DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: September 07, 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, emergency preparedness and extended survey was conducted at this facility from August 14, 2023 through September 7, 2023. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was ninety-two (92). The survey sample size was twenty-six (26) residents.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed 9/7/23: F550, F561, F584, F585, F600, F609, F655, F656, F657, F677, F695,	Please see POC for F550, F561, F584, F600, F609, F655, F656, F657, F677, F695, F711, F730, F756, F757, F760, F761, F773, F791, F803, F812, F842, F868 and F880	10/18/23

Provider's Signature Tawanna Green Title Administrator Date 10/09/23

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	F711, F730, F756, F757, F760, F761, F773, F791, F803, F812, F842, F868 and F880.		

Provider's Signature [signature] Title Administrator Date 10/05/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

(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 annual, complaint, emergency preparedness and extended survey was conducted at this facility from August 14, 2023 through September 7, 2023. The facility census was 92 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, emergency preparedness and extended survey was conducted at this facility from August 14, 2023 through September 7, 2023. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was ninety-two (92). The survey sample size was twenty-six (26) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CBC - Complete blood (cell) count; CG - Caregiver; CMP - Comprehensive Metabolic Panel; CNA - Certified Nursing Assistant; CO2 - Carbon Dioxide; COPD - Chronic obstructive pulmonary disease;	F 000		

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

Electronically Signed | 10/06/2023

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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DM- Diabetes;
DON - Director of Nursing;
GM - Gram;
L - Liter;
LPN - Licensed practical nurse;
MD - Doctor of medicine;
Meds - Medications;
MG - Milligrams;
Min - Minute;
MRR - Monthly Regimen Review;
NHA - Nursing Home Administrator;
NP - Nurse practitioner;
O2 - Oxygen;
OOB - Out of bed;
PRN - As needed;
Q - Every;
RN - Registered nurse;
SQ - Subcutaneously;
SSI - Sliding scale insulin;
TID- three times a a day;
UM - Unit Manager;

Acute Respiratory Failure - sudden condition that occurs when fluid builds up in the air sacs in lungs then lungs unable to release oxygen into blood and organs;
AC- before meals
ADLs (Activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;
anorexia- an eating disorder characterized by abnormally low body weight;
BMI (Body mass index)- a person's weight in kilograms divided by the square of height in meters. It screens for weight categories that may lead to health problems;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15.

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F 000	Continued From page 2 13-15 Cognitively intact 8-12 Moderately impaired 0-7 Severe impairment; Carbon Dioxide - (CO2) gas formed during breathing; Care Plan - outlines the plan of action that will be implemented during a patient's medical care; Cellulitis - inflammation of the tissues indicating a local infection; Cerebral Vascular Accident (CVA) - (Stroke) a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Chronic Obstructive Pulmonary Disease - (COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing; CMP (comprehensive metabolic panel) - blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function; Complete Blood Count (CBC) - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia; Conjunctivitis - Also known as Pink eye is the inflammation or infection of the transparent membrane that lines your eyelid and eyeball; Culture & Sensitivity (C&S) - laboratory test to identify what bacteria is causing an infection and which antibiotic will effectively kill the bacteria; Deliriun - acutely disturbed state of mind; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;	F 000		

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F 000	Continued From page 3 Diabetic ketoacidosis- a serious complication of diabetes in which the body produces an excess of blood acids (ketones). This condition occurs when there is not enough insulin in the body. Diabetes mellitus - more commonly referred to as "diabetes" - a chronic disease associated with abnormally high levels of the sugar glucose in the blood; Emergency Medical Services (EMS) - the sytem that provides emergency medical care, paramedics; Erythromycin - a broad-spectrum antibiotic; Extensive assist - while the resident performed partof the activity over the last 7 day period, help of following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last7 days; or resident involved in activity, staff provide weight-bearing support; Gerichair - wheelchair type - chair that reclines; Germicide - kills germs; Glucometer - an instrument for measuring the concentration of glucose in the blood; HbA1c- Hemoglobin A 1 c- a lab blood test that provides insight into a patient's blood sugar and diabetes management over the past 3 months; Heel Protector - A pillow-like boot that provides low friction cushioning to the heel; History and physical (H&P)- the initial formal document that physicians produce through interview with the patient, the physical exam and the summary of the testing either obtained or pending; Hospice - service that provides care to residents that are terminally ill; Hoyer lift - sling-type hydrolic lift; HumaLOG- a type of insulin; Hypoxia / Hypoxic - deficiency in amount of oxygen reaching body tissues;	F 000		

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F 000	Continued From page 4 ICD 10- the International Classification of Diseases, a coding system used for documenting diseases and billing in healthcare; Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own; Interdisciplinary Team - professional from different fields and departments who work together with the resident to develop and implement an individualized plan of care; Leukocytosis- abnormal elevated white blood cell count; MDS assessment- Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Medication Administration Record (MAR) - list of daily medications to be administered; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Mental status change - altered mental status most often refers to an abnormal change in a person's responsiveness and awareness. It can affect speech, thought, mobility, memory, attention span, or alertness. It can range from slight confusion to complete unresponsiveness (coma). Altered mental status can be a sign of a serious underlying medical condition; Metabolic derangement- a cluster of lab values that reflect the disruption of the body's normal metabolic processes; Minimum Data Set (MDS) - a standardized assessment form used in nursing homes; Nasal cannula - tube placed into nostrils to deliver	F 000		

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oxygen;
NIDDM- non-insulin dependent diabetic;
Ointment - a salve for application to the skin;
Ophthalmic - of, relating to, or situated near the eye;
Prostodontics - a specialized branch of dentistry dedicated to making artificial teeth;
Saturation/sats - the measure of the amount of hemoglobin that is bound to a molecular oxygen at a given time point;
Sliding scale insulin - commonly utilized to manage diabetes, where a finger stick blood glucose is obtained and the dosage of insulin is tailored to the level of the blood glucose;
Standing orders - provide written authorization for nurses, medical assistants, and other members of the healthcare team to complete certain clinical tasks without first obtaining a physician order;
Stat- used as a directive to medical personnel during an emergency situation; means :instantly" ot "immediately";
Subcutaneously - a route by which a medication is injected under the skin;
Synjardy- a fixed-dose combination anti-diabetic medication used to treat type 2 diabetes. it contains empagliflozin and metformin;
Torso - the trunk of the human body;
Three times a day (TID) - a common term used to describe the frequency that a medication is given to a patient;
Tramadol - a pain reliever used to treat moderate to severe pain in adults;
Urinalysis (UA) - diagnostic test used to detect and assess a disease or illness OR diagnostic test used to determine presence of infection;
Urinary Tract Infection (UTI) - bacteria in urine;
Urine culture and sensitivity (C&S) - a microscopic study of the urine culture performed to determine the presence of pathogenic bacteria

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F 000	Continued From page 6	F 000		
	in patients with suspected urinary tract infection;			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		10/25/23

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be

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F 550	Continued From page 7 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 random observation and interview, it was determined that for one (Unit 2) of two units reviewed, 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: 8/17/23 12:36 PM - The Surveyor observed that R15's lunch tray had plastic utensils. R15 was unable to pick up his grilled chicken caesar salad as the plastic fork kept bending as R15 tried to spear it with the plastic utensil. 8/17/23 12:40 PM - A random observation of Unit 2's lunch trays by the Surveyor revealed that seven rooms (229 B, 236 A, 236 B, 238 A, 238 B, 240 A and 240 B) out of thirty-six (36) rooms with lunch trays had plastic utensils on their tray. 8/17/23 12:49 PM - During an interview, E2 (DON) stated that she was not aware of any issues with the kitchen's dishwasher but "that is not my area." 8/17/23 12:49 PM - During an interview, when notified of the plastic utensils on lunch trays and asked if there was a problem with the dishwasher in the kitchen, E1 (NHA) stated, "That's a dignity issue. Let me check into that. They usually tell me if there is a problem with equipment."	F 550	A. R15 was immediately provided with metal silverware as well as all other current residents who are able to use silverware. B. All current residents who are able to use silverware have the potential to be impacted by deficient practice. C. Root cause analysis (RCA) was completed by the interdisciplinary team on 10/02/2023. It was determined that silverware was not being returned to the kitchen by nursing staff on meal trays after meal service, causing a shortage of silverware for the next meal service. Additional silverware was ordered during the survey. NPE/designee will provide education to all current nursing staff to ensure that silverware is returned to the kitchen post meal service. D. The Dietary Manager/designee will audit trays after meal service to ensure silverware is being returned post meal service. Audits will occur daily x three days or until 100% compliance is achieved, then weekly for three weeks or until 100% compliance is achieved, and then monthly for three months or until 100% compliance is achieved. Audit	

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F 550	Continued From page 8 8/18/23 9:20 AM - During a follow-up interview, E1 stated that there were no issues with the dishwasher on 8/17/23. E39 (kitchen supervisor) stated that "Sometimes the residents hoard the silverware but I have extra." E1 stated that she instructed E36 to utilize the extra silverware when E39 runs out of the standard silverware for the food trays. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 550	results will be presented to the QAPI committee for review. (AUDIT 1)	
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 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	F 561		10/25/23

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F 561	Continued From page 9 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 record review, observation, and interview, it was determined that for one (R264) out of five residents reviewed for activities of daily living (ADLs), the facility failed to get R77 out of bed in accordance with her preference. Findings include: Review of R264's clinical record revealed: 6/4/22 - Admission to the facility. A care plan initiated on 6/23/22 revealed, "Resident/Patient is at risk for or is experiencing adjustment issues related to: Change in customary lifestyle and routines and/or difficulty accepting placement in center." A care plan initiated on 6/23/22 revealed, "Review ADL status for impact on social involvement and provide ADL assistance, as needed, to increase social involvement." A care plan initiated on 7/23/22 revealed, "It is important for me to go outside when the weather is good and enjoys sitting/relaxing and smoking-on occasion." 10/11/22 - A physician's order documented the resident is a total lift with all transfers into wheelchair. An annual MDS dated 6/11/23 confirmed R77 is an extensive assist with most ADL's, requiring	F 561	A. R77 was immediately offered to get out of bed and was interviewed again to determine her get out of bed preferences and plan of care updated. B. All current residents who have the ability to communicate their get out of bed preferences have the potential to be impacted by this deficient practice. An audit was performed on 8/21/2023 to identify all current residents with the ability to communicate preferences for getting out of bed and their preferences were added to the CNA tasks. C. Root cause analysis was completed on 10/02/2023. The primary factor identified revealed current nursing staff assigned to R77 were not aware of Resident R77's preference at the time of the survey due to her daily changing preference for times to get out of bed. NPE/designee will provide education to current nursing staff related to communicating to those residents whose preferences change on a daily basis to confirm what time they would like to get out of bed at the beginning of their shift in effort to accommodate their preferences. D. The Director of Nursing/ designee will audit all current residents with get out of bed preferences to ensure the requests	

