DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights Healthcare & Rehab Center DATE SURVEY COMPLETED: June 8, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from May 25, 2023 through June 8, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 168. The sample totaled 54 residents.	Please Cross refer to the 2567-L survey ending June 8, 2023 responses posted on ePOC: CMS Ftags listed in the left column, 2023: F550, F553, F561, F584, F609, F656, F657, F677, F684, F685, F686, F688, F689, F695, F756, F757, F758, F761, F803, F812, F814, F867, F880, and F943.	7/26/23
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed June 8, 2023: F550, F553, F561, F584, F609, F656, F657, F677, F684, F685, F686, F688, F689, F695, F756, F757, F758, F761, F803, F812, F814, F867, F880, and F943.		

[illegible] Director of Nursing 7/30/2023

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Director of Nursing 1/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Survey was conducted at this facility from May 25, 2023 through June 8, 2023. The facility census on the first day of the survey was 168. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation, interviews and document review.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from May 25, 2023 through June 8, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 168. The sample totaled 54 residents. Abbreviations/definitions used in this report are as follows: Aseptic - using practices and procedures to prevent contamination; Acute - illness that occurs suddenly OR new, sudden; Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Bilateral - affecting both sides; BIMS (Brief Interview for Mental Status) - an assessment tool/test to measure thinking ability with score ranges from 0 to 15:	F 000		

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

Electronically Signed | 06/30/2023

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

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F 000	Continued From page 1	F 000		

13-15: Cognitively intact
8-12: Moderately impaired
0-7: Severe impairment;
C. Difficile - bacterial overgrow that releases toxins that attack the lining of the intestines;
Cataract - clouded, blurred, and/or dimmed vision;
CMS - Center for Medicare and Medicaid Services;
Cognitive - mental processes or thinking;
Contracture - joint limitations with fixed high resistance to passive stretch of a muscle;
CNA - Certified Nurse Aide;
Dementia - chronic condition with symptoms including problems with memory, thinking, social;
DON - Director of Nursing;
Dysphagia - difficulty swallowing;
Escherichia coli (E. coli) - a type of bacteria commonly found in the gastrointestinal (GI) tract;
eMAR - electronic Medication Administration Record;
eTAR - electronic Treatment Administration Record;
Femur - thigh bone;
GERD (Gastroesophageal Reflux Disease) - occurs when stomach acid or occasionally, stomach content, flows back into your food pipe;
Kardex - CNA plan of care for individual residents;
MD - Medical Doctor;
MDS - Minimum Data Set/standardized assessment forms used in nursing homes;
ML (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
Pneumonia - lung inflammation caused by a bacterial or viral infection;
PRN - as needed;

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F 000	Continued From page 2 Proton Pump Inhibitor (PPI) - medications that causes prolonged reduction of stomach acid production; Proteus - type of bacteria; Pseudomonas - type of bacteria; Psychotropic (medication) - medication capable of affecting the mind, emotions and behavior; QAA - Quality Assessment and Assurance; Range of Motion (ROM) - extent to which a joint can be moved safely; RN - Registered Nurse; RP - Responsible Party/Resident representative; Tracheostomy - an opening made in the throat to assist breathing; UM - Unit Manager; Urinary Tract Infection (UTI) - bacteria in urine; Urologist- physician that specializes in disorders of the urinary tract; Weight Bearing - supporting the weight of your body.	F 000		
F 550 SS=B	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.	F 550		7/26/23

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F 550	Continued From page 3 §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 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 observations and interview, it was determined that the facility failed to promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her own individuality. Findings include: 5/25/23 12:15 PM - The lunch trays delivered to the Christina unit were observed to have plastic cutlery (knife, fork and spoon) on all of the trays. 5/31/23 12: 20 PM - The lunch trays delivered to the Christina unit were observed to have plastic	F 550	A-Deficient practice for lunch meal services was unable to be corrected at that time of occurrence. B- Residents residing at this facility have the potential to be affected by this deficient practice. C- NHA will educate new food service director on the importance of ensuring proper silverware is served to residents at meal time. New food service director will educate dining staff on ensuring proper	

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F 550	Continued From page 4 cutlery on all of the trays. 5/31/23 12:45 PM - During an interview, E37 (Dietary Aide) stated that the plastic cutlery was on the lunch trays because the trays were late to be delivered and it was faster to get the trays out to the units by putting plastic cutlery on the trays. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 550	silverware is served to residents at meal time. RCA: Facility failed to provide proper silverware during meal service, utilized plastic cutlery. ¿ The facility failed to promote care for residents in a manner and environment that maintained or enhanced each residents dignity and respect in full recognition of his or her own individuality. Why occurred: Dietary staff were inappropriately instructed to use plastic cutlery during meal service by dietary director. Using plastic Cutlery due to meal service being late is not an acceptable use of plastic cutlery. Silverware is to be utilized at all times except in instances of emergencies. D- Contracted Foodservice Director /designee will perform daily audits of meal trays to ensure plastic cutlery is not in use. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or	

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F 550	Continued From page 5	F 550	recommendation.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:	F 553		7/26/23

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F 553	Continued From page 6 Based on record review, facility policy review, and interview, it was determined that the facility lacked evidence that two (R34 and R154) out of four residents reviewed for care planning, was afforded the opportunity to participate in their care planning conference. Findings include: The facility's policy on care planning titled, "Care Plans, Comprehensive Person-Centered," last revised December 2016, reads, " ...The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ...Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care ...The resident will be informed of his or her right to participate in his or her treatment ...". 1. Review of R154's clinical record revealed: 9/28/22 - R154 was admitted to the facility with a past medical history of brain damage and was assessed to have a BIMS (brief interview of mental status) score of 14 (13 to 15 - Intact cognitive response). 3/16/23 - R154's quarterly MDS (Minimum Data Set) assessment identified R154 was usually understood/usually understands with a BIMS score of 13. 5/25/23 10:39 AM - During an interview, R154 informed the Surveyor that he "Does not get to go" to his care plan conferences.	F 553	A-R154 has been invited to his next care conference scheduled 6/14/23, R34 will be invited to next care conference when scheduled, taking into account when resident is out of the facility. B-Residents residing at this facility have the potential to be affected by this deficient practice. C-Staff educator/designee will educate RNAC's and social services on inviting residents and resident representatives to participate in care plan conference. Conferences will be scheduled according to resident availability. RCA: Facility failed to invite residents to participate in their care plan conference. For R154 social service employee documented incorrect cognitive status resulting in resident not being invited to care conference meeting. Social worker is unable to be educated at this time due to not being employed any longer at the facility. For R34 was out of the facility at the time of the care conference and the facility failed to reschedule for another time. RNAC's and social services will schedule and invite residents to their care plan conferences, taking into account when residents are out of the facility, i.e. dialysis days D-NHA/designee will perform daily audits	

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F 553	Continued From page 7 5/31/23 10:00 AM - Review of R154's clinical record revealed that R154 had care plan meetings on 9/28/22, 10/5/22, 12/28/22 and 3/22/23. It was documented on each care conference summary of attendees, "cognitive issue," and the resident did not participate or attend with his resident representative. 5/31/23 11:06 AM - During an interview, E29 (Social Services) stated, " ...I will invite [the resident] despite a cognitive issue with a BIMS of 13/14 that's a good BIMS ...". 5/31/23 12:02 PM - E29 confirmed that the facility lacked evidence that R154 was ever invited to attend his care planning conference. 2. R34's clinical record revealed: 2/1/22- R34 was admitted to the facility. 9/28/22 - R34's Care Plan Conference Summary documented her attendance at the conference with her signature. 1/10/23 - R34's MDS assessment documented a BIMs score of 12, showing mildly impaired cognition. 1/18/23 - R34's Care Plan Conference Summary documented that R34 was NOT in attendance. January 18th was a Wednesday; R34 was scheduled for her hemodialysis treatments on Monday - Wednesday - Fridays. 4/6/23 - R34's MDS assessment documented a BIMs score of 15, showing R34 was cognitively intact.	F 553	of residents care plan schedule to ensure resident participation if desired. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 553	Continued From page 8 4/13/23 - R34's Care Plan Conference Summary documented that R34 was NOT in attendance. April 13th was a Thursday, so R34 was in the facility on the day of this conference. 5/26/23 12:37 PM - During an interview, R34 reported awareness of the monthly Care Plan meeting and stated that she does not get invited. "They call my brother in Virginia, but I want to attend." 5/31/23 12:08 PM - R34 confirmed her signature on the 9/28/22 Care Plan meeting attendance sheet and confirmed that she attended the meeting. 6/8/23 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 553		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		7/26/23

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F 561	Continued From page 9 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to help and support one (R123) sampled resident for self-determination who wanted to be transferred back to bed. Findings include: Review of R123's clinical record revealed: 2/15/21- R123 was admitted to the facility with a diagnosis of a stroke with right sided weakness. 3/3/21 - R123's care plan for ADL's (Activities for Daily Living), revised on 1/11/23, documented R123 was unable to do ADLs without assistance secondary to having a stroke and included: Transfers: Hoyer assist times two staff. 6/3/22 - Review of an Employee Performance Improvement/Action Notification documented: On May 27, 2022, R123 wanted to be transferred back to bed after attending an event, E18 (CNA) pushed R123 to her room. E18 stated, "There was not a Hoyer pad and (R123) was left sitting up in her wheelchair at the bedside by (E18)." Further	F 561	A-R123 was transferred back to bed later by 3-11 staff. B-Residents residing at this facility that are dependent on staff for transfers have the potential to be affected by this deficient practice. C-Staff educator/designee will educate nursing staff on ensuring residents needs are being met and timely upon request. RCA: Facility failed to ensure that resident was transferred back to bed upon request. C.N.A. did not appreciate or understand the importance of honoring residents request of going to bed in a timely manner. D-Don/designee will perform daily observations of residents to ensure their needs are being met in a timely manner. Daily audits will be completed until we consistently reach 100% success over 3	

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F 561	Continued From page 10 documentation stated, "(E18) failed to respond to (R123's) request, additionally (E18) failed to ask for assistance and had not notified the Nurse a Hoyer pad was needed to transfer (R123) to bed." E18 was terminated for failure to perform job duties. 6/3/22 - Review of E18's documented statement revealed, "Around or about 3:00 PM R123 wanted to go back to bed but there wasn't a Hoyer pad under her, so I left her by the bed." 1/4/23 - An Annual MDS Assessment documented that R123 was totally dependent for transfers and required a Hoyer lift and two staff for assistance. 3/30/23 - A Quarterly MDS Assessment documented that R123 was totally dependent for transfers and required a Hoyer lift and two staff for assistance. 6/7/23 3:22 PM - An interview with E2 (DON) revealed, "I don't one hundred percent remember what happened, but I know that (R123) was at a barbecue and when she came back from the activity, she wanted to go back to bed and she had not been transferred back to bed by (E18), and after further investigation, E18 had been terminated." The facility failed to ensure that R123 was given the opportunity to exercise her right of self-determination by choosing to be transferred back to bed. Findings were reviewed with E1 (NHA), E2 during the Exit Conference on 6/8/23 at 2:30 PM.	F 561	consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 584	Continued From page 11	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		7/26/23

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F 584	Continued From page 12 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and observation of three out of five units toured, it was determined that the facility failed to provide a safe, clean, and homelike environment. Findings include: 1. 6/1/23 12:03 PM - During an observation of the Ashland unit, room A16 was observed with the air conditioning unit having a broken cover. 2. 6/1/23 12:17 PM - During an observation of the Christina unit, room C9's bathroom floor was observed to be sticky with a strong smell of urine. 3. 6/1/23 12:27 PM - During an observation of the Hammond unit, room H101 was observed to have brownish/black discoloration on the floor underneath a supply cart, and dust/grime on the floor near the radiator. Lastly, it was observed that room H104's air conditioning unit's cover was off, laying against the wall and bedside table revealing a dirty filter that was black in color. 6/1/23 12:47 PM - E32 (Maintenance Supervisor) confirmed findings. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON) on 6/8/23, at approximately 2:30 PM.	F 584	A-Room H104 A/C cover was replaced and A/C filter was cleaned. Room A16 A/C unit cover was repaired. Room C9 Bathroom floor was cleaned. Room H101 floor was cleaned. B- Residents residing at this facility have the potential to be affected by this deficient practice. C- Maintenance Director and environmental Services director/designee will educate maintenance and Housekeeping staff on ensuring all A/C covers in resident rooms are in place, A/C filters are clean and resident room floors are clean. RCA: Facility failed to ensure A/C covers in resident rooms were in place and in good working order along with A/C filters being clean. Facility failed to ensure residents room floors were clean. Facility failed to provide a safe, clean, and homelike environment. Facility staff failed to notify maintenance staff timely of A/C covers that was not in place and broken for repairs. The A/C filters are on a preventative maintenance schedule and room H104 was scheduled for cleaning the following week. Environmental director failed to ensure	

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F 584	Continued From page 13	F 584	proper follow-up of cleanliness of resident room floors. D- Maintenance director/designee will perform daily audits of resident rooms to ensure A/C covers are in place and in good working order (A/C filters and clean floors separate below). Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Maintenance director/designee will perform monthly audits of A/C filters are clean to ensure they are clean. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Environmental services director/designee will conduct daily random room audits of 6 rooms per day per unit (Eastburn unit- 3 rooms per day- smaller) to ensure cleanliness of resident room floors. Daily	

