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: Pinnacle Rehabilitation & Health Center

DATE SURVEY COMPLETED: May 30, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Revised	
	eral Report. An unannounced Annual and Complaint Survey was conducted at this facility from May 9, 2024, through May 30, 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 133. The investigative sample totaled 30 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 May 30, 2024: F550, F558, F578, F585, F609, F610, F641, F644, F645, F656, F657, F658, F677, F684, F686, F689, F690, F692, F695, F711, F756, F757, F761, F773, F812, F842, and F880.	

Provider's Signature Anne M Strodel Title Administrator Date 7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT BLVD SMYRNA, DE 19977

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F 000	INITIAL COMMENTS	F 000		

REVISED REPORT POST IDR

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Abbreviations/definitions used in this report are as follows:

ADON - Assistant Director of Nursing;
cm - Centimeter;
CNA - Certified Nurse's Aide;
DON - Director of Nursing;
EMR- electronic medical record;
L - Liter;
LPN - Licensed Practical Nurse;
MD - Medical doctor;
mg/dL - Milligram per deciliter;
mg - Milligram;
mL - Milliliter;
mmol/L - Millimole per liter;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
NPO - nothing by mouth;
PEG - percutaneous endoscopic gastrostomy tube, a feeding tube;
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
SLP - speech language pathologist.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2024

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Abdominal pad dressing - a dressing that is used to absorb discharges from abdominal and other heavily draining wounds;
Acute - rapid onset and relatively short duration;
Advance Directive - a 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;
Antispychotic Medication - a type of psychiatric medication which are available on prescription to treat psychosis;
Aphasis- a lnguage disorder caused by damage to specific brain rgions that affect the ability to comprehend and formulate speech;
Bipolar Disorder - mood disorder;
Bladder Incontinence - loss of control of bladderfunction;
Bladder retraining - a planned program to develop regular voiding times;
Blood urea nitrogen (BUN) test - measures how much urea nitrogen is in your blood. It helps a healthcare provider determine if your kidneys are working as they should;
Border gauze - an absorptive dressing that has absorptive gauze in the middle and an adhesive tape around the edges;
Braden Scale - tool used to determine risk for development of pressure ulcers;
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);

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Calcium Alginate dressing - dressings that use the power of seaweed to absorb wound drainage, reduce bleeding, and boost wound healing;
Care Plan - outlines the plan of action that will be implemented during a patient's medical care;
Cervical - Having to do with the neck;
Creatinine (CRE) test - A measure of how well your kidneys are performing their job of filtering waste from your blood; increased quantities found with renal/kidney disease;
Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue;
Dehiscence - separation of wound edges;
Dehydration - when the body loses more fluid than it takes in, and the body doesn't have enough water and other fluids to carry out its normal functions;
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;
Diabetes Mellitus (DM) - disease where sugar levels are too high;
Dialysis - a treatment for people whose kidneys are failing by removing waste products and excess fluid from the blood;
Diuretic - a medication that helps the body get rid of extra fluid and salt. They are used to treat high blood pressure, edema (extra fluid in the tissues), and other conditions;
Edentulous - lacking teeth; toothless;
Epithelial Cell - among the most abundant cells covering the skin, body cavities, and blood vessels;

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Fusion - surgery to connect two or more bones;
Hydrochlorothiazide - A diuretic, a water pill;
Hydrocolloid dressing - a wound treatment that contain gel-forming agents that provide a moist environment favorable for wound healing and a barrier against exogenous bacteria;
Hydrogel dressing - a wound treatment that provides a moist environment in the wound site which promotes tissue re-growth;
Hypertension - high blood pressure;
Hypotension - low blood pressure, means that the pressure of blood circulating around the body is lower than normal or lower than expected;
Hypovolemic shock - an emergency condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body;
Incontinence - Incontinence - loss of control of bladder &/or bowel function;
Interdisciplinary Team (IDT) - a coordinated group of staff from several different fields who work together towards a common goal or project;
Intravenous - within a vein;
Intravenous fluid bolus - to deliver a single, relatively large dose of fluids over a short period of time within the vein;
Kilogram - a unit of measurement used to measure much heavier objects, 1 kilogram equals 2.2 pounds;
Kling dressing - absorbent gauze roll, which stretches and conforms to the body shape and clings to itself as it is wrapped;
Laminectomy - surgery that creates space by removing bone spurs and tissues of the spine;
Lethargy - A condition marked by drowsiness and an unusual lack of energy and mental alertness;
Levophed - A medication used to treat life-threatening low blood pressure;
Lisinopril - A medication for high blood pressure;
Lithium - a mood stabilizing medicine used to

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treat certain mental illnesses;
Lithium toxicity - a life-threatening condition that causes intestinal and neurological symptoms. It can also lead to kidney damage;
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;
Med-honey dressing - a wound treatment
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;
Neuropathy - when nerve damage leads to pain, weakness, numbness or tingling in one or more parts of your body;
Occupational therapy - a healthcare provider who helps you improve your ability to perform daily tasks;
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;
Posterior - back surface of the body; the back or behind;

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Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
Psychoactive Medication - A drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior;
Psychotic symptoms - include the following: confused thinking; having false beliefs that are not shared by others; hearing, seeing, smelling or tasting something that isn't there;
Renal Failure - A condition in which the kidneys stop working and are not able to remove waste and extra water from the blood or keep body chemicals in balance;
Saline - salt water solution;
Schizoaffective disorder - condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations or delusions and mood disorder symptoms, such as mania or depression;
Serous - a thin, clear, light yellow watery fluid found in many body cavities;
Serosanguineous - drainage containing serum and blood;
Skin prep dressing - skin protectant designed to shield skin from bodily fluids, adhesives and frictional forces;
Stage II (2) Pressure Ulcer - skin blisters or skin forms an open sore. The area around the sore may be red and irritated;
Stroke - blood flow to the brain is blocked or there is sudden bleeding in the brain and the brain cannot get oxygen and nutrients from the blood;
Sutures - row of stitches holding together the edges of a wound;
Timed (or scheduled) toileting program - fixed time interval toileting assistance for resident's with urinary incontinence;

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F 000	Continued From page 6 Treatment Administration Record (TAR) - list of daily/weekly/monthly treatments to be performed; Urinalysis - a common test that can assess many different aspects of your health with a urine sample.	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 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	F 550		7/24/24

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F 550	Continued From page 7 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 the facility failed to promote R18's dignity by keeping R18's urinary collection bag in a privacy bag. Findings include: Review of R18's clinical record revealed: 12/13/20 - R18 was admitted to the facility. 3/26/24 - A significant change MDS indicated R18 has an indwelling urinary catheter. 5/9/24 10:06 AM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/10/24 1:16 PM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/13/24 9:09 AM - An observation of R18 sitting by the nurses station and the urine collection bag was uncovered. 5/14/24 2:13 PM - An interview with E36 (CNA) confirmed R18's urinary collection bag was covered at this time and confirmed the privacy bag was put in place today.	F 550	A. R18's foley catheter bag was provided with a privacy bag on 5/14/24. B. Residents with foley catheter will be reviewed to ensure privacy bag is in place. C. The root cause was determined to be due to lack of oversight to ensure residents with foley catheter has privacy bag is in place. *Staff Educator/Designee will re-educate nursing staff and new hires to ensure residents with foley catheter has privacy bag in place. D. Weekly audit by IP/Designee will be conducted to ensure residents with foley catheter has privacy bag in place x 4 weeks until a 100% compliance is achieved. The following will be a monthly audit x 3 or until compliance is sustained. The audit findings will be reported to QA committee.	

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F 550	Continued From page 8 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for one (R65) out of one sampled resident reviewed for choices and preferences, the facility failed to accommodate R65's preference for showers. Findings include: Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 11/30/23 - A significant change MDS assessment revealed that R65 was dependent for transfers and showering and also revealed it was very important for R65 to be able to chose a bath or a shower. 5/9/24 11:33 AM - An interview with R65 revealed that R65 has not had a shower or washed her hair since September 2023. R65 stated that staff told her the bariatric shower bed was broken and she was unable to shower. A review of CNA documentation from August	F 558	A. R65 was offered received shower. R65's shower and bathe preference were discussed with the resident and plan of care updated on 6/20/24. B. All active resident's bath and shower preferences will be discussed with resident/family. Plan of care will be updated as per preference. C. The root cause was determined to be due to lack of consistent oversight and understanding the needs of bariatric residents to ensure bathing and shower preference are discussed with residents. Nursing staff and new hires will be re-educated by Staff Development/Designee on honoring preferences as per plan of care. New admitted bariatric residents will be reviewed to ensure bathing/shower preference are discussed and honored as per plan of care.	7/24/24

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F 558	Continued From page 9 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024 revealed that R65 has been only receiving bed baths from staff. 5/14/24 10:57 AM - An interview with E19 (RN) revealed that she was unaware of R65's preference for showers and could not confirm if one of the shower beds was bariatric. 5/15/24 9:27 AM - An interview with R65 and E19 confirmed that E65 will receive a shower during this shift and the new schedule for showers is Wednesday and Saturday. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 558	D. Daily audit by Unit Manager/Designee will be conducted to ensure bathing/shower preferences are honored as per plan of care x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained. The audit findings will be reported to the QA committee.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		7/24/24

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F 578	Continued From page 10 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R18, R65 and R116) out of six residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: 1. Review of R18's clinical record revealed: 12/13/20 - R18 was admitted to the facility. 3/26/24 - A significant change MDS revealed R18 was cognitively intact with a BIMs score of 15.	F 578	A. Three residents identified during the annual/complaint survey have been offered an opportunity to formulate an advanced directive. B. All residents have the potential to be affected by this practice, so a full house review of all residents will be completed to ensure that all residents were offered the opportunity to formulate an advanced directive C. The root cause was staff□s lack of knowledge on the importance of offering residents the opportunity to formulate an	

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F 578	Continued From page 11 5/9/24 10:06 AM - An interview with R18 confirmed the facility did not offer to assist in formulating an advanced directive for him upon admission. 5/13/24 - A review of the electronic medical records lacked evidence that R18 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R18 did not have an advanced directive and was not previously offered to formulate one upon admission. 2. Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 2/29/24 - A quarterly MDS revealed that R65 was cognitively intact with a BIMs score of 15. 5/9/24 10:42 AM - An interview with R65 confirmed the facility did not offer to assist in formulating an advanced directive for him upon admission. 5/9/24 11:18 AM - A review of the electronic medical records lacked evidence that R65 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R65 did not have an advanced directive and was not previously offered to formulate one upon admission. 3. Review of R116's clinical record revealed: 2/1/23 - R116 was admitted to the facility.	F 578	advanced directives upon admission. Procedures were updated as well as the admission agreement to include advanced directive The Admissions/designee and Social Services staff will be in-serviced on the changes in process and given opportunities for questions by NHA or designee. D. Weekly audits of new admissions will be completed by Social Services & Admissions team members. Audits will continue for 4 weeks to ensure 100% compliance. Monthly audits will continue throughout the year to ensure compliance is sustained. The audit findings will be reported at the quarterly QA committee meetings	

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F 578	Continued From page 12 1/30/24 - A review of an annual MDS revealed that R116 was cognitively intact and had a BIMs score of 15. 5/9/24 11:28 AM - An interview with R116 confirmed the facility did not offer to formulate an advanced directive for him upon admission. 5/9/24 11:58 AM - A review of the electronic medical records lacked evidence that R116 had an advanced directive on file. 5/14/24 11:47 AM - An interview with E1 (NHA) confirmed that R116 did not have an advanced directive and was not previously offered the opportunity to formulate one upon admission. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		7/24/24

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accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing

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written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, it was

A. R80, all belongings were located

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F 585	Continued From page 15 determined that for one (R80) out of two reviewed for Personal Property, the facility failed to maintain evidence demonstrating the result of R80's grievance regarding her missing personal items. The facility grievance policy also lacked documentation a specific process for how the resident/family were informed of the results of the grievance investigation. Findings include: "Resident and Family Grievance Policy ...1. Director of Social Services has been designated as the Grievance Official ... 4. Grievance may be voiced in the following forums: a. Verbal complaint to a staff member of Grievance Official ..." Review of the facility "Resident and Family Grievance Policy" revealed the policy lacked a documented, specific process for how the resident/ family were informed of the results of the grievance investigation. 1/14/24 - R80 was admitted to the facility with diagnoses, including but not limited to, end stage renal disease, diabetes and difficulty walking. 5/10/24 10:53 AM - During an interview, R80 stated that she (R80) was transferred to the hospital two times. She returned to a different room on both occasions, and her belongings were packed by the facility staff. R80 stated that she was missing several items clothing, a bag of correspondence (mail from Social Security, banking), all her toiletries and coloring books. R80 further stated that she informed Social Services, but she still has not recovered some of the items. 5/13/24 11:45 AM - During an interview, E14	F 585	except for the bag of correspondence during the state survey in May 2024. Family and residents were informed on status. B. The Grievance form was updated to address the documentation of specific process for how the resident/family will be informed of the results. The root cause was that the process was not clear on the grievance process. C. All staff will be educated and understand the grievance process by Staff D/or designee. D. Weekly audit by NHA/designee will be conducted to ensure residents grievances are properly addressed x 4 weeks until a 100% compliance is achieved. The following will be a monthly audit x 3 or until compliance is sustained. The audit findings will be reported to QA committee.	

