss. After signing into R366's EMR and looking at the documented weights, E7 confirmed that R366 had a significant weight loss of 17 pounds in 3 weeks. Prior to this conversation, E7 was unaware of R366's weight loss. E7 clarified that PCM in the notes stands for protein-calorie malnutrition. E7 stated, "He [R366] does have some dietary interventions that show on his diet ticket. He gets ice cream for lunch daily. E7 confirmed that R366's albumin level on 7/15/24 was 2.9 and that R366 would benefit from protein supplementation. E7 stated. "He should have other supplements so I will get with the doctor about it." E7 confirmed that there were only two nutrition notes; both on 7/15/24, which was 3 days after R366's admission. 8/2/24 - E12 ordered in R366's EMR. "Boost three times a day for PCM risk; varied % PO	F 692		

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F 692	Continued From page 35 intakes, wt loss. Offer 240 ml Boost TID - prefers chocolate." 8/2/24 - E13 (PA) ordered in R366's EMR, "Liquid protein one time a day for increased needs for wound healing. Offer 30 ml q/day of PUCH 20 liquid protein supplement." 8/5/24 4:06 PM - During a telephone interview, E12 stated, "We go over the residents with weight changes at the IDT meeting on Tuesdays. Normally I address it in my notes." 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 692		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 711	F711	10/7/24

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F 711	Continued From page 36 determined that for one (R366) out of twenty-three residents reviewed for physician visits, the facility failed to ensure the physician visits included evaluation of R366's condition and total program of care to address R366's significant weight loss. Findings include: Cross refer to F692. 7/12/24 - R366 was admitted to the facility with diagnoses including, but not limited to, enterocolitis due to c-diff infection, S/P abdominal surgery with wound vac (wound management system) in place on his abdominal incision wound and protein-calorie malnutrition. 7/12/24 10:43 PM - R366's weight was documented in the EMR by E20 (LPN) as 182.5 pounds. 7/15/24 9:47 PM - E13 (PA) documented in R366's progress notes, "... Vital signs: weight 181.2 lbs... Patient also does receive TPN (total parental nutrition) due to poor nutritional intake. Diagnosis, Assessment and Plan: Unspecified severe protein-calorie malnutrition - present on admission, Nutrition consult ...". 7/15/24 11:35 AM - R366's lab work documented an albumin level of 2.9 g/dl, with a normal albumin range as 3.5 to 5.0 g/dl, and a total protein level of 6.3g/dl, with a normal total protein level of 6.3 to 8.2 g/dl. 7/15/24 - E13 ordered in R366's EMR, "Boost one time a day for PCM risk. Offer 240 ml Boost q day - prefers chocolate." 7/16/24 - E12 (MD) documented in R366's	F 711	A. Unable to correct due to R366 no longer residing at the facility. B. All patients have the potential to be affected by this deficient practice. Dietitian, or designee, to audit all daily weight patients for a correlating physician□s note that identifies the weight loss and documents the interventions put in place for anyone determined to have lost 3 or more pounds in one day. C. Dietician, Medical Director/Physicians Assistant, and all nurses to have education by Staff Education Coordinator on identifying high risk weight loss/gain patients and the implementation of interventions in a timely manner. Weight loss/gain patients to be reviewed and discussed with Medical Director and clinical team at weekly High-Risk meetings, ensuring there is additional follow-up that occurs at the same meeting the following week to evaluate current interventions/supplements for effectiveness and make changes if applicable. All education on this to be completed by October 7, 2024. Root cause analysis identified MD failed to make notation regarding weight loss and implement intervention. Dietitian was unable to provide a written list of weight changes to review at weekly High-Risk meeting; thus, creating breakdown in communication between nursing, dietitian, and providers. D. A facility wide audit of daily weights to be completed by Dietitian, or designee,	

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F 711	Continued From page 37 admission History and Physical note, "... Vital signs: weight 180.9 lbs 7/16/24 10:17 AM ...". The physician note dated 7/16/24 failed to provide evidence of interventions with regard to R366's nutritional status. 7/23/24 7:16 PM - E12 documented in R366's progress notes, "... Vital signs: weight 167.4 lbs (Warnings : -5% change, False. -7/5% change, False) 7/22/2024 1:11 PM)... Labs: All Labs, images, reports and previous notes reviewed ...". The provider note dated 7/23/24 did not address the documented 13.5 pound weight loss or document any treatments intiated to intervene regarding the weight loss. 7/24/24 1:02 PM - R366's weight was documented in the EMR by E24 (LPN) as 167.0 pounds. 7/30/24 9:35 AM- R366's weight was documented in the EMR by E24 (LPN) as 167.7 pounds. 7/30/24 7:38 PM - E12 documented in R366's progress notes, "... Vital signs: weight 167.7 lbs (Warnings : -5% change, False. -7/5% change, False) 7/30/2024 9:35 AM)... Labs: All Labs, images, reports and previous notes reviewed ...". The provider note dated 7/23/24 did not address R366's weight loss or document any treatments regarding this weight loss. 8/2/24 3:10 PM - During a telephone interview, E7 (Dietician) confirmed that R366 had a significant weight loss of 17 pounds in 3 weeks. E7 stated, "He [R366] does have some dietary interventions	F 711	confirming that anyone with a weight loss/gain of three or more pounds in one day has a physician note in the EMR addressing it and implementing interventions if necessary. Audits to be performed three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 711	Continued From page 38 that show on his diet ticket. He gets ice cream for lunch daily. E7 confirmed that R366's albumin level on 7/15/24 was 2.9 and that R366 would benefit from protein supplementation. E7 stated. "He should have other supplements so I will get with the doctor about it." 8/5/24 4:06 PM - During a telephone interview, E12 (MD) stated, "We go over the residents with weight changes at the IDT meeting on Tuesdays. Normally I address it in my notes." The physician failed to identify and address R366's weight loss/nutritional status in the weekly progress notes dated 7/16/24, 7/23/24 and 7/30/24. Upon reviewing the 7/15,24 lab results, the physician failed to order additional nutritional supplementation for R366, who in addition to his c-diff infection, had a gaping abdominal incision. Both of these health issues would increase R366's caloric needs. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 711		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740		10/7/24

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F 740	Continued From page 39 and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined, for one (R3) out of two sampled residents, with mood and behavioral issues, the facility failed to provide the necessary behavioral health services to attain the highest practicable mental and psychological well-being. Findings include: Review of R170's clinical record revealed: 4/3/24 - R170 was admitted to the facility. 4/10/24 - An incident report was submitted to the state agency regarding an allegation of sexual abuse by R170. 4/10/24 1:00 PM - R170 was placed on fifteen minute checks by staff. 4/10/24 5:22 PM - A review of the physician's orders revealed that R170 was placed on alert charting to monitor for inappropriate touching of others to start at 11:00 PM. 8/8/24 9:19 AM - An interview with E19 (CNA) confirmed that E19 wrote a witness statement that stated she had witnessed R170 inappropriately touching staff on 4/7/24. E19 confirmed that the behaviors were reported to a supervisor. Facility documentation lacked evidence of R170's inappropriate behavior's were reported to the facility. 8/8/24 9:22 AM - An interview with E22 (LPN) confirmed that behavior monitoring was started on 4/10/24 for R107's inappropriately touching of	F 740	F740 A. Unable to correct deficiency due to R170 no longer residing at facility. B. All patients have the potential to be affected by this deficient practice. DON, or designee, to audit Risk Management System for last two weeks for the identification of any display of sexual behavior by residents and ensure that necessary behavioral health services were offered/provided. Audit to be completed by October 7, 2024. C. All facility staff to receive education by Staff Education Coordinator on the identification and importance of reporting any sexually inappropriate behaviors exhibited by residents towards employees as soon as they occur and for nurses to immediately report such behaviors to DON and physician by phone and begin behavioral monitoring at time of incident. Education to be completed by October 7, 2024. Root cause analysis revealed knowledge deficit of facility staff recognizing that inappropriate sexual behaviors towards staff require immediate notification and intervention, not just resident to resident inappropriate behavior. D. DON, or designee, to audit Risk Management System of incidents for sexually inappropriate behaviors and ensure verification of immediate provider notification and the initiation of applicable	