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F 584	Continued From page 14	F 584	audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		7/26/23

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F 609	Continued From page 15 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify the State Agency within two hours after an allegation of mistreatment for one (R222) out of 54 sampled residents. Findings include: Review of R222's clinical record revealed: 11/9/22 2:46 PM - A Social Service note by E56 (SW) for R222 stated, "... (SW) met with resident (R222) in her room and she (R222) complained that she was being mistreated by staff and asking SW to look for a home for her...". 11/11/22 12:30 - R222's allegation of mistreatment was reported to the State Agency two days after R222's allegation of mistreatment on 11/9/22. The facility failed to report R222's allegation of mistreatment to the State Survey Agency in a timely manner. 6/5/23 11:20 AM - Findings were confirmed by E2 (DON). Findings were reviewed during the Exit Conference with E1 (NHA), E2 and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 609	A-R222 no longer remains at the facility. There is no opportunity to correct the alleged deficiency. B- All residents residing at the facility have the potential to be affected by this deficient practice. C- Staff educator/designee will educate staff on what constitutes abuse and neglect and the timeliness of reporting to the supervisor. Staff educator/designee will educate nursing administration regarding the need to report to the state agency within 2 hours after an alleged violation of abuse, neglect, exploitation or mistreatment is made. RCA: The facility failed to report an allegation of mistreatment to the state agency in a timely manner. The allegation was initially reported as a concern and the supervisor failed to investigate timely or notify DON and NHA of the concern for reporting in the 2hour time frame. The nursing supervisor will contact the	

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F 609	Continued From page 16	F 609	DON or Nursing Home Administrator immediately, with any allegations of abuse, neglect, exploitation or misappropriation to ensure proper notification has been completed to the state licensing department. D-Don/designee will review reports of abuse, neglect, exploitation or misappropriation for timely reporting. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
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 assessment. The comprehensive care plan must	F 656		7/26/23

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F 656	Continued From page 17 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 interviews, it was determined that the facility failed to develop a care plan and/or add interventions as needed	F 656	A- R84 care plan was updated to include smoking as a focus area. R22 care plan was updated to include refusal to wear	

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F 656	Continued From page 18 related to smoking for two (R22 and R84) out of five residents sampled for smoking. Findings include: 1. R84's clinical record revealed: 6/4/18 - R84 was admitted to the facility. 9/23/22 - R84's care plan review lacked smoking as a focus area. 3/6/23 - The Minimum Data Set (MDS) assessment documented R84 as having mild cognitive impairment. 5/26/23 11:52 AM - R84's Smoking Screen Evaluation answered Safety question 10 "Plan of care is used to assure resident is safe while smoking? Yes." 5/29/23 - R84's care plan was revised, however, it continued to lack smoking as a focus area. 2. R22's clinical record revealed: 4/5/18 - R22 was admitted to the facility. 3/30/23 13:23 PM - R22's Smoking Screen Evaluation answered Safety question 8 "Resident need for adaptive equipment 8b. smoking apron (checked), 8c. supervision (checked)." 3/31/23 - The MDS assessment documented that R22 was cognitively intact. 4/24/23 - R22's at risk for injury related to smoking care plan review lacked an intervention for utilization of a smoking apron.	F 656	smoking apron. B- All residents who smoke have the potential to be affected by this deficient practice. C- Staff educator/designee will educate licensed staff to ensure residents who smoke have smoking care plans in place and updated timely with any changes or refusals. RCA: Facility failed to recognize that a smoking care plan was not in place for R84 and failed to update R22 care plan in a timely manner for refusal to wear a smoking apron. For R84 returned from the hospital and did not have the ability to smoke at that time. when resident became recovered and became more mobile, facility failed to reinstate her smoking care plan. For R22 facility staff failed to timely update her smoking care plan with her recent refusals to wear a smoking apron. Facility wide sweep was conducted of care plans of all residents who smoke to ensure their care plans are correct and updated. New admissions and re admissions will be reviewed upon admission to determine the need for a smoking care plan and/or any changes or refusals. D--Don/designee will audit smoking care plans to ensure residents who smoke	

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F 656	Continued From page 19 5/29/23 - The facility's Smoking Policy for Residents, dated July 2017, stated, "Policy Statement- This facility shall establish and maintain safe resident smoking practices. #10 The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision." 6/5/23 11:00 AM - During an interview, E2 (DON) stated if a resident refuses the smoking apron, "They are still allowed to smoke, but we keep a double eye on them." The policy is that "Someone is out with the smokers at all times, but if they are not wearing the smoking apron, we keep a closer eye on them." 6/5/23 12:48 PM - During an interview, R22 stated that she's been educated about the need for wearing a smoking apron, but "I don't need it. They're not going to be telling me what I have to do." 6/5/23 - R22's care plan was revised and utilization of a smoking apron was added and to document refusals to wear a smoking apron. 6/8/23 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 and E3 (ADON).	F 656	have smoking care plans in place and updated timely to include any changes and refusals. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		7/26/23

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F 657	Continued From page 20 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R60) out of 32 sampled residents for care plan review, the facility failed to revise the care plan to reflect an identified need. Findings include: Review of R60's clinical record revealed: 2/14/23 - R60 was admitted to the facility. 2/15/23 - R60 had a care plan problem for inability to do her own ADLs without assistance related to weakness, with interventions that included requiring total care for her weekly shower two days per week and to clean and	F 657	A-R60 continues to reside at the facility. Care plan has been updated to reflect the behavior of refusing nail care. B- All residents residing at the facility have the potential to be affected by this deficient practice. C- Staff educator/designee will educate licensed staff regarding the need to update care plans with nail care refusals. RCA: Facility failed to update the care plan for R60 to include the behavior of refusing nail care.	

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F 657	Continued From page 21 check fingernails and toenails. 5/30/23 9:10 AM - R60 was observed in bed with very long fingernails on both hands; dirty fingernails were also observed on her left contracted hand. 6/1/23 9:51 AM - R60 was observed in bed with long fingernails on both hands; dirty fingernails were also observed on her left hand. 6/1/23 11:06 AM - R60 was observed in bed with long fingernails on both hands; dirty fingernails were also observed on her left hand. 6/1/23 11:35 AM - E52 (CNA) was observed in R60's room and asked R60 if she needed help with anything. R60 shook her her and said, "No." E52 explained to the Surveyor that R60 has refusal behaviors. E52 further explained that she has not trimmed R60's fingernails, "She (R60) refused all the time." 6/1/23 11:44 AM - In an interview, E54 (LPN) stated that R60 was known by Nursing staff to be resistant with showers and bathing, including nail care. E54 further stated that R60's Kardex had instructions for Nursing staff to check and clean fingernails on shower days, but no trimming nails. 6/1/23 11:55 AM - In a follow up interview, E54 stated that Nursing staff are aware of R60's resistance to nail care. E54 further confirmed the care plan did not include R60's behavior of refusing nail care. 6/1/23 1:50 PM - Findings were discussed with E2 (DON).	F 657	R27 has diagnosis of Anxiety disorder which causes her behavior of refusals of care. Staff did not attempt other calming or redirection techniques to encourage resident to allow nail to be provided. D- Don/designee will audit current resident care plans to ensure that residents that refuse nail care have a care plan in place. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 Findings were reviewed during the Exit Conference with E1 (NHA), E2 and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for two (R26 and E27) out of five residents sampled for inability to carry out their own ADL's (Activities for Daily Living), the facility failed to provide care and services for toileting. In addition, R26's water pitcher wasn't placed within reach and R26 was not set up for lunch in a timely manner. R27's fingernails were long, untrimmed and ungroomed. Findings include: 1. R26's clinical record revealed: 12/30/2017 - R26 was admitted to the facility with a diagnosis of Dementia. A facility policy titled "Activities of Daily Living (ADLs), Supporting", revised on 3/2018, included: Policy interpretation and implementation 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: c. elimination (toileting), d. dining (meals and snacks). 5. A resident's ability to perform ADL's	F 677	A- R26 no longer resides at the facility. There is no opportunity to correct the alleged deficiency. R27 fingernails have been trimmed and groomed. B- All residents residing at the facility have the potential to be affected by this deficient practice. C-Staff educator/designee will educate staff on providing care and services for toileting. Staff educator/designee will also educate staff on timely meal setup and placing resident bedside table and water cup with in reach before leaving room. Staff Educator/designee will educate staff on providing personal hygiene and grooming of resident fingernails as care planned. RCA: Facility failed to ensure care and services for toileting was provided for R26, timely meal setup and placing bedside table and water cup with in reach. Facility failed to ensure proper personal hygiene and grooming of fingernails for	7/26/23

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F 677	Continued From page 23 will be measured using clinical tools, including the MDS (Minimum Data Set) assessment. 12/30/17 - R26's care plan for "Bowel and Bladder", revised on 10/12/22, included: R26 is incontinent of bowel and bladder. R26 will stay clean, dry, and comfortable with no skin breakdown or irritation and documented scheduled toileting while awake as tolerated at 12:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM for safety. 12/30/17 - R26's care plan "Actual and Potential for Falls", revised on 10/12/22, included: 1. offer toileting before meals and at bedtime. 2. Responsible party and frequent visitor were educated they are not to provide direct care. 12/30/17 - R26's care plan for "ADLs", revised on 10/12/22, included: R26 is unable to do her own ADLs without assistance secondary to weakness and documented assist with meal tray, opening items and setup as needed. 1/1/18 - R26's care plan for "Potential for alteration in nutrition and hydration" included: R26 had a "potential for alteration in nutrition and hydration related to varied oral intake secondary to dementia and advanced age and documented to encourage food and fluids as needed, resident requires set-up and supervision for meals; occasionally requires varying levels of assistance." 9/26/22 - An annual MDS Assessment documented that R26 required extensive assistance of two staff for toileting and supervision with limited assistance of one staff	F 677	R27. WHY occurred: CNA failed to refer to R26 PLAN of care regarding toileting. CNA failed to understand the importance of providing toileting before meal for R26 so that when meal arrived resident would be ready to enjoy her meal. CNA failed to ensure that R26 needs were being met by placing water cup with in reach before leaving the room. Staff note that resident refuses nail care at times. Staff note that R27 is fearful of having her nails cut or touched by staff due to a diagnosed skin disorder that causes fragile skin and skin tears. R27 has agreed to allow staff to soak her nails and to trim and file most nails. Education was provided to resident on the benefit of keeping nails cleaned, trimmed and filed. D- Don/designee will perform daily random observations of resident care and services for toileting, timely meal setup and having bedside stable and water cup with in reach. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved.	

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F 677	Continued From page 24 person for eating. 12/20/22 - A quarterly MDS Assessment documented that R26 was totally dependent for toileting and required supervision with limited assistance of one staff person for eating. 5/31/23 9:50 AM - R26 was observed in bed watching television, no staff were seen in the room. 5/31/23 11:47 AM - Continuous observation of R26 revealed R26 in bed and awake, with no staff seen in the room. 5/31/23 12:08 PM - Continuous observation of R26 revealed R26 watching television with no staff seen in the room. 5/31/23 12:37 PM - R26 was observed in bed with no staff seen in the room. 5/31/23 12:43 PM - E10 (Unit Clerk) was observed placing R26's lunch tray on the bedside table. E10 spoke with R26 and said, "Hold on until I can get to you, ok?" E10 then exited R26's room. 5/31/23 12:55 PM - Continuous observation revealed R26 had still not been set up for lunch. 5/31/23 1:13 PM - E12 (CNA) entered R26's room and proceeded to set R26 up to eat lunch. R26 had waited 30 minutes to be set up for lunch to eat. Additionally, R26 had not had her brief changed as care planned. 6/1/23 10:31 AM - An observation revealed that R26's bedside table and water cup were not	F 677	Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 677	Continued From page 25 within reach. 6/1/23 10:34 AM - A brief interview with E12 revealed that R26 had been provided morning care. 6/1/23 10:36 AM - A random observation revealed E14 (LPN) entering R26's room and E14 didn't move R26's bedside table and water cup so they'd be within reach. E14 exited R26's room. 6/1/23 11:07 AM - Observed R26's beside table and water cup not within reach. 6/1/23 11:32 AM - Observed R26's bedside table and water cup not within reach. 6/1/23 11:56 AM - Observed R26's call light on, E11 (CNA) answered and asked R26 if they needed anything. E11 exited the room. R26's bedside table and water cup remained out of reach. 6/1/23 12:01 PM - An observation of E9 (LPN) in R26's room revealed that the bedside table and water cup remained out of R26's reach. 6/5/23 - An interview with E53 (Companion) revealed that E53 visited R26 every Monday for two hours to assist R26 with her meals. Additionally, E53 said, "Staff only entered R26's room to bring in her meal tray and that R26 was not provided any other care when E53 was present." The facility policy and procedure for ADLs lacked specificity for a resident that was unable to carry out ADLs without staff support and assistance as care planned.	F 677		