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F 561	Continued From page 10 assist of 2 (transfer, bed mobility, toilet, personal hygiene). 8/14/23 10:38 AM - R77 stated that she needs a Hoyer lift to get into her wheelchair, but there are not enough aides to get residents like her out of bed. R77 said that that she often has to wait until after 3:30 PM to get out of bed because staff are too busy. R77 said that once in the wheelchair, she likes to go outside and that it is good for her mental health to socialize with the other residents there. 8/15/23 approximately 2:52 PM - The surveyor was in R77's room after resident rang the call bell. E9 (CNA) acknowledged that resident wanted to get out of bed. R77 said, "It's 2:52." E9 responded, "I know, but you are a two-person lift. I can't lift you by myself. It's 'rounds time.'" "E9 stated that as soon as she can find someone else, she will get R77 out of bed. 8/15/23 3:04 PM - R77 was still in bed. R77 again stated she likes to get up and go outside to socialize with people because it is a "nice ambiance." R77 stated that not getting up really affects her mental health. R77 stated that when her roommate is out of bed, she was often in a wheelchair at the nurse's station. R77 said, "Even she likes to get out of bed." 8/16/23 8:31AM - An interview with R77 stated, she did not get out of bed on 8/15/23 until 3:41 PM. R77 said it is her preference to get out of bed closer to 2:00 PM. She said that after she was in her wheelchair in the hallway, she saw E9 (CNA) in the hallway. E9 had told resident she needed to leave at 3:00 PM.	F 561	are being met daily times three days or until 100% compliance is achieved, weekly times three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 2)	

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F 561	Continued From page 11 8/16/23 12:46 PM - R77 observed still in bed in hospital gown. 8/16/23 2:05 PM - R77 observed dressed and sitting in bed. R77 said she was waiting on "halter (sic) (hoyer lift)" and that an aide was coming in with it, so R77 can be moved. 8/16/23 2:30 PM - Surveyor observed R77 in a wheelchair in the courtyard. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 561		
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;	F 584		10/25/23

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F 584	Continued From page 12 §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 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two out of two resident units, the facility failed to provide a clean and homelike environment. Findings include: 1. 8/14/23 2:50 PM - During an observation of Unit 1, room 116 bathroom had scuffs noted on wall, the toilet was stained and appeared uncleaned and tiles behind the toilet were loose and elevated in the air. A repeat observation for room 116 on 8/18/23 9:22 AM revealed scuffs remained on wall and the toilet not cleaned. 8/14/23 9:52 AM - Room 120 revealed that the door handle to room did not engage with lock when the handle was turned. The bathroom had black stains noted on floor in multiple areas, stains noted around base of toilet and stains inside toilet. The hot water faucet knob was missing the end piece resulting in a flat edge	F 584	A. There was no negative impact to residents as a result of this deficient practice. Deficiencies cited for rooms 116, 120, 118, 119 and 201 were all corrected on 8/22/2023. B. All current residents have the potential to be impacted by this deficient practice. Audits of each resident room was performed 0n 10/05/2023 to identify and correct scuff marks, black stains around toilets, loose tiles, loose knobs and holes in the walls. C. Root cause analysis determined the deficiencies occurred due to lack of use of the TELS Work Order system.	

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F 584	Continued From page 13 exposed. A repeat observation on 8/18/23 at 9:24 AM revealed that the door handle was not functioning, the sink knob was still not replaced or repaired, and stains remain on the floor and inside toilet. 8/15/23 9:24 AM - Room 119 revealed the bathroom hot water knob was loose and moved inappropriately when turned. Also noted multiple holes in the wall facing the toilet. A repeat observation on 8/18/23 revealed that the sink knob remained loose and holes have not been repaired. 8/15/23 9:28 AM - Room 118 revealed a brown substance dripped on the floor next to the tube feeding pump. The bathroom revealed a brown substance smeared across the wall next to the towel bar. A repeat observation on 8/18/23 at 9:16 AM revealed the brown substance on floor was still present at the base of the tube feeding pump, as well as the brown smear noted on the bathroom wall near the towel bar. 8/18/23 10:29 AM - An interview with E6 (CNA) revealed the process of reporting disrepair was through the Unit Clerk who enters the work order in the system which notifies maintenance to complete the repair. 8/18/23 10:52 AM - An interview with E7 (housekeeping) revealed that multiple disrepairs from Unit 1 were reported. E7 will report disrepair to Unit Clerk and Maintenance department. Confirmed the disrepairs in room 116, 118, 119, and 120 on Unit 1. 2. 8/17/23 2:33 PM - During an interview, E9 (CNA) revealed that room 201 floods " ...when it storms the water goes under the unit on the wall	F 584	Additionally, flooding and water in rooms was caused by poor drainage in the gutters. The gutters have been cleared, stains cleaned. Rain since the survey has revealed no water is entering the rooms. Education (ATTACHMENT C) on the TELS system provided to the nursing current nursing staff and current management team by the Director of Maintenance/designee by 10/25/2023. D. The Director of Maintenance/designee completed an audit of all current resident rooms on 10/05/2023. Thereafter, audits to occur before new resident admissions. 10 rooms will be audited weekly x one month until 100% compliance is achieved, 10 rooms will be audited bi-weekly for two months until 100% compliance is achieved and 10 rooms to be audited monthly for three months until 100% compliance is achieved. Audit results to be reported and monitored by the QAPI Committee.	

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F 584	Continued From page 14 by the window. Staff or aides put blankets down or we mop it up. We all have reported it." 8/17/23 2:41 PM - An interview with E19 (CNA) stated room 201 continues to flood where they have told maintenance and the nurse about the issue. 8/17/23 2:55 PM - During an observation of Unit 2, room 201B revealed the wall molding peeling away from the wall, wall paint peeling off and floor tiles buckling from the wall. This wall is an exterior wall of the R26's room where a window and vent unit are located. An interview with R26 and CG3 (R26's daughter) revealed " ...the room floods every time it rains and nurses and staff put towels and blankets down." R26 uses plastic containers to keep personal belongings off the floor so they do not get wet. CG3 stated maintenance told her " ...they were supposed to fix it in May." 8/18/23 11:26 AM - An interview with E18 (Director of Maintenance) confirmed the flooding in R26's room " ...was an issue last year ...I haven't heard anything since." 8/18/23 11:39 AM - An interview with E1 (NHA) confirmed the finding of the R26's room. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON).	F 584		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		10/25/23

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F 585	Continued From page 15	F 585		

that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

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

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

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F 585	Continued From page 16 be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation	F 585		

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F 585	Continued From page 17 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to establish a Grievance Policy that informed the residents of their right to obtain written decision regarding their grievance. The posted grievance policy did not have the correct name of the current Grievance Official and contact information. Also, the grievance policy was not prominently displayed at wheelchair level in large print to accommodate wheelchair bound and /or poor visual acuity residents. The grievance box for completed grievance forms outside the main office is not marked as the grievance box nor is it at wheelchair level. Additionally for R70, the facility failed to inform R70 of the outcome of his grievance investigation or offer R70 a resolution to his grievance. Findings include: 1- Review of the facility revealed: 8/15/23 9:13 AM - The Surveyor observed three pin up boards on three different hallways that were covered with glass that displayed the typewritten Grievance/ Concerns Policy & Procedure as depicted in the 2023 Welcome packet. The posting stated E45 (former NHA) was the Grievance Official and stated his contact	F 585	A. R20 and R70 were not negatively impacted by this alleged deficient practice. B. All current residents have the potential to be impacted by this deficient practice. C. A root cause analysis was conducted on 10/02/2023. The primary factor identified was frequent change in Administration and no protocol for updating signage. 1 - The signage has been corrected/updated to reflect current Administration and to increase visibility. Font size on signage has been increased for visibility to residents in wheelchairs. 2 □ The current staff involved in Resident R70's grievance has been terminated. The grievance form has been updated to reflect completion. D. The Nursing Home Administrator (NHA)/designee will audit signage monthly until 100% compliance is achieved.	

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F 585	Continued From page 18 information in order to file a grievance. The pin up boards were located at approximately sixty to sixty-five inches from the floor. The font of the print was similar to the font of this paper. 8/15/23 10:34 AM - The 2023 Welcome packet, which was given to all residents upon admission to the facility, stated under Grievances/Concerns Policy & Procedure "...Grievances may be filed with the Administrator who serves as the Grievance Officer". 8/16/23 12:11 PM - During an interview, E1 (NHA) confirmed that E1 was the current Grievance Officer. 8/16/23 2:15 PM - The Surveyor observed a plastic pocket, letter size wall file on the left-hand side wall of the main office doorway that was not marked or labeled. This wall file did not have a lid and was located at approximately forty-eight inches from the floor. 8/17/23 10:45 AM - During an interview, E2 (DON) confirmed that the plastic pocket, letter size wall file on the wall outside the main office was the grievance mailbox. E2 also stated that the residents could also give the completed grievance form to the unit managers. 8/21/23 11:11 PM - R20, who was wheelchair bound, came out to the hallway outside the dining room, and stated that she (R20) was unable to read the policies in the glass-covered pin up board located on the hallway wall. 2- Review of R70's clinical record revealed:	F 585	Grievance forms will be audited weekly for 4 months until 100% compliance is achieved. Audit findings to be reported and monitored by the QAPI Committee.	

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F 585	Continued From page 19 6/16/22 - Review of R70's Grievance investigation revealed that the facility did obtain witness statements. The facility did report the concern to the State and completed an investigation. 8/18/23 1:15 PM - The 2023 Welcome Packet, which was given to all residents upon admission to the facility, stated under Grievances/Concerns Policy & Procedure "...A review of your grievance will be completed and you will be notified of resolution within 72 hours of filing your grievance." 8/18/23 2:05 PM - Review of the Grievance/Concern form for the 6/16/22 grievance was incomplete and did not delineate if the grievance was confirmed or not. It did state that the resolution was discussed with R70 face-to-face but did not state what the resolution was nor give the date of this conversation. The Grievance/Concern form for the 7/11/22 grievance was incomplete and did not delineate if the Grievance/concern was confirmed or not. It also did not state what the resolution of the grievance/concern was. 8/21/23 11:30 AM - During an interview, R70 did not recall the content of the conversation regarding the 6/16/22 grievance but did remember that he was spoken to regarding it. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 585		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		

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F 600	Continued From page 20 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R21) out of fourteen residents reviewed for abuse, the facility failed to ensure that R21 was free of sexual abuse by R6, a resident with a history of sexually inappropriate behavior. The facility's failure to monitor R6 allowed the sexual abuse of R21 on 5/22/22. An Immediate Jeopardy (IJ) was identified and due to the facility's corrective measures following the incident, this is being cited as an immediate jeopardy, past non-compliance with and abatement date of 5/24/22, which was verified by interviews and review of facility records. Findings include: OPS300 Abuse Prohibition Policy (Genesis) stated, "...The Center will implement an abuse prohibition program through the following: ...prevention of occurrences ...Federal Definitions: Sexual Abuse is a non-consensual sexual contact of any type with a resident... 5. Actions to prevent abuse, neglect ... 5.2 identifying, correcting and intervening in situations in which abuse, neglect	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 21 ... is more likely to occur; ... If the suspected abuse is patient-to-patient, the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. 6.3.1 The center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. 6.3.2 The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation...". 5/23/19 - R21 was admitted to the facility with diagnoses including schizophrenia and dementia. 5/24/19 - R6 was admitted to the facility with diagnoses including vascular dementia. 7/27/19 - Per an Incident report filed with the Department of Health Care Quality (DHCQ), E28 (former DON) documented that R6 initiated a sexually inappropriate interaction with R3, who was R6's cognitively impaired roommate at the time. This incident was documented to acknowledge that R6 (the perpetrator) had a known history of a sexually inappropriate interaction with another resident in the facility. 7/27/19 - R6 was moved to a double room without a roommate until a private room was available. 7/27/19 - E28 (former DON) updated R6's care plan with focus that R6 "... exhibits sexually inappropriate behaviors as evidenced by touching roommate's genitals ...Interventions included: explore [R6]'s history and available medical records for sexual abuse, sexual dysfunction, inappropriate sexual behavior, deviant sexual	F 600		

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practice or vulnerability to sexual victimization, monitor conditions that may contribute to inappropriate behaviors including psychiatric disorders, dementia, evaluate [R6]'s understanding of sexually inappropriate behaviors (triggers, coping mechanisms), evaluate for Psych/Behavior health consult, social services visits to provide support, as needed, divert [R6] by giving alternate objects or activities, familiarize [R6] with own belongings and surroundings, listen to [R6] and try to calm, remove [R6] from environment."

