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: Lofland Park

DATE SURVEY COMPLETED: July 2, 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 June 24, 2024 through July 2, 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 ninety-three (93). The survey sample totaled thirty-two (32) 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 July 2, 2024: cross refer: F580, F657, F658, F684, F757, and F921.	Cross Refer to the CMS 2567-L for F580, F657, F658, F684, F757, and F921 with expected complete date of 8/15/2024.

Provider's Signature [signature] RN, LNHA Title Administrator Date 7/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085040	A. BUILDING _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFLAND PARK CENTER	715 E. KING STREET SEAFORD, DE 19973

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E 000	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from June 24, 2024 through July 2, 2024. The facility census was 93 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 and Complaint Survey was conducted at this facility from June 24, 2024 through July 2, 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 ninety-three (93). The survey sample totaled thirty-two (32) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; FM - Family Member; LPN - Licensed practical nurse; MD - Medical Director; MDS - Minimum Data Set; NHA - Nursing Home Administrator; NP - Nurse Practitioner;	F 000		

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

Electronically Signed | 07/26/2024

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F 000	Continued From page 1 PRN - as needed; RN - Registered nurse; SW - Social Worker; UM - Unit Manager; Audiology - branch of science that studies hearing, balance and related disorders; Brief Interview for Mental Status (BIMS) - assessment of the resident's mental status. The 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); Kling dressing - absorbent gauze roll, which stretches and conforms to the body shape and clings to itself as it is wrapped; Medication Administration Record (MAR) - list of daily medications to be administered; MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; 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; Preadmission Screening and Resident Review (PASSR) - 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;	F 000		

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F 000	Continued From page 2 Serosanguineous - drainage containing serum and blood; Treatment Adminstration Record (TAR) - list of daily/weekly/monthly treatments to be performed.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		8/15/24

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F 580	Continued From page 3 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R100) out of two residents reviewed for change in condition, the facility failed to consult the Physician when R100 experienced a change in condition. Findings include: Review of R100's clinical record revealed: 7/26/23 - R100 was admitted to the facility. 8/1/23 - An admission MDS revealed that R100 had diagnoses including but not limited to hypertension and atrial fibrillation. 8/3/23 - A careplan for R100 revealed resident is exhibiting or at risk for cardiovascular symptoms or complications related to hypertension, atrial fibrillation, hypotension, stroke, and electrolyte imbalance. Interventions included but not limited to administer medications as ordered and monitor	F 580	A. R100 was discharged from the facility B. Current residents with medications held for parameters were reviewed by 7/26/2024 to make sure notifications for changes in condition were made to the medical provider. C. On 7/18/2024 a root cause analysis was completed which determined that a more formal review of blood pressure medications with hold parameters needed to occur at least bi-weekly. The NHA/DON or designee will run a report from the electronic health record at least twice a week, which will be discussed in the morning clinical leadership meeting for follow up as indicated with the medical provider for medications with a pattern of being held 5-7 days for blood pressure parameters. It was also determined that	

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F 580	Continued From page 4 for side effects and effectiveness, report any abnormalities to the physician. Also observe for mental status and report any changes to the physician. 9/12/23 - A physician's order was written for metoprolol 50 mg give one tablet twice daily for hypertension and hold for systolic blood pressure less than 110 mg/dL. A review of R100's MAR for December 1 to December 15, 2023 revealed that the metoprolol 50 mg tablet was held twenty out of thirty opportunities for systolic blood pressure under 110 mg/dL. 6/28/24 11:43 AM - An interview with E4 (MD) revealed that as a provider he would expect nursing to notify him or any provider of an established pattern occurring over five to seven days of low blood pressure or medication held. The process would be once the provider is notified of the change they would monitor the resident more closes. E4 confirmed he was unaware of R100's medication being held twenty times in fifteen days in December 2023. The progress notes lacked evidence that anyone notified the provider of the change in condition. 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 580	licensed nurses need education on using the appropriate code for hold parameters in the EMAR under the chart code for parameters out of range - med not given (attachment A). In addition, licensed nurses need education on Nursing Policy 122 Change in Condition: Notification of (attachment B). Education for licensed nurses will occur by 8/14/2024. D. The DON or designee will complete audits (attachment C) of all current residents with blood pressure medications being held due to ordered parameters to determine if medical provider was notified for pattern of low blood pressure or medication being held. The audits will occur bi-weekly for 3 weeks until 100% compliance is achieved on 3 consecutive reviews, then weekly for 3 weeks until 100% compliance achieved on 3 consecutive reviews, then monthly for 3 months until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Committee monthly for review & recommendations.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		8/15/24