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F 740	Continued From page 40 others. 8/8/24 10:25 AM - An interview with E12 (MD) confirmed that behavior monitoring and interventions can be initiated by nursing. E12 confirmed that R170's inappropriate behavior's were not reported before 4/10/24 (date in incident) and confirmed that E12 would have expected staff to notify the on call provider of sexually inappropriate behaviors. The facility lacked evidence of initiating behaviorial monitoring for R107 when staff witnessed R107 exhibiting inappropriate sexual behaviors towards staff. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 740	interventions three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated. If 100% compliance is reached, then it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		10/7/24

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F 757	Continued From page 41 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R102 and R366) out of five residents sampled for medication review, the facility failed to ensure that the residents were free from unnecessary meds. Findings include: 1. Review of R102's clinical record revealed: 2/22/24 - R102 was admitted to the facility under hospice care. 5/13/24 - A review of the physician's orders for R102 revealed an order for Haldol (antipsychotic medication) 2mg give one tablet two times a day for nausea and vomitting, hospice. The order was entered by E13 (PA) and approved by E12 (MD). 6/21/24 - A review of the physician's orders for R102 revealed an order for Haldol (antipsychotic medication) 5mg give one tablet at bedtime for agitation. 7/30/24 10:35 AM - An interview with FM1 (Son) revealed that R102 was always sleeping when FM1 comes to the facility to visit. FM1 stated he had spoken to the Unit Manager to express his concerns regarding R102's change in status. 8/1/24 12:00 PM - An interview with E26 (CNA) confirmed that R102 was sleeping more often in	F 757	F757 A. Unable to correct deficiency for R366, as he no longer resides at facility. R102 received medication reduction to decrease lethargy and daytime sleepiness. B. All residents have the potential to be affected by this deficiency. Unit Managers, or designee, to audit 10% of residents on psychotropic medications for the last two weeks and review Medication Administration Records (MARS) to determine if any of those medications were held for lethargy and if MD notification occurred as a result. Audit to be completed by October 7, 2024. C. All nurses to be educated by Staff Education Coordinator by October 7, 2024 on adverse medication effects versus therapeutic effects of psychotropic medications and the importance of notifying provider, and hospice if applicable, if medications need to be held due to lethargy or other indications. Root cause analysis indicated knowledge deficit of nurses regarding adverse effects and identifying when a dose should be reduced or discontinued and the proper procedure for doing so, including notifying	

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F 757	Continued From page 42 the dayroom and E26 noticed R102 was missing meals due to sleeping. 8/1/24 12:15 PM - An interview with C2 (RN Hospice) revealed the agency received a call from FM1 about R102's excessive daytime sleeping and C2 was at the facility to assess R102's medications. 8/1/24 12:26 PM - An interview with E25 (UM) revealed that R102 was sleeping more during the day and that E25 shared this information with E13, but is unable to recall when the conversation occurred. 8/1/24 12:30 PM - An interview with C2 confirmed that R102's medication was reduced per C2's recommendation. 8/8/24 10:33 AM Interview with E12 (MD) confirmed that he was not informed of R102's excessive daytime sleepiness. The facility lacked evidence of staff reporting to the providers of R102 increased lethargy and daytime sleepiness.	F 757	the physician for a med review. D. Unit Managers, or designee, to audit MARS for held psychotropic medications with correlating MD notification three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations; and then once monthly until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	
F 758 SS=E	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	F 758		10/7/24

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F 758	Continued From page 43 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or 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:	F 758		

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F 758	Continued From page 44 Based on clinical record review and interview, it was determined that for four (R14, R90, R100, R47 and R366) out of five residents reviewed for unnecessary psychotropic medications, for R14, the physician failed to ensure that that an appropriate diagnosis was reflected in the resident's chart while antipsychotic medications were being administered. For two residents (R90 and R100), the facility failed to limit an as needed (PRN) psychotropic medication to 14 days. For R366, the facility failed to ensure adequate monitoring (AIMS assessments) and adequate indication for quetiapine (Cross refer to 645). Findings include: 1. Review of R14's clinical record reevealed: 7/9/24 - R14 was admitted to the facility. 7/8/24 - A Preadmission screening and Resident Review (PASARR) Level 1 was completed and revealed that R14 has a diagnosis of generalized anxiety disorder for which Seroquel (Quetiapine Fumarate) is prescribed. 7/9/24 - Discharge Instructions from R14's previous rehabilitation center revealed that R14 was prescribed Seroquel for generalized anxiety disorder. 7/9/24 - An order for Quetiapine Fumarate Oral Tablet 50 MG ... Give 1 tablet by mouth in the evening for generalized anxiety was added to R14's MAR. 8/8/24 10:18 AM - In an interview, E12 (MD) stated that the absence of generalized anxiety disorder from R14's list of diagnoses was an oversight and needed to be fixed. E12 stated that	F 758	F758 A. Appropriate diagnosis (generalized anxiety) for the use of psychotropic medications updated in resident's chart for R14 and updated PASARR screening referral sent to reflect updated anxiety diagnosis. For R90, referral made for psych NP to evaluate use/need for PRN Ativan and get end date in place. PRN order for Alprazolam completed and not renewed due to no usage for R102. Unable to correct deficiencies for R366 due to patient no longer residing at facility. B. All residents have the potential to be affected by this deficient practice. MDS Coordinator, or designee, to audit all patients on antipsychotics for AIMS test, appropriate diagnosis, and stop dates for PRN medications or acceptable rationale for continued use. Audit to be completed by October 7, 2024. C. Education to be provided by Staff Education Coordinator to psych NP, MD, PA, and nurses on requirements for use of antipsychotic medications by October 7, 2024 to include AIMS test upon admission, appropriate diagnosis for correlating antipsychotic medication, stop dates for PRNs or justifiable rationales for extended use. Root cause analysis identified AIMS test was automatically populating to the 15th of each month for initial assessment, instead of prompting at time of admission and every six months. MD recognized it was an oversight on his behalf in not carrying over a previous diagnosis and that he needs to be	

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F 758	Continued From page 45 the diagnoses at least need to match those from the previous facility. 2. Review of R90's clinical record revealed: 3/8/23 - R90 was admitted to the facility with diagnoses including but not limited to Alzheimer's disease. 6/14/23 - A new diagnosis of Generalized anxiety disorder for R90. 5/7/24 - R90 had a Physician's order for xanax 0.5 mg, give 1 tablet by mouth every 6 hours as needed for restlessness/agitation, please renew every 14 days while in use. The aforementioned order did not have an end date. 8/6/24 10:19 AM - During an interview E12 (MD) stated that they begin a resident for 14 days and then the order will renew every 180 days. After reading the order to E12 with the order saying to renew every 14 days, E12 stated, "We need to take a look at that." There was a lack of documentation by the facility for the rationale in the medical record to extend the order beyond 14 days and no evidence of an evaluation. 3. Review of R100's clinical record revealed: 10/16/23 - R100 was admitted to the facility with the following diagnoses: generalized anxiety disorder, major depressive disorder, and adjustment disorder with depressed mood. 2/20/24 - A review of R102's physician's orders	F 758	consistent in including previous diagnoses from previous providers for the indication of medication use. Root cause analysis for end date indicated the provider was trying to prevent the patient from not having enough doses due to pharmacy issue. Pharmacy consultant aware of issue and working to resolve it so facility provider can be in compliance with appropriate end dates going forward. D. MDS Coordinator, or designee, to audit all patients with new psychiatric diagnoses or patients with psychotropic medications initiated for AIMS test, appropriate diagnosis use for appropriate medication, and stop dates for PRN medications or documented acceptable rationale for extended use. Audits to be performed three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then one month later the audit will be repeated until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 758	Continued From page 46 revealed an order for Alprazolam (anti-anxiety medication) 0.25 mg give one tablet every eight hours as needed for anxiety/tearfulness for 180 days. 8/8/24 10:27 AM - An interview with E12 (MD) confirmed that PRN (as needed) medications are prescribed initially with a 14 day stop date and change to 180 day stop date. E12 confirmed that R102's alprazolam order did not have a rationale for continued use and will update the order. 4. Review of R47's clinical record revealed: 6/19/18 - R47 was admitted to the facility. 9/29/18 - A review of R47's medical diagnoses revealed R47 has insomnia. 5/24/24 - A review of the physician's orders revealed an order for Trazadone 100 mg at bed time for restlessness. 8/8/24 10:29 AM - An interview with E12 (MD) revealed that restlessness is not a common diagnosis for the use of trazadone and most likely was provided by an outside provider. E12 agreed that the provider using sleeplessness is a more appropriate diagnosis. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference. 5. Review of R366's clinical record revealed: Facility's "Policy for Utilization of Psychotropic Medications in Skilled Nursing Facility -...1. Assessment and Indication - Clear Indication: Psychotropic medications should only be	F 758		