7/30/19 - R6 was evaluated by C1 (Psychiatrist) who recommended, "If possible, patient should be in a single room and monitored when out of his room."

8/1/19 - R6's care plan was updated with an intervention, "motion sensor to R6's doorway."

9/19/19 - E30 (MD) ordered "door alarm in place and functioning correctly, check every shift."

1/6/20 - A Psychiatry Consultant recommended fluoxetine (anti-depressant) 10 mg by mouth daily for "sexually disinhibited behaviors."

10/28/20 - R6 was moved to a private room.

11/1/21 - R6's fluoxetine dosage increased by Psych NP from 10 mg (milligrams) to 20 mg daily. Fluoxetine was being utilized for depression but was increased to treat R6's Compulsive Sexual Behaviors (CSB). This drug was known to cause drug-induced sexual dysfunction with a decrease in sexual desire and function.

3/4/22 - R6's quarterly MDS assessment

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F 600	Continued From page 23	F 600		

documented a BIMS score of 12, which is in the range of moderate cognitive impairment. In the Behavior section, R6 was documented as having no hallucinations/delusions, no aggressive or sexually abusive behaviors, no wandering and no refusals of care. In the Functional Status section, R6 was documented as independent for bed mobility and locomotion and required supervision for transfer, walk in room, dressing, toileting and personal hygiene.

4/22/22 - R21's quarterly Minimum Data Set (MDS) assessment documented a BIMS score of three, which indicated a severe cognitive impairment.

5/22/22 - Per a facility-reported Incident report to Department of Health Care Quality (DHCQ), R21 was involved in sexually inappropriate interaction with R6. R6 was deemed by police authorities to be the aggressor/perpetrator and R21 was the victim.

5/22/22 4:15 PM - E31's (LPN) Witness Statement documented, "... I was coming out of room (number) and I observed R6 standing in the doorway of his room. R21 was leaning against the wall holding the handrail facing the nurses' station. I observed R6 with his hand in R21's pants. R21's pants were moving. I said "Get out of there!" I told both parties to "Go to your room." R6 backed up into his room. R21 was led to his room."

5/22/22 5:58 PM - E32 (on-call MD) ordered 1:1 observation of R6 for sexual behaviors.

5/22/22 11:00 PM - Documentation of 1:1 observation of R6 was initiated.

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F 600	Continued From page 24 5/24/22 4:44 PM - E33's (MD) Progress note of R6 documented "... seen for inappropriate behavior. Reportedly had unwanted physical contact with another resident. Will discontinue fluoxetine and start sertraline (anti-depressant) to decrease libido...". 5/24/22 2:52 PM - For R6, E33 (MD) ordered "sertraline 50 mg by mouth daily for depression" and discontinued fluoxetine 20 mg daily. 5/25/22 - R6's care plan was updated with the following interventions: "private room" and "1:1 for inappropriate touching of other residents." 5/27/22 - E33 (MD) discontinued R6's sertraline 50 mg daily and reordered fluoxetine 20 mg by mouth daily. 9/15/22 - R6's Significant Change MDS assessment documented a BIMS score of 11, which is in the range of moderate cognitive impairment. In the Behavior section, R6 was documented as having no hallucinations/delusions, no aggressive or sexually abusive behaviors, no wandering and no refusals of care. In the Functional Status section, R6 was documented as requiring extensive assist with 2 staff for transfers; extensive assist with 1 staff for bed mobility, dressing, toilet use and personal hygiene, and supervision with physical assist of 1 staff for walking and locomotion. 11/16/22 - E33 (MD) discontinued 1:1 observation for R6 due to the decrease in functional status. 6/29/23 2:55 PM - E25 (NP) discontinued door alarm for R6 as it was "no longer needed."	F 600		

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F 600	Continued From page 25 8/15/23 through 8/21/23 - Observations by the Surveyor revealed that R6 remained in his room after being placed in his wheelchair by staff and the Surveyor never witnessed R6 self propelling his wheelchair inside or outside his room. 8/21/23 11:32 AM - During a combined interview, E19 (CNA) stated, "When the door alarm bongs, staff is suppose to visualize whether a staff member went in the room or if R6 is coming out. If R6 is coming out, R6 needs to be kept in someone's (staff) eyesight. No one person is assigned this." This statement was confirmed by E36 (LPN). 8/21/23 12:41 PM - Interview with E33 (MD) revealed that sertraline was started on 5/24/22 and discontinued on 5/27/22 because it was deemed that fluoxetine was a better drug for Compulsive Sexual Behaviors (CSB). E33 also stated that there was no order for "direct sight visualization" with the door alarm. E33 stated, "Staff were aware that they needed to do this." There was no evidence of any other sexual resident-to-resident incidents involving R6 after 5/22/22. 8/23/23 9 AM - Based on interviews and record reviews of facility documentation, an Immediate Jeopardy (IJ) was called and reviewed with the facility leadership, including E1 (NHA) and E2 (DON). During this conference, both E1 and E2 confirmed that to their knowledge, there had been no other incidents of sexually inappropriate contact by R6 with other residents. Both acknowledged that they did not work in the building at the time of the previous assault in	F 600		

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F 600	Continued From page 26 2019 and were unaware of the 2019 incident prior to the Surveyor bringing it to their attention. 8/23/23 3:30 PM - E1 (NHA) submitted an acceptable documentation of corrective action plan that was fully abated on 5/24/22 signed, dated and timed. The facility's corrective actions at the time of the incident included: - notifying the responsible party for both residents; - initiating 1:1 observation of R6; - notifying the police; - filing an incident report and follow up investigation with the State Agency; - consulting with the Medical Director; - obtaining labs on R21 to rule out medical issues; and - engaging Social Services to interview each resident. R6 remained care planned for this behavior. Due to the corrective actions taken by the facility after the 5/22/22 incident and no further sexual resident-to-resident incidents involving R6, this occurrence was deemed to be past non-compliance. 8/23/23 3:41 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 600		
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	F 609		10/25/23

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F 609	Continued From page 27 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R393) of fourteen (14) residents reviewed for abuse, the facility failed to ensure that an allegation of abuse was reported to the State Agency within the two hour time frame. Findings include: 8/2/23 - R393 admitted to the facility with diagnoses that included traumatic brain injury and epilepsy. 8/8/23 - R393's Minimum Data Set (MDS) Assessment documented moderate cognitive impairment, extensive two-person assist to transfer and use the toilet, frequently incontinent of bladder and always incontinent of bowel.	F 609	A. R393 was re-interviewed and did not offer any concerns related to current or previous allegations of abuse. B. All current residents have the potential to be impacted by this deficient practice. Current social services staff interviewed to determine if social services received any allegations of abuse within the last 30 days to ensure they were reported to the appropriate agency within a two hour time frame. C. A root cause analysis was completed by the interdisciplinary team on	

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F 609	Continued From page 28 8/9/23 - During an interview, E44 (CNA) alleged witnessing R393 as the recipient of a verbally abusive statement from E2 (DON) in which R393 was told to "just shit on himself ..." when R393 was asking to go to the bathroom. E44 then verbally reported this allegation to E8 (Social worker), who asked E44 to write a statement. 8/21/23 9:37 AM - The Surveyor was given a witness statement written by E44 (CNA) documenting R393 making an allegation of verbal abuse against another staff member. E44 stated, "I'm not sure what happened with this." 8/21/23 1:02 PM - During an interview, E1 (NHA) when shown the witness statement and asked about the investigation stated, " ...Where did you get that witness statement? I cannot investigate something that I don't know about. So, no, I don't have an investigation file for that." 8/21/23 1:37 PM - During a telephone interview, E8 (social worker) confirmed that after being verbally told on 8/9/23 of the interaction between E2 and R393, E8 " ...did ask E44 to write a witness statement. I spoke with the Administrator (E1). Then I interviewed the patient (R393) and his roommate (R43) at the direction of the Admin. Both denied the allegation. I did not write anything about the interviews down. This was the first time I dealt with this type of allegation. I have been working here one year. I know it [allegations of abuse] must be reported within two hours. The prior Administrator would do all the reporting to the State. I don't even know how to report in the State software." 8/21/23 2:50 PM - Findings were reviewed with	F 609	10/02/2023 which determined a need for re-education to the social services department related to OPS300 Abuse Prohibition and reporting of allegations of abuse within a two hour time frame to appropriate agencies. NPE/designee will provide re-education to current social services employees on OPS300 Abuse Prohibition with a focus on the proper sequence for investigation and reporting allegations of abuse. D. The Administrator/designee will audit 100% of reported abuse allegations to the social services department to identify that any allegations of abuse received by the social services department were acted upon within a two hour time frame. Audits will occur daily times 3 days or until 100% compliance achieved, weekly times 3 weeks or until 100% compliance achieved, and monthly times 3 months or until 100% compliance achieved to determine if OPS300 policy has been followed to ensure any events were reported within a two hour time frame. Audit results will be presented to the QAPI committee for review. (AUDIT 3)	

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F 609	Continued From page 29 E1, E2 (DON) and E3 (ADON).	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		10/25/23