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F 657	Continued From page 5 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review it was determined that for one (R37) out of 32 residents reviewed for care plans the facility failed to update and revise a care plan. Findings Include: Review of R37's clinical record revealed: 12/11/23 - R37 was readmitted to the facility from the hospital. 12/16/23 - A quarterly MDS assessment documented... 1. "Yes, a hearing aid or other	F 657	A. R37 care plan was updated for hearing aid on 6/26/2024 B. Current residents with hearing aids coded on the Minimum Data Set were reviewed with care plan revisions completed by 7/26/2024. C. On 7/18/2024 a root cause analysis was completed which determined that licensed nurses need education on OPS416 Person-Centered Care Plan (attachment D) for understanding the	

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F 657	Continued From page 6 hearing appliance was used to complete the assessment for hearing." 1/18/24 9:00 PM - An order for R37 documented to "insert hearing aids in the AM and remove at bedtime. Wipe clean daily." 3/20/24 8:16 PM - A care plan evaluation note by E2 (DON) documented, "Resident seen by audiology for hearing impairment. Resident has hearing aides (sic) to assist [with] his impairment. Care plan reviewed and remains appropriate - continue current [plan of care]." 6/6/24 1:41 PM - R37's care plan documented impaired communication as evidenced by impaired hearing. 6/15/24 - A significant change MDS assessment documented... 1. "Yes a hearing aid or other hearing appliance was used to complete the assessment for hearing." 6/26/24 1:00 PM - Review of the TAR (Treatment Administration Record) revealed E9 (LPN) signed that R37's hearing aids had been inserted. 6/26/24 1:08 PM - During an interview E13 (CNA) stated, "[R37] was not wearing his hearing aids right now, most of the time he doesn't like wearing them." 6/26/24 1:11 PM - During an interview E9 stated, "[R37] usually puts his hearing aids in, but most of the time he doesn't like wearing them." E9 also confirmed, nursing signs for inserting and removing hearing aids. In addition, E9 stated, "Well most of the time [R37] takes them out and you might find them in his bed or somewhere, he	F 657	importance for reviewing & revising care plans after each assessment to reflect accurate care needs for residents. Education for licensed nurses will occur by 8/14/2024 (attachment A).. D. The DON or designee will complete audits (attachment E) of all current residents with hearing aids from the Minimum Data Set The audits will occur weekly for 4 weeks until 100% compliance is achieved on 3 consecutive reviews, then monthly for 4 months until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Committee monthly for review & recommendations.	

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F 657	Continued From page 7 did have them in this morning." 6/26/24 1:25 PM - A second interview and observation with E9 revealed R37 did not have his hearing aids inserted. 6/26/24 1:53 PM - During an interview E3 (RN-UM) confirmed that R3 is not care planned for hearing aids and that R37's care plan had not been revised to reflect him refusing to wear his hearing aids. E3 RN-UM confirmed that hearing aids would be added to R37's care plan. 7/1/24 12:15 PM - During an interview E1 (NHA) confirmed R37's care plan was not revised. 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 657		
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 four (R2, R11, R76 and R100) out of thirty-two residents reviewed for care plans, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by having LPN's and a SW complete the admission assessments. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2023 ... Admission Assessments	F 658	A. R100 was discharged from the facility. R2, R11 & R76 admission assessments were evaluated by the DON & documented in the Electronic Health Record (EHR) by 7/26/2024. B. Current residents admitted within the last 90 days were reviewed by 7/26/2024. Any assessments upon admission that were not completed by the RN are being	8/15/24