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F 758	Continued From page 47 prescribed for specific, documented indications such as major psychiatric disorders, severe behavioral symptoms, or significant distress where non-pharmacological interventions have been insufficient... 3. Monitoring and Evaluation: Regular Monitoring: Monitor the resident regularly for effectiveness and side effects, including changes in behavior, cognitive function and overall well-being ...". 7/12/24 - R366's discharge summary from [hospital] documented, "... Hospital Course: ...He [R366] also required a sitter due to "sundowning" episodes ... Prescription Medications: Seroquel (Quetiapine) 25 mg oral tablet, 50 mg = 2 tabs ...". 7/12/24 - R366 was admitted to the facility. 7/12/24 5:40 PM - E12 (MD) ordered in R366's EMR, "Quetiapine 50 mg - give 1 tablet by mouth one time a day for delirium." 7/14/24 - R366's admission MDS documented in Section N Medications that "antipsychotics were received on a routine basis only." 7/18/24 - E27 (Consultant pharmacist) documented in R366's July Medication Regimen Review (MRR), "... 2. Current Order: High Risk Medication Monitoring: Antipsychotic Medication (Quetiapine): Routine Antipsychotic use must be evaluated by MD on admission for potential dose reduction or discontinuation; Perform AIMS (a tool to assess involuntary movements caused by antipsychotic medicine) test within 30 days of admission & every 6 months. Please provide rationale for use with diagnosis of delirium."	F 758		

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F 758	Continued From page 48 7/31/14 - E12 documented on the July MRR that he agreed with recommendation #2 but did not order AIMS test or provide a rationale for the use of quetiapine with the diagnosis of delirium. 8/5/24 4:06 PM - During a telephone interview, E12 confirmed that he did not order the AIMS test in R366's EMR and he did not document a rationale for the usage of quetiapine in the setting of delirium in R366's EMR. 8/5/24 - E13 (PA) ordered in R366's EMR, "AIMS test every 6 months ...for anti-psychotic usage." 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 758		
F 760 SS=J	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 record review and interview, the facility failed to ensure for four (R13, R88, R108 and R165) residents of seven reviewed were free from a significant medication error when staff failed to administer insulin. Additionally, staff failed to conduct finger stick blood sugar monitoring, some of which included sliding scale insulin coverage based on the results. The facility's failure placed the residents at risk for a serious adverse outcome, hypogycemia and hyperglycemia. Due to this failure an Immedicate Jeopardy (IJ) was called on 8/2/24 at 1:40 PM. The IJ waws abated on 8/6/24 at 3:05 PM.	F 760	F760 A. None of the residents involved had any adverse outcomes. RN is no longer employed at facility. Abatement plan completed. B. All patients have the potential to be affected by this deficient practice. DON, or designee, to audit previous two weeks of MARS/TARS/DARS for completion/correction by October 7, 2024. C. All nurses to continue to receive	10/7/24

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F 760	Continued From page 49 Findings include: The manufacturer's instructions documented that "Basaglar is a long-acting insulin used to control high blood sugar in adults with Type 1 or Type 2 diabetes." The manufacturer's instructions documented that "Insulin Lispro Injection are fast-acting insulins used to control high blood sugar in adults... with diabetes." The manufacturer's instructions documented that "NovoLog® is a man-made insulin used to control high blood sugar in adults and children with diabetes mellitus." 1. Review of R13's July 2024 MAR revealed the following orders: 7/2024 - Basaglar Subcutaneous Solution Pen-injector 32 100 Unit/ml (Insulin Glargine) inject 32 units subcutaneous one time a day related to Type 2 Diabetes Mellitus without complications. 7/2024 - Insulin Lispro Subcutaneous Solution Cartridge 100 unit/ml (Insulin Lispro) inject 12 units subcutaneously before meals related to Type 2 Diabetes Mellitus without complications. 7/2024 - A glucose meter check before meals and at bedtime. 7/6/24 - No evening or night blood sugar checks were completed. Insulin Lispro was not administered at 4:00 PM. 7/7/24 - No morning, pre-lunch, evening or night blood sugar checks were obtained. Basaglar	F 760	education on mandatory completion of medication administration and treatments, including updated Policy for Reviewing MARs, DARs, TARs at shift change and the implementation of the Sign-Off Sheet located inside every narcotic record book. D. DON, or designee, to audit MARS/TARS/DARS for completion weekly x 4 weeks, then monthly x 2 months, until 100% compliance is achieved. Audits will then be reviewed at facility monthly QAPI meetings to determine if additional action is required.	

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F 760	Continued From page 50 insulin was not administered at 8:00 AM. Insulin Lispro was not administered at 8:00 AM, 11:00 AM and 4:00 PM. 2. Review of R88's July 2024 MAR revealed the following orders: 7/2024 - Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) inject 10 units subcutaneously one time a day for diabetes. 7/2024 - Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject as per sliding scale as follows: if 0 - 140 = 0... 141 - 180 = 6u; 181 - 220 = 8u; 221 - 260 = 10u 261 - 300 = 12u; 301 - 350 = 14u; 351 - 399 - 16u... ... subcutaneously before meals and at bedtime for Diabetes Mellitus. 7/6/24 - No afternoon or evening blood sugar check was completed. The MAR reflected that the sliding scale injection of Novolog Flex Pen insulin was not administered at 4:30 PM and 8:00 PM. 7/7/24 - No morning, pre-lunch or evening blood sugar check was obtained. Insulin Glargine was not administered at 12:00 PM. The sliding scale injection of Novolog Flex Pen insulin was not administered at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM. 3. Review of R108's July 2024 MAR revealed the following orders:	F 760		

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F 760	Continued From page 51 7/2024 - Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 8 units subcutaneously at bedtime for Diabetes Mellitus. The MAR also had a space labeled "BS" (blood sugar) where the blood sugar result should be referenced. 7/2024 - Insulin Lispro with Transport Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Lispro) Inject 4 units subcutaneously before meals for Diabetes Mellitus. The MAR also had a space labeled "BS" (blood sugar) where the blood sugar result should be referenced. 7/6/24 - No evening or night blood sugar checks were obtained. Lantus was not administered at 9:00 PM. Insulin Lispro was not administered ad 4:00 PM. 7/7/24 - No evening or night blood sugar checks were obtained. Lantus was not administered at 9:00 PM. 4. Review of R165's July 2024 MAR revealed the following orders: 7/2024 - Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 14 units subcutaneously at bedtime for Diabetes Mellitus. MAR also had a space labeled "BS" (blood sugar) where the blood sugar result should be referenced. 7/2024 - Novolog FlexPen Solution Pen-injector 100 unit/ml (Insulin Aspart) Inject as per sliding scale... if 151 - 200 - 0u.... 201 - 250 = 2u; 251 - 300 = 4u; 301 - 350 = 6u;	F 760		

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F 760	Continued From page 52 351 - 400 = 8u; 401 - 450 = 10u... ...subcutaneously before meals and at bedtime for Diabetes Mellitus. 7/6/24 - No evening or night blood sugar checks were obtained. Insulin Aspart was not administered at 6:00 PM. Lantus was not administered at 9:00 PM. 7/7/24 - No pre-lunch, evening or night blood sugar checks were obtained. Insulin Aspart was not administered at 11:00 AM or 4:00 PM. Lantus was not administered at 9:00 PM. 8/1/24 approximately 2:04 PM - In an Interview, E2 (DON) and E3 (ADON) stated when they were alerted that several residents stated their medications were not administered, they conducted an immediate investigation and notified family members. The nurse involved, E18, was terminated and was also reported to the State. A review of the MAR's show that E18 gave all the oral medications, but did not give any insulin or check blood sugars. They stated that they cannot prove whether the oral medications were given, although they were signed off as being given. None of the residents had any adverse outcome. 8/2/24 1:40 PM - Based on interviews and review of the facility documentation and other sources, an Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA), E2 (DON) and E3 (ADON). 8/2/24 3:25 PM - E1 (NHA), E2 (DON), and E3 (ADON) submitted evidence of an acceptable completed Abatement Plan signed, dated and	F 760		