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F 655	Continued From page 30 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R91 and R192) out of two new admissions reviewed the facility failed to ensure a written summary of their baseline care plan was provided. Findings include: 1. Review of R91's clinical record revealed: 6/16/23 - R91 was admitted to the facility. Review of R91's clinical record lacked evidence that the facility provided the resident and their representative with a summary of the baseline care plan. During an interview on 8/15/23 at 8:50 AM with CG1, it was reported that R91 and CG1 did not receive a copy of the baseline care plan summary. During an interview on 8/17/23 at 10:10 AM E4 (RNC) stated, "Families/residents are sat down with staff at the 72 hour care plan meeting and they receive the summary then." 2. Review of R192's clinical records revealed: 8/5/23 - Admission to facility.	F 655	A. R91 was provided with a copy of their baseline care plan on 8/21/2023. Unable to correct deficient practice on R192 as they were discharged on 8/17/2023. B. All current residents have the potential to be negatively impacted by the deficient practice. An audit of all residents admitted within the last 30 days will be conducted to ensure baseline care plans were provided to resident/responsible parties. C. A root cause analysis was conducted on 10/02/2023 by the interdisciplinary team which determined that the Social Services department needed re-education on regulation 483.21 requiring the facility to provide the resident/resident representative with a copy of their baseline care plan. The administrator/designee will re-educate current social services employees on regulation 483.21. D. The Administrator/designee will audit all admissions weekly times three weeks or until 100% compliance achieved, then	

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F 655	Continued From page 31 8/11/23 - Admission MDS revealed R192 was cognitively intact. 8/17/23 10:10 AM - E4 (Corporate) stated to two members of the Survey team that the facility sat families down at a 72-hour care plan meeting. 8/17/23 12:35 PM - R192 confirmed she did not get a copy of her baseline care plan. 8/21/23 1:32 PM - R192 stated she did not receive a copy of any care plan. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 655	monthly times three months or until 100% compliance is achieved to ensure that baseline care plans were provided to residents/responsible party. Audit results will be presented to the QAPI committee for review. (AUDIT 4)	
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 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).	F 656		10/25/23

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F 656	Continued From page 32 (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 interview and record review, it was determined that for two (R13 and R82) out of twenty-six (26) of the investigative sampled residents the facility failed to develop and implement a comprehensive person centered care plan for identified needs. Findings include: 1. Review of R13's clinical record revealed: 9/11/09 - R13 was admitted to the facility. 4/25/23 - A physician order was written for a hospice consult per family request.	F 656	A. Both R13 and R82□s care plans were updated on 8/21/2023 to reflect hospice and oxygen plan of care. B. All current residents receiving hospice services and those who have orders for oxygen have the potential to be affected by this deficient practice. An initial audit will be conducted to identify all residents receiving hospice services and ordered oxygen to ensure a plan of care is in place.	

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F 656	Continued From page 33 5/7/23 - A quarterly MDS documented severe cognitive impairment. 6/30/23 - Review of the hospice binder included a signed admission to hospice contract. 8/7/23 - Review of R13's care plan revealed a lack of evidence that a person centered care plan with interventions was developed for hospice services. 8/18/23 3:40 PM - During an interview E3 (UM) comfirmed R13's care plan lacked evidence that a person centered care plan with interventions was developed to identify that R13 was receiving hospice services. 2. Review of R82's clinical record revealed: 5/23/23 - A physician order was written to administer oxygen at 2-3 L/min (liters per minute) using a nasal cannula for drop in O2 (oxygen) saturations keep above 92% PRN (as needed). 8/14/23 - Review of R82's care plan lacked evidence of a care plan for the use of oxygen. 8/16/23 10:42 AM - During an interview with R82, it was confirmed the use of oxygen at night. 8/18/23 3:25 PM - During an interview E3 (UM) comfirmed R82's care plan lacked evidence that a care plan for oxygen was developed. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 656	C. A root cause analysis was conducted on 10/02/2023 and revealed that care plans were not being completed upon receiving new orders for hospice services and oxygen usage. The DON/designee will provide re-education to Clinical Reimbursement Coordinator on updating all care plans to reflect new orders for hospice services and oxygen usage. D. DON/designee will complete audits on all residents with new orders for hospice services and oxygen usage to ensure a comprehensive person-centered care plan has been developed. Audits will be conducted weekly times three weeks or until 100% compliance is achieved, and then monthly times 3 months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 5)	
F 657 SS=D	Care Plan Timing and Revision	F 657		10/25/23

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F 657	Continued From page 34 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. (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 interviews and record review, it was determined that for one (R15) out of twenty-six (26) residents reviewed for comprehensive care plans, the facility failed to provide R15 the opportunity to participate in his care plan meetings. Findings include: R15's clinical record revealed:	F 657	A. R15 was immediately offered a care plan meeting and his care plan meeting schedule was changed to allow him the opportunity for participation in his care plan meetings. B. All current residents who are receiving	

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F 657	Continued From page 35 5/3/21 - R15 was admitted to the facility with a diagnosis of end-stage renal Disease, which required offsite dialysis three days a week. According to the clinical record, R15 was scheduled and transported for offsite dialysis every Monday, Wednesday and Friday (M/W/F). Review of E40's (Social Worker) care plan meeting notes revealed that R15 was "Invited but not in attendance" for the following dates: - 2/8/23 at 2:15 PM; - 5/3/23 at 10:30 AM; - 7/26/23 at 10:40 AM. Despite R15's scheduled dialysis days for M/W/F, the facility repetitively scheduled R15's care plan meetings on Wednesdays (2/8/23, 5/3/23 and 7/26/23). The facility failed to provide the resident with multiple opportunities to participate in his own care plan meetings. 8/15/23 at 9:02 AM - During an interview, R15 stated that he "has been here two years and has never been to a care plan meeting." 8/16/23 at 11:44 AM - During an interview, E38 (RN) confirmed that R15's dialysis days were M/W/F. 8/16/23 at 1:22 PM - During an interview, E41 (RN/MDS) confirmed that R15's most recent care plan meeting occurred on Wednesday, 7/26/23. 8/21/23 at 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 657	dialysis services have the potential to be impacted by this deficient practice. An initial audit of all dialysis patients was conducted to ensure care plan meetings are not scheduled on dialysis days to allow the residents to participate in their care plan meetings. C. A root cause analysis was conducted on 10/02/2023 by the interdisciplinary team and determined a lack of communication between nursing department and social services department related to the resident□s dialysis schedule. NPE/designee will provide education to current unit managers to communicate dialysis schedules to the social services department to ensure the resident has the opportunity to participate in his/her care plan meeting. D. The DON/designee will audit all current residents and any admitted residents who receive dialysis services monthly times 3 or until 100% compliance to ensure that their care plan meetings are not scheduled on dialysis days to allow for participation in their meetings. Audit results will be presented to the QAPI committee for review. (AUDIT 6)	
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		10/25/23

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F 677	Continued From page 36 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 interview and record review it was determined that for one (R60) out of five residents reviewed for ADL care provided for dependent residents, the facility failed to provide the necessary assistance to get OOB (out of bed). Findings include: 7/25/19 - R60 admitted to facility with diagnoses including stroke and persistent vegetative state. 10/11/22 - E33 (MD) ordered "Resident (R60) is a total lift for all transfers." 10/12/22 - E33 (MD) ordered "Heel protectors to bilateral feet at all times ...". 4/7/23 - E33 (MD) wrote "OOB seating and positioning Clarification Order: patient to be positioned OOB in geri-chair, 3X/wk (three times per week) for 2-3 hours as tolerated." 8/14/23 1:14 PM - During a telephone interview, CG2 (R60's daughter) stated, "I want her to sit in the chair. They don't get her OOB like they use to." CG2 stated that she believes the staff use a lift to get her OOB. 8/16/23 8:48 AM - R60 was lying in bed towards the left side (with pillow prop) with heel protectors on bilateral feet with pillow between her legs.	F 677	A. R60 was immediately assisted out of bed to geri-chair on 8/21/2023. B. All current residents who are dependent and have current orders to get out of bed at scheduled times have the potential to be impacted by this deficient practice. An audit of all current dependent residents with orders for schedules to get out of bed will be conducted to ensure that the orders are being followed. C. A root cause analysis was conducted on 10/02/2023 by the interdisciplinary team and determined that nursing staff failed to provide the necessary assistance related to getting dependent residents out of bed at scheduled times due to frequent refusals over time. DON/designee will provide re-education to all licensed nurses to ensure that the ordered out of bed schedules are being communicated to non-licensed nursing staff ensuring the necessary assistance is provided and orders are being followed to get residents out of bed. D. DON/designee will audit all current dependent residents with orders/schedules to get out of bed to	

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F 677	Continued From page 37 8/16/23 11:34 AM - R60 was lying in bed propped on left side so leaning right with torso with bilateral heel protectors on her feet. 8/16/23 11:58 AM - CNA documented hand splints on but they were not. 8/16/23 12:53 PM - R60 was lying in the middle of the bed with bilateral heel protectors on. 8/16/23 1:45 PM - R60 was lying in the middle of bed with bilateral heel protectors on. 8/16/23 3:06 PM - R60 was lying to the left in bed with bilateral heel protectors on. 8/17/23 8:09 AM - R60 was lying in bed on left side with bilateral heel protectors on. 8/17/23 11:28 AM - R60 was lying to the left side with bilateral heel protectors on. 8/17/23 11:29 AM - During an interview, E25 (NP) stated, "I don't think R60 gets OOB", when asked where R60's geri-chair was stored/located. 8/18/23 10:08 AM - R60 was lying in the middle of the bed with bilateral heel protectors on. 8/18/23 1:22 PM - R60 was lying in the middle of the bed with bilateral heel protectors on. 8/18/23 1:52 PM - R60 was lying in bed towards the right in bed with bilateral heel protectors on. 8/18/23 3:15 PM - R60 was lying towards the right in bed with bilateral heel protectors on. 8/18/23 4:00 PM - The Surveyor's review of R60's	F 677	ensure that necessary assistance is being provided ensuring out of bed schedules are being followed. Audits will occur daily times three days or until 100% compliance is achieved, weekly times three weeks or until 100% is achieved, then monthly times three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 7)	

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F 677	Continued From page 38 CNA Task documentation for "TASK: OOB to geri-hair 3/wk for 3 hours each time" during the 14 day look back from 8/3/23 to 8/17/23 revealed only one documented instance that R60 was OOB. 08/21/23 11:34 AM - During an interview, E19 (CNA) replied when asked if R60 gets OOB, "It has been a while since I have seen her OOB." 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 677		
F 695 SS=D	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 two (R82 and R243) out of two residents reviewed for respiratory care, the facility failed to provide professional standards of practice by ensuring the oxygen tubing and humidifier bottle was labeled and changed weekly. Findings include: 1. Review of R82's clinical record revealed: 1/8/23 - R82 was admitted to the facility.	F 695	A. R82 and R243 oxygen tubing and water bottle was immediately changed and labeled and order was placed on the chart to change oxygen tubing and humidifier bottle. B. All current residents who are receiving oxygen have the potential to be impacted by this deficient practice. Initial audit of all current residents receiving oxygen was conducted on 8/21/2023 to ensure oxygen	10/25/23