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F 658	Continued From page 8 * - RN ... *= Once a care plan is established, the LPN may do assessments ...". 1. Review of R2's clinical record revealed: 5/15/24 - R2 was admitted to the facility. 5/15/24 - E5 (LPN) completed the following assessments: Elopement Evaluation, Bed Rail Evaluation, Clinical Admission, Braden Scale Evaluation and Lift Transfer Evaluation. An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission process for R2. 2. Review of R11's clinical record revealed: 3/4/24 - R11 was admitted to the facility. 3/4/24 - E6 (LPN) completed the following assessments: Elopement Evaluation, Bed Rail Evaluation, Clinical Admission, Fall Risk Evaluation and Lift Transfer Evaluation. An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission process for R11. 3. Review of R76's clinical record revealed: 2/22/24 - R76 was admitted to the facility. 2/22/24 - E7 (LPN) completed the following assessments: Bed Rail Evaluation, Clinical Admission, Fall Risk Evaluation and Lift Transfer Evaluation.	F 658	evaluated by a RN & documented in the EHR. Those with admissions greater than 14 days have had all areas assessed by the RN completing the initial MDS assessment which initiated the development of the comprehensive care plan. All residents without a RN completing the assessments upon admission will be evaluated by a RN & documented in the EHR by 8/14/2024. C. On 7/18/2024 a root cause analysis was completed which determined that licensed nurses need education on NSG113 Nursing Documentation & Delaware Board Of Nursing Scope of Practice (attachment F) for understanding the importance for a Registered Nurse (RN) completing all assessments upon admission. Education for licensed nurses & the Dementia Program Director will occur by 8/14/2024 (attachment A). In addition, it was determined that we add a column for new admission RN sign off on the Daily Clinical Review/Follow Up form utilized at daily clinical leadership meetings (attachment G) for increased monitoring of follow through with policy. D. The DON or designee will complete audits (attachment H) of all admissions for determining compliance with all assessments being completed by a Registered Nurse. The audits will occur daily for 3 days until 100% compliance is achieved on 3 consecutive reviews, then weekly for 3 weeks until 100% compliance is achieved on 3 consecutive reviews, then monthly for 3 months until 100%	

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F 658	Continued From page 9 2/22/24 - E8 (Dementia Program Director/SW) completed the Elopement Evaluation. An LPN and a SW, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission process for R76. 7/2/24 10:15 AM - In an interview, E2 (DON) confirmed that LPN's are not to do initial assessments and that they should be completed by an RN. 4. Review of R100's clinical record revealed: 7/26/23 - R100 was admitted to the facility. 7/26/23 - E12 (LPN) completed the following admission assessments: bed rail evaluation, oral health evaluation, and lift transfer evaluation. 7/2/24 10:15 AM - In an interview, E2 (DON) confirmed that LPN's are not to do initial assessments and that they should be completed by an RN. 7/2/24 10:30 AM - An interview with E3 (RN Director UM) confirmed the following admission assessments are expected to be completed at the time of admission by an RN: admission assessment, bed rail, Braden, incontinence, lift evaluation, AIMS (if needed), elopement, fall risk, and pain. 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 658	compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Committee monthly for review & recommendations.	
F 684 SS=D	Quality of Care	F 684		8/15/24