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(Social Work assistant) stated, " When items are reported missing by a resident to Social Work, we tell the director of the department assigned to that missing item. We give them an hour or two to look for the item. If we find it, we give it back to the resident. If we don't find it, we ask the resident for receipts and then replace or pay for the item. We document the grievance in out computer grievance log."

5/13/24 1:25 PM - During an interview, E1 (NHA) confirmed that E7 (Director of Social Work) was the facility's Grievance Official.

The surveyor reviewed the Grievance log and found no evidence of a grievance regarding R80's missing personal items, including her bag of correspondence.

5/13/24 3:09 PM - During an interview, E7 stated, "The facility knew about the bag of correspondence and we looked for it. We told the daughter and the resident that we could not find the bag [of correspondence]. We called her previous roommate to see if she accidentally took the bag home when she was discharged. The roommate's family claimed they didn't have it ...We did not document anything in our grievance log ... [R80] did not tell us that she was still missing clothing."

5/14/24 10:40 AM - During a telephone interview, F1 (R80's daughter) stated, "When mom was admitted [to the facility] in January, I brought her new clothes, a bag of personal mail, which included her new social security card, coloring books, crayons, a fan, bed pads and some Depends briefs as well as toiletries and lotions. The fan had my name on it and Mom's room

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F 585	Continued From page 17 number. Mom was sent to the hospital on 1/20 until 2/9. They never called me to come get her stuff. It was put in storage. When my Mom came back, they couldn't find the stuff ... Mom went out to the hospital again on 2/19 to 2/26, and her stuff was missing again. I looked in one of the storage rooms and I found her fan and bible. All her books have her name in them. I also found Mom's clothes under another resident's name. I got those clothes back for Mom." The facility was not able to provide evidence of R80's written grievance decision regarding her missing correspondence that included the date the grievance was received, a summary statement of the resident's grievance, steps taken to investigate the grievance, a summary of the pertinent findings, a statement of whether the grievance was confirmed or not confirmed, any corrective action taken as a result of the grievance and the date the written decision was issued. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate Consultant).	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined for four (R2, R46, R98 and R106) out of thirty residents in the investigative sample, the facility failed to ensure the MDS was accurate. Findings include:	F 641	A. R2, R46, R98 & R106 have been reviewed for accuracy and corrected. B. Audits will be conducted of active resident's most recent MDS in last 30 days for missed coding in section E-	7/24/24

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1. Review of R2's clinical record revealed:

7/26/23 - A dental report confirmed that R2 was edentulous (has no teeth).

11/9/23 - An annual MDS revealed that under "No natural teeth or tooth fragment(s) (edentulous)," the response was recorded as "no."

11/30/23 - A dental report confirmed that R2 was edentulous.

2/8/24 - A quarterly MDS was completed and revealed that the above statement was not addressed. Section L for dental was not completed.

5/7/24 - A quarterly MDS was completed and revealed that the above statement was not addressed. Section L for dental was not completed.

5/13/24 8:56 AM - In an interview, R2 confirmed he has no teeth.

5/17/24 9:55 AM - In an interview with E37 (RNAC), it was confirmed that resident was edentulous, yet the MDS does not reflect this. E37 also confirmed that the quarterly assessment was inaccurate.

2. Review of R46's clinical record revealed:

9/11/15 - R46 was admitted to the facility with diagnoses including but not limited to anxiety.

5/7/24 - An quarterly MDS revealed that R46 had no behavioral occurrences during the review

behaviors, section H- bladder continence and section L- dental status. For the MDSs identified as miscoded in any of those 3 sections, the RNAC will modify the MDS s to correct the miss coded information and transmit them to CMS.
C. The root cause was determined to be due to lack of thorough understanding of the other sources of information utilized for coding of behaviors, bladder continence and dental status.

Educations will be completed by Staff Development/designee for MDS staff and nursing staff on of appropriately assessing and reviewing documentation of bladder status and behaviors prior to coding of MDS section

Educations will be completed by Staff Development/designee for MDS staff on reviewing dental report when completing section L related to of MDS. Educations will be completed by Staff Development/designee for Social services on reviewing behavioral documentation when completing behavioral section of the MDS

D. Random audits will be completed on 20% of residents having MDSs completed monthly x 3 months then 20% of residents having MDSs completed quarterly x 2 quarters to ensure compliance and audit findings will be reported at the QA committee.

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period.

5/2024 - A review of the CNA behavior flow sheet revealed that R46 had verbal aggression from 5/1/24 to 5/7/24.

5/16/24 10:35 AM - An interview with E37 (RNAC) revealed that she is not responsible for the section documenting the behaviors in the MDS.

5/16/24 10:42 AM - Interview with E7 (SW) confirmed that social services is responsible for documenting the behavior section of the MDS. E7 confirmed that R46 had documented behaviors and the MDS was inaccurate.

3. Review of R98's clinical record revealed:

7/24/23 - R98 was admitted to the facility.

4/25/24 - A quarterly MDS revealed that R98 had no behavioral occurrences during the review period.

4/2024 - 5/2024 - A review of the CNA behavior flow sheet revealed that R98 had verbal and physical aggression from 4/18/24 to 4/25/2024.

5/16/24 10:42 AM - Interview with E7 (SW) confirmed that social services is responsible for documenting behavior section of the MDS. E7 confirmed that R98 had documented behaviors and the MDS was inaccurate.

5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).

4. Cross Refer F690

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Review of R106's clinical record revealed:

6/23/23 - R106 was admitted to the facility.

6/30/23 - An admission MDS assessment revealed that R106 was always continent of bladder and was not on a toileting program.

5/28/24 12:00 PM - A review of R106's hourly voiding diary from 6/24/23 through 6/30/23 revealed that R106 was found wet in 5 out of 238 opportunities.

5/28/24 12:55 PM - In an interview, E61 (Regional MDS Consultant) stated that R106's 7 day look back period was between 6/24/23-6/30/23. E61 further stated that during the look back period, R106 only had one incontinent episode and E61 thought it was an erroneous coding by the staff. E61 added, "I went to the floor and interviewed the staff, they (CNAs) said [R106] was continent of bladder. I did not know there was a voiding diary so I did not see the rest of the CNA documentation where it showed [R106] had more than one incontinent episodes during the look back period."

5/28/24 1:00 PM - During an interview, E21 (Corporate Clinical Nurse) confirmed that R106's MDS admission assessment for bladder incontinence was coded inaccurately.

5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).

F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		7/24/24

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F 644	Continued From page 21 §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 four (R2, R28, R46 and R116) out of six residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: 1. Review of R2's clinical record revealed: 12/1/21 - R2 was admitted to the facility. 8/4/22 - A review of R2's medical record revealed that R2 had a PASRR level 1 that indicated the following: "The Level 1 screen indicates that a PASRR disability is not present because of the following reason: A neurocognitive disorder/dementia is primary and progressed ..."	F 644	A. R2, R28, R46 & R116 residents PASARR assessment was completed and current. B. An audit will be done on all residents to ensure that all residents have had as assessment with the pre-admission screening and PASARR review completed and that all recommendations were incorporated into the resident□s assessment, care plan& transition of care. The root cause was that there was not a clear understanding of the PASARR regulation. C. Education on F644 regulation will be completed for the admission/designees and social services team member by NHA/designee.	

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6/21/23 - A diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms was added to R2's diagnoses, yet there was no request for an updated PASRR since the one completed in 2022.

5/13/24 11:07 AM - S1 (PASRR State Authority) confirmed that a resident review PASRR should have been completed due to this new mental health diagnosis as it suggested a new primary mental illness.

5/14/24 approximately 11:50 AM - An interview, E7 (Social Services Director) and E14 (Social Work Assistant) confirmed that, per S1, an updated screening should have been completed for R2.

2. Review of R28's clinical record revealed:

4/2/21 - R28 was admitted to the facility with diagnoses, including but not limited to, stroke affecting the right dominant side and aphasia (a language disorder).

4/2/21 - R28's Preadmission Screening and Resident Review (PASARR) stated, "PASARR Level I Determination: No Level II Required - No SMI (significant mental illness)/ID (intellectual disability). Rationale: The Level I screen indicated that a PASARR disability is not present because of the following reason: There is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted."

D. Daily audits by NHA/Designee will be conducted to ensure all newly admitted residents had coordination of PASARR and assessment completed and obtained 100% compliance. Following with weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained. The audit findings will be reported to the QA committee

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4/13/23 - E6 (MD) completed and signed a Physician's Affidavit that stated, "Based on tests and my examination of this patient [R28], it is my professional opinion that she does have a disability that significantly interferes with the ability to make responsible decisions regarding health care, food, clothing, shelter or finances. In my opinion, the patient [R28] does not have sufficient mental capacity to understand the nature of guardianship in order to consent to the appointment of a guardian."

5/16/24 12:40 PM - During an interview, E6 confirmed that she completed the Physician's Affidavit that deemed R28 to have an intellectual disability. When asked about the term "intellectual disability", E6 replied, "It says it right on the paperwork (pointing to the Physician's Affidavit document that asked "describe the disability") ... I wrote aphasia due to stroke, poor cognition." When asked if E6 informed Social Services to request a new PASARR evaluation for a new diagnosis of intellectual disability, E6 replied, "Twenty years working in long-term care, I don't even know what a PASARR is."

5/16/24 12:49 PM- During an interview when asked if R28 had a new PASARR evaluation after being deemed to have an intellectual disability, E7 (Social Services Director) stated, "No, I wasn't told that there was a new diagnosis that warranted an updated PASARR evaluation."

5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant).

3. Review of R46's clinical record revealed:

9/11/15 - R46 was admitted to the facility with

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diagnoses including but not limited to anxiety.

10/1/15 - A level I PASARR revealed that R46 does have a serious mental illness and individual needs can be met in a nursing facility.

6/19/20 - R46 was diagnosed with major depressive disorder recurrent, severe with psychotic symptoms.

2/8/23 - R46 was diagnosed with bipolar disorder and insomnia.

5/16/24 9:26 AM - A review of the progress notes for R46 revealed that the facility submitted an updated PASARR review for R46.