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F 677	Continued From page 26 2. R27's clinical record revealed: 11/30/17 - R27 was admitted to the facility with a diagnosis of a stroke with left sided weakness and contractures to the left upper extremity. 11/30/17 - R27's care plan for ADLs (Activity of Daily Living), revised on 2/2/23, documented, 1. R27 is unable to do her own ADLs without assistance secondary to Stroke, 2. R27 will be well groomed, 3. Extensive care for weekly shower two days a week using shower bed, 4. Clean and check fingernails and toenails. 1/23/23 - An annual MDS Assessment documented that R27 required extensive assist of one staff for personal hygiene, grooming and bathing. 3/26/23 - A quarterly MDS Assessment documented that R27 required extensive assist of two staff for personal hygiene, grooming and bathing. 5/25/23 12:28 PM - A random observation with E7 (LPN) revealed that R27's right and left hand fingernails were long and had dark debris underneath the nailbeds and nail fungus (common infection of the nail). 5/31/23 10:21 AM - During an observation with E7, she said R27's left hand fingernails were pressed against the palm of her (R27's) hand. E7 also revealed that R27's left hand was sticky, had an odor and she updated E48 (Nurse Practitioner). 5/31/23 10:27 AM - During an interview, E48 said,	F 677		

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F 677	Continued From page 27 "I ordered medication for R27's nail fungus and asked E7 to cut her fingernails." The facility failed to provide appropriate support and assistance for R27's personal hygiene and grooming and had not cut, filed, and trimmed the resident's fingernails in accordance with R27's documented plan of care for ADL's. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/8/23 at 2:30 PM.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of facility documentation, it was determined that for one (R370) out of three (R24, R222 and R370) residents reviewed in the investigative sample, the facility caused harm by failure to ensure that R370 received adequate nursing care after R370 had an unwitnessed fall on 10/1/22. R370 didn't receive ongoing post fall assessments and pain management for injury/pain related to the fall until 10/4/23, three days later. For R222, the facility failed to implement the behavior care plan intervention of two CNAs in the room when	F 684	A- R370 and R222 no longer reside at the facility. There is no opportunity to correct this alleged deficient practice. R24 has her heel protectors on per physician orders. B- All residents who reside at this facility have the potential to be affected by this deficient practice. C- Staff educator/designee will reeducate staff that falls must be reported	7/26/23

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F 684	Continued From page 28 offering care as needed. For R24, the facility failed to ensure that the resident received her heel protectors per the Physician's order and plan of care. Findings include: Review of the facility Employee Handbook, revised 7/1/12, Policy #200 Workplace Safety, Resident Injuries: Resident injuries including falls, must be reported immediately to your supervisor. Residents are not to be moved until a nurse or other healthcare professional has seen them. 5/20/21 - R370 was admitted to the facility. Hospice care in the facility was initiated for R370 and a hospice care plan was created that included an approach to administer pain medications (meds) as needed and to monitor for the response. The following pain meds were in place: Acetaminophen Tablet 325 MG, give two tablet by mouth two times a day for pain. Tramadol Tablet 50 MG, give 1 tablet by mouth every twelve hours as needed for moderate pain. Morphine Sulfate Solution 20 MG/ML Give 0.25 ml by mouth every 4 four hours as needed for severe pain. 7/20/22 - The quarterly Minimum Data Set (MDS) assessment revealed a BIMS (Brief Interview for Mental Status) score of 3, which meant R370 had a severe decline in mental status. 9/16/22 - A fall risk assessment documented R370 as being at high risk for falls with a score of 12; any score greater than 10 is high risk.	F 684	immediately to your supervisor and that residents are not to be moved until a thorough assessment by an RN has been completed. Staff educator/designee will educate nursing staff on non verbal signs of pain and completion of before and after pain scores are documented. Staff educator/design will reeducate staff to follow physician's orders and apply heel protectors as indicated. Staff educator/design will reeducate staff on having two staff members present in the room while care is being provided when care plan indicates. Staff educator/designee will reeducate nursing staff and agency staff where to find care requirements in PCC. RCA: Facility failed to ensure that R370 received adequate nursing care after an un-witnessed fall, as well as resident not receiving ongoing post fall assessments and pain management for injury/pain related to the fall. The facility failed to ensure that R24 received her heel protectors per physicians order and care plan, and facility failed to implement for R222 the behavior care plan intervention of two CNAs in the room when offering care as needed. The licensed nurse failed to act when he was notified when resident was found on the floor. The licensed nurse failed to pass along the fall incident to the oncoming shift. Nurse is no longer employed at the facility. CNA did not follow residents plan of care	

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F 684	Continued From page 29 10/1/22 - A facility video recording revealed that R370 fell in the hallway at approximately 8:40 PM; R370 did not receive a fall assessment from a Nurse before E16 (CNA) and E17 (CNA) lifted R370 with their hands and moved her. 10/2/22 - Review of a staff statement that was completed as part of the facility's investigation of the 10/1/22 fall, revealed that E18 (CNA), who was caring for R370 on the 7AM-3PM shift, believed that R370 was in pain because R370 was usually willing to get out of bed, but that on this day R370 was not willing to get out of bed or stand to use her walker, as she normally had done other times when E18 cared for R370. Additionally, E18 observed R370 moaning during lunch. E18 told the Nurse caring for R370 that she thought R370 was in pain. 10/2/22 10:21 AM - A nursing progress note revealed that R370 was having nonverbal signs of pain. Tylenol was administered at 8:00 AM, however, the resident was still showing nonverbal signs of pain at 10:21 AM. 10/2/22 - A review of the medication administration record (MAR) revealed that R370's pain was assessed at a 7 on a scale of 0-10 (with 10 being the most pain). R370 was given Tramadol 50 MG tablet by mouth at 10:21 AM. R370's untimed post pain assessment was documented as E for effective, a post pain number assessment was not documented. Pain medications, other than routine Acetaminophen, were not documented as given to R370 again on 10/2/22. 10/3/22 - A review of the MAR revealed that R370's pain was assessed at a 7 on a scale of	F 684	for R24. CNA failed to understand the importance of have the residents heel protectors in place as ordered to prevent skin breakdown and report to nursing if resident refuses to wear them. CNA failed to follow R222 behavior care plan intervention of having two cna's in the room when offering care. CNA believed that she could address residents concerns independently. D-Don/designee will perform daily audits of fall incident reports to ensure adequate nursing care after a fall, ongoing post fall assessments and pain management for injury/pain related to the fall. Don/designee will also perform daily audits of residents with heel protectors to ensure placement per physician order. Don/designee will perform daily audits of behavior care plan interventions of two C.N.A's in the room when offering care. Facility will conduct a sweep to determine which residents with behaviors require 2 care givers for care. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed	

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F 684	Continued From page 30 0-10. R370 was given Morphine 0.25 ml by mouth at 8:10 AM. R370's untimed post pain assessment was documented as E for effective, a post pain number assessment was not documented. Pain medications, other than routine Acetaminophen, were not documented as given to R370 again on 10/3/22. 10/3/22 - A MAR review revealed a 4:45 PM Physician's order for a Stat (immediate) X-Ray to R370's bilateral hips. The chart lacked documentation of when the Stat x-ray was obtained. 10/4/22 - Review of the MAR revealed that R370's pain was assessed at a 6 on a scale of 0-10. R370 was given Morphine 0.25 ml by mouth at 5:20 AM. R370's untimed post pain assessment was documented as E for effective, a post pain number assessment was not documented. Additionally, R370s pain was assessed at an 8 on a scale of 0-10 and R370 was given Morphine 0.25 ml by mouth at 10:16 AM. R370's untimed post pain assessment was documented as E for effective, a post pain number assessment was not documented. 10/4/22 9:07 PM electronically signed - An Encounter note by E21 (NP) revealed that on 10/3/22, E21 was notified by nursing staff that R370 had complained of lower extremity (leg) pain during activities of daily living (ADLs) and an x-ray was ordered. On the 10/4/22 exam, R370's left lower leg was observed to be swollen and R370 showed signs of pain when the leg was moved. The 10/3/22 x-ray revealed a fracture of the left leg/hip. R370 was sent to the emergency room and was admitted to the hospital.	F 684	for further evaluation or recommendation.	

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F 684	Continued From page 31 10/4/22 7:55 AM - electronically signed - An X-Ray report revealed that R370 had a left femur fracture. It was still unclear when the X-ray was obtained and why it took 15 hours to get results. 10/5/22 - A facility incident report, dated 10/3/22, for R370, documented an Incident Description: "At the start of the 7-3 shift during rounds observed resident to be moaning and groaning, shivering in bed ....CNA administered care to resident, and stated that the resident complaint (sic) of moderate amount of pain. Resident was crying while being turned during am (morning) care. Care giver stated resident screamed when she touched leg ....". Immediate Action Taken-Description of Action Taken: "Resident was assessed, and observed swollen left hip; sensitive to touch, also complained of increased pain. Resident was given routine Tylenol 0800-(8:00 AM); was ineffective, resident continues to moans (sic) and groans (sic). At 0830 (8:30 AM) ... Morphine 0.25 ml administered; meds effective. NP (Nurse Practitioner) was notified and ordered Stat X-Ray to bilateral hips 3 views. 10/4/22 X Ray result came back; positive for Acute displaced fracture of left Femur ...". 5/25/23 - A review of hospital records revealed that R370 was admitted to the hospital on 10/4/22 at 6:00 PM for a hip fracture and that R370 had surgical hip repair on 10/5/22. 6/6/23 2:33 PM - During an interview, E2 (DON) stated that R370's 10/1/22 fall was unknown to the facility until they performed an investigation after R370 was found to have a hip fracture on 10/4/22.	F 684		

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F 684	Continued From page 32 6/6/23 8:31 AM - During an interview, E34 (LPN) stated that if a resident sustains a fall, the fall should be reported to the Nursing Supervisor. Additionally, a verbal fall report would be given during the nursing shift to shift reports, so that fall assessments would be continued by the oncoming Nurses. 6/7/23 12:15 PM- During a phone interview, E17 (CNA) stated that she was working at the facility on 10/1/22 on the 3:00 PM-11:00 PM shift. E17 was doing rounds and discovered R370 on the floor outside of her room. E17 was not assigned to R370, so she went to get E16, the CNA that was assigned to R370. E17 told E19 (LPN) who was caring for R370, that the resident had fallen, but stated that E19 did not move from the nursing desk where he was sitting. The two Aides then proceeded to lift R370 with their hands and put her to bed. E17 stated that E19 did not assess R370 before she and E16 put R370 in bed. 6/7/23 12:25PM - During a phone interview, E16 (CNA) stated that she was assigned to care for R370 on the 3:00 PM-11:00 PM shift on 10/1/22. E16 said that E17 found R370 on the floor and came to get E16 to assist with R370. E16 stated that she and E17 proceeded to lift R370 with their hands and put her to bed. E16 stated that E19 (LPN) did not assess R370 before she and E17 put R370 in bed. R370 experienced harm when staff failed to assess the resident for injury and pain post fall. Staff reports and pain medication assessments revealed that R370 had nonverbal signs and symptoms of pain which required the administration of Tramadol on 10/2/22 for moderate pain and Morphine on 10/3/22 and	F 684		

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F 684	Continued From page 33 10/4/22 for severe pain. Additionally, the result of the STAT x-ray ordered on 10/3/22 at 4:45 PM did not return until 10/4/22 at 7:55 AM, more than twelve hours after the order was written. R370 remained at the facility for two and a half days with a broken leg before receiving medical treatment at the hospital. During this time there was lack of assessment and intervention for injury and pain. 2. Review of R24's clinical record revealed the following: 2/5/16- R24 was admitted to the facility. 1/30/18- A Physician's order was written for heel boots to bilateral feet as tolerated every shift while in bed. 1/30/18- R24 was care planned for the potential for impaired skin integrity related to incontinence and decreased mobility. 1/30/18- Interventions included, but were not limited to: heel boots to bilateral feet as tolerated when in bed. 7/5/19- A Physician's order was written to consult therapy for interventions as needed. 5/26/23 10:30 AM- R24 was observed lying in her bed. Her right foot was in a soft cast and the left foot/heel was resting directly on the bed. A blue heel protector was on the ledge of the window sill on the right side of the bed and one was in the clear bin near the bedside drawer. No heel boots were on R24. 5/26/23 11:00 AM- R24 was observed lying in bed	F 684		

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F 684	Continued From page 34	F 684		

in the same position. Her left foot/heel was resting on the bed. Heel protectors continued to be on the window ledge and in the bin.

5/26/23 11:05 AM- R24's heel protectors were in the same places. R6 (RN) confirmed that R24's heel protectors remained on the window ledge and in the bin. R6 stated, "She (R24) kicks them off sometimes."

5/26/23 11:30 AM- R24 was observed with a soft cast on her right foot and a heel protector on her left foot only.

6/8/23 2:30 PM- Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON.)

3. Review of R222's clinical record revealed the following:

6/11/21 - R222 had a care plan developed and revised (9/9/21) for making false accusations towards staff with interventions including, but not limited to, having two CNA's in the room when offering care as needed.

5/27/22 - A facility Complaint/Grievance Report filed by FM1 revealed that a 3-11 PM shift CNA "has been extremely nasty to her mother (R222)."