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F 695	Continued From page 39 1/14/23 - An admission MDS indicated R82 was cognitively intact and diagnoses of acute respiratory failure with hypoxia and COPD. 5/23/23 - A physician order was written to administer oxygen at 2-3 L/min (liters per minute) using a nasal cannula for drop in O2 (oxygen) saturations, keep above 92% PRN (as needed). 8/14/23 - An observation of R82's oxygen tubing revealed a label dated 7/22/23. 8/16/23 - A review of R82's physician orders revealed no order to change oxygen tubing. 8/16/23 10:18 AM - During an interview E3 (UM) stated that they haven't been changing the tubing because R82 "hasn't been using it" and she is PRN and the tubing was outdated. E3 reviewed the physician orders and confirmed there was no order to change the oxygen tubing. In addition, E3 stated it is included in standing orders for oxygen use, and wasn't sure what had happened. 8/16/23 10:42 AM - During an interview R82 confirmed that she uses her oxygen at night. 2. Review of R243's clinical record revealed: 7/28/23 - R243 was admitted to the facility. 8/2/23 - An admission MDS documented R243 was cognitively intact and diagnoses of acute respiratory failure with hypercapnia and hypoxia, COPD and Asthma. 8/14/23 - A physician order was written to administer oxygen at 2-5 L/min (liters per minute) using a nasal cannula every shift.	F 695	tubing and water bottle was labeled and dated and that all current residents receiving oxygen had an orders to change oxygen tubing and humidifier bottle weekly. C. A root cause analysis was conducted on 10/02/2023 by the interdisciplinary team and determined that current licensed nurse were not following PROCEDURE NPE/designee to provide re-education to all licensed nursing staff on PROCEDURE and required order for changing oxygen tubing and humidifier bottle. D. DON/designee will audit all current residents who are receiving oxygen to ensure residents have orders to change oxygen tubing and humidifier bottles weekly and that both oxygen tubing and humidifier bottles are labeled and changed weekly. Audits will occur weekly times 3 weeks or until 100% compliance is achieved, then monthly times three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 8)	

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F 695	Continued From page 40 8/14/23 - An observation of R243's oxygen tubing and humidifier bottle revealed neither one was labeled. 8/16/23 - Review of R243's physician orders revealed no order to change oxygen tubing. 8/16/23 10:25 AM - During an interview E3 (UM) stated that sometimes the nurse changes R443's tubing quickly as the nasal cannula "gets blood on it but I know that's not an excuse for not labeling it." E3 then reviewed the physician orders and confirmed there was no order to change the oxygen tubing or humidifier bottle. In addition, E3 stated it is included in standing orders for oxygen use, and wasn't sure what had happened. 8/17/23 10:13 AM - During an interview E11 (RN) confirmed there was no label on the tubing or the humidifier bottle. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).\	F 695		
F 711 SS=J	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and	F 711		10/25/23

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F 711	Continued From page 41 §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R5, R15, R91 and R102) out of four residents reviewed for Insulin, the facility failed to ensure that the physician reviewed the residents' total program of care as presented in the interfacility transfer documentation. For R91, the physician's failure to ensure that the resident's total program of care was accurately evaluated upon his admission and throughout his stay in the facility placed R91 in Immediate Jeopardy (IJ) of a serious, adverse outcome. The Physician's failure to order an insulin sliding scale, finger stick blood sugar checks, Trojeo (concentrated insulin) medication daily, and the correct frequency of Synjardy (combination anti-diabetic medication containing empagliflozin and metfomin) resulted in R91's metabolic derangement and resultant diabetic ketoacidosis (DKA). R91 was admitted to a hospital critical care unit with the diagnosis of diabetic ketoacidosis (DKA) requiring a continuous insulin drip five days after his admission to the facility. The IJ was identified on 8/31/23 at 3:15 PM and was abated on 9/7/23 at 3:20 PM. In addition, for R5, several notes (12/13/22, 3/22/23, 5/7/23, 7/16/23) documented that R5 was no longer on insulin when, in fact, the physician had restarted insulin in February 2022. For R15, several notes documenting R15's	F 711	A. R5, R15, R91 and R102 were not negatively impacted by this deficient practice. R91 has been discharged from the facility on 6/20/2023. Medical records for R5, R15, and R102 were audited on 9/07/2023 to ensure the plans of care were appropriate, with proper follow-up in place. B.. All current residents diagnosed with Diabetes may be impacted by this deficient practice. An audit of current diabetic residents was conducted on 10/02/23 to ensure compliance with F711. C.. A root cause analysis was conducted on 09/07/2023 when the Immediate Jeopardy was abated. A primary factor identified was a discrepancy between the referring facility's Discharge Reconciliation Report and Discharge Summary which wasn't discovered by the Center's admitting Current staff. The following protocol has been instituted in reference to admissions: Physician/on-call Providers will review with clinical Current staff all orders, medication, treatment and allergies to make appropriate plan of care decisions. The Medical Director provided	

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F 711	Continued From page 42 decreased appetite and remaining on remeron (anti-depressant used for appetite stimulation) for appetite enhancement when, in fact, R15 had gained 28 pounds in the past year and was not and has never been on remeron. For R102, fingerstick blood sugar monitoring and management of diabetes were omitted from the plan of care/treatment orders. Findings include: 1. Cross refer F773 and F760. According to the U.S. Food and Drug Administration (FDA) for Synjardy medication - "Drug Safety Communications- FDA warns that Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors for diabetes may result in a serious condition of too much acid in the blood issued on May 15, 2015. Safety Announcement...Medicines in the SGLT2 inhibitor class include canagliflozin, dapagliflozin and empagliflozin...In patients taking an SGLT2 inhibitor, ketoacidosis can occur even if the blood sugar is less than 250 mg (milligrams)/ dL (deciLiter)...In many cases, ketoacidosis was not immediately recognized because the blood glucose levels were below those typically expected for diabetic ketoacidosis...In some cases, predisposing factors for ketoacidosis were identified. These included: reduction of insulin dosage, acute febrile illness, reduced caloric intake due to illness or surgery, pancreatic disorders suggesting insulin deficiency and alcohol abuse." According to the Journal of Investigative Medicine - HIGH IMPACT CASE REPORTS "... Since the approval of SGLT2 inhibitors by the U.S.FDA for type 2 diabetes, there have been several reports of euglycemic diabetic ketoacidosis in patients using this class of medication... DKA (diabetic	F 711	education (ATTACHMENT I) to all on-call providers on 09/07/2023 through 09/13/2023. The provider review is to include the following: " Review of the Discharge Summary (from referring facility) " Verification of allergies " Verification of prescribed treatments " Review of all recommendations. If not in agreement, rationale for deviation from recommendations will be documented. " Initiation of proper protocols in response to recommendations and treatments " For residents with a diagnosis of Diabetes, 3 days of blood monitoring will occur, to include, finger sticks to monitor blood sugar stability with appropriate response to glucose results. " Review of labs included in discharge summary and review of admission labs done at the Center. Physician will document response to abnormal/critical labs and appropriate response. " D. DON/designee will audit documentation provided by the physician pertaining to admissions of residents with a diagnosis of Diabetes. Audits will occur daily times three until 100% compliance is achieved, three times a week until 100%	

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F 711	Continued From page 43 ketoacidosis) is defined by the triad of hyperglycemia (high blood sugar) (greater than 250 mg/dL), anion-gap acidosis and increased plasma ketones. Euglycemic DKA is defined as DKA without hyperglycemia (high blood sugar)." J Investig Med High Impact Case Rep. 2017 Apr-Jun; 5(2): 2324709617710040 1. R91's clinical record and hospital records revealed: 6/1/23 - Hospital A record documented that R91 was discharged to home with home health referral after a right total knee replacement on 5/31/23. Hospital A discharge summary documented, "Discharge Medication Reconciliation-Home Medications Active:... Synjardy (combination anti-diabetic medication containing empagliflozin and metformin) 12.5mg - 1000mg by mouth twice a day,... Toujeo (concentrated insulin) Solostar 300 units/ml (milliliter) 24 units SQ (subcutaneously - under the skin) once a day (at bedtime),... Ozempic (semaglutide - anti-diabetic medication) 1 mg (milligram) SQ Q (every) Tuesday,... Humalog insulin Kwikpen- SSI (sliding scale insulin) TID (three times a day) AC (before meals)...". 6/5/23 - R91 was admitted to an acute rehabilitation center from home. 6/16/23 - R91 was admitted to the facility from acute rehabilitation center B with diagnoses including diabetes and aftercare following joint replacement therapy. Of note, 6/16/23 was a Friday. 6/16/23 - R91's "Discharge Reconciliation Report" from acute rehabilitation center B listed these	F 711	is achieved for three weeks, then weekly until 100% compliance is achieved for 3 weeks, then monthly for three months until 100% compliance is achieved. Audit results will be reported to and monitored by the QAPI Committee.	

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F 711	Continued From page 44 medications to be continued upon transfer to the facility, "... Synjardy (Patient OWN medication) 12.5 - 1000 mg by mouth twice a day - last given 6/16/23 at 8:57 AM,... Ozempic (Patient OWN Medication) inject 1 mg under the skin once a week on Tuesday - last given 6/14/23 at 12:15 PM...". Additionally, acute rehabilitation center B's Discharge Summary stated, "... Recommendations/Plan:... DM2; Diabetes: monitor accuchecks. Continue DM meds - Synjardy and insulin reg for sliding scale PRN...". Of note, review of the records from acute rehabilitation center B noted that the Toujeo (concentrated insulin) was not listed or administered during his confinement there. Upon admission to the facility, R91 had already missed eleven doses (6/5/23 to 6/15/23) of his nightly Toujeo (concentrated Insulin) medication. 6/16/23 8:36 PM - E46 (LPN) entered a telephone order from E33 (MD), "Synjardy 12.5 - 1000 mg by mouth one time a day for diabetes." 6/16/23 - E33 gave a verbal order for R91 to have a complete metabolic panel (CMP) and complete blood count (CBC) drawn. This blood work includes a fasting blood sugar level. 6/17/23 8:56 AM - E33 signed the Synjardy 12.5 - 1000 mg by mouth one time a day order in R91's medical record. This was not consistent with the acute rehabilitation center discharge paperwork listing this medication's frequency as BID (twice daily) and not daily. 6/17/23 11:17 AM - R91's lab work was reported to the facility. The lab work revealed an elevated Anion gap of 19 (normal range for this lab was 8	F 711		

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F 711	Continued From page 45 to 16). An anion gap measures the difference or gap between the negatively charged and positively charged electrolytes in a patient's blood. If the anion gap becomes too high, the person's blood is more acidic than normal. There was no documentation that the staff called the physician to report the labs or that the physician reviewed the labs. 6/17/23 to 6/19/23 8:00 AM - R91's Medication Administration Record (MAR) reflected R91 receiving a dose of Synjardy 12.5 - 1000 mg by mouth each day. 6/19/23 - E33 documented in R91's History & Physical (H&P), "External Records and/or discussions: Today I reviewed external hospital notes/ discharge summary from: [Hospital A] health note/ Discharge date 5/31, {Acute rehab center B] D/C 6/16, Summary: see HPI...". E33 signed this note on 6/20/23 at 7:46 AM. Despite reviewing R91's 6/1/23 hospitalization (Hospital A) and 6/16/23 acute rehab center B's records, the Physician failed to recognize the following: - R91's Synjardy was ordered twice a day at acute rehab center B and was listed on the transfer/discharge medication list as "BID" or twice a day but was ordered at this facility as once a day; and - R91 was on Toujeo (concentrated insulin) 24 units SQ (subcutaneously) once daily at Hospital A. E33 documented that he reviewed this document in his H&P note but did not recognize that R91 had not been ordered this medication to manage his diabetes while in the facility or at acute rehab center B.	F 711		