5/17/24 1:15 PM - An interview with E7 (SW) confirmed that an update was submitted to reflect the new diagnoses for R46.

4. Review of R116's clinical record revealed:

1/10/23 - A level I PASARR was submitted for R116 and confirmed no level II required.

2/1/23 - R116 was admitted to the facility.

1/30/24 - R116 was diagnosed with persistent mood (affective) disorder and mood disorder due to unknown physiological condition with mixed features.

5/14/24 10:07 AM - An interview with E7 (SW) confirmed the last PASARR requested for R116 was 1/10/23 prior to admission. E7 confirmed that no further updates have been submitted to the state PASARR authority.

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F 644	Continued From page 25 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	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 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	F 645		7/24/24

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F 645	Continued From page 26 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) 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 interview and record review, it was determined that for one (R47) out of six residents sampled for PASARR review, the facility failed to provide evidence that a Delaware State PASARR was obtained prior to admission. Findings	F 645	A. R47 PASARR assessment was completed and current. B. An audit will be done on all residents admitted in the last 30 days to ensure that the facility can provide evidence that a	

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F 645	Continued From page 27 include: Review of R47's clinical record revealed: 12/15/15 - R47 was admitted to the facility with diagnoses including but not limited to major depressive disorder. 9/19/16 - R47 was diagnosed with delusional disorder, anxiety disorder and mood disorder due to unknown physiological condition. 2023 - 2024 - A review of clinical records lacked evidence of a level I PASARR and a referral for update to the State PASARR authority. 5/17/24 1:15 PM- An interview with E7 (SW) confirmed that R47 was admitted without a PASARR level I or any PASARR review and will submit one today. E7 confirmed that she contacted the State PASARR authority and a level I was not on file. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 645	Delaware state PASARR was obtained prior to admission.The root cause was that staff did not have a clear understanding of the regulation. C. Education on F645 regulation will be completed for the admission/designees and social services team members by the NHA/designee. D. Daily audits by NHA/Designee will be conducted to ensure all newly admitted residents had a Delaware state PASARR obtained prior to admission and obtained remain at 100% compliance. Following with weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained. The audit findings will be reported to the QA committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		7/24/24

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F 656	Continued From page 28 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R40 and R106) out of	F 656	A. R40's care plan was revised to reflect person centered care plan with	

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three residents reviewed for bowel and bladder, the facility failed to develop a person centered care plan to address incontinence. Findings include:

1. Review of R40's clinical record revealed:

1/23/20 - R40 was admitted to the facility.

2/6/24 - An admission assessment documented R40 was cognitively intact , always incontinent of bowel, bladder was not rated, and no toileting plan initiated.

4/30/24 - A quarterly MDS documented R40 was cognitively intact, always incontinent of bowel and bladder, and no toileting plan in place.

5/10/24 - Review of R40's care plan revealed a lack of evidence that a person centered care plan with interventions was developed to address R40's incontinence.

5/13/24 9:23 AM - During an interview, E39 (LPN) confirmed that R40 is incontinent of bowel and bladder "she calls for help when she needs to be changed."

5/13/24 approximately 11:30 AM - During an interview E48 (RN/UM) confirmed R40's care plan lacked evidence that a person centered care plan was developed to include incontinence care.

Cross Refer F690

2. Review of R106's clinical record review:

6/23/23 - R106 was admitted to the facility.

interventions was developed to address incontinence.

R106's care plan was revised to reflect person centered care plan with interventions was developed to address incontinence.

B. Active residents with bladder incontinence in MDS completed in the last 30 days will be reviewed to ensure a person-centered care plan with interventions was developed to address incontinence.

C. The root cause was determined to be lack of thorough understanding and oversight of residents with bladder incontinence based on assessment to ensure that person centered care plan with interventions was developed to address incontinence.

Staff Development/Designee will in-service nursing management team to ensure residents with bladder incontinence has a person-centered care plan with interventions to address incontinence.

New admissions with bladder incontinence will be reviewed to ensure person centered care plan with interventions was developed to address incontinence.

D. Weekly audit by Unit Manager/Designee will be conducted to ensure that residents with bladder incontinence has a person-centered care

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F 656	Continued From page 30 6/30/23 - An admission MDS assessment revealed that R106 was cognitively impaired, was always continent of bladder and was not on a toileting program. 9/28/23 - A quarterly MDS assessment revealed that R106 was cognitively impaired, occasionally incontinent of bladder and was not on a toileting program. 12/26/23 - A quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. 3/26/24 - A quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program. 5/28/24 8:30 AM - A review of R106's care plan revealed a lack of evidence that a person centered care plan with interventions was developed to address R106's bladder incontinence. 5/28/24 11:10 AM - During an interview, E35 (LPN Sup) confirmed that R106 did not have a bladder incontinence care plan with interventions. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).	F 656	plan with interventions was developed to address incontinence x 4 weeks or until a 100% compliance is achieved, then monthly x 3 months or until compliance is sustained. The audit findings will be reported to the QA committee.	
F 657 SS=E	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	F 657		7/24/24

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be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that for five (R2, R32, R55, R88 and R120) out of five sampled residents for care plan timing and revision, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include:

The facility policy entitled Comprehensive Care Plans, last reviewed 4/24, indicated "4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not

A. R2, R32, R55, R88, R120's care plans will be reviewed to ensure that the facility completes a comprehensive care plan with input from the interdisciplinary team which includes, the attending physician, registered nurse, nurse aid, and a member from food & nutrition, as well as the resident and the resident representative as practicable.
B. All residents have the potential to be affected related to care plan meetings and input from the IDT

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limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: i. The RAI Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists ...."

Review of R2's clinical record revealed:

12/1/21 - R2 was admitted to the facility.

5/14/24 - A review of the quarterly care plan meeting for 5/25/23 lacked evidence of input from the Physician. A review of the quarterly care plan meetings for 8/17/23, 11/9/23 and 2/15/24 lacked evidence of input from the Physician and certified nursing assistant.

2. Review of R32's clinical record revealed:

5/19/16 - R32 was admitted to the facility.

5/14/24 - A review of the quarterly care plan meeting for 4/27/23 lacked evidence of input from the Physician. A review of the quarterly care plan meeting notes for 7/27/23 and 1/4/24 lacked evidence of input the full interdisciplinary team as sign in sheets were not received. A review of the quarterly care plan meeting for 4/18/24 lacked

C. The NHA/designee will educate the social services team on the regulation requirement and care plan meeting procedures including input from the IDT provider, food and nutrition and CNA. The Resident Care Conference Attendance form was updated to include the CNA & provider□s signature as participants and have invited/included in care plan meetings.
D. Daily audits by NHA/Designee will be conducted to ensure the that the facility completes a comprehensive care plan prepared by an interdisciplinary team which includes, input from the attending physician, registered nurse, nurse aid, and a member from food & nutrition, as well as the resident and the resident representative as practicable. Following with weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained. The audit findings will be reported to the QA committee

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evidence of input from the Physician and certified nursing assistant. Additionally, the facility lacked evidence that R32 had a quarterly care plan meeting in October, 2023.

3. Review of R55's clinical record revealed:

10/27/16 - R55 was admitted to the facility.

5/14/24 - The facility lacked evidence of that R55 had a quarterly care plan meeting between 7/27/23 through 1/24/24. A review of the quarterly care plan meeting for 1/25/24 lacked evidence of input from the Physician, certified nursing assistant and a member of the food and nutrition services staff. A review of the quarterly care plan meeting for 4/18/24 lacked evidence of input from the Physician and certified nursing assistant.

4. Review of R88's clinical record revealed:

2/14/22 - R88 was admitted to the facility.

5/14/24 - A review of the quarterly care plan meeting for 11/9/23 lacked evidence of input from the Physician, certified nursing assistant and Social Worker. A review of the quarterly care plan meetings for 1/25/24 and 4/18/24 lacked evidence of input from the Physician and certified nursing assistant.

5. Review of R120's clinical record revealed:

7/21/23 - R120 was admitted to the facility.

5/14/24 - A review of the quarterly care plan meeting for 11/2/23 lacked evidence of input from the Physician and certified nursing assistant. Review of the quarterly care plan meetings for

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F 657	Continued From page 34 1/25/24 and 4/11/24 lacked evidence of input from the Physician, certified nursing assistant and a member of the food and nutrition services staff. 5/14/24 approximately 11:50 AM - In an interview, E7 (Social Services Director) and E14 (Social Work Assistant) confirmed that they were unaware of all mandatory IDT members that need to provide input at resident care plan meetings. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 657		
F 658 SS=D	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 interviews, it was determined that for one (R3) out of four residents reviewed for Medication Administration, the facility failed to ensure that R3's care met accepted, professional standards. The nurses documented signing out multiple medications as being administered via the oral route when in fact, the medications were being given via the enteral route due to R3 being NPO. Findings include: "Nursing Rights of Medication Administration ... It is the standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the "five rights" or "five R's" of	F 658	A. R3's medication administration route had been clarified on 5/15/24. B. Residents with PEG tube/NPO status will be reviewed to ensure that medication administration route is accurate. C. The root cause was determined to be due to lack of oversight to ensure the route for medication administration is accurate. Staff development/Designee will in-service licensed nurse and new hires to ensure the route for medication administration is accurate and the	7/24/24

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medication administration ...The traditional five rights in traditional sequence include: right drug, right patient, right dose, right route, and right time."
National Library of Medicine, September 4, 2023.

Review of R3's clinical record revealed:

7/5/18 - R3 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis.

2/14/24 - R3 was admitted to the hospital for an altered mental status.

3/1/24 - While hospitalized, R3 underwent placement of a percutaneous endoscopic gastrostomy tube (PEG- a feeding tube) for the diagnoses malnutrition/ failure to thrive.

3/7/24 - R3 was re-admitted to the facility.

3/7/24 10:26 PM - E15 (RN Nursing supervisor) entered orders for acetaminophen, atorvastatin, bisacodyl, cholecalciferol, clopidogrel, cyanocobalamin, labetolol, losartan, Maalox, metformin, milk of magnesium, pantoprozole, polyethylene glycol and senna. All fourteen medications were ordered to be administered by mouth.

3/10/24- E11(Dietitian) documented in R3's EMR an order, "NPO (a medical term that means nothing by mouth)".

3/12/24 - E16 (Speech therapist) performed a "Cognitive Impairment SLP (Speech Language Pathologist) Screen with R3 and documented R3 as "Strictly NPO".

importance of following the 5 rights of medication administration.

All new admissions with PEG tube/NPO status will be reviewed to ensure the route for medication administration is accurate.

D. Daily audit by DON/Designee will be conducted to ensure that residents with PEG tubes are reviewed to ensure the route for medication administration is accurate x 5 days or until a 100% compliance is achieved. The following will be a weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained.

The audit findings will be reported to the QA committee.

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F 658	Continued From page 36 5/14/24 8:25 AM - The surveyor attempted to observe R3's 8:00 AM medication pass. E18 (LPN) stated that she had already given her AM medications via R3's PEG tube. E18 confirmed that R3's 5/14/24 AM medications were in fact given via the enteral [PEG tube] route. 5/15/24 9:15 AM - During the observation of R3's 8:00 AM medication pass, E6 (MD) was called for clarification of the medication administration route, and it was changed from "by mouth" to "via PEG Tube." E18 stated that since R3's admission on 3/7/24, the nursing staff, including herself, had been administering R3's medications via the enteral [PEG-Tube] route but were signing the medications out on R3's Medication Administration Record (MAR) under the order that stated "by mouth." The facility failed to ensure that the services provided by the nursing staff met the professional standards of quality with regards to the Five Rights of Medication Administration. 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant).	F 658		
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 and interviews, it was	F 677	A. (1) R18 was provided with incontinent	7/24/24

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determined that for four (R18, R54, R65, and R79) out of six residents reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include:

1. Review of R18's clinical record revealed:

12/13/20 - R18 was admitted to the facility.