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F 684	Continued From page 10 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that for one (R99) out of nine residents reviewed for skin conditions, the facility failed to assess a surgical site. Findings include: Review of R99's clinical revealed: 8/25/23 - R99 was admitted to the facility with diagnoses including but not limited to third degree burn to left hand and donor graft site to left thigh. 8/25/23 - A physician's order documented to cleanse left hand with soap and water, apply xeroform gauze, then wrap with kling dressing and ACE (elastic wrap), every evening shift. The order for the left thigh wound as follows: "do not remove xeroform from thigh wound. Allow to fall off/lift off on its own. May trim away edges as it lifts. as needed for graft extraction site." 8/30/23 - An admission MDS revealed R99 had a surgical wound and burn of second or third degree with treatments of surgical wound care and applications of non-surgical dressings. 8/30/23 - A care plan revealed that R99 was at	F 684	A. R99 was discharged from the facility. B. Current residents with post-surgical wounds were reviewed by 7/26/2024. All current residents with post-surgical wounds have documented assessments of the area in the EHR. C. On 7/18/2024 a root cause analysis was completed which determined that licensed nurses need education on NSG236 Skin Integrity & Wound Management (attachment I) for understanding the importance documenting all wound types, including post surgical wounds into the Point Click Care Skin & Wound area upon admission & in the weekly Skin Check UDA. Education for licensed nurses will occur by 8/14/2024 (attachment A). In addition, it was determined that we add a column for new admission skin pictures on the Daily Clinical Review/Follow Up form utilized at daily clinical leadership meetings (attachment G) for increased monitoring of follow through with policy.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 risk for skin breakdown related to recent surgery, actual skin break down related to left hand burn, and left thigh graft. Interventions included but not limited to provide wound care as ordered, observe skin condition daily with ADL care and report abnormalities, and observe for signs and symptoms of skin break down. 8/30/23 1:40 PM - A skin and wound evaluation revealed a third-degree burn, present on admission, no location indicated, no odor, light exudate, and serosanguineous drainage. A review of the skin and wound tab of the electronic records revealed an image of R99's left hand burn. 9/6/23 - A progress note revealed R99 had a follow up appointment with burn center. The facility lacked evidence of record of follow up visit with burn center on 9/6/23 regarding the progress of left hand burn and left thigh surgical graft site. 9/12/23 - A physician's order revealed to monitor xeroform to left thigh donor site daily (3-11) every evening shift for donor site. 9/13/23 - A progress note revealed that R99 was going to an appointment with a family member to follow up for burns. The facility lacked evidence that R99's post surgical graft site was monitored from 8/25/23 through 9/12/23. 6/28/24 - An interview with E11 (RN UM) revealed that the physician's notes from the 9/6/23 follow up appointment were not in the medical record	F 684	D. The DON or designee will complete audits (attachment J) of all admissions for determining compliance with all wounds having pictures in Point Click Care & weekly skin check audits. The audits will occur daily for 3 days until 100% compliance is achieved on 3 consecutive reviews, then weekly for 3 weeks until 100% compliance is achieved on 3 consecutive reviews, then monthly for 3 months until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Committee monthly for review & recommendations.	

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	085040	A. BUILDING _____ B. WING _____	C 07/02/2024

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F 684	Continued From page 12 and she would continue to look for them. 7/1/24 10:20 AM - An interview with E9 (LPN) revealed that when a new resident is admitted the nurse will complete a head to toe assessment and document it. If the resident has a complex wound the nurse would contact the Wound Care nurse and she will complete initial wound assessment. E9 stated as the nurse she would document daily in the skilled charting what she observes daily in relation to wounds even if order says not to remove dressing. 7/1/24 2:05 PM - An interview with E10 (WC RN) revealed that she will try to complete the admission skin assessment if she is present during admission, if not the assigned nurse is responsible. E10 stated she will remove the dressing to complete the assessment even if the orders stated not to remove. E10 stated that she is not responsible for monitoring graft sites or surgical wounds unless they dehisce. 7/2/24 10:30 AM - An interview with E3 (UM Director RN) revealed the expectation is for the nurses to document exactly what they see during an assessment. The nurse completing the admission is expected to look for treatment orders and if unable to locate those orders, to follow up with physician via telephone. If no treatment orders are found, the expectation is the nurse to document the condition of the dressing daily at minimum. In reference to physician appointments outside of the facility, the resident would take an envelope with all the necessary paperwork for the provider and if no papers are returned, the expectation is for the nurse to call the provider and have the notes sent over. The nurse should document the call and details about	F 684		