3/27/22 - A written statement by E67 (former DON) documented that on 3/26/22 on the 11 PM-7 AM shift "...it was identified that CNA (E41) was assigned to the resident (R222)...E41 stated that she responded to the call light in the bedroom and assisted the resident to the bathroom, utilizing her rollator. After toileting, E41 was assisting the resident back to the bed, the

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F 684	Continued From page 35 rollator swayed from side to side and as the staff member was attempting to maneuver the rollator, the resident verbalized that the staff was making her sick to her stomach and stated that she did not want her to come back to care for her because she (E41) mistreats her (R222) every night...E41 also indicated that she has not provided care to resident (R222) in quite a long time." 6/5/23 1:03 PM - During an interview, E41 stated that she remembered what happened that night on 3/26/22. E41 also stated R41 had a behavior of making false accusations towards staff providing her care. E41 further confirmed that on 3/26/22 late evening she entered R222's room and was by herself when she provided assistance to R222 to the bathroom. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/8/23 at 2:30 PM.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	F 685		7/26/23

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F 685	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R154) out of two sampled residents reviewed for vision and hearing, the facility failed to ensure that the resident received proper treatment to maintain vision. Findings include: Review of R154's clinical record revealed: 5/2/23 - Due to a complaint of a decrease in vision, R154 received an eye exam in the facility from the facility's vision provider. The eye exam found R154 to have cataracts (clouded, blurred, and/or dimmed vision) in both eyes. The vision provider gave the facility a copy of the eye exam result, which included a referral for R154 to have eye surgery. 5/25/23 - During an interview with R154, he stated, "I have cataracts. I am supposed to have surgery. I don't know when, they never told me. I cannot see well." 6/1/23 10:00 AM - E29 (Social Service) described how the facility carries out recommendations made by their vision provider and stated that the vision provider, "comes into the building, Social Services receives the consults/recommendations and places it in the Dr.'s book for the NP (Nurse Practitioner) to review. The NP signs off, informs the UM (Unit Manager) of the recommendation, and then the UC (Unit Clerk) is made aware so that they can set up the appointment and transport." 6/1/23 10:06 AM - During an interview with E30 (Unit Clerk), it was revealed that she did not have	F 685	A-R154 cataract surgery has been scheduled for August 15, 2023. B- All residents residing at the facility with any vision impairments have the potential to be affected by this deficient practice. C-Staff educator/designee will educate Unit managers and supervisors on proper follow through of any recommendations from the vision consultant. RCA: Facility failed to ensure R154 received treatment to maintain vision. Once the unit manager received the initial recommendation from the vision consultant there was no follow up to ensure that the recommendation was completed or discussed with physician. All recommendation from vision consultant will be reviewed at morning meeting to ensure that all recommendations and follow ups have been made timely. D- Don/designee will perform weekly audits of vision consultant recommendations to ensure that the recommendations and follow ups have been made. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will	

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F 685	Continued From page 37 any recommendations that R154 should have eye surgery and stated, "They have not told me anything." 6/1/23 10:11 AM - E29 confirmed that R154's eye surgery referral was not acted upon by the facility. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON) on 6/8/23, at approximately 2:30 PM.	F 685	be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R219) out of four residents reviewed for pressure ulcers, the facility failed to ensure that R219 received the necessary treatment and services to promote the healing of a Stage 3 right hip pressure ulcer (PU - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin). Findings include:	F 686	A- R219 no longer remains at the facility. There is no opportunity to correct the deficient practice. B- All residents with pressure ulcers have the potential to be affected by this deficient practice. All residents requiring services from wound healing solutions recommendations will be reviewed by the	7/26/23

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F 686	Continued From page 38 R219's clinical record revealed: 3/10/22 - R219 was admitted to the facility with diagnoses that included, but were not limited to Quadriplegia (paralysis of arms and legs) and Peripheral Vascular Disease (PVD - common circulatory problem in which narrowed arteries reduce blood flow to your limbs). 10/8/22 - A Physician's Order by E20 (MD) documented, "Consult - Wound care consultant - Evaluate and treat as indicated." 10/9/22 - A Physician's Order by E20 (MD) documented to apply Collagenase ointment to R219's hip wound daily and cover with gauze and Tegaderm (transparent film dressing). Review of R219's eMAR revealed that nursing staff signed off that this treatment was done from 10/10/22 through 10/19/22. 10/12/22 - R219 was seen by a Wound Care Consultant (WCC) for her Stage 3 right hip pressure ulcer. R219 was noted to be incontinent of both urine and bowel. The WCC recommended "... Bactroban (antibacterial medication) ... Silver Alginate... cover with clean dry dressing (CDD)" to R219's right hip PU. 10/13/22 - A Physician's Order by E21 (NP) documented to apply Bactroban ointment then Silver Alginate and cover with a CDD to R219's right hip. Review of R219's eMAR revealed that nursing staff signed off that this treatment was done from 10/14/22 through 10/19/22. The facility failed to discontinue the 10/9/22 Physician's Order, which resulted in two different	F 686	MD/NP. C- Staff educator/designee will educate staff on reviewing the Wound Care Consultants recommendations and on providing accurate transcription of orders, discontinuing old orders, and on including PRN orders. RCA: The facility failed to discontinue a Physicians Order which resulted in two different wound care treatments being signed off as done on resident's right hip. Facility failed to identify the incomplete physician's order that was missing a PRN order. The nurse failed to transcribe wound care solutions recommendations correctly and completely. Resulting in multiple treatment orders for the same area. The nurse did not obtain complete treatment order for R219 by neglecting to add the PRN portion of the order. All residents requiring services from wound healing solutions recommendations will be reviewed by the MD/NP. The Wound care nurse will be the point person for wound care. The Wound Care Nurse will transcribe the order once the MD/NP agrees on the recommendation. The DON/designee will then follow up with the recommendations and the orders to ensure that they are transcribed correctly and completely. D-Wound care nurse/designee will perform random daily audits of resident	

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F 686	Continued From page 39 wound care treatments being signed off as done by nursing staff on R219's right hip PU from 10/14/22 through 10/19/22. On 10/20/22, both treatments were discontinued and a new treatment was ordered. 11/16/22 - R219 was seen by the WCC for the right hip PU and recommended to change the treatment to "... apply medical-grade honey gel to wound base then apply calcium alginate to wound base, cover with CDD, twice a day and PRN (as needed)." 11/17/22 - A Physician's Order received by phone from E20 (MD) was entered as "... apply medihoney alginate and cover with CDD...". Review of R219's eMAR revealed that nursing staff signed off that this treatment was done from 11/17/22 through 11/23/22. Despite the WCC recommending Calcium Alginate, the facility failed to identify the incomplete Physician's Order of "Alginate." 11/23/22 - R219 was seen by the WCC for the right hip PU and recommended to change the treatment to "... apply Silver Alginate... BID (twice a day) and PRN...". 11/23/22 - A Physician's Order received by phone from E20 (MD) was entered as "... apply Silver Alginate ... BID." Despite R219 being incontinent of both urine and bowel, the facility failed to identify the incomplete Physician's Order that was missing a "PRN" order. A PRN treatment order would be performed if R219's wound dressing was soiled due to incontinence or it became dislodged.	F 686	wound care recommendations and orders to ensure accurate transcription of orders, discontinuing old orders and on including PRN orders. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 686	Continued From page 40 Review of additional Physician Orders following the WCC's recommendations revealed that "PRN" orders were not captured on 11/30/22, 12/8/22 and 12/29/22. 6/8/23 at approximately 9:30 AM - During an interview, findings were reviewed and discussed with E2 (DON). 6/8/23 at 2:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E5 (RN Risk Manager).	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for two (R27 and	F 688	A- -R154 splints were applied to bilateral hands. R 27 is receiving Passive Range	7/26/23

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F 688	Continued From page 41 R154) out of four residents reviewed for ROM (Range of Motion)/mobility, the facility failed to provide restorative nursing services to maintain or prevent further decline in function/mobility. The facility failed to provide R154 with restorative services while R154's orthotic devices (an artificial support or brace for the limbs or spine) for contracture management were in the laundry. For R27, the facility failed to ensure that R27 received PROM (Passive Range of Motion) exercise daily as prescribed. Findings include: 1. Review of R154's clinical record revealed: 9/28/22 - R154 was admitted to the facility with contractures (the shortening of certain tendons, muscles or other connective tissues causing loss of full extension of the affected joints) of both hands. 3/13/23 - R154's Physician orders read, "Left Upper extremity wrist hand orthotic devices on as tolerated to a maximum of 1 hour." 4/6/23 - R154's Physician orders read, "Upper extremity orthotic devices on as tolerated. Right hand palm protector and left hand orthotic to be donned for 2 hours, as tolerated, for contracture management, with skin checks performed every shift." 5/25/23 10:47 AM - During an interview, R154 informed the Surveyor that he has splints and they are inside his bedside drawer. The Surveyor obtained permission to check his bedside table; the Surveyor did not see any orthotic devices or palm protectors in R154's bedside table. The Surveyor asked R154 if he wears them. R154 replied, "They put them on me sometime (sic)."	F 688	of Motion. B- All residents residing at the facility ordered splints have the potential to be affected by this deficient practice. C –Staff Educator/designee will educate staff on ensuring that splints are applied as ordered. Staff Educator/designee with educate staff on ensuring that residents receive PROM as ordered. RCA: Facility failed to provide restorative nursing services to maintain or prevent further decline in function/mobility. Facility failed to ensure R154 splints were in place per order. Facility failed to ensure that R27 received Passive Range of Motion as ordered. Facility aide did not understand the importance of ensuring the placement of R154 orthotic device. She failed to notify the unit manager that the orthotic device was missing from resident room. the orthotic device was found in laundry and put in place at that time. C.N.A.s were not properly educated on R27 PROM orders. Consequently this resulted in inefficient PROM for R27. Facility sweep of residents ordered splints has been completed to ensure all residents that require splints are in place. Facility sweep of resident who are to receive PROM have been done as is being provided as ordered.	

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F 688	Continued From page 42 5/25/23 1:02 PM - R154 was observed with a visitor, not wearing splints or a palm protector. 5/30/23 10:57 AM - R154 was observed lying in bed not wearing splints or a palm protector. 5/31/23 1:12 PM - R154 was observed sitting up in bed not wearing splints or a palm protector. 5/31/23 3:10 PM - R154 was observed sitting up in bed talking with an Activity Aide, not wearing splints or a palm protector. 5/31/23 3:13 PM - An interview with E68 (CNA), confirmed that R154's orthotic devices were not in the resident's room and stated, "They are usually here, therapy must have took them." 6/1/23 8:20 AM - During an observation, R154 was sitting up in bed, without any orthotic devices on. The Surveyor observed one orthotic device sitting on R154's windowsill. 6/1/23 8:38 AM - During an interview, E3 (ADON) confirmed the findings and informed the Surveyor that R154's splints were, "dirty and just came up from laundry this morning." 6/1/23 9:07 AM - E3 returned with R154's missing orthotic device/palm protector since only one was returned from the laundry. E3 asked R154 if he wanted to wear the orthotic devices. R154 stated, "Yes ...I want to get cleaned ...first." E3 informed E33 (CNA) to put them on R154 after he was cleaned up. 6/2/23 1:53 PM - R154 was observed wearing his orthotic devices.	F 688	D- Don/designee will perform daily audits of residents with splints to ensure they are applied per physician's orders. Audits will also be done to ensure that PROM is being done per order. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 688	Continued From page 43 2. R27's clinical record revealed: A facility policy titled "Range of Motion Exercises", revised in 10/2021, included: The purpose of this process is to exercise the residents' joints and muscles. 1. If ROM (range of motion) exercise is PROM (passive range of motion), to exercise the shoulder, you will need to support the resident's arm at the elbow and wrist 2. To exercise the elbow, you will need to support the resident's arm at the wrist and elbow and 3. To exercise the wrist, you will need to support the resident's arm and hand. A facility policy titled "Restoring Nursing Services", revised in 7/2021, included: Policy Statement; Residents will receive restorative nursing care as needed to help promote optimal safety and independence. 1. Restorative goals and objectives are individualized and resident centered and are outlined in the resident's plan of care. 11/30/17 - R27 was admitted to the facility with a diagnosis of a stoke with left side weakness and contractures to the left upper extremity. 11/30/17 - Record review of R27's contracture measurements documented that the left wrist and hand joint contracture status was severe on admission. 1/5/18 - R27's care plan for "Actual Contractures", revised (2/2/23), documented 1. PROM to all extremities (all joints) BID (twice a day) for fifteen minutes, 2. Upper extremity orthotic devices on as tolerated, 3. Rolled washcloth to be donned in resident's left hand for	F 688		

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F 688	Continued From page 44	F 688		

up to three hours as tolerated.

11/14/20 - Record review of R27's contracture measurements documented that the left wrist and hand joint contracture status remained severe.

9/1/22 - Record review of R27's contracture measurements documented that the wrist and hand left joint contracture status remained severe.

1/23/23 - An Annual MDS Assessment documented that R27 had impairment on one side in the upper extremity.

3/9/23 - A Physicians order was written for PROM to all extremities and all joints BID for fifteen minutes. Stop if the resident complains of pain and notify the Nurse.

3/17/23 - A Physicians order was written for upper extremity orthotic devices on as tolerated, left hand carrot orthotic to be donned for two hours as tolerated for contracture management and skin checks performed every shift.

3/26/23 - A Quarterly MDS Assessment documented that R27 had impairment on one side in the upper extremity.