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F 711	Continued From page 46 6/19/23 1:35 PM - Four days after admission, E25 (NP) entered an order in R91's medical record for sliding scale insulin coverage and STAT lab work for another CMP and CBC. 6/19/23 4:52 PM - Records indicate the blood work was collected at the facility. 6/19/23 6:56 PM - R91's STAT labs were reported to the facility with a serum glucose of 258 and an anion gap of 29 (normal lab range 8-16). Both labs were abnormally elevated. There was no evidence that the facility contacted the provider with the laboratory results or that these labs were reviewed by the Physician on 6/19/23. 6/19/23 5:58 PM - E47 (nurse) documented finger blood sugar (BS) as 309 and administered 8 units of insulin. 6/19/23 11:21 PM - E47 documented BS as 309 and administered 8 units of insulin. 6/20/23 5:37 AM - E47 documented BS as 317 and administered 8 units of insulin. 6/20/23 7:30 AM - Emergency Medical Services (EMS) was called due to R91's altered mental status. 6/20/23 8:20 AM - C4 (Emergency room MD) documented in the hospital Emergency room note, "... Nursing home noted that he (R91) was tachycardia today, encephalopathy (altered mental status) and called EMS. On paramedic's arrival (sic), they noted the patient's blood sugar was in the 400's. They gave 10 units of insulin and sugars (sic) improved to 60...".	F 711		

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F 711	Continued From page 47 6/20/23 2:21 PM - C5 (Critical Care MD) documented in the Critical Care Medicine Admission note, "... Per record, patient has been in rehab, family is unaware whether he has been receiving his anti-glycemic medication... Assessment and Plan: Acute encephalopathy likely secondary to metabolic derangement/DKA (diabetic ketoacidosis)... PCO2 in VBG (Venous blood gas) is not elevated. UA (urine analysis) shows no evidence of infection... Leukocytosis (elevated white blood cell count) without any focus of infection. The elevated white cell count could be reactive...High anion gap metabolic acidosis secondary to DKA. The inciting factor for DKA is unknown at this time but suspect may have been secondary to medications, stress... No signs of infections the leukocytosis is likely reactive...On insulin drip per protocol... latest anion gap 7 however chloride is significantly elevated at 120 and bicarb is still below 20... Plan to continue insulin drip until bicarb level is above 20...Disposition: ICU (intensive care unit) level of care. Prognosis is guarded...". 8/31/22 12:39 PM - During an interview, E33 stated that he did not recall getting a call about R91's admission orders. He could not remember if the Synjardy frequency was reduced intentionally. "The only reason it would be reduced was to get the patient back on their home dose." The hospital pre-op (pre-operation) History & Physical (dated 5/23/23) documented that R91 was on Synjardy but does not give the dosage or frequency. When asked about reviewing the Hospital records as documented in his Admission Note (dated 6/19/23), E33 did not recall reading that R1 was on Toujeo 24 units Q (every) evening. E33 stated that he was not on call or in the building on the weekend of 6/17/23	F 711		

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F 711	Continued From page 48 to 6/18/23. 8/31/23 3:15 PM - Based on interviews and record reviews of facility documentation, an Immediate Jeopardy (IJ) was called and reviewed with the facility leadership including E1 (NHA) and E2 (DON). 9/1/23 - E1 (NHA) submitted an acceptable Abatement Plan signed, dated and timed which included: providing education to all on-call and inhouse providers regarding admitting residents to the facility and E33 (MD) taking on-call daily until all other providers received education regarding admissions to the facility. 9/7/23 3:20 PM - The Surveyors confirmed that the on-call schedule for the facility only scheduled providers who had been trained and affirmed their understanding of the training. Currently, E33 (MD) and E25 (NP) were the only providers taking on-call coverage in the building. The surveyors confirmed that education was disseminated to all the market on-call providers at the facility and the building was in the process of collecting the affirmation of understanding from these providers prior to listing them on the facility on-call schedule. The facility was deemed to have fully abated this IJ. 2. Review of R5's clinical record revealed: 8/19/20 - R5 was admitted to the facility with diagnoses including stroke and diabetes. 3/23/22 - E27 (MD) ordered "Insulin Glargine 100 units/ml inject 50 units subcutaneously one time a day for diabetes."	F 711		

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F 711	Continued From page 49 3/23/22- E27 (MD) ordered "HumaLOG solution (Insulin Lispro) inject as per sliding scale: if 0-149 = 0 (units); 150-200 = 6 (units); 20-1-250 = 10 (units); 251-300 = 14 (units); 301-350 = 16 (units); 351+ = 18 (units); subcutaneously before meals for Diabetes AND inject 10 units subcutaneously before meals for diabetes." 4/30/22 12:47 PM- E27 (MD) documented in R5's Progress Note," ...Chief Complaint & History: [R5} was seen on 4/28/2022 ...blood sugars are better controlled ...Lantus 50 units + High dose sliding scale coverage AC. HgA1c (hemoglobin A1 c- lab test for diabetes management) Q (every) 3 months for now. 4/27/2022 sugars 212 am/ 138 with lunch/ 148 at dinner ...Assessment/Plan & Other Information: ...NIDDM (non-insulin dependent diabetes mellitus) 2005, started insulin 2013, now stopped 8/2020 ..." R5 was on a daily dose of insulin and insulin sliding scale at the time of the 4/30/22 Progress note. 5/23/22 2:30 PM- E27 (MD) discontinued the Insulin Glargine 50 units order. 5/23/22- E27 ordered "Lantus (Insulin Glargine) solostar pen 100 unit/ 1 ml (milliliter) insulin pen- inject 50 units subcutaneously one time a day for DM (diabetes)". 7/28/22 4:06 PM- E27 (MD) documented in R5's Progress Note," ...Assessment/Plan & Other Information: ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ..." R5 was on a daily dose of insulin and insulin sliding scale at the time of the 7/28/22 Progress	F 711		

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F 711	Continued From page 50 note. 8/18/22- E27 ordered "HumaLOG solution 100 unit/ml (Insulin Lispro (Human))- inject as per sliding scale: if 0-149= 0 (units); 150-200= 6(units); 201-250= 10 (units); 251-300 = 14 (units); 301-350 = 16 (units); 351+ = 18 (units); subcutaneously before meals for diabetes AND inject 10 units subcutaneously before meals for diabetes". 8/23/22 4:13 PM- E27 (MD) documented in R5's Progress Note," ... Chief Complaint & History: Do (sic) well with better glucose control ... insulin coverage 10 units with meals + ss (sliding scale) coverage + 50 units of insulin glargine ...Assessment/Plan & Other Information: ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". 10/7/22 6:57 PM- E27 (MD) documented in R5's Progress Note," ...Review of Systems: ... Blood sugars reviewed with the nursing staff >100<200 mg/ dl (deciliter) all ...Assessment/Plan & Other Information: ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". R5 was on a daily dose of insulin and insulin sliding scale at the time of the 10/7/22 Progress note. 12/13/22 9:11 PM- E27 (MD) documented in R5's Progress Note," ...Assessment/Plan & Other Information: ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ..." R5 was on a daily dose of insulin and insulin sliding scale at the time of the 12/13/22 Progress note.	F 711		

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F 711	Continued From page 51 2/3/23 4:42 PM- E27 (MD) documented in R5's Progress Note," ...Chief Complaints & History: ... Multiple sweets in the room though HgA1c are appropriate ... NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". R5 was on a daily dose of insulin and insulin sliding scale at the time of the 2/3/23 Progress note. 3/22/23 4:41 PM- E27 (MD) documented in R5's Progress Note," ...Assessment/Plan & Other Information: ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". R5 was on a daily dose of insulin and insulin sliding scale at the time of the 3/22/23 Progress note. 5/7/23 4:24 PM- E27 (MD) documented in R5's Progress Note," ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". R5 was on a daily dose of insulin and insulin sliding scale at the time of the 5/7/23 Progress note. 7/16/23 1:10 PM- E27 (MD) documented in R5's Progress Note," ...NIDDM 2005, started insulin 2013, now stopped 8/2020 ...". R5 was on a daily dose of insulin and insulin sliding scale at the time of the 7/16/23 Progress note. During the time period of 4/30/22 to 7/16/23, E27 (MD) wrote nine Progress Notes on R5 stating that R5, who was a diabetic, was no longer being	F 711		

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F 711	Continued From page 52 managed with with insulin when in fact, R5 was on a daily dose of insulin and was being additionally monitored with finger stick blood glucose with an insulin sliding scale. 3. Review of R15's clinical record revealed: 5/3/21- R15 admitted to the facility with diagnoses including end-stage renal disease and diabetes. 9/15/21- E30 (MD) ordered R15's diet as a "regular diet, dysphagia advanced texture-ground meat only- no salt packet, sugar free condiments, 1500 ml (milliliter) fluid restriction". 8/3/22- R15 documented as weighing 168.4 pounds. 6/22/23- E33's (MD) R15 Progress Note documented," ...Diagnosis, Assessment & Plan: ... R63.0 (the International Classification of Diseases {ICD} 10 code for Anorexia)- decreased appetite, encourage supplements, Remeron and follow weights." Also the Medication List in this Progress note does not include Remeron. 6/25/23- R15 documented as weighing 206 pounds. 7/7/23- R15 documented as weighing 204.6 pounds. 7/19/23- E33's (MD) R15 Progress Note documented," ...Diagnosis, Assessment & Plan: ... R63.0 (the ICD 10 code for Anorexia)- decreased appetite, encourage supplements, Remeron and follow weights." In the History section, the Medication List does not include	F 711		

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F 711	Continued From page 53 Remeron. 8/3/23- R15 documented as weighing 196.9 pounds, which reflected a gain of 28.5 pounds in one year. 8/3/23- E33's (MD) R15 Progress Note documented," ...Diagnosis, Assessment & Plan: ... R63.0 (the ICD 10 code for Anorexia)- decreased appetite, encourage supplements, Remeron and follow weights." In the History section, the Medication List does not include Remeron. R15's Order recap printout, which showed all orders for a resident since time of Admission, revealed that R15 has never been on Remeron (mirtazapine). 8/16/23 11:44 AM- During an interview, E38 (RN) confirmed that R15 was not ordered Remeron on electronic medical record. 8/17/23 8:34 AM- During an interview with E37 (Nutritionist), E37 stated that R15 was on a regular diet for preference and that this order was approved by the C2 (Dialysis NP). E37 stated that R15's Body Mass Index (BMI) when adjusted for amputations was 35.6. E37 acknowledged the 28 pound weight gain over a year during this interview. During the time period of 6/22/23 to 8/3/23, E33 failed to provide an accurate account of R15's care in the three Progress notes (6/22/23. 7/19/23, 8/3/23) that he wrote. 4. Review of R102's clinical record revealed:	F 711		