3/26/24 - A significant change MDS revealed that R18 was dependent for toileting hygiene which includes perineal hygiene and using the toilet, commode or urinal. R18 was also dependent for chair to bed to chair transfer. R18 has a BIMS score of 15 and is alert and oriented.

5/9/24 10:56 AM - An interview with R18 revealed that he has been up in his chair since 6:00 AM and requested for his CNA to change him. R18 stated, "She told me I have to wait until after lunch to be changed."

5/9/24 12:56 PM - An observation of R18 following the CNA to his room to receive care.

5/9/24 - A review of the CNA documentation flow sheet revealed that E43 (CNA) only provided perineal hygiene once during the shift.

5/9/24 1:34 PM - A review of the CNA Kardex revealed that R18 was incontinent of urine and dependent for perineal care.

5/16/24 9:02 AM - An observation of R18 sitting in his wheelchair at the nurses station.

5/16/24 12:02 PM - An observation and interview with R18 revealed he was still sitting at the nurses station and stated he had not been changed this

care. Staff will be educated in frequency checking and assisting with toileting needs.

(2) R54's toileting needs were discussed with the resident when out of bed. Nursing staff will be educated in frequency checking and assisting with toileting needs.

(3) R65's bathing/shower preference were reviewed. Nursing staff will be educated on honoring preferences related to showering/ hair and documentation.

(4) Staff will offer to trim R79's nails.

B. Active residents who are incontinent will be reviewed to ensure:

(1 and 2) Staff are compliant with checking and assisting with toileting needs for residents who need assistance.

(3) Active dependent residents bathing/shower-hair care preferences will be reviewed, and plan of care will be updated.

C. The root cause was determined to be lack of oversight to ensure toileting needs are met, bathing/shower preferences are honored, and nails are trimmed based on resident needs.

Staff Development/Designee will re-educate nursing staff and new hires on toileting needs, bathing/shower preferences are honored, and nails are trimmed based on resident's needs.

D. Random daily audit of 5 residents per unit by DON/Designee will be conducted

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shift.

5/16/24 1:50 PM - An interview with E44 (CNA) confirmed that R18 only gets checked once a shift and provided continence care due to being a Hoyer lift transfer. E44 confirmed that R18 went back to bed at 2 PM and then provided care.

5/16/24 2:04 PM - An interview with E43 (CNA) confirmed that R18 remained in his chair until after lunch on 5/9/24 and continence care was provided once.

2. Review of R54's clinical record revealed:

7/7/23 - R54 was admitted to the facility.

7/13/23 - An admission MDS revealed that R54 was dependent for toileting hygiene which includes perineal hygiene and using the toilet, commode or urinal. R54 was also dependent for transfers in and out of bed.

9/6/23 - A facility grievance form revealed that R54 reported that staff left her in the geri-chair from 11:00 AM to 9:00 PM on 9/5/23. The grievance form stated that R54's brief and clothing were wet and R54 was crying. R54 asked to go back to bed and was told by staff that they "were short handed and she would have to wait."

5/16/24 11:30 AM - An interview with E45 (former DON) revealed that R54 was left up in her chair for several hours when the facility started the investigation. E45 stated she cannot recall all the details from the date but remembers investigating. E45 stated that R54 is alert and oriented and the grievance report was accurate.

to ensure that resident's toileting needs are met, dependent resident bathing/shower preferences are honored, and nails are trimmed x 5 days or until a 100% compliance is achieved. The following will be a weekly audit x 4 weeks, then monthly x 3 months or until compliance is sustained.

The audit findings will be reported to the QA committee.

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3. Review of R65's clinical record revealed:

6/2/20 - R65 was admitted to the facility.

2/29/24 - A quarterly MDS assessment revealed that R65 was dependent for transfers and showering.

5/9/24 11:33 AM - An interview with R65 revealed that R65 has not had a shower or washed her hair since September 2023. R65 stated that staff told her the bariatric shower bed was broken and she was unable to shower.

A review of CNA documentation from August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024 revealed that R65 has only received bed baths from staff and lacked evidence of hair being washed.

5/14/24 10:53 AM - An interview with E24 (CNA) revealed that R65 has been receiving bed baths and hair usually does not get washed during a bed bath.

4. Review of R79's clinical record revealed:

1/2/20 - R79 was admitted to the facility.

2/27/24 - A quarterly MDS revealed that R79 requires substantial/maximal assist with showering.

5/9/24 9:45 AM - An interview with R79 revealed that he needs staff member assist with nail care. An observation of R79 revealed multiple long, overgrown nails on right hand.

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F 677	Continued From page 40 5/10/24 2:06 PM - An observation of R79 with multiple, long overgrown nails on right hand. 5/13/24 9:10 AM - An observation of R79 in the shower with the door closed and no staff assistance noted during the time of observation. 5/13/24 10:00 AM - An observation of R79 after shower with multiple, long overgrown nails on right hand. 5/14/24 10:45 AM - An interview with E47 (CNA) revealed on shower day the staff is expected to provide all care including oral care, shaving, nail care, and peri care. E47 confirmed that signing off the shower tasks confirms all tasks involved were completed. E47 confirmed that R79 has not received nail care and had multiple long, overgrown nails on the right hand. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		7/24/24

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F 684	Continued From page 41 Based on record review, interview, and review of other facility documentation, it was determined that for three (R294, R106 and R397) out of three sampled residents reviewed for quality of care, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice. For R294, the facility failed to provide orders or provision of care for this resident's surgical wound. 1. 10/11/23 - Interagency Discharge Orders revealed that wound care instructions were given for the resident's surgical wound to the left forearm. These instructions also stated that the patient "underwent C2-T1 fusion and C2-C7 laminectomy for cervical cord compression. Please follow up with (the doctor) in 2 weeks." 10/11/23 - Resident admitted to facility status post C2-T1 fusion and C2-C7 laminectomy (surgical procedure to the neck). 10/13/23 (Sunday) - A nursing note revealed: "There are 7 sutures intact to left forearm. Pt (patient) is wearing cervical neck collar due to post op spinal surgery. Pt requested to wait until Monday to remove the neck stabilizer for skin assessment." The facility lacked evidence of the neck wound. 10/14/23 - A nursing note revealed: "Has wounds present: left lower leg Treatment to wound performed on shift as ordered. Scant amt (amount) of drainage. Serous drainage (thin, watery, clear) noted from wound. Turned & repositioned frequently. Offloading of affected area. Skin treatments performed as ordered." The facility lacked evidence of the neck wound.	F 684	A. (1) R294 had been discharged. Unable to correct the deficiency. (2) R106's neurology consult is scheduled on 7/8/2024. (3) R397 had been discharged. Unable to correct deficiency. B. (1) Active residents with surgical wounds will be reviewed to ensure routine assessment and monitoring is in place. Active residents with cervical collar will also be reviewed to ensure routine assessment and monitoring orders are in place. (2) Hospital Discharge summaries of residents admitted in the last 14 days will be reviewed to ensure any recommended specialist follow up is scheduled. (3) Active residents on fast acting insulin will be reviewed to ensure a hold parameter is in place and administered with meals. C. (1) The root cause is determined to be a lack of oversight from the. Licensed nursing staff and physician/extender to ensure routine assessment and monitoring of surgical site care (cervical collar) order is in place. Staff Development/Designee will re-educate licensed nurses and new hires to ensure routine assessment and monitoring of surgical site (e.g. cervical collar) order is in place. During the new admission chart check, the nursing team will verify that routine assessment and monitoring of	

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10/14/23 - Wound care order, as follows: "Treatment to LLE (left lower extremity) clean with NSS (normal saline solution), pat dry, apply xeroform then apply ABD (abdominal gauze pad) and cover with Kerlix (gauze bandage roll) every day shift." There was no evidence of treatment ordered for the cervical wound. The facility lacked evidence of the neck wound.

10/14/23 - A nursing note revealed: "Resident medicated with oxycodone 5 mg IR as ordered for c/o pronounced Neck, Left, shoulder, and Left arm pain subjectively rated 10/10 by resident...Visual assessment of skin revealed no new areas of concern. Dressing to LLE (left lower extremity) wound changed." The facility lacked evidence of the neck wound.

10/16/23 - A nursing note revealed: "Neck brace remains in place. Stitches to left forearm remain intact." The facility lacked evidence of the neck wound.

10/16/23 - A nursing note revealed: "s/s of pain: neck Pain medication given...Neck brace remains in place. Stitches to left forearm remain intact (late entry)." There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound.

10/17/24 - Note by E7 (Director of Social Work) revealed: "(Resident) was able to complete her BIMS assessments she scored 15/15 which indicates she is cognitively intact."

10/17/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and

surgical site order is in place.

(2) The root cause was determined to be timely review of hospital discharge summaries to assure any recommended specialist follow up is scheduled.

Staff Development/Designee will re-educate licensed nurses and new hires to ensure timely review of hospital discharge summaries to assure any recommended specialist follow-up is scheduled.

(3) The root cause was determined to be physicians identifying parameters on when to hold the insulin and nursing□s follow up with physician

Staff Development/Designee will educate Physicians, licensed nurses and new hires to ensure a hold parameter order is obtained for fast acting insulins and fast acting insulins are administered with meals and when to notify physicians .

During the new admission chart check, the nursing team will verify that the hold parameter is in place and administered with meals for fast acting insulins.

D. (1) DON/Designee will conduct a daily audit of new admissions and residents with new surgical wounds to ensure that assessment and monitoring of surgical site order is in place x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months.

(2) Unit Manager/Designee will

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intact." There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound.

10/18/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and intact .... Skin treatments performed as ordered." There is no evidence that the cervical collar was removed to inspect the cervical wound. The facility lacked evidence of the neck wound.

10/19/23 - An NP note revealed: "Wound # 4 Mid upper back Surgical Treatment Recommendations:
1. None.
2. Per Surgeon's request, monitor daily for s/s of infection.
3. Secure with bordered gauze.
4. Change daily.
PREVENTATIVE MEASURES:
The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon. Keep all surgical follow-up appointments."

10/19/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s (signs/symptoms) of pain: neck pain level 10 - 10/19/2023 2:48 PM Pain scale: Numerical Pain medication given. Patient resting in bed at start of shift. 10/10 neck pain reported, unchanged with pain medication. No distress noted. Patient picked up for dialysis this am and has not returned yet." There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck

conduct a daily audit of new admissions to ensure hospital discharge summaries with any recommended specialist follow-up is scheduled. x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months.

(3) Unit Manager/Designee will conduct a daily audit of new admissions and new orders to ensure blood sugar parameter to hold and administer with meals is in place when a resident is on a fast-acting insulin x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months.

The audit findings will be reported to the QA committee.

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pain.

10/20/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: left lower leg. Dressing to wound remains clean, dry, and intact. s/s of pain: neck pain level 10 - 10/21/2023 1:18 PM Pain scale: Numerical Pain medication given. Pain remains unchanged." There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain.

10/21/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s of pain: neck pain level 10." There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain.

10/22/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: LLE Dressing to wound remains clean, dry, and intact. Displays s/s of pain: neck pain level 10." There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain.

10/23/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: left lower leg Dressing to wound remains clean, dry, and intact." There is no evidence that the cervical collar was removed to inspect the cervical wound.

10/24/23 - An NP note revealed: "Patient was unable to be evaluated by the skin and wound team today; patient was not in facility at the time of visit. Of note, the patient is currently in isolation for active Covid infection, which is likely impeding

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wound healing."