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F 760	Continued From page 53 timed. 8/6/24 3:05 PM - The facility's Immediate Jeopardy was abated at this time. The acceptable abatement plan included documentation of an updated Policy for Reviewing Medication Administration Records (MAR), Drug Administration Records (DAR), and Treatment Administration Records (TAR) at Shift Change; Sign Off Sheet to be completed at shift change; education presented to staff entitled "Mandatory Completion of Medication Administration and Treatments for All Staff; and sign in sheet for the aforementioned training. All current licensed nursing staff were educated beginning on August 2, 2024 and finishing on August 5, 2025. Review of training records, sign in sheets and interview with DON revealed that the above abatement plan was completed. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 760		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's	F 803		10/7/24

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F 803	Continued From page 54 reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure the dietician approved menus are followed to meet the nutritional needs of the residents and for two (R49 and R97) out of ten sampled residents, the facility failed to ensure that residents received the selected food from the menu. Findings include: 7/30/24 11:20 AM - During a tour of the kitchen, the posted menu indicated that the lunch option for that Tuesday was ravioli, green beans, and mashed potatoes with gravy. Review of the facility submitted menu for the week of July 28th through August 3rd indicated that the planned lunch for July 30 was baked beef patty, green beans, mashed potatoes and gravy. An interview with E6 (Dietary Director) revealed that the ravioli was a substitution for the baked beef patty listed on the original menu. 8/7/24 10:23 AM - An interview with E7 (Dietician) revealed the substitution of ravioli on July 30, 2024 was not brought to the attention of the	F 803	F803 A. The facility is unable to correct original deficiencies involving previous meals served to residents during survey time related to non-menu items being served, missing items on food trays, and lack of menu substitutions. No adverse effects noted secondary to deficient practice. B. All residents have the potential to be affected by this deficient practice. Menus will be reviewed and approved by dietitian and will follow a set four-week cycle. C. All dietary staff members will be educated by the Dietitian, or designee, on adherence to prescribed diet and menu, completion of ticket items on trays, and process for providing substitution items. Education to be completed by October 7, 2024. Root cause analysis of this deficiency indicated a broad knowledge	

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F 803	Continued From page 55 dietician for approval as an adequate substitute as part of that meal. 2. 7/31/24 9:18 AM - A random observation of R49's breakfast tray revealed missing almond milk and cranberry juice. R49 stated he doesn't get what is on the meal ticket and that he receives fruit punch instead of cranberry juice. The meal ticket showed R49 was supposed to have the almond milk and cranberry juice. 8/1/24 9:13 AM - A random observation of R49's breakfast tray revealed missing breakfast ham, cranberry juice and almond milk. There were no substitutions on the tray form the missing breakfast ham or the almond milk. Instead of cranberry juice there was apple juice on the tray. 8/1/24 9:16 AM - An observation of R49 telling E9 (CNA) that he did not receive what he wanted, E9 apologized and stated she would call the kitchen. 8/1/24 9:23 AM - An interview with E9 revealed that she called the kitchen and they did not have cranberry juice. 8/1/24 12:54 AM - A random observation of R49's lunch tray revealed missing creamed corn and mechanical soft refried beans. The meal ticket showed R49 was supposed to have the creamed corn and mechanical soft refried beans and there were no substitutions provided. 8/2/24 11:14 AM - A interview with E7 (Dietician) revealed that what is printed on the meal ticket should be on the resident's tray. E7 stated that they did not have creamed corn in the kitchen and the facility just recently stopped carrying almond milk, which confirmed there was none in	F 803	deficit with dietary employees, as well as many instances where the employees unintentionally followed the menu for the wrong day of the week, or cooked the wrong meal- creating a domino effect for future meals- as the ingredients were already used forcing additional unplanned substitutions to happen, often with lack of communication to residents and floor staff. D. To monitor above solutions, dietitian, or designee, will audit a random 10% of facility residents□ trays for correct diet, menu items, and appropriate substitutions. Audits to be completed weekly three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then once monthly the audit will be repeated until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 803	Continued From page 56 the facility. E7 stated since the kitchen did not have any refried beans they were supposed to substitute mashed potatoes. 3. 8/7/24 1:38 PM - A random observation of R97's lunch tray revealed that chocolate ice cream and iced tea were missing from the tray. A review of the printed lunch ticket confirmed chocolate ice cream and iced tea were on R97's menu order for lunch. 8/7/24 1:42 PM - An interview with E11 (CNA) confirmed that the chocolate ice cream and iced tea were missing from the tray. E11 called down to the kitchen to have the missing items sent to the unit. E11 confirmed that items are consistently missing on trays during meal time. 8/8/24 1:04 PM - A random observation of R97's lunch tray revealed that six ounces of beef and barley soup, four ounces of carrot raisin salad, one cookie, and one carton of milk was missing off the tray. A review of the printed lunch ticket confirmed that the soup, salad, cookie, and milk were on R97's menu order for lunch. 8/8/24 2:00 PM - An interview with E11 (CNA) confirmed the above mentioned items were not delivered on the tray. E11 stated that R97's visitor had provided food that he brought for R97. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 803		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/7/24

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F 812	Continued From page 57 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 7/30/24 8:58 AM - During the initial tour of the kitchen, there was food and other small bits of debris on the floor near the walk-in refrigerator and adjacent to the back of the tray line. 7/30/24 9:34 AM - During a tour of the kitchen, frozen hot dogs in a pan were being thawed in a sink under warm running water. Acceptable methods for thawing frozen food under running water require the water to be cold. 7/30/24 10:05 AM - During a tour of the kitchen, several food items including, cake slices, leftover cooked meat, and corn kernels in the walk-in	F 812	F812 A. Items in kitchen walk-in refrigerator missing date labels were disposed of unless prepare dates were known and within acceptable storage timeframe, in which case items were labeled appropriately. Rusted storage shelves were removed and restored on September 5, 2024 by maintenance personnel. New sanitizing solution in kitchen was prepared and verified by test strips indicating appropriate concentration levels. Un-labeled nutritional shakes in Kent Unit nourishment refrigerator disposed of, as well as the un-labeled take out container in the Sussex Unit nourishment refrigerator due to not being able to confirm when food was placed in fridge. On September 5, 2024 Kitchen deep cleaned by dietary staff and any	

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F 812	Continued From page 58 refrigerator were missing the date label. 7/30/24 10:58 AM - Observation of the walk-in refrigerator revealed the storage shelves were rusted in numerous areas. 7/30/24 11:05 AM - During a tour of the kitchen, the surveyor observed E6 (Dietary Director) test the sanitizer level of the solution in two red sanitizing buckets. When E6 tested the sanitizing solution, the test strips from each of the two buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. Further testing of the chemical sanitizer at the three-compartment sink by E6 revealed the sanitizer level at the sink was not at a sufficient level to provide proper sanitization. 7/30/24 1:57 PM - Observation of nourishment refrigerator in the Kent hallway revealed two (2) cartons of nutritional shake that were undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 7/30/24 2:13 PM - Observation of nourishment refrigerator adjacent to the Sussex hallway nurse's station revealed a take-out container labeled with a resident's name, but no date to indicate when the item should be discarded. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 812	debris on floor was eliminated. Kitchen cleaning schedule also updated to increase frequency of floor cleaning. B. All residents have the potential to be affected by this deficient practice, however, no residents were adversely affected. C. Root cause analysis indicated a department wide knowledge deficit regarding fundamentals and lack of enforcement/leadership for completion of scheduled cleaning/rounding routines. Of note, new dietary manager to start 9/23/24. All dietary staff members will receive education regarding the department cleaning schedule including mixing of sanitizing solution, routine environmental rounding checklist, communication of maintenance needs, and proper thawing of food items. All education will be provided by the dietitian, or designee, and will be completed by October 7, 2024. D. The following audits will be completed by dietitian, or designee: Audits of walk-in refrigerator and nourishment refrigerators ensuring all items are labeled and dated appropriately, audits of completion of kitchen cleaning schedule and environmental rounding checklist with appropriate maintenance follow up if needed, and audits of food thawing appropriately. Audits to be completed three times a week until 100% compliance is achieved at three consecutive evaluations and then one time a week	