5/3/23 - A Restorative Nursing Program (RNP) Form for R27 was signed by E13 (Director of Rehabilitation- DOR) and E9 (LPN, Unit Manager), yet had no documentation that caregiver training was completed for PROM BID daily for R27.

5/25/23 12:58 PM - A random observation revealed that R27 had contractures to the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 688	Continued From page 45 elbow, wrist, and hand. 5/31/23 10:10 AM - An interview and observation with E4 (LPN) revealed that R27's nails were pressed into the palm of R27's left hand. 6/1/23 11:36 AM - During an interview, E8 (RN) revealed, "She wears that carrot as tolerated, if she wants it out, she takes it out." 6/2/23 9:42 AM - An interview with E13 (DOR) revealed, "The CNA (Certified Nursing Assistant) and Nurses are trained by the Therapist and/or the Unit Manager to perform ROM for Restorative Nursing services. 6/2/23 9:42 AM - An interview with E8 (RN) revealed, "No, I don't observe the CNA doing range of motion, so no, I don't know that it's being done." Additionally, E8 said, "I have not had any training or education on range of motion." 6/2/23 10:16 AM - An interview with E9 (LPN) revealed, "Yes, the Nurse observes the CNA doing ROM." 6/2/23 10:31 AM - During an interview, E15 (CNA) revealed that "she worked for an agency and had not received range of motion training from the facility for (R27)." E15 said, "R27's minutes for PROM included morning care that involved bathing, turning - repositioning in bed and getting dressed. Additionally, E15 stated that R27 completed her own PROM for the left upper extremity and had lifted her left arm up with the right hand. E15 also revealed that E8 (RN) entered the room at the time R27 raised her left arm up, observed a dressing on R27's left arm and exited the room.	F 688		

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 688	Continued From page 46 6/7/23 8:44 AM - An interview with E7 (LPN) revealed, "No I don't observe the CNA when they are doing a resident's range of motion." Interviews and documentation identified that staff had not received training or education for RNP for Range of Motion. Furthermore, staff interviews also identified that staff considered delivering care to the resident counted as ROM exercises. There was no evidence that R27 was receiving fifteen minutes of PROM exercise daily as prescribed. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference in 6/8/23 at 2:30 PM.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, it was determined that for three (R24, R104, and R221) of twelve residents reviewed for accidents, the facility failed to ensure that the residents' environment remained free of accident hazards. For R104, the facility failed to provide adequate supervision and appropriate care in accordance with professional standards of	F 689	A-Deficient practice was unable to be corrected for R104, R221 and R24 due to having passed the time of occurrence. B- All residents residing at the facility have the potential to be affected by this deficient practice.	7/26/23

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F 689	Continued From page 47 practice as evidenced by failure to adequately supervise and mitigate accidents when R104 fell out of bed while receiving care. This fall resulted in harm as R104 was transferred to the hospital and was subsequently diagnosed with a right hip fracture. For R221, the facility failed to ensure that the proper Hoyer lift sling was used to transfer the resident from a wheelchair to his bed during which time the resident fell, complained of pain and sustained harm with a left rib fracture. For R24 the facility failed to ensure that the proper equipment was used to transfer R24 from her wheelchair to her bed. The facility's investigation failed to identify the root cause analysis of the fall and educate staff members in a timely manner. Findings include: 1. Review of R104's clinical record revealed: 11/19/21- The Agency Orientation Checklist, which was signed as reviewed and completed by E45 (Agency CNA), included Education on Bed Mobility that stated, "How do you find out what the mobility status is of your residents? (if the answer is "ask that is NOT correct!) You must look at the Kardex or the POC (plan of care) for each resident ... Orders MUST be followed regardless of what you think you or the resident can do ...If they are assist of 2 bed mobility, that means when ever (sic) you are providing care that involves moving the resident, you MUST have 2 people." 2/15/22 - 2/16/22- E45 signed a facility Inservice Attendance record for Bed Mobility/Transfers. 2/28/22- R104 was admitted to the facility for long term care with diagnoses including Alzheimer's dementia.	F 689	C-Staff educator/designee will educate nursing staff on ensuring residents environment remains free of accident hazards. Education will include; following each residents proper mobility status that is listed on the Kardex in POC, ensuring that proper lift slings are being used for residents requiring a mechanical lift for transfers. Staff educator/designee will also in-service to ensure that a proper investigation is conducted to properly identify RCA so that education can be provided timely. RCA: Facility failed to follow the resident's plan of care to ensure proper staff was being utilized for bed mobility. Facility failed to use proper slings to safely transfer two residents who needed a mechanical lift for transfer. Facility failed to do a proper investigation of a fall so that identification could be made of the RCA and timely education to staff could be provided. For R104 hospice aide failed to seek report from floor nurse pertaining to mobility status prior to starting care. Facility has updated hospice binders to include residents current care plans and bed mobility status. For R104 agency aide did not check bed mobility status of resident on POC prior to providing resident care. Agency aide was educated prior to this event on checking POC prior to providing resident care. For R221 staff failed to utilize proper sling	

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 689	Continued From page 48 R104's Admission Orders stated, "TRANSFER STATUS: assist X2 (2 person), BED MOBILITY: assist X2 (2 person)...". 3/1/22- R104 was care planned for falls with interventions that included, but were not limited to, bed in the lowest position when care is not being provided, bilateral fall mats down when in bed and call bell within reach at all times. Additionally, R104 was care planned for inability to perform ADL's (activities of daily living) without assistance related to cognitive loss, with interventions that included, but were not limited to, bed mobility- assist X2 (2 persons), transfers- hoyer (mechanical lift) assist X2, and non-ambulatory (does not walk). 3/6/22- R104's Minimum Data Set (MDS) assessment documented ADL Self-Performance for bed mobility as 4 (total dependence) with 3 (two+ person) physical assist. 3/11/22 10:45 AM- R104 rolled off the bed onto a floor mat while E61 (Hospice CNA) was providing care unassisted, despite R104's need for two person assistance for bed mobility. 3/11/22 11:00 AM- E64 (ADON) performed On the Spot Education/Coaching with E61. 3/11/22 12:47 PM- The monthly Documentation Survey report revealed that E63 (CNA) signed off R104's CNA Task of "Bed mobility Assist X2" as "4 (total dependence) with 3 (two+ person) physical assist." 3/11/22- R104's Care Plan was revised to add under the Fall care focus, the intervention	F 689	who is a bilateral above the knee amputee and needed a full body sling. Facility conducted a sweep of all residents who are amputees to update tasks to include fully body slings are to be used for transfers with mechanical lifts. For R24 staff failed to utilize proper sling size while transferring resident from wheelchair to bed. it appears that staff did not check POC for proper sling size for R24 prior to transfer. Facility will conduct sweep of all residents utilizing mechanical lifts for transfer to ensure that the proper sling size is being utilized. For R24 incident 4/12/23 RCA indicated that resident has a stoma from a previous tracheostomy she has episodes of coughing where she begins to have full body spasms causing stiffening of body especially hands and feet. It is believed that during this spasm it may have caused her right ankle to roll over and slide off the foot rest. D-DON/Designee will complete daily audits on ensuring that all hospice binders include updated resident bed mobility status, residents with amputees have the proper sling being utilized, residents requiring mechanical lifts for transfer have the proper sling size being used. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 689	Continued From page 49 "provide education to ancillary staff." 4/8/22 11:15 AM- R104 rolled off the bed while having incontinence care performed unassisted by E45 (Agency CNA) and landed onto a fall mat. The fall resulted in R104 being transferred to the hospital and being diagnosed with a right femur fracture. 4/8/22 11:25 AM- E45's Witness statement documented, "I was doing my residents care and turned around to put brief in trash bag on the floor. When I look (sic) back over, the resident was on the floor with floor mat under her. The bed was at waist length (sic) because I'm 5'7". I told the nurse right when I seen (sic) her fall." 4/8/22 11:45 AM- E6 (RN/Unit Manager) provided On the Spot Education/Coaching to E45 (Agency CNA). 4/8/22 12:48 PM- The monthly Documentation Survey report revealed that E45 erroneously signed off R104's CNA Task of "Bed mobility Assist X2" as "4 (total dependence) with 3 (two+ person) physical assist." 4/8/22 7:52 PM- The hospital Trauma History and Physical/ Consult documented "CT (computed tomography scan) of the abdomen/chest/pelvis did show patient did have a (sic) intertrochanteric (extracapsular fracture of the proximal femur) fracture on the right hip." 4/9/22 12:58 AM- The hospital History and Physical documented, "Assessments/Plan- fall while briefly unattended ...Right hip pain ...intertrochanteric fracture of right hip."	F 689	week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 689	Continued From page 50	F 689		

4/11/22- Despite already being documented as a "2 person assist" for bed mobility (Care Plan 3/1/22), R104's Care Plan was revised to add under the fall care plan focus "2 person bed assist for all care."

4/14/22 12:12 PM- The hospital Discharge Summary documented, " ...following a fall she (R104) was found to have intertrochanteric fracture of the right hip and fracture of the sacrum (large triangular bone at base of the spine). He (sic) underwent operative repair on April 9."

6/1/23 10:20 AM- During an interview, E6 (RN/Unit Manager) stated that the facility process for training agency CNAs involved "a book at the Main desk that they have to read." When asked about Agency CNAs' access to PCC (Point Click Care- electronic documentation), E6 stated, "They have their PCC sign-on prior to coming on the floor and have access to the TASKs tab so they can see what they need to do for the resident."

6/1/23 1:12 PM- During an interview, E65 (Scheduler) stated that the Orientation book for Agency staff is "kept at the office at the Main Desk ... the Hospice Aides and staff, as well as Agency staff have to read and sign off on the Orientation book prior to working on the floor."

6/8/23 11:10 AM- E1 (NHA) stated that she "was not able to find E45's Agency CNA Orientation sign in sheet." E1 stated, "There was no group education after either of R104's falls- only On the Spot educations with the specific CNA each time." Additionally, E1 confirmed that Agency and Hospice staff are made to read and sign off on the facility Orientation book kept at the Main desk

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 689	Continued From page 51 prior to working with residents on the floor. 2. Review of R221's clinical record revealed: 2. 7/11/22 - R221 was admitted to the facility with diagnoses including, but not limited to, orthopedic aftercare following surgical amputation of the legs. 7/12/22 - R221 was care planned for the potential for falls with interventions that included, but were not limited to, bed mobility with assistance of two staff and transfers with assistance of two staff with a Hoyer lift (mechanical lift). 7/13/22 - A Physician's order reordered R221's transfer status of assistance of two with a Hoyer lift and bed mobility assistance of two staff with an end date of 8/5/22. 8/15/22 - A Physician reordered R221's transfer status as above (7/13/22) with an end date of 12/2/22. 10/12/22 - The quarterly MDS assessment documented R221 as cognitively intact, bed mobility required extensive assistance with two person physical assist and total dependence for transfers with two staff assist. The MDS also indicated that transfers between the bed and chair or wheelchair as not steady and only able to stabilize with staff assistance. 12/1/22 at 1:07 PM - A nurse's note documented staff were called to R221's room, the resident was lying on the floor, the base of the Hoyer lift was under the resident's head and R221 reported a headache, left rib pain and left elbow pain. The resident was sent to the Emergency Room (ER).	F 689		

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F 689	Continued From page 52 12/1/22 at 1:35 PM - According to the nurses note, the assigned CNA (E24) notified the Nurse that R221 fell from the sling (that connects to the Hoyer lift) to the floor. Per the note, the Nurse went to the room and found the resident lying on the floor on his left side. The resident reported hitting his head, was assessed and found to have a headache, left rib pain and left elbow pain. R221 was sent to the ER for further evaluation. 12/1/22 - Per a witness statement, E24 (CNA) was transferring the resident with two people, R221 fell out of the lift, and she went to get the Nurse. 12/1/22 - Per a witness statement, E28 (CNA) was asked to assist with the transfer and, as soon as the lift was away from the bed she reached out for the chair, looked back and the resident was on the floor. 12/7/22 - The root cause analysis submitted by E2 (DON) documented that R221 was transferred from the chair to the bed using a mechanical lift sling with assistance of two staff. However, the incorrect type of sling was utilized. The resident was a bilateral above the knee amputee and the split leg/divided leg sling was used. R221 returned to the center from the ER with a diagnosis of a left rib fracture. 6/7/23 at 9:32 AM - During an interview, E24 (CNA) stated that she "didn't have the proper sling and that she had the one that crisscrossed. (R221) just slipped through the sling." She reported, " it wasn't her by herself. She had another aide with her. They then had the Nurse come. They didn't pick him up, they used the	F 689		

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F 689	Continued From page 53	F 689		

Hoyer lift to get him off the floor. Right away the Administrator inserviced us that day. E24 reported that the Administrator showed them how it's done."

6/7/23 at 10:32 AM - During an interview, E28 (CNA) stated that she "went into the room to assist with transferring the resident." She stated that "the other E24 (CNA) already had him in the sling and when they went to lift him up, he just fell through." She reported that "an inservice on use of the full body sling was given right away and included written information and demonstration." She stated that "the full body sling is what they use for transferring the resident now."

6/7/23 at 3:15 PM - During an interview with E1 (NHA), E1 revealed there was no reevaluation or repeat of the Hoyer lift competencies after the 12/1/22 inservice. The facility failed to ensure that the proper mechanical lift device (sling) was used to transfer R221 and subsequently a left rib fracture was sustained.