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F 684	Continued From page 13 it in the progress notes. 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 684		
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 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 record review and interview, it was determined that for one (R11) out of five residents reviewed for medication review, the facility failed to ensure that an order for a PRN medication for anxiety was re-evaluated after 14 days. Findings include:	F 757	A. R11 PRN for medication for anxiety was evaluated by the medical provider on 7/17/2024. B. Current residents with PRN medication for anxiety were reviewed by 7/26/2024 to ensure all were evaluated per policy.	8/15/24

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F 757	Continued From page 14 3/4/24 - Resident admitted to the facility. 3/18/24 - A Physician's order was entered into the MAR: "clonazepam Oral Tablet 1 MG (Clonazepam) *Controlled Drug* Give 1 tablet by mouth as needed for anxiety May take 3x/day as needed." The facility lacked evidence that a PRN order for anxiety was re-evaluated by a provider after 14 days of being ordered. 7/1/24 1:33 PM - In an interview, E4 (MD) stated that usually a new PRN order for an anti-anxiety medication is evaluated 14 days after the patient first starts, but not thereafter. E4 stated that this will be "fixed." 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 757	C. On 7/18/2024 a root cause analysis was completed which determined that licensed nurses need education on Medication Management (attachment K) for understanding the importance for making sure residents are free from unnecessary medications. Education for licensed nurses will occur by 8/14/2024 (attachment A). In addition, the facility transitioned to a new pharmacy on 7/24/2024 & DON or designee will review a new pharmacy report available to ensure regulation is met & PRN anxiety medications are re-evaluated for use. This report will be run weekly beginning 7/31/2024. D. The DON or designee will complete audits (attachment L) of all current residents with hearing aids from the Minimum Data Set The audits will occur weekly for 4 weeks until 100% compliance is achieved on 3 consecutive reviews, then monthly for 4 months until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Committee monthly for review & recommendations.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 921		8/15/24

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F 921	Continued From page 15 by: Based on observation and interview, it was determined that the facility failed to provide a safe and sanitary environment for the staff. Findings include: 6/24/24 11:24 AM - A large section of the floor in the service area between the entry doors to the kitchen and the entry door to the ware washing room was covered with standing water. Water was dripping from the ceiling area adjacent to the interior hallway doors onto the floor. An additional area of water was dripping from the ceiling near the entrance to the ware washing room onto the floor and into a mop bucket that had been placed under a portion of the dripping area. 6/24/24 1:46 PM - During an interview, E1 (NHA) confirmed the dripping and standing water and stated that the water had come from the second-floor shower room, passed through a managers' office located on the first floor, and dripped into the service area on the ground floor. 7/2/24 1:50 PM - Findings were reviewed with E1 (NHA) and E2 (DON) at the exit conference.	F 921	A. No residents were affected by this deficient practice. The area affected was evaluated on 6/25/2024 to determine there was a faulty shower stem in the shower room. The maintenance supervisor was able to secure parts & completed the repair on 7/10/2024. B. Current residents were not affected by the deficient practice as the environment was in a service area of the facility. C. On 7/18/2024 a root cause analysis was completed which determined that education for all staff is needed for ensuring the facility is providing a safe, functional, sanitary & comfortable environment for residents, staff & the public. Education for all staff will occur by 8/14/2024 (attachment A). In addition, it was determined that staff left water running in a shower stall, which attributed to a large amount of water flooding to the lower level. Signs were made & placed in 1st & 2nd floor shower rooms as a reminder for staff to turn off shower after use (attachment M). D. The NHA or designee will complete audits (attachment N) of areas within the facility daily for 3 days until 3 consecutive reviews with 100% compliance, then weekly for 3 weeks until 100% compliance is achieved on 3 consecutive reviews, then monthly for 3 months until 100% compliance achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance	

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F 921	Continued From page 16	F 921	Performance Committee monthly for review & recommendations.	