10/25/23 - A nursing note revealed: "Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. Peri-wound skin is intact. neck pain level 10 - 10/25/2023 4:18 PM Pain scale: Numerical Pain medication given. Pain remains unchanged." There is no evidence that the cervical collar was removed to inspect the cervical wound even with complaints of neck pain.

10/26/23 - A nursing note revealed: "Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. s/s of pain: neck pain level 10 - 10/26/2023 2:27 PM Pain scale: Numerical Pain medication given. Pain remains unchanged." There is no evidence that the cervical collar was removed to inspect the cervical wound.

10/27/24 - A nursing note revealed: "Patient had offsite appointment today (10/27/23 @1245) at (the hospital) for surgical follow up. Patient was to be taken by facility transport staff, but patient states that she is not feeling well and is refusing to go out for appointment. Unit manager made aware."

10/27/23 - A nursing note revealed: "Has wounds present: LLE Treatment to wound performed on shift as ordered. Scant amt of drainage. Serosanguinous drainage (thin, red tinged) noted from wound. Peri-wound skin is intact. Displays s/s of pain: Neck pain level 10 - 10/27/2023 7:28 PM Pain scale: Numerical Pain medication given.

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Pain remains unchanged." There is no evidence that the cervical collar was removed to inspect the cervical wound.

10/28/23 - A nursing note revealed the following: "Late entry ... neck brace removed and surgical site to posterior neck assessed with no s/s infection/drainage noted, sutures intact ...."

10/28/23 - A nursing note revealed: "Skin is warm & dry. Has wounds present: left lower leg Treatment to wound performed on shift as ordered. No drainage noted." There is no evidence that the cervical collar was removed to inspect the cervical wound.

10/29/23 - A nursing note revealed: "skin is warm & dry. Has wounds present: LLE dressing to wound remains clean, dry, and intact." There is no evidence that the cervical collar was removed to inspect the cervical wound.

10/31/23 - A nursing note revealed: "s/s of pain: neck pain level 10 - 10/31/2023 3:57 PM Pain scale: Numerical Pain medication given. Pain remains unchanged. Has wounds present: LLE Treatment to wound performed on shift as ordered" with no mention made of evaluation of cervical area.

The facility lacked evidence that assessment, signs/symptoms of infection and ongoing monitoring of R294's cervical surgical wound. The MAR/TAR for October 2023 lacked evidence that wound care was ordered for R294's cervical wound. Review of R294's records revealed that she was assessed eighteen times for the LLE wound and only once for the cervical wound from 10/11/23 through 10/31/23. Additionally, the

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records document that the cervical collar was only removed once by nursing staff in the 21 days that R294 was in the facility.

11/1/23 6:18 AM - A wound care note written by E40 (NP) revealed the following: "Wound: 4: Location: Mid upper back; Primary Etiology: Surgical dehiscence; Wound Status: Reopened; Odor Post Cleansing: None; Stage/Severity: Full Thickness; Size: 15 cm x 8 cm x 8 cm. Calculated area is 120 sq cm. Wound Edges: Unattached. Periwound: Intact; Exposed Tissues: Bone. Exudate: Heavy amount of Sanguineous. Wound # 4 Mid upper back Surgical dehiscence. Treatment Recommendations: 1. immediate referral to ER (Emergency Room). PREVENTATIVE MEASURES: The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understands to contact operating surgeon. Keep all surgical follow-up appointments. This is the first assessment of R294's surgical wounds by me. Patient reports hearing a popping/crack sound yesterday during a transfer but did not report it to staff... Significant surgical dehiscence to the mid-upper back wound was found on exam .... 911 was called by staff nurse for immediate referral to the hospital."

11/1/23 11:30 AM - A nursing note revealed: "Patient resting in bed at start of shift. Tolerated meal and all medication as prescribed. Resident voiced no c/o (complaints of) pain. Resident transferred to hospital for dehiscence of surgical site posterior area of neck."

11/1/23 1:08 PM - A nursing note revealed: "Late entry: Resident assessed during wound rounds. Resident's posterior surgical incision found to be

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acutely dehisced. Resident's shirt and bed linens saturated in fresh red blood. Resident quickly sent to hospital for evaluation."

5/15/24 11:59 AM - In an interview, E9 (NP) stated that whoever does the resident's admission would enter wound care and then wound care NP's would then follow the resident. E9 stated that when surgical glue is used, it doesn't require any overt treatment plan, but staff would still need to ensure that the wound was still intact. E9 would expect the cervical collar to be removed daily for skin inspection. E9 stated that the surgeon "drives" the care for surgical wounds and facility providers would not make these orders.

5/16/24 11:42 AM - In an interview with E6 (MD), E9, and E6 (NP), E6 stated that the that the wound team follows the orders given by the surgeon and that they come to the facility once a week. The wound care providers put orders in, but that nurses can also enter a verbal order. E6 further stated that if nursing had questions about the discharge instructions, the nurse should call the surgeon for clarification. E6 stated that she and her providers do not provide wound care orders for surgical wounds due to legal considerations.

Cross Refer F689

2. Review of R106's clinical records revealed:

6/23/23 - R106 was admitted to the facility.

6/23/23 - R106's hospital discharge summary indicated that R106 was for follow up with neurology as an outpatient.

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5/16/24 - During an interview, E21 (Corporate Clinical Nurse) stated that R106's neurologist while at the hospital recommended for R106 to continue his medications to include Seroquel, an antipsychotic and Carbidopa/Levodopa for Parkinson's Disease.

A review of R106's physician's orders lacked evidence that R106 was ordered for a neurology consult.

5/21/24 2:42 PM - In an email correspondence, the surveyor requested copies of R106's neurology consult notes and when R106 was seen by an outpatient neurologist per hospital discharge summary on 6/23/23.

5/23/24 12:26 PM - In an email correspondence, E1 (NHA) documented that the facility was "not been able to get our hands on this consult. When [R106] returned from the hospital in August, it wasn't listed as needing follow up. We have asked the hospital for a full release of the hospital records to determine if he was seen in the hospital by neurology. There is work in place currently in coordination with the [clinic] to get an appointment scheduled..."

5/23/24 12:26 PM - Findings were confirmed by E1 (NHA).

3. Review of R397's clinical record revealed:

10/26/23 - R397 was admitted to the facility with diagnoses including type II diabetes and morbid obesity due to excess calories.

10/27/23 12:30 PM - A physician's order was

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written for Humalog quick pen inject 25 units intramuscularly three times a day for diabetes.

10/28/23 - A care plan was written for "potential/alteration in Nutritional status related to a need for therapeutic, fluid restricted diet secondary to DM, cardiac dx, morbid obesity. Expected weight variances related to diuretic use. Interventions included record percent of each meal and/or supplement consumed and Record weight and notify physician, patient, family or significant other of any significant change as needed."

11/3/23 to 11/7/23 - A review of the CNA task sheet revealed that R397's meal consumption was documented as 0% from 6 PM on 11/4/23 through 6 PM on 11/7/23.

11/7/23 12:30 PM - A physician's order was written for Humalog quick pen inject 20 units intramuscularly three times a day for diabetes. Blood glucose check revealed a blood glucose level of 99 mg/dL. The MAR indicated the medication was held by the nurse at this time. The physician's order lacked parameters to hold the administration of insulin.

11/7/23 5:30 PM - A review of the MAR revealed that R397's blood glucose was 73 mg/dL and the insulin was signed out as administered.

11/7/23 5:46 PM - A progress note documented R397 had abnormal labs and was being transported to the hospital.

11/8/23 4:38 AM - A progress noted documented R397 was admitted to the hospital with hypoglycemia (low blood glucose) and acute

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kidney injury.

11/23/23 - A discharge summary from the admitting hospital revealed that R397 presented with hypoglycemia after insulin administration from facility.

5/14/24 10:53AM - An interview with E9 (NP) revealed that when R397's blood glucose was 73 mg/dL, "...I would have expected to be notified." E9 assessed R397 on 11/7/23 and stated that staff failed to mention R397's low intake and low blood glucose readings. E9 stated he ordered labs and diagnostic tests related to R397's assessment earlier that day. When the labs came back abnormal, R397 was sent to the hospital.

5/14/24 11:32 AM - An interview with E34 revealed that she would administer insulin if the blood glucose is above 70 mg/dL and the resident has eaten. E34 stated that if the blood glucose is below 70 mg/dL and the resident has not eaten, she will call the provider. E34 confirmed that she administered the Humalog to F397 despite a low meal intake.

5/14/24 3:07 PM - An interview with E52 revealed confirmed that she uses nursing judgment when blood glucose levels are in the 80 - 90 mg/dL when administering insulin. E52 confirmed that she held the Humalog for R397 on 11/7/23 at 12:30 PM due to low blood glucose and poor intake.

The facility documentation lacked evidence of assessment and nursing judgement related to R397's blood glucose of 73 mg/dL and administration of Humalog. R397 had not consumed a meal in four days and the

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F 684	Continued From page 52 documentation lacked evidence of consulting a medical provider prior to administering the insulin. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: REVISED POST IDR Based on observation, interviews and record review it was determined that for one (R110) out of two residents reviewed for pressure ulcers, the facility failed to provide care and services to prevent an avoidable deep tissue injury from developing, causing harm. Findings include: Review of R110's clinical record revealed: 7/7/23 - R110 was admitted to the facility with diagnoses including but not limited to diabetes	F 686	A. R110s order for wound treatment was clarified on 3/13/24 E18 will be educated and a return demonstration completed on how to wrap a wound. B. Active residents with foot wound dressings will be reviewed to assure that dressings are applied in order to prevent further skin breakdown. Order will be clarified as applicable. Licensed staff will be re-educated and return demonstration completed to ensure	7/24/24

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mellitus with other circulatory complications, dementia, progressive neuropathy and stroke.

7/7/23 - A care plan, last revised 1/4/24, documented that R110 was at risk for alteration in skin integrity related to diabetes, impaired mobility and incontinence. The care plan included to notify physician and significant other of any change in skin condition, observe skin condition with activities of daily living every day and report abnormalities and turn and reposition with skin checks every two hours.

1/9/24 - A quarterly MDS for R110 documented that R110 was "dependent to move from sitting to lying, lying to sitting on the side of the bed, for lower body dressing and putting on/off footwear, required moderate assistance to sit to stand and required substantial assistance (the staff does more than half of the effort) to walk 10 feet. R110 was documented to use a wheelchair with setup assistance. R100 was at risk of developing pressure ulcers with no current ulcers. There were pressure reducing devices for the chair and bed in place and ointments/medications other than to the feet being used."

3/6/24 - A review of the physician's orders revealed a treatment order for the right heel to cleanse with normal saline, air dry, apply hydrogel, calcium alginate and a clean dry dressing every day shift and as needed.

The aforementioned treatment order was for R110's right heel for a diabetic foot ulcer.

3/12/24 - A nursing Braden Scale documented R110 with a score of 16 (15 - 18 is considered at risk of skin breakdown).

the foot dressing kling wrap is appropriately applied to prevent further skin breakdown.

C. The root cause was application of foot dressing further compromised by medical condition.

Staff Development/Designee will re-educate licensed nurse and new hires and return demonstration completed to ensure Kling wrap dressings are not restrictive in order to prevent further skin breakdown

D. Wound Nurse/Designee will conduct a daily audit of residents with kling wrap order to ensure Kling wrap dressings are not restrictive x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months.

The audit findings will be reported to the QA committee.

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3/13/24 - A wound evaluation form documented a new pressure related deep tissue injury to the right, top of foot with measurements of 5 cm x 7 cm x 0 cm with 100% epithelial cells in the wound bed and the wound edges are attached. The document listed the treatment to apply skin prep and leave open to air twice a day. No color description of the wound was provided.

3/13/24 - A review of a physician's order revealed a treatment order for R110 for the right, top foot to apply skin prep and leave open to air. Do not wrap with kling. Change every day and evening shift and as needed.