3. Review of R24's clinical record revealed:

2/5/16- R24 was admitted to the facility.

7/27/16- R24's transfer order stated, "Hoyer lift and purple sling with assist of 2 for transfers. Assist of 2 with bed mobility."

3/14/23 7:23 PM- A Health Status Note in the Electronic Medical Record (EMR) revealed that R24 was being transferred from the wheelchair to the bed by two staff members (E25 CNA and E26 LPN) and "She started to slide out of the sling of the Hoyer lift. She was lowered down to the floor

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 689	Continued From page 54 by the CNA. No pain observed but some redness was noted to her left elbow." 3/15/23- R24's post fall therapy evaluation stated, "No therapy needs, refer to nursing." 4/11/23- Per the EMR, R24 was noted with redness, pain and swelling to her right foot. 4/12/23- R24 was ordered an Xray of the right foot which revealed a mildly displaced and impacted (pressed firmly together) subacute comminuted (producing multiple bone splinters and fragments) fracture of the distal tibia and a nondisplaced subacute oblique fracture of the distal fibula at the level of the ankle joint. R24 was sent to the ER for evaluation and received an order to follow up with Orthopaedics. 4/12/23- The investigation was completed by DON (E2) and stated that the fractures were "most likely" obtained when R24 had a coughing spasm that might have caused her right ankle to roll over and then slide off the footrest after she was placed in her chair. 4/21/23- R24 was seen by the Orthopedic Specialist (E31) whose finding stated, "This fracture may be from a month or so ago as there is already evidence of early healing." 4/24/23- R24's therapy order stated- foam padding to the wheelchair leg. 6/1/23 10:00 AM- R24 was sitting on a green sling in the wheelchair in her room. 6/1/23 10:30 AM- R24 was sitting on a green sling in the wheelchair in her room. E25 (CNA)	F 689		

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F 689	Continued From page 55 confirmed the sling was incorrect and stated, "It should have been a purple one." E6 (RN, Unit Manager) also confirmed the sling was incorrect and stated, "I have to follow up with the staff." 6/1/23 12:05 PM- E6 provided a list of eight (8) staff members who were educated today for "Sling for lifts to match color in task- not left under resident once in chair." 6/8/23 2:30 PM- Findings were reviewed during Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for four (R6, R24, R80 and R89) out of five sampled residents for respiratory care, the facility failed to change the oxygen tubing, in addition, the facility failed to follow the manufacturer's instructions for cleaning the oxygen concentrator's filter for R80 and R89. For R6, the facility failed to ensure that staff used sterile gloves when providing respiratory care to R6 during a procedure that required the use of	F 695	A-R89 no longer resides at facility. There is no opportunity to correct the alleged deficiency.¿ R6, R24, R80 oxygen tubing has been changed.¿ R24 oxygen supplies for trach/stoma care has been placed in residents room. R 80 and R89 oxygen filters have been cleaned according to the manufacturers instructions.	7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 56 sterile gloves. For R24, the facility failed to provide emergency tracheostomy (trach- an opening surgically created in the neck into the windpipe to allow air to fill the lungs) and as needed (PRN) oxygen supplies for trach care. Findings include: Review of the manufacturer's recommended instructions to clean the oxygen concentrator filter included: 1. Remove the filter and clean at least once a week depending on environmental conditions. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. Note environmental conditions that may require more frequent cleaning of the filters that include high dust and air pollutants. 1. Review of R80's clinical record revealed: 8/30/22 - R80 was admitted to the facility with diagnoses including lung cancer. 2/16/23 - A Physician's order listed: Oxygen two liters a minute by nasal cannula, continuous every shift. 2/16/23 - A Physician's order listed: Clean oxygen concentrator filter one time a day for oxygen use. 2/22/23 - A Physician's order listed: Change oxygen tubing one time a day every Wednesday. 5/26/23 9:16 AM - An observation of R80's oxygen filter revealed the filter had layers of gray dust particles, additionally, R80's tubing was dated 3/8/23.	F 695	E42 (LPN) was educated about using sterile gloves when changing the inner cannula of R6□s tracheostomy. B- Residents residing at the facility requiring oxygen have the potential to be affected by this deficient practice.¿ Residents having a tracheostomy have the potential to be affected by this deficient practice. C-Staff Educator/designee will educate licensed staff on the need to change oxygen tubing according to facility P&P and to ensure all supplies to deliver stoma/Trach care PRN are in the room. Staff Educator/designee will educate licensed staff on the need for cleaning of the oxygen concentrator filter.¿ Staff Educator/designee will educate licensed staff on the need to use sterile technique when changing the inner cannula when providing trach care. RCA: Facility failed to ensure oxygen tubing was changed on R89, R80, R24 and R6 according to physicians orders.¿ Facility failed to ensure the filter for the oxygen concentrator was cleaned on R80 and R89 and facility failed to ensure that sterile gloves were used when changing the inner cannula when providing trach care. Failed to ensure for R24 that oxygen supplies for trach/stoma supplies were in the room. Facility staff failed to observe weekly that oxygen tubing was changed per physician	

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F 695	Continued From page 57 5/26/23 11:43 AM - During an observation with E4 (LPN) said, "Yes, the tubing is dated 3/8/23 and the filter is dirty." 2. Review of R89's clinical record revealed: 3/30/23 - R89 was admitted to the facility with a diagnosis of Chronic Obstructive Pulmonary Disease. 3/30/23 - A Physician's order listed: Oxygen four liters a minute by nasal cannula, continous every shift. 3/30/23 - A Physician's order listed: Clean concentrator filter one time a day for oxygen use. 4/5/23 - A Physician's order listed: Change oxygen tubing one time a day every Wednesday. 5/26/23 9:20 AM - An observation of R89's oxygen filter revealed the filter had layers of gray dust particles, additionally, R89's tubing was dated 5/11/23. 5/26/23 11:46 AM - During an observation with E4 (LPN) said, "Yes, the tubing is dated 5/11/23 and the filter is dirty." 3. 2/5/16- R24 was admitted to the facility. 8/17/19- R24's orders included, but were not limited to- Oxygen at 2 Liters per minute via trach stoma (trach site on the neck) as needed to maintain oxygen saturations (noninvasive way of monitoring blood oxygen levels) over 92%.	F 695	orders. Nursing administration failed to ensure oxygen tubing had been changed weekly. Facility failed to educate nursing staff on cleaning concentrator filters weekly while changing oxygen tubing. Nursing administration failed to ensure oxygen supplies for R24 for PRN Trach/stoma were in the room. LPN had been previously educated on trach care but failed to follow sterile technique by not using sterile gloves when changing the inner cannula. LPN was reeducated at time of occurrence and had successfully demonstrated use of sterile technique. Staff Educator will continue to observe LPN for use of sterile technique during trach care. Facility process change will include 11-7 supervisor weekly observing residents with oxygen needs to ensure that oxygen tubing has been changed and concentrator filters have been cleaned. 11-7 supervisor will also ensure oxygen supplies for trach/stoma's are in the room. Staff Educator will ensure sterile gloves are used when changing the inner cannula when providing trach care by conducting trach care competencies with nursing staff annually, as needed, upon hire and including agency staff. D-DON/Designee will complete weekly audits of correct date on oxygen tubing,	

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F 695	Continued From page 58 Stoma care every shift and as needed. Suction as needed for increased secretions. 8/17/19- R24's Care plans were revised to include, but were not limited to- R24 has altered respiratory status related to Chronic Obstructive Pulmonary Disease and utilizes oxygen therapy. Provide oxygen at 2 liters per minute via nasal cannula (tubing used to deliver supplemental oxygen) to keep oxygen saturations above 95%. R24 has ineffective airway clearance related to accumulation of tracheobronchial secretions, moisture at stoma and inability to mobilize secretions. 8/17/19- R24's care plan interventions included, but were not limited to- Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions. Provide oxygen as ordered. Suction as needed. Treatment to trach stoma as ordered. 5/26/23 10:30 AM- R24's trach stoma site was noted with a large area of thick yellow secretions (a clothing protector was on her neck/chest area.) A suction machine was on a table beside the bed, however, a suction cannister, tubing, sterile water, oxygen tank/concentrator and tubing for PRN oxygen use were not found in the room. The Surveyor spoke to E6 (RN) about the secretions. E6 stated that the resident usually received care "depending on the Aide. The Aide is currently giving a shower and will take care of her soon." 5/26/23 10:45 AM- R24 was noted with a clean	F 695	cleanliness of concentrator filters, and supplies for trach/stoma care are in room.¿ DON/Designee will observe random trach care to ensure that sterile gloves are being used during changing of the inner cannula. Audits will be conducted weekly until 100% success over 3 consecutive evaluations, and then continue monitoring bi-monthly until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 695	Continued From page 59 dressing on the trach site. Absence of emergency trach(s) and PRN O2 (oxygen) supplies were confirmed with E6. When asked what would happen if R24 needed emergency respiratory care, E6 stated, "We would have to get supplies and call the respiratory team." E6 did not answer when asked what would happen if R24 had an emergency respiratory event in the middle of the night. 5/26/23 11:05 AM- The absence of an emergency trach and PRN 02 supplies were confirmed with E2 (DON.) When asked what the staff would do if the resident was in respiratory distress E2 stated "Obviously they would not be able to do anything." E2 further stated, "They would call a respiratory code and the respiratory team would come with the cart." E2 did not answer when asked what would happen if R24 had an emergency respiratory event in the middle of the night. 5/26/23 12:05 PM- E2 entered the conference room with a bin containing respiratory supplies. E2 stated, "This was in the resident's drawer." The Surveyor stated that the resident's supply drawers were checked and supplies were not found. E2 returned at approximately 12:15 PM and stated, "The staff told me they just put the supplies in the drawer." 5/26/23 12:30 PM- An Emergency trach and PRN 02 supplies were observed in R24's room. The Tracheostomy Care Policy, revised 2/2022, revealed under General Guidelines: "1. Aseptic technique must be used: ... c. During tracheostomy tube changes. 2. ...Sterile gloves must be used during aseptic procedures."	F 695		

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F 695	Continued From page 60 4. 8/2/18 - R6 was admitted to the facility with chronic respiratory failure and a tracheostomy (trach). 3/28/23 - A Physician order was written to change R6's tracheostomy inner tube every day and as needed. 5/31/23 10:30 AM- An observation of R6's trach care revealed that E42 (LPN) did not use sterile gloves when changing the inner tube of R6's trach. 6/1/23 1:30 PM - An observation of R6's trach care revealed that E42 (LPN) did not use sterile gloves when changing the inner tube of R6's trach. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 6/8/23 at 2:30 PM.	F 695		
F 756 SS=E	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	F 756		7/26/23

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F 756	Continued From page 61 (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 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 interview, it was determined that for three (R34, R117 and R222) out of six residents sampled for medication review, the facility (Nursing and/or Physician) failed to consistently act on irregularities identified during Medication Regimen Reviews (MRRs) by the Pharmacist. Findings include: Review of the Medication Regimen Review (MRR) policy, dated May 2019, stated, "The consultant pharmacist reviews the medication regimen of each resident at least monthly ...the attending physician documents in the medical record that the irregularity has been reviewed and	F 756	A-R222 no longer resides at the facility. There is no opportunity to correct the alleged deficiency. R34's NP did not agree with the pharmacy recommendations and resident continues on his Prilosec. R34 Eliquis order was updated in PCC to specify that the medication was related to Atrial Fibrillation. R117's Ativan order was changed to 14 days.	