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F 812	Continued From page 59	F 812	until 100% compliance is achieved at three consecutive evaluations. Then once monthly the audit will be repeated until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following 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	F 880		10/7/24

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F 880	Continued From page 60 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 observation and interviews, the facility	F 880	F880	

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F 880	Continued From page 61 failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. It was determined that for two (R101, R165) out of twenty-one residents for infection control, the facility failed to initiate enhanced barrier precautions on residents with MDRO colonization. The facility 's IPCP surveillance program failed to meet national standards and was lacking in process surveillance of staff practices. Findings include: Cross refer F881 and F842. Facility's "Infection Surveillance Policy... Procedure:... 2. Identify individual cases and trends of significant infections to intervene and prevent the spread to other residents and staff.... 5. When infection or colonization with epidemiologically important organisms is suspected, culture may be sent, if appropriate, to a laboratory for identification or confirmation... 9. The Attending physician will determine the treatment plan for the resident... 10. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will ensure staff are educated and interventions are in place... 12. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data... The data may include: a. lab reports, including culture and sensitivities... d. vital signs, especially temperature... 13. All multidrug- resistant reports require immediate attention...". Facility's "Enhanced Barrier Precautions (EBP) Policy... ... Procedures: 1. EBP will be used in	F 880	A. Enhanced barrier precautions initiated for R165. Unable to correct deficient practice for R101, as resident is deceased. Unable to correct deficient practice for R367 due to resident no longer resides at facility. B. All residents have the potential to be affected by this deficient practice. Infection Preventionist, or designee, to audit line listing back to April 1, 2024 to confirm EBP in place for any patients with MDROs by reviewing all culture results. Audit to be completed by October 7, 2024. Line listing to be modified to include name of the pathogen, infection site, type of precautions, start and stop date of antibiotics prescribed, invasive procedure/risk factors, facility/community acquired section and signs/symptoms. Additional surveillance tools to be implemented to provide monthly analysis on infection trends and patterns C. All nurses, medical director, and physician assistant to receive education from Staff Education Coordinator on the McGeer criteria/indications for obtaining C&S, the process of monitoring sensitivity reports- especially over the weekend. IP nurse, or designee, to call lab for results 48 hours after specimen is received by lab. Sensitivities to be pulled and called to physician in timely manner to determine if current antibiotic is effective, then uploaded into EMR if results are not showing under Results tab. All information regarding such to be placed on 24-hour report sheet to ensure follow-up is	

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F 880	Continued From page 62 addition to standard precautions and when: a. A resident has an infection or colonized CDC-targeted MDRO and Contact Precautions do not otherwise apply or; b. A resident has a chronic wound or indwelling medical device even if the resident is not known to be infected or colonized with a CDC-targeted MDRO...". Per the CDC document, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent the Spread of Multidrug- esistant Organisms (updated July 12, 2022), "focusing only on residents with active infections fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g months) which contributes to the silent spread of MDROs." McGeer Criteria for Infection Surveillance: Syndrome- UTI without indwelling catheter Criteria- Must fulfill both 1 and 2. 1. At least one of the following sign or symptom: -Acute dysuria (pain on urination) or pain, swelling or tenderness of testes, epididymis or prostate -Fever or leukocytosis (elevated white blood cell count), and greater than 1 of the following: --acute costovertebral angle pain or tenderness --suprapubic pain --gross hematuria --new or marked increased in incontinence --new or marked increase in urgency --new or marked increase in frequency -If no fever or leukocytosis, then greater than 2 of	F 880	completed and reviewed at weekly High-Risk meeting. Laundry and housekeeping staff to receive education from IP nurse on safe handling of general soiled laundry and laundry soiled by residents on various types of precautions. All education to be completed by October 7, 2024. Root cause analysis indicated knowledge deficit for clinical staff regarding McGeer criteria and the importance of following it, as well as a lack of communication system for follow-up of lab results and provider notification. Knowledge deficit also identified, along with insufficient training/orientation of new laundry employees, regarding safe handling of soiled laundry under various circumstances. D. IP nurse, or designee, to audit all C&S reports for final sensitivities, notification of provider, and any antibiotic changes that occur as a result- three times a week until 100% compliance is achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations. Then once monthly the audit will be repeated until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 880	Continued From page 63 the following: --suprapubic pain --gross hematuria --new or marked increased in incontinence --new or marked increase in urgency --new or marked increase in frequency 2. At least one of the following microbiologic criteria -greater than 10 to the fifth CFU/ml of no more than 2 species of organisms in a voided urine sample -greater than 10 to the second CFU/ml of any organism(s) in a specimen collected by an in-and-out catheter. 1. Review of R21's clinical record revealed: 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Report dated 4/9/24, which the facility provided as part of their infection line listing, R21 was documented ... with infection "ESBL" no location of this infection was noted on "Macrobid 100 mg BID thru (sic) 4/14." This line listing did not specify the name of the pathogen, its location or describe R21's signs and symptoms of infection. The line listing did not document the infection as healthcare-associated infection (HAI) or community-acquired. The line listing also did not document that R21 was on contact precautions. 2. Review of R71's clinical record revealed: 11/1/23 - R71 was admitted to the facility with diagnoses including, but not limited to, dementia and congestive heart failure.	F 880		

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F 880	Continued From page 64 4/7/24 - E33 documented in R71's progress note, "Resident noted to have difficulty holding a lucid conversation today. Husband thinks there is a change. Incontinent of urine. Urine in brief was odorous with red tinge. Will obtain a UA specimen for testing. Afebrile. 98.5." 4/8/24 - E12 (MD) ordered in R71's EMR, "STAT UA (urinalysis)... CBC (complete blood count) and BMP (basic metabolic panel) r/t (related to) change in mental status ...". 4/10/24 - R71's microbiology urine culture final report documented. "Final ESBL- producing organism... >100,000 CFU/ml. Attention: ESBL producing organism, contact isolation required... 1. Klebsiella oxytoca ESBL." The report then listed that the pathogen was resistant to eight antibiotics. Based on McGeer's UTI without indwelling catheter criteria, this progress note along with the microbiology culture results provided documentation that met criteria for a UTI due to hematuria and new incontinence in the setting of no fever. 4/10/24 - E13 (PA) ordered in R71's EMR, "Contact precautions for ESBL (extended-spectrum beta-lactamases) in urine until end of abt therapy...". 8/7/24 2:16 PM - During a telephone interview regarding R71's urinary tract infection, E12 (MD) stated, "Yes, we knew it was an MDRO." When asked about differentiating an infection from a colonization, E12 stated that pathogen had growth of greater than 100,000 CFU/ml is universally considered an infection.	F 880		

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F 880	Continued From page 65 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Report dated 4/9/24, which the facility provided as part of their infection line listing, R71 was documented... with infection "UTI" on "Augmentin 500-125 BID thru (sic) 4/17." This line listing did not specify the name of the pathogen or describe R71's signs and symptoms of infection. The line listing did not document the infection as healthcare- associated infection (HAI), which it was since R71 had not left the facility since being re-admitted after a hospitalization on 2/14/24. 3. Review of R95's clinical record revealed: 3/5/24 - R95 was admitted to the facility. 5/11/24 3:52 PM - R95's EMR in the Results tab documented, "Collection date 5/9/24 7AM, Received date: 5/9/24 12:03 PM, Reported date: 5/11/24 3:52 PM Urine cath - 1 Organism growth final status." This lab result report was documented as "Reviewed by E13 (PA) on 6/24/24 at 8:46 AM." The surveyor was not able to find any documentation in R95's EMR of the specific pathogen that grew from this sample. The only documentation of a pathogen was "1 organism growth'" in the Results tab of R95's EMR. Upon request for the final microbiology culture with sensitivities, the surveyor was provided the document below. 5/11/24 - R95's microbiology urine culture final	F 880		