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F 711	Continued From page 54 8/14/23 - Hospital discharge summary documented that R102's fingerstick blood sugar was being checked four times a day: before breakfast, lunch, dinner and at bedtime. R102's orders included insulin lispro (Humalog Medium scale). 8/18/23 - R102 was admitted to the facility from acute care hospital where R102 was treated for cellulitis (inflammation of the tissues indicating a local infection) and multiple venous stasis ulcers (wound on the leg or ankle caused by abnormal or damaged veins) to the right and left lower legs. 8/18/23 - An admission record documented "Type 2 Diabetes Mellitus with Diabetic Neuropathy." 8/19/12 - A care plan was initiated, Problem: "The resident has a diagnosis of diabetes, the resident will be free of all symptoms of hypo/hyperglycemia such as: sweating Interventions included: - Administer hypoglycemic medications as ordered. - Educate resident on the signs and symptoms of hypo/hyperglycemia. - Monitor for signs and symptoms of hyper/hypoglycemia. 8/22/23 - A nurse practitioner's progress note documented " ...male with a past medical history significant for diabetes ...worsening wounds to bilateral lower extremities ...." 8/22/23 - An order recap report included one order related to diabetes: Consistent carbohydrate diet r/t diagnosis with no current meds.	F 711		

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F 711	Continued From page 55 8/31/23 approximately 2:00 PM - During an interview, E7 confirmed that R102 was not getting fingerstick blood sugar checks and no insulin was ordered. 8/31/23 2:12 PM - During an interview, E2 confirmed that R102 was not getting fingerstick blood sugar checks and no insulin was ordered. 8/21/23 2:50 PM- Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 711		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (E13, E14, E15, and E16) out of five certified nursing assistants reviewed, the facility failed to complete an annual evaluation. Findings include: 8/18/23 approximately 9:00 AM - E1 (NHA) brought documentation regarding the following CNA's evaluations, which occurred on the following dates: E13 (CNA), column undated (date of hire 7/12/22) E14 (CNA), 10/4/21 (date of hire 4/13/21) E15 (CNA), 5/10/22 (date of hire 4/5/88) E16 (CNA), 5/30/20 (hire date 5/29/01)	F 730	A. E13, E14, E15 and E16 were provided annual evaluations on 9/27/2023. B. All current employees have the potential to be affected by this deficient practice. The Human Resource Manager conducted an audit of all current employees to identify employees needing annual evaluations. Outdated evaluations will be completed by 10/25/2023. C. A root cause analysis was conducted by the interdisciplinary team and	10/25/23

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F 730	Continued From page 56 8/21/23 12:56 PM - When questioned about yearly performance reviews, E2 (DON) stated it is not the company's policy to do a yearly review for CNA's. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 730	determined that with a change in leadership, the schedule for annual employee evaluations was not continued. NHA/designee will re-educate the HR department of annual Performance Review policy. D. NHA/designee will audit all current employees to ensure annual evaluations due for each month are completed. Audits will occur monthly x three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 9)	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		10/25/23

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F 756	Continued From page 57 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 it was determined that the facility failed to develop and maintain policies and procedures for the Medication Regimen Review (MRR) that included time frames for the various steps in the process. Findings include: A review of the facility policy "6.1 Pharmacist Consultant Services" dated 8/1/16, stated, "POLICY- Residential Care Facilities with more than 10 beds shall retain the services of a pharmacist consultant no less than quarterly ...PROCESS- 1. On a quarterly basis, the pharmacist consultant shall review: 1.1 Written policies and procedures for pharmaceutical services ...1.4 Medication records, and initial and date the records when reviewed; 1.5 Adherence to stop orders; and 1.6 Staff performance in carrying out pharmaceutical policies and procedures. 2. The Pharmacist	F 756	A. No residents were negatively impacted by this deficient practice. B. All current residents have the potential to be impacted by this deficient practice. C. A root cause analysis was conducted on 10/03/2023 concerning why the drug regimen reviews didn't contain the necessary information. A primary factor identified was lack of understanding of the F756 regulation. An audit was conducted of all pharmacy reviews and all were found to be in compliance. DON/designee has educated Current staff on the regulation and policy.	

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F 756	Continued From page 58 Consultant shall provide the Center Executive Director with a timely, written report of findings, with specific recommendations in each of the areas reviewed." This policy did not address the federally mandated time frames for the various steps in the MRR process. It did not address the steps the pharmacist must take when he/she identifies an irregularity that requires urgent action to protect the resident. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 756	D. Audits of drug/pharmacy compliance will be conducted by the DON/designee. Audits will occur monthly for three months until 100% compliance is achieved. Audit results will be reported to and monitored by the QAPI Committee.	
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	F 757		10/25/23

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F 757	Continued From page 59 section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R5) out of six residents reviewed for medication review, the facility failed to ensure that R5's erythromycin eye ointment was not continued for an excessive duration after confirming no active infection in June 2023. Findings include: 8/19/20 - R5 was admitted to the facility. 4/5/23 - E22 (NP) ordered erythromycin ophthalmic ointment 5 mg (milligrams) /gm (gram) instill 1 drop in both eyes four times a day for conjunctivitis for 7 days for R5. The stop date listed for this order was 4/12/23. 4/20/23 - E27 (MD) restarted R5 on erythromycin ophthalmic ointment 5 mg/gm instill 1 drop in both eyes three times a day for chronic conjunctivitis. 5/7/23 4:24 PM - E27 documented in R5's Progress Note, " ...Vision issues have improved in general about both eyes ....Review of Systems: Sight has gradually gotten better by degree ...." There is no mention of conjunctivitis/pink eye or it's treatment in E27's note. 6/2/23 - R5's Medication Regimen Review (MRR) recommended evaluation of erythromyocin eye drops (sic)as the order was missing a stop date. E25 (NP) acknowledged receipt of this recommendation and signed the MRR on 6/5/23 but wrote to "consult eye doctor or E27" to obtain the physician response to the recommendation. The facility failed to failed to follow up with either	F 757	A. R5□s Erythromycin order was immediately reviewed by the attending physician and the order was discontinued. B. All current residents receiving antibiotic eye drops have the potential to be impacted by this deficient practice. An audit will be conducted by the DON/designee of all current residents receiving antibiotic eye drops to ensure the order has a stop date. C. A root cause analysis conducted on 10/03/2023 by the interdisciplinary team determined that there was a delay in communication between the nursing staff and the provider related to the lack of signs and symptoms of infection therefore relating to the prolonged use of the antibiotic eye drops. NPE/designee will provide re-education to all current licensed nursing staff related to identifying the need for a stop date for antibiotic eye drops upon resolution of signs and symptoms of infection. D. DON/designee will complete audits of all current residents receiving antibiotic eye drops to ensure that antibiotic eye drops are not continued for an excessive duration without active symptoms. Audits will occur weekly times three weeks or until 100% compliance is achieved, then monthly times three months or until 100% compliance is achieved. Audit results will	

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F 757	Continued From page 60 individual to obtain a stop date as requested until 8/17/23 when this Surveyor brought the issue to their attention. 6/7/23 - R5 was sent to an outpatient appointment at a retina specialist. E26 (Ophthalmologist) documented," ...OD (right eye) ... OS (left eye) Lid Margin" quiet and normal no crusting or discharge." E26's Impression/Plan in his note made no mention of conjunctivitis/pink eye. 8/17/23 - E2 (DON) documented a note in R5's medical record,"...Per E27, at this time, it can be discontinued as the resident has not had an outbreak in the last 2 months." 8/17/23 - R5's erythromycin eye gel/ointment discontinued. R5 was on erythromycin eye gel ointment for a total of 119 days or 17 weeks spanning from 4/20/23 to 8/17/23. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 and E3 (ADON).	F 757	be presented to the QAPI committee for review. (AUDIT 10)	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one of six residents reviewed for medication review, the facility failed to ensure that R91 was free from significant medication	F 760	A. Unable to correct due to R91 being discharged from the facility on 6/20/23.	10/25/23

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F 760	Continued From page 61 error. Findings include: Cross refer F711 and F773 Synjardy, which is the trade name for a fixed-dose combination anti-diabetic medication used to treat type 2 diabetes. It contains both empagliflozin and metformin and is taken by mouth. It is used to control high blood sugars in people with type 2 diabetes. Controlling high blood sugar helps prevent kidney damage, blindness, nerve problems, loss of limbs and sexual function problems. Proper control of diabetes reduces the patient's risk of stroke and heart attack. 6/5/23 - R91 admitted to an acute care rehabilitation center. 6/16/23 - R91 admitted to the facility with diagnoses including diabetes and aftercare following joint replacement therapy (recent full revision right total knee replacement on 5/31/23). 6/16/23 - R91 transferred from the acute care rehabilitation center to the nursing home ("the facility"). R91's "Discharge Reconciliation Report" from the acute care rehabilitation center listed these medications to be continued upon transfer to the facility, "...Synjardy (Patient own medication) 12.5- 1000 mg by mouth twice a day- last given 6/16/2023 at 8:57 AM...." 6/16/23 8:36 PM - E46 (LPN) entered telephone order from E30 (MD), "Synjardy 12.5- 1000 mg by mouth one time a day for diabetes" in R91's medical record. Of note, 6/16/23 was a Friday.	F 760	B. All newly admitted residents have the potential to be affected by this deficient practice. DON completed an audit of admitted residents from the last 30 days to ensure medication orders from admitting hospital were transcribed correctly. C. A root cause analysis was conducted on 09/07/2023 by the interdisciplinary team to determine that the assigned nurse transcribed the admission orders incorrectly therefore communicating the wrong dose to the on-call provider. NPE/designee will provide re-education related to transcription of orders with a focus on thoroughly reviewing the transfer paperwork from the admitting hospital to ensure accurate transcription D. DON/designee will audit all new admissions/readmissions to ensure that all orders were transcribed correctly from the admitting hospital and communicated to the provider as such. Audits will occur three times a week times three weeks or until 100% compliance is achieved, then weekly times three weeks or until 100% compliance is achieved, and then monthly times three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 11)	

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F 760	Continued From page 62 6/17/23 8:56 AM - E33 (MD) signed the Synjardy 12.5 - 1000 mg by mouth one time a day order in R91's medical record. 6/17/23 to 6/19/23 8 AM - R91's Medication Administrator Record (MAR)(list of daily medications to be administered) reflected R1 receiving a dose of Synardy 12.5 - 1000 mg by mouth each day. 6/19/23 10:58 AM - C3 (Pharmacist) documented a medication regimen review was performed with no irregularities found. Neither the Physician (E33) nor the Pharmacist (C3) recognized that the Synjardy was ordered twice a day at the acute rehab center and was listed on the transfer/discharge medication list as "BID" or twice a day and was ordered at this facility as once a day. 8/31/22 12:39 PM - During an interview, E33 (MD) stated that he did not recall getting a call about R91's admission orders. He could not remember if the Synardy frequency was reduced intentionally. "The only reason it would be reduced was to get the patient back on their home dose." The hospital pre-op (pre-operation) History & Physical (dated 5/23/23) documented that R91 was on Synjardy but does not give the dosage or frequency. 8/31/23 5:20 PM - The findings were reviewed with E1 (NHA) and E2 (DON).	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		10/25/23