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F 756	Continued From page 62 what (if any) action was taken to address it. The consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record." 1. Review of R222's clinical record revealed: 6/7/23 - R222's MRRs from November 2022 - February 2023 were reviewed. The Pharmacist identified irregularities on 12/31/22, 1/24/23, 1/27/23, 2/24/23 and 2/28/23. 1. a. Consultant Pharmacist Recommendations to the Physician on the following dates revealed: 1/24/23 - "The resident has been taking Protonix 40 mg QD (once a day) since 12/1/22 for GERD (Gastroesophageal Reflex Disease). It is recommended to review the PPI (Proton Pump Inhibitor) use after 12 weeks of therapy. Chronic PPI therapy has been associated with many potential adverse side effects, and the increased risk for pneumonia or C. Difficile diarrhea which maybe related to bacterial overgrowth. If indicated can the Protonix therapy be discontinued at this time? If therapy is still indicated would a decrease in dose be of benefit?" 2/24/23 - "Can we have a stop date for the Fexofenadine (antiallergy medication) therapy? Resident has been receiving Fexofenadine 180 mg QD for congestion since 1/4/23...". There was no response by the Physician found in the clinical record. 6/8/23 11:45 AM - In an interview, E2 (DON)	F 756	B- All residents residing at the facility have the potential to be affected by this deficient practice. C-Don/designee will provide education to the nursing administration along with the medical director/designee on the importance of timely responses to the monthly consultant pharmacist recommendations. RCA: : Facility failed to consistently act on irregularities identified during Medication Regimen Reviews by the Pharmacist. The facility failed to follow up to ensure that these recommendations were completed timely. Once the unit managers received the initial recommendations there was no follow up to ensure that the recommendation were completed or discussed with physician. DON /designee has initiated a new process for follow up of recommendations. Upon receipt of recommendations DON will distribute to appropriate units and keep a copy to reconcile that all recommendations have been addressed appropriately and timely. NP is aware of this process and will address recommendations separately with the unit manager to ensure proper follow through in a timely manner. D- Don/designee will perform daily audits of residents pharmacy recommendations to ensure that recommendations have	

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F 756	Continued From page 63 stated that E48 (NP) addressed these issues with the resident. E2 also confirmed that no signed and dated Physician response was found in R222's clinical record. 1. b. Consultant Pharmacist Recommendations to Nursing Staff on the following dates revealed: 12/31/22 - "The physician agreed with the previous pharmacy recommendation to discontinue the Hiprex (antibiotic) therapy on 12/6/22. This change has yet to be made in the orders. No progress note has been made on the recommendation... Please update the orders to Discontinue the Hiprex therapy at this time per the agreed recommendation." 1/27/23 - As above on 12/31/22. 2/28/23 - As above on 12/31/22 and 1/27/23. There was no response by Nursing found in the clinical record. 6/8/23 10:24 AM - In an interview, E2 (DON) stated that nursing staff was unable to pick up the pharmacy recommendation and confirmed that the Physician's agreement to discontinue the order for Hiprex was not followed through by Nursing. 2. Review of R117's record revealed: 6/6/23 - Review of R117's MRR's from January 2023 - May 2023 revealed that the Consultant Pharmacist identified irregularities on the 2/26/23 and 3/30/23 MRR's. Consultant Pharmacist Recommendations to Physician on the following dates revealed: 2/26/23 and 3/30/23 - "Resident has a current	F 756	been acted upon and that physician signatures have been obtained.. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 756	Continued From page 64	F 756		

order for Ativan prn. CMS regulations require that all prn psychotropic are limited to a duration of 14 days. Can the prn Ativan therapy be discontinued at this time? If the Ativan therapy is to continue for more than 14 days, the prescriber must document the rationale in the medical record and indicate the duration of therapy for the prn order."

There was no response by the Physician to the 2/26/23 and 3/30/23 Consultant Pharmacist Recommendations found in the clinical record.

6/7/23 1:15 PM - In an interview, E2 (DON) confirmed that the 2/26/23 and 3/30/23 Consultant Pharmacist Recommendations to Physician did not contain a signed and dated Physician/Prescriber response in the clinical record.

3. R34's clinical record revealed:

2/1/22- R34 was admitted to the facility.

5/31/23 1:59 PM- R34's MRRs for the months of January through April 2023 revealed:
-- 1/24/23- no recommendations.
-- 2/24/23- recommended the discontinuation of Prilosec (medication for gastric reflux). The MRR was not signed by E20 (PCP).
--3/29/23- recommended an update on the diagnosis for Eliquis, which was inappropriately documented as "anticoagulant." The MRR was not signed by E20.
--4/23/23- recommended the discontinuation of Prilosec. The MRR to Physician was again not signed by a Provider.

5/31/23- The April 2023 MRR was signed by E48 (NP- a Provider) and stated disagreement to the

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F 756	Continued From page 65 recommendation and "will continue, therapeutic." 5/31/23 2:07 PM- R34's Eliquis order was updated in the PCC by E6 (RN/Unit Manager) to specify that the drug was "related to Atrial Fibrillation." 6/8/23 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	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 review of facility documentation and	F 757	A-R222 no longer resides at the facility,	7/26/23

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F 757	Continued From page 66 interviews, it was determined that for one (R222) out of six residents sampled for medication (med) review, the facility failed to ensure that the residents were free from unnecessary meds. The facility failed to discontinue the antibiotic med Hiprex from 12/6/22 until 3/26/23. Findings include: Review of R222s clinical record revealed: 4/2/21 - R222 was admitted to the facility. 11/25/22 - A Consultant Pharmacist Recommendation to Physician revealed, "Resident has a current order for Hiprex 1 gram BID (twice a day) for prophylaxis. An acidic urinary ph, below 6.0 is recommended when administering Hiprex. The antibacterial activity of Hiprex is greater in acid urine, especially when treating infections due to urea-splitting organisms such as Proteus and strains of Pseudomonas. Her most recent labs completed 7/15/22 shows her urinary ph to be greater than or equal to 9.0. Is therapy indicated at this time?...". 12/6/22 - The facility Physician, E20 (MD), signed and agreed to discontinue the medication Hiprex per the pharmacy recommendation. 6/8/23 9:27 AM - Review of Consultant Pharmacist Recommendations to Nursing staff from December 2022 through February 2023 repeatedly revealed: "The physician agreed with the previous pharmacy recommendation to discontinue the Hiprex therapy on 12/6/22. This change has yet to be made in the orders. No progress note has been made on the recommendation... Please update the orders to Discontinue the Hiprex therapy at this time per	F 757	no opportunity to correct the alleged deficiency. B- All residents residing at the facility have the potential to be affected by this deficient practice. C-- Don/designee will provide education to the licensed nursing staff on following the agreed upon recommendations between the Pharmacist and the Physician orders for discontinuing a medication timely. RCA: Facility failed to ensure that the resident was free from unnecessary medication and failed to discontinue her antibiotic based on Pharmacist recommendations and Physician agreement. Once the unit managers received the initial recommendations there was no follow up to ensure that the recommendation were completed or discussed with physician. DON /designee has initiated a new process for follow up of recommendations. Upon receipt of recommendations DON will distribute to appropriate units and keep a copy to reconcile that all recommendations have been addressed appropriately and timely. NP is aware of this process and will address recommendations separately with the unit manager to ensure proper follow through in a timely manner. D- Don/designee will perform daily audits	

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 757	Continued From page 67 the agreed recommendation." 6/8/23 10:00 AM - Review of R222's December 2022 through March 2023 eMAR (electronic Medication Administration Record) revealed that R222 continued to receive the antibiotic Hiprex until 3/26/23. 6/8/23 10:24 AM - During an interview, E2 (DON) confirmed that the Pharmacist's recommendation and Physician's agreement to discontinue Hiprex administration on 12/6/22 was not followed up by Nursing until the last dose was administered on 3/26/23. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 757	of Pharmacy recommendations to ensure timely review and follow through of recommendations with physician. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 758	Continued From page 68 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and policy review, it was determined that for one (R34) out of six residents reviewed for MRR, the facility failed to ensure for R34 that the PRN psychotrophic medication, Xanax, was limited to a 14 day duration or to have the Provider document the reason for a prolonged period of PRN psychotrophic	F 758	A-R34 PRN psychotropic medication was changed to a routine order. B- All residents residing at the facility, who receive PRN psychotropic medications, have the potential to be affected by this deficient practice.	

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F 758	Continued From page 69 medication (30 days). Findings include: Cross refer to F756 Review of the Medication Regimen Review (MRR) policy, stated, "The consultant pharmacist reviews the medication regimen of each resident at least monthly ...The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: ...a. medications ordered in excessive doses or without clinical indications ...g). incorrect medications, administration times or dosage forms; or...". R34's clinical record revealed: 2/1/22- R34 was admitted to the facility. 5/8/23 1:00 PM- E48's (NP) Progress note documented, "Resident lying in bed in no acute distress... Assessment: ...Generalized anxiety disorder Zoloft 50 mg 1 tablet daily. Monitor resident's mood and behavior. Redirect when able...". 5/12/23 11:21 AM- E48 ordered "Xanax Oral Tablet 0.25 mg (Alprazolam) Give 1 tablet by mouth every 12 hours as needed for anxiety until 6/12/2023 23:59 (11:59 PM)." 5/26/23 1:00 PM- E48's Progress note documented "She (R34) is seen lying in bed in no acute distress ... Assessment: ... Generalized anxiety disorder Xanax 0.25 mg, 1 tablet every 12 hours Zoloft 50 mg, 1 tablet daily. Continue to monitor resident's mood and behavior. Redirect when able. Continue with supportive measures."	F 758	C-staff educator/designee will educate licensed staff to review residents receiving PRN psychotropic medications for a stop date of 14 days and review by MD. RCA: The facility failed to ensure for R34 that the PRN Psychotropic medication, Xanax, was limited to a 14 day duration or to have the provider document the reason for a prolonged period of PRN psychotropic medication. The nurse receiving the order did not realize there was a stop date of 14 days for PRN psychotropic medications or to have the MD/NP document why they were extending the medication beyond the 14 days. D- Don/designee will perform daily audits of PRN psychotropic orders to ensure a stop date of 14 days and review by MD. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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F 758	Continued From page 70 6/8/23 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when 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, interview and review of a clinical record and other resources as indicated, it was determined that for one (R93) out of five sampled residents for medication review, the	F 761	A-R93 insulin medications have been secured in residents lock drawer. Wound care carts have been secured.	7/26/23

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F 761	Continued From page 71 facility failed to store R93's insulin medications in a locked compartment in her room as she was under transmission-based precautions for Candida auris (C. auris). In addition, the facility failed to ensure that the Christina wing wound care cart was secured (locked) and accessible only to designated staff. Findings include: 1. According to the Centers for Disease Control and Prevention's (CDC) fact sheet posted on their website, "Candida auris is an emerging multi-drug-resistant yeast (a type of fungus). It can cause severe infections and spreads easily between ... nursing home residents." (https://www.cdc.gov/drugresistance/pdf/threats-report/candida-auris-508.pdf) R93's clinical record revealed: 8/29/22 - R93 was care planned for C. auris colonization (bacteria existing in an area [wound] that cause local or systemic symptoms) and was placed on transmission-based precautions. 5/30/23 at 10:30 AM - Observation revealed that R93's two different types of insulin medication injection pens were sitting on top of an overbed table and not secured in a locked compartment in R93's room. Finding was immediately reviewed with E6 (RN/UM). E6 stated that her insulin medication pens were being kept in her room instead of the medication cart to prevent transmission of C. auris. 5/30/23 at 3:30 PM - During an interview, E6 (RN/UM) stated that R93's insulin medication pens and eye drops were placed and locked in R93's bedside table along with the needles and insulin test strips.	F 761	B- Residents residing at the facility under isolation precautions with transmission based organisms that require transmission based precaution have the potential to be affected by this deficient practice. Wound care carts are to remain locked on the units. C-Staff educator/designee will educate licensed staff on residents who are on isolation for transmission based organisms that require transmission based precaution to secure residents insulin medications in a locked drawer. Staff educator/designee will educate licensed staff on need to secure wound care cart on unit. RCA: Facility failed to secure R93 insulin medications in her room. Facility failed to secure wound care cart. Nursing staff was aware that the insulin medication was to be left in resident room but they were not aware that the medication should also be locked/secured in resident look as it would be in the medication cart. If a resident is on insulin medication with transmission based organisms that require transmission based precaution, the medication will be secured in resident room in locking drawer. Nursing staff failed to understand the importance of locking the wound care cart the same as they would a medication cart.	

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F 761	Continued From page 72 2. 6/1/23 9:55 AM - An observation of the Christina wing wound and supply storage cart revealed that the cart was unlocked and it contained resident prescription ointments. 6/6/23 10:00 AM - An observation of the Christina wing wound and supply storage cart revealed that the cart was unlocked and it contained resident prescription ointments. 6/1/23 9:55 AM - During an interview, E42 (LPN) verified that the cart was unlocked and that it should be locked. 6/6/23-10:00 AM - During an interview, E57, (LPN) verified that the cart was unlocked and that it should be locked. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 761	D- Don/unit managers/supervisors/designee will perform daily audits of residents on isolation for transmission, based organisms that require transmission based precaution to ensure proper storage of insulin medication in room. Don/unit managers/supervisors/designee will perform daily audits of wound care carts to ensure wound care carts on units are locked appropriately. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		7/26/23

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F 803	Continued From page 73 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that one (R154) out of seven residents received the correct meal as issued on their meal ticket. Findings include: Review of R154's clinical record revealed: 9/28/22 - R154 was admitted to the facility with a past medical history that included Dysphagia (difficulty swallowing). 11/12/22 - A diet requisition form for R154 that was signed off by the facility read, "Nutrient Content - Regular, Texture - Dysphagia Puree." 6/1/23 8:48 AM - During a random dining observation of R154's breakfast tray, the resident received a breakfast tray of regular consistency (all solids), despite his meal ticket reading, "Regular - Puree" texture.	F 803	A-R 154 did not receive the correct meal as issued on their meal ticket, corrected at time of occurrence. B- All residents residing at the facility have the potential to be affected by this deficient practice. C-Contracted foodservice group/designee will educate foodservice staff on ensuring residents receive correct meal as issued on their meal ticket. Staff educator/designee will educate nursing staff to ensure that the residents meal is appropriate as issued on their meal ticket prior to serving to the resident in rooms or in the dining room. RCA: Facility failed to provide resident with appropriate meal as issued on their meal ticket.	