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F 880	Continued From page 66 report documented. "Final: ...>100,000 CFU/ml. Attention: Multi drug resistant organism, contact isolation required...1. Methicillin Resistant Staphylococcus aureus." The report then listed that the pathogen was resistant to two antibiotics. The microbiology urine culture final report revealed that R95 's urine was infected with MRSA. Of note, both the lab report in the Results tab of R95's EMR and R95's microbiology urine culture final report are dated 5/11/24. It is unclear why the final microbiology culture report was not uploaded into R95's EMR under the Results tab. 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Reports dated 5/14/24, 5/21/24, and 5/28/24, which the facility provided as part of their infection line listings, R95 was documented ... with infection "UTI" on "Macrobid 100 mg BID (twice a day) thru (sic) 5/29." This line listing did not specify the name of the pathogen or describe R95's signs and symptoms of infection. The line listings did not document whether R95 was on the required contact precautions. The line listing did not document whether the infection was healthcare-associated infection (HAI) or community-acquired. 4. Review of R101's clinical record revealed: 11/29/23 - R101 was admitted to the facility with diagnoses including, but not limited to, dementia. 4/19/24 - E13 (PA) documented in R101's progress note, "... Chief complaint: Behaviors/increased confusion... Diagnosis, Assessment and Plan:... Mood disorder-	F 880		

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F 880	Continued From page 67 increased confusion, rule out UTI. UA, C&S requested...". 4/19/24 - E13 (PA) ordered in R101's EMR, "UA C&S one time." 4/21/24 4:48 AM - E35 (LPN) documented in R101's progress notes, "Resident had no complaints of discomfort with urination...". 4/22/24 12:21 PM - E36 (LPN) documented in R101's alert charting, "... No s/s (signs and symptoms) of UTI. Afebrile...". 4/24/24 - R101's microbiology urine culture final report documented. "Final ESBL- producing organism ...Isolate 1:>50,000 CFU/ml. Attention: ESBL producing organism, contact isolation required ...1. Klebsiella pneumoniae ESBL." The report then listed that the pathogen was resistant to six antibiotics. The microbiology urine culture final report revealed that R101 was colonized for Klebsiella pneumoniae ESBL. 4/24/24 - E13 (PA) ordered in R101's EMR, "Ciprofloxacin HCL Oral tablet 500 mg - give 1 tablet by mouth two times a day for UTI for 7 days." 4/24/24 - E13 (PA) ordered in R101's EMR, "Contact precautions for ESBL in urine. D/C (discontinue) when ABT is completed...". The end date for contact precautions documented in R101's EMR was 5/5/24. Based on McGeer's Criteria for Infection Surveillance, R101 did not meet the criteria for an	F 880		

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F 880	Continued From page 68 infection and should not have been treated with antibiotics and contact precautions. R101 met criteria for colonization with an ESBL pathogen and therefore required ongoing enhanced barrier precautions. 8/7/24 2:16 PM During a telephone interview, E12 (MD) stated, "The pathogen with growth of greater than 100,000 CFU/ml is universally considered an infection. Infections are treated with antibiotics; colonizations are not." 8/8/24- E13 (PA) ordered in R101's EMR, "Enhanced barrier precautions for high contact care activities including gown and gloves every shift for transmission precautions for ESBL in urine." There were 94 days (from 5/6 to 8/7/24) that R101 with a known ESBL colonization received direct care in the facility without the appropriate EBP precautions. 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Report dated 4/23/24 and 4/30/24, which the facility provided as part of their infection line listing, R101 was documented ... with infection "UTI" on "Cipro (Ciprofloxacin) 500 mg BID thru (sic) 5/1." This line listing did not specify the name of the pathogen. The line listing did not document whether the infection was healthcare-associated infection (HAI), which it was since R101 had not left the facility. 5. Review of R165's clinical record revealed: 4/11/24 - R165 was admitted to the facility with	F 880		

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F 880	Continued From page 69 diagnoses, including but not limited to, osteomyelitis of the right ankle and diabetes. 4/11/24 - E12 (MD) ordered in R165's EMR, "Piperacillin-Tazobactam in Dex (dextrose) intravenous solution 2-0.25 gm/50 ml. use 50 ml intravenously every 6 hours for osteomyelitis." This order had a documented end date of 5/2/24. 4/11/24 - E12 (MD) ordered in R165's EMR, "Contact and droplet precautions x 10 days. Resident to remain in room every shift for ESBL." This order ended on 4/16/24. 4/16/24 - E12 (MD) ordered in R165's EMR, "Contact precautions for ESBL in urine every shift." This order ended on 7/16/24. Of note, R165 had an indwelling medical device, a PICC line so R165 required enhanced barrier precautions while this central line was present. Review of the provided facility line listings for April, May and June 2024 revealed no documentation of the ESBL pathogen in R165's urine. The antibiotic ordered on 4/11/24 has an indication of osteomyelitis so it was unclear if this antibiotic also treated the ESBL pathogen in R165's urine. 5/2/24 - E12 (MD) ordered in R165's EMR, "Invanz injection solution (Ertapenem Sodium) Use 500 mg intravenously one time a day for wound care until 5/16/24." The only time that R165 was not receiving IV antibiotics was from 5/16 to 7/16/24. 7/10/24 - E13 (PA) ordered in R165's EMR,	F 880		

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F 880	Continued From page 70 "Biopsy RLE (right lower extremity) Send to ER (emergency room) [hospital]." 7/10/24 to 7/16/24 - R165 was hospitalized for further management of her right ankle osteomyelitis. R165's discharge summary from the 7/10 to7/16/24 hospitalization documented, "... Brief Hospital Course -... status post bone biopsy on 7/12. Patient continues to remain asymptomatic. Normal WBC. Biopsy specimen grew MRSA (methicillin resistant staphylococcus aureus) and gram-negative staph therefore started on Vancomycin by infectious disease during the weekend... Home medications:... Vancomycin 750 mg in 150 ml 5% dextrose IVPB (intravenous piggyback) daily for 5 days." 7/16/24 - E13 ordered in R165's EMR, "Contact precautions: MRSA to wound bed RLE every shift ...". There were 90 days (from 4/16/ to 7/15/24) that R165 with an indwelling medical device received direct care in the facility without the appropriate EBP precautions. 7/17/24 - E12 ordered in R165's EMR, "Vancomycin HCL intravenous solution 750 mg/150 ml. Use 750 mg intravenously one time a day for wound for 42 days. Infuse over 60 minutes." This order has an end date of 9/12/24. 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Report dated 4/16/24, which the facility provided as part of their infection line listing, R165 was documented as housed in room K03, with infection "osteomyelitis" on "Piperacillin-Tazobactam (antibiotic) 2-0.25 q	F 880		

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F 880	Continued From page 71 (every) 6 hrs (hours)" with "no end date." The 4/23/24, 4/30/24 line listing documented the Piperacillin-Tazobatam ended on 5/12/24. The 5/7/24, 5/14/24, and 5/21/24 line listings documented the antibiotic was changed to Invanz 500mg IVPB with an end date of 5/16/24. This line listing did not specify the name of the pathogen or describe R165's signs and symptoms of infection. There were some lab results listed on the 4/16/24 line listing. The line listing did not document whether the infection was healthcare-associated infection (HAI) or community-acquired. None of the line listings documented whether R165 was on any precautions. The facility failed to update the line listing to reflect that R165 was diagnosed by biopsy on 7/12/24 with MRSA infection and again failed to document on the line listing that R165 required contact precautions. The facility failed to include documentation of R165's ESBL pathogen in her urine on their line listings. 6. Review of R367's clinical record revealed: 5/8/24 - R367 was admitted to the facility with diagnoses including, but not limited to, heart failure. 5/14/24 - E12 (MD) ordered in R367's EMR, "Urinalysis C&S r/t UTI one time for burning, urgency, frequency." 5/18/24 - R367's microbiology urine culture final report documented. "Final ESBL- producing organism ...Isolate 1:>100,000 CFU/ml.	F 880		