3/13/24 - A treatment order for R110 for the right heel and left heel to cleanse with normal saline, air dry, apply skin prep and hydrocolloid. Do not wrap with kling. Change every Wednesday and as needed.

The aforementioned treatment orders instructed staff not to use kling to wrap around R110's foot.

3/14/24 - A treatment order for R110 for the right heel to cleanse with normal saline, air dry, apply medi-honey and calcium alginate, cover with abdominal pad and wrap lightly with kling every day shift and as needed.

3/20/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, stage 2 with measurements of 4 cm x 5 cm x 0.10 cm with 100% epithelial cells in the wound bed and the wound edges are attached. The document listed the treatment to cleanse with normal saline, apply skin prep and hydrocolloid weekly. No color description of the

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wound was provided.

The wound inaccurately back staged from a deep pressure injury to a pressure ulcer stage 2.

3/27/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, unstageable with measurements of 4 cm x 7 cm x 0.10 cm with 75 - 99% epithelial cells and 1 - 24% of slough in the wound bed and the wound edges are attached. There was a moderate amount of fluid from the wound. The document did not say what type of fluid. The document listed the treatment to cleanse with normal saline, apply medical grade honey and calcium alginate then cover with border gauze weekly. No color description of the wound was provided.

5/8/24 - A wound evaluation form for R110 documented the wound to the right, top of foot as a pressure related, unstageable with measurements of 3.10 cm x 4 cm x 0.10 cm with 1 - 24% epithelial cells and 25 - 49% of slough in the wound bed and the wound edges are attached. There was a moderate amount of serosanguineous (clear to pale yellow liquid mixed with blood) fluid from the wound. The document listed the treatment to use skin prep for the area around the wound and apply a hydrocolloid dressing weekly. No color description of the wound was provided.

5/9/24 9:38 AM - An observation of R110's wound to the right, top foot appears to be on top of the right foot at the bend where the foot meets the right leg. The wound size was approximately 2.5 cm x 5 cm x 0.1 cm and was a rectangular shape. The appearance of the wound showed

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F 686	Continued From page 56 approximately 75% slough tissue with 25% epithelial cells in the wound bed. There was a small amount of serous (clear to pale yellow liquid) fluid drainage. The wound edges were intact. The wound was yellow in color. 5/14/24 10:38 AM - An interview with E18 (LPN) revealed that there was an order in place to wrap R110's right foot and she is not sure if the wound on the top of the right foot came from wrapping R110's foot. Then, the order changed to not wrap the right foot. 5/15/24 1:00 PM - An interview with E40 (Wound NP) confirmed that R110's wound on the top of the right foot was a result of being wrapped too tight with kling gauze. E40 stated she asked the staff not to wrap the foot. 5/16/24 10:35 AM - In an interview with E42 (wound RN) confirmed that the treatment order dated 3/6/24, for the right heel, did not include wrapping the right heel at all. E42 stated that staff have two options to use for a clean dry dressing and they are a border gauze (rectangular pad of gauze that has sticky border around the gauze pad; larger sized band-aide) or a kling gauze (a rolled cotton gauze). E42 stated that the staff were wrapping the kling too tight and the wound was pressured related. E42 stated they spoke with E18 about it since that unit is her full-time area. E18 told E42 that she did not want the gauze to fall off. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 686		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI	F 690		7/24/24

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F 690	Continued From page 57 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and	F 690	A. R106 had a Bowel and Bladder	

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interviews, it was determined that for one (R106) out of five residents reviewed for bowel and bladder, the facility failed to ensure appropriate treatment and services to restore and/or maintain bladder function were implemented. Findings include:

Review of R106's clinical records revealed:

Cross Refer to F641, F656, F689 and F842

The facility's policy titled, "Incontinence" with a revised date 1/2024, documented, "Based on resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services...1. ..must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain...4. Residents...incontinent of bowel and bladder will receive appropriate treatment...and to restore continence to the extent possible...5. Periodically (as required and when there is a change in pattern of elimination), staff will re-evaluate each individual's level of continence using quarterly and significant change re- evaluation tool.

6/23/23 - R 106 was admitted to the facility with diagnoses including but not limited to enlarged prostate and dementia.

6/23/23 - A facility new admission Bladder and Bowel Evaluation documented that R106 was continent of urine.

6/24/23 (revised 7/4/23) - R106 was care planned

re-assessment was completed.

B. Active residents Bowel and Bladder assessment in the last 30 days will be reviewed to identify any residents who are incontinent. Based on the assessment, residents will be evaluated for the need of a voiding diary x 3 days. Based on the results of the voiding diary, a toileting program will be considered based on the individualized need of the resident as appropriate.

C. The root cause was due to lack of consistent oversight and understanding of bladder incontinence and the need for a potential toileting program.

Regional Clinical Consultant will in-service nursing management team on assessment of bladder incontinence and need for a potential toileting program.

Staff Development/Designee will re-educate Licensed nursing team on assessment of bladder incontinence and need for a potential toileting program

D. DON/Designee will conduct a daily audit of new admission and due quarterly assessments who trigger for bladder incontinence to ensure a voiding diary is initiated if applicable based on resident□s individualized need and toileting program as applicable x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months.

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F 690	Continued From page 59 for risk for alteration in skin integrity related to decline in mental awareness, and decreased mobility. Interventions (initiated 6/24/23) included to check for incontinence and provide incontinent care as needed. 6/30/23 - R106's admission MDS assessment revealed that R106 was cognitively impaired, was always continent of bladder and was not on a toileting program. A review of R106's hourly voiding diary for the following: 6/24/23 - 6/30/23 five episodes of incontinence out of 238 opportunities. 7/1/23 - 7/31/23 fifteen episodes of incontinence out of 1090 opportunities. 8/1/23 - 8/31/23 twenty-five episodes of incontinence out of 500 opportunities. 9/1/23 - 9/30/23 fifty episodes of incontinence out of 803 opportunities. 10/1/23 - 10/20/23 eighty-seven episodes of incontinence out of 529 opportunities. There was no evidence of an individualized toileting program initiated for R106 despite the increase of incontinence episodes. A review of R106's CNA bladder continence flow sheet for the following: 6/23/23 - 6/30/23 two episodes of urine incontinence out of 22 opportunities (9%). July 2023 - six episodes of urine incontinence out of 89 opportunities (7%). August 2023 - fourteen episodes of urine incontinence out of 79 opportunities (18%). September 2023 - fifteen episodes of urine	F 690	The audit findings will be reported to the QA committee.	

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incontinence out of 76 opportunities (20%).
October 2023 - forty-eight episodes of urine incontinence out of 85 opportunities (56%).
November 2023- seventy-eight episodes of urine incontinence out of 89 opportunities (89%).
December 2023 - eighty-seven episodes of urine incontinence out of 93 opportunities (93%).
January 2024 - ninety-three episodes of urine incontinence out of 94 opportunities (99%).
February 2024 - eighty-five episodes of urine incontinence out of 87 opportunities (98%).
March 2024 - ninety-three episodes of urine incontinence out of 93 opportunities (100%).
April 2024 - seventy-five episodes of urine incontinence out of 86 opportunities (87%).

7/24/23 - R106's care plan intervention for risk for falls due to history of falls was revised to include toileting schedule every 2-3 hours and as needed.

8/17/23 - A facility Admission/Readmission Screener documented that R106 was continent of bladder.

8/17/23 - A facility readmission Bladder and Bowel Evaluation documented that R106 was incontinent of urine,

8/25/23 - R106's risk for falls care plan intervention of toileting schedule every 2-3 hours and as needed was discontinued.

9/1/23 - A facility Bladder and Bowel Evaluation documented that R106 was continent of urine.

9/26/23 - R106 was care planned for physical aggression as evidenced by hitting staff related to cognitive loss with interventions including checking for unmet needs for example toilet,

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hunger, thirst, fatigue, pain.

9/28/23 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was occasionally incontinent of bladder and was not on a toileting program.

11/8/23 - R106's care plan interventions for risk in alteration in hydration were updated to include "[R106] will have two person assist when toileting."

12/26/23 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program.

Further review of R106's clinical records lacked evidence that a quarterly Bladder and Bowel evaluation was completed during the December 2023 review period.

3/26/24 - R106's quarterly MDS assessment revealed that R106 was cognitively impaired, was always incontinent of bladder and was not on a toileting program.

3/27/24 - R106 was care planned for placing self on floor/slides off chair related as evidenced by resident intentionally sliding out of chair for comfort r/t dementia. Interventions including but not limited to offer toileting. The approach did not include a frequency of toileting.

4/5/24 - A facility Bladder and Bowel Evaluation documented that R106 was incontinent of urine.

4/24/24 - A facility Admission/Readmission Screener documented that R106 was incontinent

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F 690	Continued From page 62	F 690		

of bladder and to initiate voiding diary and develop a care plan for bladder incontinence.

5/28/24 9:01 AM - In an interview, E58 (CNA) stated, "... Before [R106] broke his ribs in August 2023, he was able to stand up and wet his briefs before he reached the bathroom...or sometimes he would reach the bathroom but he was already peeing on the floor on the way to the bathroom. He needed two staff to assist him with walking. We had to get a urinal and aim it on his genitals so that if he pees while walking to the bathroom the urinal would catch and avoid spilling urine on the floor. We used to check him every two hours because he was continent when he first came, before he had those falls. Then he became an hourly check since his first fall in July 2023..."

5/28/24 9:27 AM - During an interview, E59 (CNA) stated, "...I know [R106] since November 2023 and he was always incontinent with bladder. He was always wet with urine. He was not on a voiding diary but we just check on him every two hours and ask him if he wants to go to the bathroom. Sometimes he tells you if he wants to go, other times he was already wet..."

5/28/24 9:51 AM - In an interview, E28 (CNA) stated, "... Ever since I was assigned in this (unit), I was only able to do 1:1 sitter for [R106]. We would take him to the bathroom every two hours to check if he is wet. Or when ever I see him starting to move a lot and getting anxious, it's a signal for me to know that he may need to pee or has a bowel movement..."

5/28/24 10:05 AM - During an interview, E60 (CNA) stated, "...When I first had [R106] on my assignment in September 2023, he was both

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continent and incontinent. Sometimes he was able to tell you that he wanted to use the bathroom and found him dry but will eventually go. Other times, he's already wet when he asks us to take him to the bathroom. We toilet him every two hours...He was not on hourly toileting."

5/28/24 10:37 AM - In an interview, E39 (LPN) stated that she was not R106's primary nurse but she knew that R106 was continent of bladder and used the toilet in June 2023. E39 further stated that R106 progressively needed more help with his toilet and bathroom use "probably after his fracture (broken ribs)". When asked for the process when a resident has a change in bladder functional status from always continent to occasionally, frequently and always incontinent, E39 explained that it is an expectation for the floor nurse or charge nurse to assess and evaluate the resident's current bladder status to verify the change that the CNAs reported. E39 continued to state that once assessment was done, interventions will be put into place for example initiating a 3 - Day voiding diary establish a personalized pattern for when a resident would be found wet in his briefs and becomes incontinent and then come up with a toileting program to check the resident based on the voiding patterns.

5/28/24 11:02 AM - During an interview, E35 (LPN) stated that she was the UM (Unit Manager) in the (unit) last year 2023. E35 further stated," [R106] was continent/incontinent of bladder on admission - but mostly continent and was toileted every two hours unless he asked to be brought to the bathroom. He was for the most part to totally continent of bladder. Even if the CNAs were telling me [R106] became incontinent, I did not

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push for a change in his continent status because he was not wet, and he was always dry with me. He was continent before he fell and broke his ribs. I used to take him to the bathroom every morning and I would find him dry but he was able to go (urinate) and I would give him enough time to finish for at least 5 minutes, and not to rush him so he could completely empty his bladder.