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	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 803	Continued From page 74 6/1/23 8:50 AM - An interview with E33 (CNA) confirmed that R154 was not provided the correct tray and removed the breakfast tray. 6/1/23 9:02 AM - E33 returned with a new breakfast tray with the correct consistency of Regular-Puree for R154. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON) on 6/8/23, at approximately 2:30 PM.	F 803	The Kitchen failed to have a meal checking process in place at the time of occurrence. There was not a person responsible to ensure the residents were being served the appropriate meal as issued on their meal ticket. Food service director was not following up on the meal tray accuracy. New process for ensure residents are served the appropriate meal that was issued is to have a line checker at the end of the meal service line for each meal. The line checker will be responsible for double checking that the entire meal tray is correct before placing tray on the food cart. The director at the time of occurrence is no long employed at the building and the new director has been educated on this new process. CNA's on the units and in the dining room will be educated to ensure the residents meal is appropriate as issued on their meal ticket before serving to the resident. D- Food service director/designee will perform daily audits of meal trays (breakfast, lunch and dinner) for accuracy. Daily audits will be completed for 10 days until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if	

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F 803	Continued From page 75	F 803	100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
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 observations and interviews, it was determined that the facility failed to ensure proper food storage, food handling, and food service worker and Nursing staff personal hygiene. Findings include: The following were observed on 5/25/23 during the initial kitchen tour from 8:40 AM to 9:30 AM:	F 812	A- Kitchen hand sinks were cleaned at time of occurrence. Walk in refrigerator floor was cleaned at time of occurrence. Walk in refrigerator drain was repaired to prevent pooling of water from the condenser, Sheet trays were removed from walk in cooler. Kitchen is being power washed to ensure	7/26/23

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F 812	Continued From page 76 1. All the hand sinks were dirty and not cleaned; 2. The walk-in refrigerator floor was dirty; 3. The walk-in refrigerator was pooling water from the condenser; 4. The walk-in refrigerator was using dirty trays to hold vegetables; 5. The walls in the facility were not kept clean; Findings were reviewed and confirmed by E1 (NHA) on 5/25/23 at approximately 10:00 AM. Findings were reviewed during the Exit Conference with E1, E2 (DON), and E3 (ADON) on 6/8/23, at approximately 2:30 PM.	F 812	walls and areas around equipment are clean. B- All residents residing at the facility have the potential to be affected by this deficient practice. C- Contracted foodservice group/designee will educate foodservice staff on ensuring proper sanitation and food handling practices are in place. Contracted foodservice group/designee will educate dietary staff on new cleaning schedule being put into place. RCA: Food service staff failed to ensure hand sinks were clean, walk in refrigerator floor was clean, no dirty trays in walk in refrigerator, no pooling water on refrigerator floor from the condenser, and kitchen walls were clean. Food service director at time of occurrence did not have a cleaning schedule in place to effectively ensure proper sanitation and food handling practices were in place. This food service director is no longer employed at the facility. The New Food service director has instituted a daily cleaning schedule to ensure proper sanitation and food handling practices are in place and being followed. The cleaning schedule will include cleaning tasked of all areas of the kitchen on a daily basis. The cleaning schedule will be monitored daily by visual observations by food service	

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F 812	Continued From page 77	F 812	director/designee to ensure compliance. D- Food service director/designee will perform daily audits and visual observations of cleaning schedule to ensure proper sanitation and food handling practices are being followed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to effectively monitory and timely clean and sanitize areas of pest droppings. Findings include During the initial kitchen tour on 5/25/23 from 8:40 AM to 9:30 AM, it was observed that the dry storage shelf containing sugar had mouse dropping, mouse prints, and urine trails. E1	F 814	A-The dry storage shelf in the kitchen was cleaned upon discovery of signs of pest droppings. Cleaning will be performed daily to ensure sanitary conditions are maintained. B- All residents residing at the facility have the potential to be affected by this deficient practice.	7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 814	Continued From page 78 (NHA) was made aware and confirmed the finding at 10:00 AM. A second observation of the same location in the dry storage room was made on 5/31/23 at approximately 11:00 AM, and some of the original mouse droppings discovered on 5/25/23 were still there. E1 was made aware and confirmed the finding at 11:10 AM. Findings were reviewed during the Exit Conference with E1, E2 (DON), and E3 (ADON) on 6/8/23 at approximately 2:30 PM.	F 814	C- Contracted foodservice group/designee will educate foodservice staff on maintaining a sanitary condition to prevent the harborage and feeding of pests in dry storage room. RCA: Facility failed to effectively monitor and timely clean and sanitize areas of pest dropping. Food service director instituted a daily cleaning schedule to ensure proper sanitation and food handling practices are in place and being followed. Any signs of pests in the dry storage area will be logged in the Kitchen pest control book and maintenance will be notified. D- Don/designee will perform daily audits of dry storage room to ensure sanitary conditions are being maintained. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue once a month for 3 months after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 867 SS=F	QAPI/QAA Improvement Activities	F 867		7/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 06/08/2023

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F 867	Continued From page 79 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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F 867	Continued From page 80 prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms	F 867		

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F 867	Continued From page 81 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the QAA committee measured the success of actions, track performance and regularly review, analyze, and	F 867	A-Deficient practice was unable to be rectified at the time of occurrence. B- All residents residing at the facility have	

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F 867	Continued From page 82 act on data collected. Findings include: 6/8/23 9:08 AM - An observation of the facility's Quality Assurance Performance Improvement (QAPI) binder revealed the lack of audit tools for performance improvement project analysis. 6/8/23 9:45 AM - During an interview, E1 stated that performance project audit tools had not been created consistently for the analysis of performance projects in progress. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 867	the potential to be affected by this deficient practice. C-Staff educator/designee will educate QAA committee on ensuring to measure the success of actions, track performance and regularly review, analyze and act on data collected. RCA: Facility failed to ensure that the QAA committee measured the success of actions, track performance and regularly review, analyze and act on data collected. The QAA committee felt that after extensive in servicing and review that the areas of concern has been addressed and concerns resolved at that time. Process change will include additional monitoring and auditing of concerns that have been brought to the QAPI/QAA committee. The committee will conduct routine risk meeting to ensure that the facility is continuing to address and monitor concerns and that audits and competencies have been completed. During routine risk meetings and monthly QAPI/QAA meetings the committee will perform audits to ensure that concerns have proper follow up and monitoring in place to ensure data collected has been properly analyzed. D- NHA/designee will perform weekly audits to monitor for areas of performance improvement and monitor for successful completion of performance plans. Weekly	

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F 867	Continued From page 83	F 867	audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. QAPI audit attached. Audit will consist of identifying area of concern, reviewing weekly, continue to monitor and audit as needed until successfully completed performance improvement.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		7/26/23

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F 880	Continued From page 84 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. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 85 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 interview and review of the facility's Infection Control records, the facility failed to ensure that monthly tracking and surveillance data was collected and entered into the monthly Infection Control Logs and reviewed, analyzed and acted upon, if indicated. In addition, the facility lacked evidence that their IPCP (Infection Prevention and Control Program), including standards, policies and procedures were reviewed annually. Findings include: 1a. The facility's policy and procedure entitled "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes", last revised on 12/2016, stated, "... All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. resident name...; b. unit and room number; c. date symptoms appeared; d. name of antibiotic...; e. start date of antibiotic; f. pathogen identified...; g. site of infection; h. date of culture; i. stop date; j. total days of therapy; k. outcome; and l. adverse events."	F 880	A- Infection control book annual sign off was not in place at time of occurrence. B- All residents residing at the facility who have the potential to be affected by this deficient practice. C- NHA educated Infection Preventionist and staff development on completion of Annual review and sign off of infection control book. RCA: Facility failed to complete the annual review and sign off of the Infection Control Book. The facility did not realize that there needed to be an annual review and sign off of the Infection control book. Facility process change will include the NHA/designee to perform reviews of manuals/plans/assessment the start of each New Year. Reviews of Manuals/plans/assessment to date at this time. D- Don/designee will perform initial audit of all manuals/plans/assessments for review dates and updates. Audits will continue monthly until 100% success over	

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F 880	Continued From page 86 Review of the following months of surveillance data for residents treated for urinary tract infections (UTIs) revealed: -January 2023: for seven residents, the facility lacked data on pathogens; and for two residents, the facility lacked data on symptoms and date symptoms appeared. -February 2023: for three residents, the facility lacked data on room numbers and data on pathogens; and for two residents, the facility lacked data on symptoms and date symptoms appeared. -March 2023: for four residents, the facility lacked data on room numbers and data on pathogens; and for three residents, the facility lacked data on symptoms and date symptoms appeared. -April 2023: for seven residents, the facility lacked data on pathogens; for five residents, the facility lacked data on room numbers; for four residents, the facility lacked data on dates when symptoms appeared and for two residents, the facility lacked data on symptoms. -May 2023: for four residents, the facility lacked data on pathogens and dates when symptoms appeared; and for one resident, the facility lacked data on a room number. Without complete infection control surveillance data, the facility lacked the ability to review, analyze and conduct follow-up activity from January 2023 through May 2023. 1b. The facility's policy and procedure entitled, "Infection Prevention and Control Program" (IPCP), last revised in 2022, stated, "...The written infection control program shall be periodically reviewed by the facility and revised as appropriate."	F 880	3 consecutive evaluations, Audits will continue another month after that time, and if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Antibiotic Stewardship Program A- Antibiotic stewardship surveillance document was reviewed for organism type. B- All residents residing at the facility who have the potential to be affected by this deficient practice. C- Corporate Infection Preventionist educated Facility Infection Preventionist, DON, ADON, and Staff development on Antibiotic Stewardship program and surveillance completion to include identification of the organism and to ensure the tracking log is filled out in its entirety. RCA: Facility failed to document organism type to ensure proper antibiotic usage and failed to complete the tracking log in its entirety. Corporate IP nurse has educated current facility IP nurse on the importance of filling out all sections of the tracking log including data on pathogens, symptoms, date symptoms appear, and room number.	

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F 880	Continued From page 87 6/7/23 3:50 PM - Review of the facility's policy on "Infection Prevention and Control Program" lacked evidence that their IPCP including standards, policies and procedures were reviewed annually. 6/8/23 9:52 AM - Findings were discussed with E1 (NHA). Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (RN Risk Manager) on 6/8/23 at approximately 2:30 PM.	F 880	The lack of education was due to the fact that in a course of three or so months we had three different employees performing the IP job. It was not so much a lack of education on those in the IP spot but there was a lack of education to the ones filling in. Corporate IP Nurse has been and will continue to educate facilities IP nurse. Process change includes having our Admissions Director asking for any cultures received at the hospital or ER be sent to us at time of admission or readmission for review and tracking. RNAC/designee will also review new admissions and readmission in DHIN for this information in the hospital records. D-Don/Designee will perform daily audits of the cultures received to ensure identification of organism for proper Antibiotic usage .Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 943 SS=E	Abuse, Neglect, and Exploitation Training	F 943		7/26/23

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F 943	Continued From page 88 CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to provide training to three out of four of the Unit Managers (E6, E9, and E66) regarding the procedure for reporting incidents of abuse or neglect as evidenced by the Unit Managers (UM) being unable to or incorrectly state the time frame that such incidents need to be reported to the State Agency. Findings include: Cross refer F609 1a. 10/4/22 - E6 (RN/Unit Manager) completed Abuse and Neglect training inservice. 11/10/22 - E6 completed Abuse and Neglect training inservice. 5/15/23 4:45 PM - E6 completed Relias'	F 943	A-Deficient practice was unable to be corrected at the time of occurrence. B- All residents residing at the facility have the potential to be affected by this deficient practice. C- Staff educator/designee will educate staff in all departments with resident access on what constitutes abuse, neglect, exploitation or mistreatment and the need to report immediately to the supervisor of any suspected or mistreatment. Staff educator/designee will educate nursing administration regarding the need to report to the state agency within 2 hours after an alleged violation of abuse,	

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F 943	Continued From page 89 Preventing, Recognizing and Reporting Abuse training. 6/5/23 10:21 AM - During an interview, E6 (RN), whose hire date was 4/27/2009, stated, "The DON reports cases of suspected abuse or neglect during day shift. On the off shift or weekends when covering, I would report it." When asked about specific time frames for reporting, E6 stated, "I did not know there is one." 1b. 12/23/22 11:57 AM - E9 (LPN/Unit Manager) completed Relias' Preventing, Recognizing and Reporting Abuse training. 6/5/23 10:56 AM - During an interview with E9 (LPN), who was hired on 1/21/2020, E9 stated that "abuse and neglect need to be reported in 4 hours." 1c. 6/5/23 11:08 AM - During an interview, E66 (LPN/Unit Manager), who was hired on 2/22/23, stated, "Abuse and neglect need to be reported in 2 hours to the State... I don't have access to the State system, so the DON would need to report it on the computer." 6/5/23 1:20 PM - During an interview, E2 (DON) stated, "The RN Supervisors who do weekends and off shifts coverage have access to the State website. The LPN managers report cases of abuse immediately to me (DON) and then I (DON) put the reportable in." 6/8/23 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 and E3 (ADON).	F 943	neglect, exploitation or mistreatment is made. RCA: Facility failed to ensure unit managers were educated on the time frame and proper procedure for reporting incident of or mistreatment to the state agency timely. The allegation was initially reported as a concern and the supervisor failed to investigate timely or notify DON and NHA of the concern for reporting in the 2hour time frame. The nursing administration will contact the DON or Nursing Home Administrator immediately, with any allegations of abuse, neglect, exploitation or misappropriation to ensure proper notification has been completed to the state licensing department timely. D-Don/designee will review daily reports of abuse, neglect, exploitation or misappropriation for timely reporting to the state agency. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering	

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F 943	Continued From page 90	F 943	committee for three months or as needed for further evaluation or recommendation.	