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F 880	Continued From page 72 Attention: ESBL producing organism, contact isolation required ...1. Klebsiella pneumoniae ESBL." The report then listed that the pathogen was resistant to six antibiotics. The microbiology urine culture final report revealed that R367's urine was infected with Klebsiella pneumoniae ESBL. Based on McGeer's UTI criteria, the documentation met the criteria for a UTI with increased urgency and frequency. 5/19/24 - E12 ordered in R367's EMR, "Macrobid oral capsule 100 mg (nitrofurantoin) give 1 capsule by mouth two times a day for UTI/ESBL." This order had an end date of 5/28/24. 5/19/24 - E12 ordered in R367's EMR, "Contact precautions + ESBL in urine every shift." 8/8/24 10:27 AM - Review of the IP (Infection Prevention) Weekly Antibiotic Report dated 5/21/24, which the facility provided as part of their infection line listing, R367 was documented as housed in room K01d, with infection "UTI/ESBL" on "Macrobid 100 mg BID thru". There was no end date documented. This line listing did not specify the name of the pathogen or describe R1367's signs and symptoms of infection, which included burning, urgency and frequency. The line listing did not document whether the infection was healthcare-associated infection (HAI) or community-acquired. The line listing did not documented whether R165 was on any precautions; R367 was ordered contact precautions on 5/19/24.	F 880		

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F 880	Continued From page 73 8/7/24 1:58 PM - During an interview, E31 (IP) stated, "Ultimately, it is up to the provider to determine if the resident is colonized. I suspect that it would be noted in the chart if the resident is colonized. Then the facility would put the resident on EBP precautions if it is an MDRO." 8/8/24 10:27 AM - Review of the facility's ongoing infection prevention program system of surveillance (infection line listing) revealed the data collection tool lacked multiple significant data points. The data collection tool provided was a weekly document that failed to capture the specific name of the pathogen that was causing the infection, the infection site, the signs and symptoms of the infection such as temperature and elevated white blood cell (WBC) count, the start and stop date of any antibiotics prescribed, precautions (if any) that were implemented, invasive procedure/risk factors, and whether the infection was community-acquired or healthcare-associated infections (HAIs). It should be noted that the document that the facility provided as the facility's infection line listing was titled "IP (infection Prevent) Weekly Antibiotic Report". The surveillance documents provided by the facility for April, May and June 2024 failed to have the necessary monthly summary, analysis and interpretation of the data. These documents did not identify any infection trends or patterns. The facility infection surveillance policy lists tools called Facility-Wide Monthly Infection Report by Pathogen, Facility-Wide 12-Month Pathogen Trends and Facility-Wide 12-Month Infection Site Trends. The facility was not able to provide these	F 880		

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F 880	Continued From page 74 documents for review. The surveillance documents that were provided did not include any documentation of any follow-up activities such as staff education or random observations on all shifts of the staff appropriately implementing enhanced barrier or contact precautions on residents who were ordered those precautions. 8/9/24 9AM - In an email correspondence, E31 (Infection Preventionist) stated the facility utilizes McGeer's Criteria for Infection Surveillance. E31 also stated, "It is the provider who ultimately makes the diagnosis. Our lab provider interfaces with PCC (facility's EMR). They also email results of which our providers are part of the email thread". Regarding final culture reports, E31 stated, "We are aware they are having technical problems with their interfacing. They are working on a resolution. It is also why they email the results. It's my understanding that they are moving and when they get set up in their new spot theses (sic) issues should resolve. The paper copies we receive are placed in the paper chart." 8/9/24 9:32 AM - During a telephone interview, E12 (MD) stated, "No, the providers do not have access to the [laboratory provider]'s website to look up results when the physician is out of the facility. the providers are not given the final culture report." Regarding colonization, E12 clarified, "Anything less than 100,000 CFU/ml is considered colonized unless the resident is symptomatic. The facility uses McGeer's criteria to determine if it is an infection with regard to symptoms." 8/9/24 10:05 AM - In an email correspondence, E2 (ADON) stated "the status date on the [lab]	F 880		

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F 880	Continued From page 75 report is what day they are in in (sic) the culture series for whatever they are growing. The date we receive is when they email us. The providers are on the email blast, and E13 (PA) is in the facility 5 days a week. The supervisor is responsible for calling the provider with any updates and confirming they received the reports if they are not on site at that time and if it has not yet been addressed. 7. 7/30/24 1:29 PM - E5 (Laundry Aide) was observed placing soiled laundry into the washing machine using ungloved hands. An interview revealed that E5 was not aware of safe handling practices for general soiled laundry or for laundry belonging to residents who were on various types of precautions due to illness. During the interview, E5 stated that since being transferred to the laundry several months ago, no training regarding the safe handling of soiled laundry, including the proper use of PPE when processing the soiled laundry has been provided. 8/9/24 11:33 AM - Findings were reveiwed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced	F 881		10/7/24

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F 881	Continued From page 76 by: Based on record review and interview, it was determined that for four (R71, R101, R165, R368) out of twenty-one residents reviewed for infection control, the facility failed to implement an antibiotic stewardship program that monitored the final result of cultures to ensure antibiotics were utilized for the correct indication and duration. Findings include: McGeer Criteria for Infection Surveillance: Syndrome - UTI without indwelling catheter Criteria- Must fulfill both 1 and 2. 1. At least one of the following sign or symptom: -Acute dysuria (pain on urination) or pain, swelling or tenderness of testes, epididymis or prostate -Fever or leukocytosis (elevated white blood cell count), and greater than 1 of the following: --acute costovertebral angle pain or tenderness --suprapubic pain --gross hematuria --new or marked increased in incontinence --new or marked increase in urgency --new or marked increase in frequency -If no fever or leukocytosis, then greater than 2 of the following: --suprapubic pain --gross hematuria --new or marked increased in incontinence --new or marked increase in urgency --new or marked increase in frequency 2. At least one of the following microbiologic criteria -greater than 10 to the fifth CFU/ml of no more than 2 species of organisms in a voided urine	F 881	F881 A. R71, R101, R165, and R368 had final results of cultures obtained and analyzed to determine if antibiotics were utilized for the correct indication and duration. B. All residents have the potential to be affected by this deficient practice. IP nurse, or designee, to audit last two weeks of urine analysis results to verify final cultures were obtained if indicated and reviewed by physician for effectiveness of treatment. IP nurse to also audit indications for ordering U/As and determine if McGeer□s Criteria was met. Audits to be completed by October 7, 2024. C. Line listing updated by IP nurse to reflect separate line item for each infection per resident. IP nurse, or designee to provide education to medical director and physician assistant on ensuring provider progress notes accurately reflect infections, lab results, and antibiotic use. Education to be completed by October 7, 2024. Root cause analysis of this deficiency revealed lack of system in place for verifying final culture results, as well as, communicating them for review by the provider. D. IP nurse, or designee, to audit all residents being treated for infection to determine if providers are documenting all necessary information in progress notes pertaining to such. Weekly audits three times a week until 100% compliance is	

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F 881	Continued From page 77 sample -greater than 10 to the second CFU/ml of any organism(s) in a specimen collected by an in-and-out catheter. 1. Review of R71's clinical record revealed: 11/1/23 - R71 was admitted to the facility with diagnoses including, but not limited to, dementia and congestive heart failure. R71 was documented as having allergies to: hydrocortisone, Bactrim, Iodinated contrast media, sulfa antibiotics, seafood, shellfish in the EMR. 4/7/24 - E33 documented in R71's progress note, "Resident noted to have difficulty holding a lucid conversation today. Husband thinks there is a change. Incontinent of urine. Urine in brief was odorous with red tinge. Will obtain a UA specimen for testing. Afebrile. 98.5." Based on McGeer's UTI without indwelling catheter criteria, this progress note provided documentation that met criteria for a UTI, hematuria and new incontinence in the setting of no fever. 4/10/24 - R71's microbiology urine culture final report documented. "Final ESBL-producing organism ...>100,000 CFU/ml. Attention: ESBL producing organism, contact isolation required ...1. Klebsiella oxytoca ESBL." The report then listed that the pathogen was resistant to eight antibiotics. 4/10/24 - E12 ordered in R71's EMR, "Augmentin oral tablet 500-125 mg (Amoxicillin & pot	F 881	achieved at three consecutive evaluations, then one time a week until 100% compliance is achieved at three consecutive evaluations; and then once monthly until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	