5/28/24 11:54 AM - In an interview, E19 (RN UM/Sup) stated that since she started working in the facility, she has always known R106 to be incontinent of bladder. R19 stated that she was the temporary UM for (unit) in March 2024 and that she completed R106's quarterly bladder and bowel evaluation for the review period 4/5/24. E19 confirmed that R106's December 2023 quarterly bladder and bowel evaluation was not completed.

5/28/24 12:04 PM - During an interview, E21 (Corporate Clinical Nurse) stated that R106 showed a mix bladder continence/incontinence episodes. E21 further explained that there was no no need for a check and change or toileting program on R106 as he was showing different patterns each time. E21 stated that a staff was assigned to do 1:1 supervision on R106 and that the same staff was to take R106 to the bathroom along with another staff as R106 required a sit - to stand - up lift for toilet.

5/28/24 12:15 PM - In a follow up interview, E21 confirmed that R106's December 2024 Bladder and Bowel quarterly evaluation was not completed.

Despite the facility's awareness of R106's mixed bladder continent and incontinent status, the

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F 690	Continued From page 65 facility failed to ensure that R106 received the appropriate treatment and services to restore and/or maintain bladder function were implemented when the facility failed to perform a thorough bladder assessment and establish a person centered toileting program. R106 was continent of bladder on admission on 6/23/23. The subsequent months showed R106's decline in bladder continence from frequently incontinent in August, occasionally incontinent in September, to always incontinent of bladder beginning December 2023. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		7/24/24

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F 756	Continued From page 66 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R3) out of four residents reviewed for Medication Administration, the facility failed to ensure that R3's monthly medication review was completed. Findings include: Medication Regimen Review (MRR) Policy- "the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart ..." 7/5/18 - R3 was admitted to the facility with diagnoses, including but not limited to, multiple sclerosis. 2/14/24 - R3 was admitted to the hospital for an altered mental status.	F 756	A. R3's medication administration route has been updated to reflect via PEG tube on 5/15/24. B. Active residents with PEG tube and are on NPO will be reviewed to ensure medications administration route is accurate. C. The route cause was due to an oversight during new admission medication regimen review. NHA/Designee will re-educate D. Unit Manager/Designee will conduct a daily audit of new admissions with PEG tube/NPO and new medication orders to ensure an appropriate route for medication administration is in place x 5	

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F 756	Continued From page 67 3/1/24- While hospitalized, R3 underwent placement of a percutaneous endoscopic gastrostomy tube (PEG- a feeding tube) for a diagnosis of malnutrition/failure to thrive. 3/7/24 - R3 was re-admitted to the facility. 3/7/24 10:26 PM - E15 (RN Nursing supervisor) entered orders for acetaminophen, atorvastatin, bisacodyl, cholecalciferol, clopidogrel, cyanocobalamin, labetolol, losartan, Maalox, metformin, milk of magnesium, pantoprozole, polyethylene glycol and senna. All fourteen medications were ordered to be administered by mouth. 3/10/24- E11(Dietitian) documented in R3's EMR an order, "NPO (a medical term that means nothing by mouth)". 3/12/24 - E16 (Speech therapist) performed a "Cognitive Impairment SLP (Speech Language Pathologist) Screen with R3 and documented R3 as "Strictly NPO". 3/15/24 2:00 PM - E6 (MD) co-signed E11's NPO order on R3's EMR. 3/15/24 2:00 PM - E6 (MD) co-signed R3's medication orders that were ordered to be administered by mouth. The facility lacked evidence of a Medication Regimen Review (MRR) for R3 for the month of March 2024. On 4/27/24 and 5/12/24, E10 (registered pharmacist) documented on R3's medical records for the monthly MRR, "no recommendations".	F 756	days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	

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F 756	Continued From page 68 5/16/24 10:35 AM - During a telephone interview, E10 (Pharm D consultant) stated," I do review all the orders when performing a medication review." When asked about having "by mouth" medication orders for R3, who was "strictly NPO", E10 stated, 'I did not pick up on that." 5/16/24 2:45 PM - Findings were discussed with E1 (NHA) and E4 (Corporate consultant).	F 756		
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	F 757	A. (1) R106's GDR recommendation was	7/24/24

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determined that for four (R61, R106, R47, and R98) out of five residents reviewed for medication review, the facility failed to ensure adequate monitoring of adverse effects for R61, R47 and R98. The facility failed to ensure that R106 was free from unnecessary medication. Findings include:

1. Review of R106's clinical records revealed:

4/24/24 - R106 had a physician's order for Seroquel (quetiapine) 25 mg one tablet by mouth two times a day related to persistent mood affective disorder.

5/8/24 11:09 AM - A medical GDR (gradual dose reduction) was completed by P1 (Psych Doctor) and documented, "Discontinue Seroquel. Remeron 15 mg at night."

5/9/24 3:03 PM - A nurse progress note by E22 (RN) documented that R106 had a GDR completed and that the recommendation was to start Remeron 15 mg (milligrams) at bedtime. "NP (Nurse Practitioner) ...made aware."

5/11/24 - A Consultant Pharmacist Report noted for the facility to "evaluate quetiapine use for mood disorder." The facility's response signed and dated by the physician on 5/13/24 indicated, "NNO (no new order) per psych."

5/15/24 - A review of R106's May 2023, MAR (Medication Administration Record) revealed that R106's order for Seroquel was not discontinued on 5/8/24 and that R106 continued to receive Seroquel 25 mg one tablet by mouth two times a day.

clarified and discontinued on 5/16/24. R106's medication was re-started on 5/22/24.

(2) R61's behavior monitoring for anti-depressant use was initiated on 5/15/24.

(3) R47's monitoring for side effects of anti-coagulant use will be initiated.

(4) R98's adverse effects related to antidepressant use was initiated on 6/21/24.

B. (1) Residents with recent GDR meeting will be reviewed to ensure recommendations were reviewed and approved by facility provider and an order is in place.

(2) Residents who are on anti-depressant will be reviewed. Behavior monitoring will be initiated as indicated.

(3) Residents who are on anti-coagulant will be reviewed. Side effects will be monitored as indicated.

(4) Residents on anti-depressant will be reviewed. Side effects will be monitored as indicated.

C. (1) The root cause was due to lack of an established process when checking GDR recommendations.

Staff Development/Designee will re-educate nursing management team to ensure GDR recommendations are reviewed after the GDR meeting is completed.

(2,3,4) The root cause was due to

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F 757	Continued From page 70 5/16/24 8:37 AM - In an interview, E19 (RN Sup/UM) stated that there was a "mishap". E19 also stated that, " I did not take notes, it was E2 [DON] who took notes that showed to increase the Remeron to 15 mg but we did not hear him [P1] mention about discontinuing the Seroquel during the GDR meeting... No, I did not D/C (discontinue) the Seroquel". 5/16/24 9:55 AM - In an interview, E2 (DON) stated, "I was at the meeting and I took down notes. He (P1) did not mention to discontinue the Seroquel. I called him this morning to clarify the order. He wanted the Seroquel to be discontinued." 5/16/24 12:04 PM - Review of R106's MAR revealed that R106's order for Seroquel was discontinued. 5/16/24 12:31 PM - In an interview, P1 (Psych Doctor) stated, "We had a GDR meeting last week and I made [R106's] change to one medication at a time starting with weaning him off Seroquel. I received a call from the facility early this morning telling me that that the recommendation to discontinue the Seroquel was not done. I still want them to discontinue it." 5/16/24 1:03 PM - During an interview, E12 (NP) stated, "I do not know about [R106's] 5/8/24 GDR report". 5/16/24 1:08 PM - During an interview, E9 (NP) sated, "E19 gave me a report and showed me a list of residents on GDR review last week in (unit) but it did not include [R106]. I do not know about [R106's] Seroquel".	F 757	lack of consistent oversight to ensure side effects for anti-depressant and anti-coagulant has side effects monitored and behavior monitoring is in place. During the new admission/readmission medication review, nursing management team/designee will ensure side effects for anti-depressant and anti-coagulant are monitored as well as appropriate behavior monitoring is in place for anti-depressant use. D. DON/Designee will conduct an audit post GDR meeting to ensure recommendations are reviewed and physician order is in place as applicable x 3 months or until a 100% compliance is achieved. The following will be a quarterly review post GDR x 3 quarters. DON/Designee will conduct a daily audit of new admissions and new orders ensure side effects for anti-depressant and anti-coagulant are monitored as well as appropriate behavior monitoring is in place for anti-depressant use x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	

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2. Review of R61's clinical records revealed the following:

8/24/22 - R61 was admitted to the facility.

4/30/24 1:53 PM - A psych note documented, "Resident does have a history of depression and seems somewhat emotionally sensitive. His mood should continue to be monitored".

5/7/24 - R61 had a physician's order for trazodone 100 mg one tablet by mouth at bedtime for insomnia.

5/8/24 - R61 had a physician's order for trazodone 50 mg one tablet by mouth daily for mood.

5/9/24 (initiated 1/23/23)- R61 had a care plan for adjustment disorder with depressed mood and at risk for changes in behavior problems related to depression, tearfulness and suicidal ideation, poor impulse control/destruction, physical aggression towards another resident, making false statements regarding staff and residents, making third party threats to staff.. Interventions included Administer medications per physician order. Observe for changes in behavior/side effects.

5/14/24 11:00 AM - Review of R61's May 2024 Medication Administration Record lacked evidence that R61's behavior of tearfulness and sadness were monitored for receiving trazodone.

5/14/24 12:45 PM - In an interview, E19 (RN Sup/UM) confirmed that she was not able to include [R61's] behavior monitoring in the MAR. E19 further stated that R61's behavior should still

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F 757	Continued From page 72	F 757		

be monitored.

3. Review of R47's clinical record revealed:

12/15/15 - R47 was admitted to the facility.

1/11/16 - A care plan was initiated for R47's use of anticoagulant therapy with an intervention of observing and monitoring for side effects such as blood in urine/stool, gums/nose bleeding, bruising.

10/21/22 - A physician's order for R47 was written for Pradaxa capsule (anticoagulant) one capsule by mouth twice a day related to chronic atrial fibrillation.

8/2023 - A review of the August MAR revealed no documentation related to adverse effects of anticoagulant therapy.

5/20/24 9:27 AM - An interview with E38 (UM) confirmed adverse effects were not being monitored for R47.

4. Review of R98's clinical record revealed:

7/24/23 - R98 was admitted to the facility with a diagnosis of major depressive disorder, concurrent.

4/25/24 - A quarterly MDS revealed R98 is prescribed an antidepressant.

5/2024 - A review of R98's MAR revealed a lack of monitoring for adverse effects of trazodone.

5/20/24 9:27 AM - An interview with E38 (UM) confirmed R98 was prescribed trazodone and

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F 757	Continued From page 73 confirmed lack of monitoring for adverse effects related to trazodone. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 757		
F 761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to receive and	F 761	A. R65's controlled medication was reviewed. No adverse outcome related to	7/24/24

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F 761	Continued From page 74 document narcotic medications per professional standards of care. Findings include: Review of R65's clinical record revealed: 6/2/20 - R65 was admitted to the facility. 4/4/24 11:15 AM - A physician's order was written for oxycodone (narcotic pain medication) give one tablet by mouth every eight hours. 5/17/24 - A review of R65's narcotic count verification sheets revealed that for the months of November 2023, December 2023, January 2024, February 2024, March 2024, and April 2024 the verification sheets lacked evidence of date, time, and a nurse's signature of receipt. 5/20/24 9:27 AM - An interview with E38 (RN UM) confirmed the narcotic count verification sheets lacked the date, time, and a nurse's signature. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 761	the deficiency. Staff will be educated on appropriate documentation related to controlled medication. B. Resident's receiving controlled pain medications will be reviewed in the last week. Staff will be educated with discrepancy findings. C. The root cause was due to lack of understanding by the licensed nurse of the importance of accurate documentation. Staff Development/Designee will be re-educated on the importance of accurate documentation of controlled medications. D. Unit Manager/Designee will conduct a daily audit of controlled pain medications to ensure accurate documentation is in place x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical	F 773		7/24/24

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F 773	Continued From page 75 nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for one (R79) out of one resident sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results that fell outside of clinical reference ranges. Findings include: Review of R79's clinical record revealed: 1/2/20 - R79 was admitted to the facility. 5/9/24 9:47 AM - In an interview with R79 revealed he had pain when urinating and the facility collected urine this morning for analysis and culture. 5/10/24 3:49 PM - A review of lab results revealed that R79 was positive for a urinary tract infection. The culture was still pending at this time. 5/11/24 (Saturday) 2:52 PM - A review of lab results revealed the urine sample from R79 was positive for growth. 5/13/24 (Monday) - A physicians order was written for Bactrim DS (antibiotic) by mouth daily for urinary tract infection. 5/14/24 11:04 AM - An interview with E39 (LPN) confirmed if lab results posted during weekend hours and were out of range the on call provider should be notified of the results.	F 773	A. R79 completed antibiotic therapy. No adverse effect related to the deficiency. B. Active residents with abnormal lab (urine culture) results in the last 7 days will be reviewed to ensure documentation reflects that result was reported to the medical provider. C. The root cause was due to timely follow-through of culture results on weekends. Staff Development/Designee will re-educate licensed nurses on the process of laboratory results during weekends. D. Unit Manager/Designee will conduct a daily audit of documentation in medical records to assure abnormal lab (urine culture results) are reported to the providers in a timely manner for 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	

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F 773	Continued From page 76 The facility lacked evidence of promptly reporting abnormal lab results to the medical provider. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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: 5/9/24 9:35 AM - During a tour of the kitchen, the	F 812	.A. 1. The sanitizing solution in red sanitizer buckets was immediately discarded after the food service director and surveyor identified that the solution was not at the appropriate concentration level. The food service director re-filled the red sanitizer buckets, tested to ensure	7/24/24

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F 812	Continued From page 77 surveyor observed E48 (Dietary Services Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E48 tested the sanitizing solution in both buckets, 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. 5/9/24 9:42 AM - A container of dry rice was spilled on the floor near the sink in the kitchen and left for over an hour. 5/9/24 10:27 AM - Observation of nourishment refrigerator in the Aspen unit revealed an opened carton of Nutritional Shake that was undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 5/9/24 11:53 AM - Observation of nourishment refrigerator in the Seaside Unit revealed an opened bottle of thickened juice that was dated 4/1/24. The instructions on the carton indicate that once opened, any remaining product should be discarded after ten (10) days. 5/9/24 1:43 PM - Findings were confirmed with E1 (NHA) 5/20/24 1:35 PM - Findings reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse).	F 812	the sanitizing solution was within the appropriate range and re-distributed the buckets throughout the kitchen. 2. The rice that was found on the floor was immediately swept up and properly disposed of. 3. All items, in the nourishment refrigerators throughout the facility, that were not properly labeled and dated were immediately discarded. B. 1. The sanitizing solution, in red sanitizer buckets, was tested on 5/10/24 by regional consultant, and will be audited to ensure the sanitizing agent is within appropriate range to provide proper sanitization in the kitchen. 2. The floor was inspected on 5/10/24, by the food service director and regional consultant, to ensure no visible food or debris were found on kitchen floor. 3. All pantry/nourishment refrigerators were checked on 5/10/24, by FSD and regional dietary consultant, to ensure all items were properly labeled and dated. C. The root cause analysis was determined that staff failed to follow policy and procedure for food safety, storage, and sanitation by the rice being spilled on the floor, the ineffectiveness of the sanitizing solution, and items found in pantry refrigerators past the expiration date. All dietary staff received additional education on 5/15/24, by food service director and regional consultant, on Food safety and sanitation related to the rice, sanitizing solution, and labeling and dating of thickened liquids and nutritional supplements. In addition, the dietary employee who delivers snacks to the units will check the pantry refrigerators daily to ensure all items are	

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F 812	Continued From page 78	F 812	properly labeled and dated. D. 1. The food service director will audit the cleanliness of the kitchen floor, pantry refrigerators for labeling and dating of all items leaving the kitchen, and the sanitizing solution effectiveness. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		7/24/24

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 80 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that the facility failed to ensure, in accordance with professional standards and practices, that medical records for two (R40 and R106) out of five residents of the investigative sampled residents were accurate. Findings include: Review of R40's clinical record revealed: 1/23/24 - R40 was admitted to the facility with diagnoses, including but not limited to, bipolar disorder, schizoaffective disorder bipolar type, and depression. 2/22/24 - E8 (NP) documented in R40's electronic medical record (EMR), "Risperdal (an anti-psychotic agent) 1 mg (milligram)- Give 1 tablet by mouth at bedtime for total 5 mg" and "Risperdal 4 mg - Give 1 tablet at bedtime for total 5 mg". 5/16/24 12:45 PM - During an interview, E1(NHA) confirmed that R40's Risperdal orders in the EMR did not contain a diagnosis.	F 842	A. (1) R40's Diagnosis for Risperdal has been clarified on 5/29/24. No adverse effect related to the deficiency. (2a) R106s 1:1 Supervision had been signed off since 1/29/2024. (2b) R106's Bowel and Bladder assessment was reviewed on 6/17/24 and a voiding diary was initiated. B. Active residents receiving anti-psychotic will be reviewed to ensure an appropriate diagnosis is in the medication order. (2a) Active residents on 1:1 supervision will be reviewed to ensure appropriate documentation is in place. (2b) Active residents Bowel and Bladder assessment in the last 30 days will be reviewed. Residents with Voiding Diary and toileting program will be reviewed to assure that documentation is available. C. (1) The root cause was due to lack of thorough review during admission/readmission or when a new	

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F 842	Continued From page 81 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse). 2. Cross Refer F689 and F690 Review of R106's clinical records revealed: 6/23/23 - R106 was admitted to the facility. a. 8/3/23 - R106's care plan interventions for risk for fall was updated to include 1:1 Supervision. 5/15/24 3:30 PM - A review of R106's CNA flowsheets from September 2023 through January 2024 revealed a lack of evidence that the staff documented a 1:1 supervision completed for R106. 5/16/24 9:08 AM - During an interview, E21 (Corporate Clinical Nurse) stated that there were no documentation of R106's hourly 1:1 Supervision for the months starting September 2023 through January 2024. E21 further stated that R106's hourly 1:1 Supervision was indicated in the CNA Kardex as FYI (For Your Information), "but the CNAs only started signing it off as assigned task on 1/30/24". b. 8/17/23 - A facility readmission Bladder and Bowel Evaluation documented that R106 was incontinent of urine. 9/1/23 - A facility Bladder and Bowel Evaluation documented that R106 was continent of urine...Resident [R106] has occasional bladder incontinence, toileting program initiated..." 4/5/24 - A facility Bladder and Bowel Evaluation	F 842	order for anti-psychotic is initiated. Staff Development/Designee will re-educate licensed staff and new hires to ensure diagnosis for anti-psychotic use is in place. During new admission/readmission review and when there is a new order for anti-psychotic, nursing management team will ensure diagnosis is entered in the medication order. (2a) The root cause was due to lack of understanding on the importance of indicating proof of documentation when a 1:1 Supervision is ordered. (2b) The root cause was due to lack of thorough understanding of the bladder incontinence program and the importance of accurate documentation. D. (1) DON/Designee will conduct a daily audit of new admissions/readmissions and new orders of anti-psychotic diagnosis are entered in the medication order 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. (2a) DON/Designee will conduct a daily audit of residents on 1:1 Supervision to ensure appropriate documentation is in place 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. (2b) DON/Designee will conduct a daily audit of new admissions/readmissions and quarterly Bladder assessment for incontinence to	

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	085020	A. BUILDING _____ B. WING _____	05/30/2024

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F 842	Continued From page 82 documented that R106 was incontinent of urine...Incontinent (Initiate Voiding Diary)..." 5/28/24 9:00 AM - A review of R106's CNA flowsheets from October 2023 through January 2024 revealed a lack of evidence that R106's voiding diary and hourly toileting program were accurately documented from 10/21/23 - 1/29/24. 5/28/24 2:10 PM - During an interview, E21 (Corporate Clinical Nurse) stated that since R106 was already on the hourly 1:1 staff supervision, the staff was also to take R106 to toilet every hour. E21 stated that the 1:1 supervision was not signed off by the CNAs in their task until 1/30/24. 5/28/24 2:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E21 (Corporate Clinical Nurse).	F 842	ensure appropriate documentation is in place 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	
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	F 880		7/24/24

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F 880	Continued From page 83	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(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.

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F 880	Continued From page 84 §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 interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. Findings include: 1. 5/9/24 10:49 AM - Laundry Aide (E41) was observed placing soiled laundry into the washing machine using ungloved hands. An interview revealed that E41 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. 2. A facility policy titled " Infection Prevention and Control Program" with a revision date of 1/2024 documented " This facility has established and maintains an infection prevention and control program designed to provide a...sanitary...environment to help prevent the development and transmission of...infection..." Review of R113's clinical record revealed: 9/1/23 - R113 was admitted to the facility. 5/20/24 9:10 AM - During an interview, R113 stated on 10/18/23 E24 (CNA) was cleaning out the toilet bowl from her bedside commode over	F 880	A. (1) E41 was immediately educated on proper linen handling on for various types of precautions on 5/9/24. (2) R113 has no adverse effect related to the deficiency. E24 will be educated related to appropriate cleaning of bedside commode. B. (1) Active staff in the laundry department was immediately re-educated on proper linen handling for various types of precautions. (2) Nursing staff will be educated on appropriate cleaning of bedside commode. C. (1) The root cause was due to staff□s lack of knowledge in safe handling of soiled linen. (2) The root cause was due to staff's lack of understanding on how to appropriately clean the bedside commode bowl in a sanitary manner. Staff Development/Designee will educate laundry staff regarding safe handling of soiled linen for various types	

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F 880	Continued From page 85 the sink in her room which is located opposite the bed. R113 had taken a video using her cell phone and proceeded to show it to the surveyor. The video clearly showed a person holding the bedside commode bucket over the sink but the contents were not visible. R113 stated that she spoke to the social worker and also submitted a complaint to the state agency. 5/20/24 9:18 AM - During an interview (E21) (corporate clinical nurse) confirmed that she had been made aware of the incident and that E7 (SW) went to speak with R113. E21 stated that an investigation was conducted and staff education provided. 5/20/24 1:35 PM - Findings were reviewed with E2 (DON), E4 (Consultant), and E21 (Corporate Clinical Nurse). 5/21/24 - A document was submitted via email to the state agency. The document comprised of a telephone interview with E24 and a statement of a brief education regarding the proper procedure for emptying a commode toilet bowl. The document was dated 5/20/24, the incident took place on 10/8/23.	F 880	of precautions due to illness. Staff development/Designee will educate nursing staff (CNA) and new hires (CNA) on how to appropriately clean bedside commode bowl in a sanitary manner. D. (1) Infection Preventionist/Designee will conduct a daily audit of laundry staff to ensure staff understands the proper soiled linen handling for various types of precautions x 5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. (2) Infection Preventionist/Designee will conduct a daily audit of staff by observation or verbal confirmation on 5 nursing staff on how to appropriately clean bedside commode bowl in a sanitary manner x5 days or until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks then monthly x 3 months. The audit findings will be reported to the QA committee.	