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F 881	Continued From page 78 Clavulanate) - give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days." Of note, Augmentin was not a drug that the final microbiology report tested for sensitivity. Levaquin, a fluroquinolone antibiotic, was the only drug listed on the microbiology sensitivities that came in an oral form and did not contain sulfa, which R71 was allergic to. It was unclear why the physician chose to use Augmentin rather than Levaquin, which was documented as an effective antibiotic for this pathogen. 4/11/24 10:05 AM - E34 (LPN) documented in R71's progress note, "Resident has continued to decline physically and mentally, recently diagnosed with UTI 1st dose of antibiotic administered. MD assessed and advised to send resident to ER for further evaluation r/t (related to) tachycardia and low-grade fever. Resident will be transported via ambulance to [hospital]. POA (power of attorney) advised." R71 was hospitalized for UTI and encephalopathy from 4/11/24 to 4/15/24. 2. Review of R101's clinical record revealed: 11/29/23 - R101 was admitted to the facility with diagnoses including, but not limited to, dementia. 4/19/24 - E13 (PA) documented in R101's progress note, "... Chief complaint: Behaviors/increased confusion... Diagnosis, Assessment and Plan:... Mood disorder - increased confusion, rule out UTI. UA, C&S requested...". 4/19/24 - E13 ordered in R101's EMR, "UA C&S	F 881		

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F 881	Continued From page 79 one time." Review of R101's documented temperatures from 4/21/24 to 4/30/24 revealed R101 to have no documented fevers during this time span. Review of R101's orders during April 2024 revealed that no CBC lab work was ordered so the provider was not able to confirm any elevation in WBCs. 4/21/24 4:48 AM - E35 (LPN) documented in R101's progress notes, "Resident had no complaints of discomfort with urination...". 4/22/24 12:21 PM - E36 (LPN) documented in R101's alert charting, "...No s/s of UTI. Afebrile...". Based on McGeer's UTI without indwelling catheter criteria, the documentation in R101's EMR does not meet criteria for UTI without indwelling catheter. 4/24/24 - R101's microbiology urine culture final report documented. "Final ESBL-producing organism... >50,000 CFU/ml. Attention: ESBL-producing organism, contact isolation required ...1. Klebsiella pneumoniae ESBL." The report then listed that the pathogen was resistant to six antibiotics. The microbiology urine culture final report revealed that R101 was colonized for Klebsiella pneumoniae ESBL. 4/24/24 - E13 ordered in R101's EMR, "Ciprofloxacin HCL Oral tablet 500 mg - give 1 tablet by mouth two times a day for UTI for 7	F 881		

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F 881	Continued From page 80 days." Based on McGeer's Criteria for Infection Surveillance, R101 did not meet the criteria for an infection and should not have been treated with antibiotics. R101 met criteria for colonization with an ESBL pathogen. 8/7/24 2:16 PM - During a telephone interview, E12 (MD) stated, "The pathogen with growth of greater than 100,000 CFU/ml is universally considered an infection. Infections are treated with antibiotics; colonizations are not." 3. Review of R165's clinical record revealed: 4/11/24 - R165 was admitted to the facility with diagnoses, including but not limited to, osteomyelitis of the right ankle and diabetes. 4/11/24 - E12 (MD) ordered in R165's EMR, "Piperacillin-Tazobactam in Dex (dextrose) intravenous solution 2-0.25 gm (grams)/50 ml. use 50 ml intravenously every 6 hours for osteomyelitis." This order had a documented end date of 5/2/24. 4/11/24 - E12 ordered in R165's EMR, "Contact and droplet precautions x 10 days. Resident to remain in room every shift for ESBL." This order ended on 4/16/24. 4/16/24 - E12 ordered in R165's EMR, "Contact precautions for ESBL in urine every shift." This order ended on 7/16/24. Review of the provided facility line listings for April, May and June 2024 revealed no documentation of the ESBL pathogen in R165's	F 881		

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F 881	Continued From page 81 urine. The antibiotic ordered on 4/11/24 has an indication of osteomyelitis so it was unclear if this antibiotic also treated the ESBL pathogen in R165's urine. The facility line listing failed to document the ESBL pathogen in R165's urine and therefore also failed to monitor if the antibiotic prescribed for the osteomyelitis would also treat the ESBL UTI. 4. Review of R368's clinical record revealed: 3/4/24 - R368 was admitted to the facility. 3/5/24 - E12 (MD) ordered in R368's EMR, "Foley catheter care every shift." This order was discontinued on 4/1/24. 3/28/24 - E13 (PA) ordered in R368's EMR, "Remove foley catheter for trial void." 3/28/24 - E24 (LPN) documented in R368's progress notes, "[foley] removed for trial void, 400 ml noted in collection bag and Pt (patient) urinated immediately after removal." 3/29/24 11:58 AM - E37 (LPN) documented in R368's progress notes, "... resident verbally requested to go to the restroom to urinate... urinated in toilet... Resident denies any pain/discomfort." 3/30/24 10:42 PM - E38 (LPN) documented in R368's progress notes, "... voided large amount yellow urine, denies urinary pain or discomfort." 3/31/24 3:01 AM - E39 (RN) documented in R368's progress notes, "... Resident voiding large	F 881		

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F 881	Continued From page 82 amounts without difficulty, no pain ...". 4/3/24 - E12 ordered in R368's EMR, "UA, C&S d/t (due to) decline in ADLs...". 4/4/24 9:48 PM - R368's lab results report documented a WBC of 5.5 with a normal range of 3.7 to 8.9. R368 had a normal white blood cell count. 4/5/24 12:22 AM- E33 (LPN) documented in R368's progress notes, "... No complaints of pain with urination ...". Review of R368's progress notes from 3/28/24 to 4/12/24 revealed no documentation noting any fevers, increased incontinence, frequency or urgency. 4/6/24 - R368's Microbiology urine culture final report documented. "Final - >25,000 CFU/ml ...1. Proteus mirabilis." The report then listed that the pathogen was resistant to two antibiotics. This pathogen was sensitive to Ciprofloxacin. 4/6/24 - "Cipro oral tablet 250 mg (Ciprofloxacin) (antibiotic) - give 250 mg by mouth two times a day for UTI for 5 days" entered in R368's EMR as a verbal order from E12 (MD). 4/6/24 6:46 PM - E22 (LPN) documented in R368's progress notes, "... Report received positive UTI on call notified with N.O. (new order) for Cipro 250 mg BID x 5 days...". 4/8/24 - E13 documented in R368's progress notes, "...Vital signs:... T 97.6... History of present illness:... daughter noticed increased confusion so UA culture was sent on 4/5/24. Culture result	F 881		

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F 881	Continued From page 83 positive, Cipro started...". This provider note did not document the pathogen or the isolate count. 4/9/24 - E12 documented in R368's progress notes, "...Vital signs:... T 97.7... Chief complaint: COPD... All labs, images, reports and previous notes reviewed...". E12's 4/9/24 progress note failed to mention R368's UTI, lab results or course of antibiotics. Based on McGeer's Criteria for Infection Surveillance, R368 did not meet the criteria for an infection and should not have been treated with antibiotics. 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 881		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that essential kitchen equipment is maintained in safe operating condition. Findings include: 7/30/24 11:11 AM - An observation of the walk-in freezer revealed significant ice build-up on a damaged protective grate covering the freezer fans.	F 908	F908 A. No residents were adversely affected by this deficient practice. Maintenance personnel corrected significant ice build up of walk-in freezer and ordered new protective grate covering the freezer fans. B. All residents have the potential to be affected by this deficient practice.	10/7/24

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F 908	Continued From page 84 8/9/24 11:33 AM - Findings were reviewed with E1 (NHA), E2 (ADON), E3 (QA RN) and E4 (MDS LPN) during the exit conference.	F 908	Environmental rounds checklist to be implemented with kitchen cleaning schedule- that includes identifying ice build up in walk-in freezer and the identification and reporting of any damaged equipment to maintenance personnel. Checklist to be implemented by October 7, 2024. C. Maintenance personnel, or designee, to provide education to all dietary staff on the importance and process of maintaining essential kitchen equipment in safe operating condition. Root cause analysis revealed environmental rounding checklist was not being performed/completed and ice buildup was due to staff propping freezer door open for extended periods of time while they received and put away delivery. Dietary staff to also be educated on not propping freezer door open. All education to be completed by October 7, 2024. D. Dietary Director, or designee, to audit environmental rounds checklist for completion and appropriate follow-up three times a week until 100% compliance is achieved at three consecutive evaluations and then one time a week until 100% compliance is achieved at three consecutive evaluations. Then once monthly the audit will be performed again until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will decide if further audits will be needed.	