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F 761	Continued From page 63 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that medications were stored and labeled properly in two out of six medication carts and in one out of two medication rooms reviewed. In addition, the facility failed to monitor refrigerator temperatures in one medication fridge on Unit 1. Findings include: 8/17/23 1:07 PM - During a medication storage review of the Unit 1 Medication Room the following was observed inside the medication	F 761	A. All biologicals were immediately labeled properly in the medication carts and in the medication rooms. All identified outdated biologicals were discarded. Refrigerator temperatures were obtained immediately and remain current. B. All current residents have the potential to be impacted by this deficient practice. UM/designee audited 100% of medication carts and medication rooms to identify any further outdated biologicals. All	

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F 761	Continued From page 64 room: 1. Expired on 6/30/23 Flu vaccine: two bottles and one box of pre-filled syringes. 2. Expired on 4/17/23 Epi-pen (medication to treat allergic reactions). 3. Expired on 8/22 bottle of Pedialyte. 4. Expired on 12/22 package of Cepacol throat lozenges. 5. Expired on 11/22 bottle of Magnesium. 6. Albuterol inhalation solution: opened and no date. 8/17/23 1:23 PM - A review of temperature log for the medication fridge revealed that facility failed to monitor temperatures. 8/17/23 1:27 PM - An interview with E11 (RN) confirmed medications were expired and undated and the temperature log was not monitored twice a day. 8/18/23 10:11 AM - During a medication storage review of the Unit 1 Medication Cart 1 the following was observed inside the medication cart: 1. Bottle of artificial tears: opened and no open date. 2. Box of Albuterol inhalation solution: opened and no date. 3. Five bottles of floor stock medications with no open date. 4. Bottle of Maalox with no open date. 5. Bottle of Senna syrup with no open date. 8/18/23 10:47 AM - An interview with E11 and E3 (ADON) confirmed medications were undated.	F 761	refrigerators audited to ensure documentation of obtained temperatures. C. A root cause analysis was conducted by interdisciplinary team and determined that all current licensed nursing staff need re-education on the policies and procedures for storage of drugs and biologicals as well as the policy for obtaining refrigerator temperatures to ensure proper temperature controls. NPE/designee will re-educate all licensed nursing staff on POLICY of drugs and biologicals. D. DON/designee will conduct audits of the facility medication rooms and medication carts to ensure that there are no outdated biologicals and that all refrigerators have documentation of obtained temperatures. Audits will occur daily times three weeks or until 100% compliance is achieved, weekly times three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 12)	

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F 761	Continued From page 65 8/18/23 10:50 AM - During a medication storage review of the Unit 1 Medication Cart 3 the following was observed inside the medication cart: 1. Novolog flex pen: opened with no open or discard date. 2. Lantus pen: opened with no open or discard date. 3. Nine floor stock bottles opened with no date. 4. Bottle of Valproic Acid liquid (medicine to treat seizures): opened and no date. 8/18/23 11:11 AM - An interview with E3 and E17 (LPN) confirmed for undated items. 8/18/23 2:30 PM - During a medication storage review of the Unit 2 Medication Cart 2 the following was observed inside the medication cart: 1. Two Lispro Insulin Pens: no open date or discard date. 2. Tribeca Insulin Pen: no open date or discard date. 3. Basalgar Insulin Pen: no open date or discard date. 4. Bottle of Olopatadine eye drops: no open date or discard date. 5. Bottle of Brimonidine eye drops: no open date or discard date. 6. Fourteen Bottles of floor stock medication: no open dates. 7. Five containers of prescription creams: undated and open. 8. Two bottle of prescription pills: undated and open. 8/18/2303:00 PM - An interview with E2 (DON)	F 761		

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F 761	Continued From page 66 confirmed undated and open medications. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 and E3.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for four (R91, R102, R103 and R104) out of four residents sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results that fell outside of clinical reference ranges. In addition, the facility failed to have a policy and procedures, for notification of the practitioner, when laboratory results fall outside of the clinical reference range. Findings include: Cross refer F711 and F760 1. Review of R91's clinical record revealed: 6/16/23- R91 admitted to the facility with	F 773	A. R91, R102, R103 and R104 lab results were communicated to the provider on 8/21/2023 and no further orders were obtained. B. All current residents receiving laboratory services have the potential to be affected by this deficient practice. DON/designee will audit labs from the last 30 days to ensure all lab results that fell outside of the clinical reference ranges were promptly reported to the ordering medical practitioner.	10/25/23

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F 773	Continued From page 67 diagnoses including diabetes and aftercare following joint replacement therapy (recent full revision right total knee replacement on 5/31/23). Of note, 6/16/23 was a Friday. 6/16/23 - E33 (MD) gave a verbal order for a complete metabolic panel (CMP) and complete blood count (CBC) to be drawn. 6/17/23 7:50 AM - R91 had CMP and CBC labs drawn. 6/17/23 11:17 AM - R91's CMP and CBC lab results are reported to the facility with nine lab values marked as "abnormal" or not within the normal clinical range. Some of the abnormal results included: a serum CO2 (carbon dioxide) level of 16 (normal range for CO2 at this lab was 22 to 29), an anion gap level of 19 (normal range at this lab was 8 to 16) and a glucose level of 182 (normal range at this lab was 70 to 140). Abnormal labs were resulted in orange text. 6/19/23 - E25 (NP) ordered CMP and CBC lab work STAT (immediately) "for altered mental status". E25 (NP) also ordered a UA (urinalysis) C&S (urine culture and sensitivity test to rule out a urinary tract infection) "for altered mental status". 6/19/23 4:52 PM - R91 had CMP and CBC labs drawn STAT. R1 had a UA C&S sent to the lab for analysis. 6/19/23 6:56 PM - In a little over two hours later, R1's STAT labs were reported to the facility with twelve lab values marked as "abnormal." Some of the abnormal results included: a white cell blood count (WBC) level of 15.2 (normal level for this	F 773	C. A root cause analysis was conducted by the interdisciplinary team and determined that lab values were being reviewed in PCC, however, it was not being documented that they were promptly notifying the ordering medical practitioner of out of range results. NPE/designee will provide re-education on when to notify medical practitioners promptly of laboratory results that fell outside of reference ranges and to document the notification in the resident chart. D. DON/designee will conduct audits of laboratory results to ensure the ordering medical practitioner is notified promptly of laboratory results that fell outside of the clinical reference ranges and notification is documented in the residents chart. Audits to occur daily times three weeks or until 100% compliance is achieved, weekly times three weeks or until 100% compliance is achieved, and then monthly times three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 13)	

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F 773	Continued From page 68 lab was 3.7 to 8.9), a serum Chloride level of 110 (normal level for this lab was 98 to 107), a serum CO2 level of 5.0 (normal level for this lab was 22 to 29), and an anion gap level of 29 (normal levels for an anion gap lab was 8 to 16). Abnormal labs were resulted in orange text. 6/21/23 2:33 PM - R91's UA results are reported to the facility. 6/30/23 5:24 PM - E3 (ADON/UM) marked R91's lab work dated 6/17/23 as "reviewed." This was the only documentation in the medical record that acknowledged these labs had been reviewed. This acknowledgement occurred 13 days after the lab results were reported to the facility. 6/30/23 5:24 PM - E3 (ADON/UM) marked R91's lab work from 6/19/23 as "reviewed."This was the only documentation in the medical record that acknowledged these labs had been reviewed. This acknowledgement occurred 11 days after the lab results were reported to the facility. Of note, these labs were ordered STAT, meaning the provider was interested in having the results immediately. 6/30/23 5:24 PM - E3 (ADON/UM) marked R91's UA results as "reviewed."This was the only documentation in the medical record that acknowledged this UA had been reviewed. This acknowledgement occurred 9 days after the lab results were reported to the facility. 8/31/23 - At approximately 8:50 AM during an interview, E2 (DON) stated that their contracted laboratory company will call with a "critical" result, which would be marked "red" on the report. By protocol when alerted to a critical lab value, the	F 773		

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F 773	Continued From page 69 staff then would call both the provider on-call or the in house provider and the DON. "Abnormal" lab results from this contracted lab would be marked as "orange" and does not require a phone call to the provider and DON. E2 was not certain what was the critical result range for the anion gap lab result was for the facility. During this interview, E2 (DON) also stated that the labs were not marked as "reviewed" until "they are done completely. Sometimes they need to be addressed at IDT (interdisciplinary team) meetings." E2 clarified that the provider was typically notified about the results prior to labs being marked "reviewed". When asked how it is documented that the provider was notified, she stated, "we may need to look at that.". 8/31/23 12:40 PM - During an interview when questioned about being notified of lab results, E33 (MD) stated that per protocol, he gets notified of "critical" lab values immediately after the nurse is informed of the results. 2. Review of R102's clinical record revealed: 8/18/23 - R102 was admitted to the facility with diagnoses including bilateral lower extremities cellulitis and diabetes. Of note, 8/18/23 was a Friday. 8/21/23 9:34 AM - R102 had a complete metabolic panel (CMP) and complete blood count (CBC) lab work collected. 8/22/23 4:04 PM - R102's labs reported to the facility with seven abnormal results that were marked "orange" on the report. Orange text meant the labs were abnormal.	F 773		

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F 773	Continued From page 70 8/31/23 9:53 AM - R102's lab work from 8/21/23 was still listed as "To be reviewed" in Point Click Care (PCC, the electronic record). There was no documentation that the provider/physician was notified about the seven abnormal lab values. This was eight days after the abnormal lab values were reported to the facility. 3. Review of R103's clinical record revealed: 8/25/23 - R103 was admitted to the facility with diagnoses including stroke and diabetes. Of note, 8/25/23 was a Friday. 8/28/23 7:42 AM - R103 had a CMP lab work collected. 8/28/23 11:21 AM - R103's labs reported to the facility with seven abnormal results that were marked "orange" on the report. Orange text meant the labs were abnormal. 8/31/23 9:27 AM - R103's lab work from 8/28/23 is still listed as "To be reviewed" in PCC. There was no documentation that the provider/physician was notified about the seven abnormal lab values. This was three days after the abnormal lab values were reported to the facility. 4. Review of R104's clinical record revealed: 8/25/23 - R104 was admitted to the facility with diagnoses including stroke and diabetes. Of note, 8/25/23 was a Friday. 8/28/23 7:31 AM - R104 had a CMP and CBC collected.	F 773		

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F 773	Continued From page 71 8/28/23 11:35 AM - R104's labs reported to the facility with five abnormal results that were marked "orange" on the report. Orange text meant the labs were abnormal. 8/31/23 9:39 AM - R104's lab work from 8/28/23 was still listed as "To be reviewed" in PCC. There was no documentation that the provider/physician was notified about the five abnormal lab values. This was three days after the abnormal lab values were reported to the facility. 8/31/23 5:20 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 773		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		10/25/23

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F 791	Continued From page 72 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for four (R7, R16, R20 and R60) out of six sampled residents for dental services, the facility failed to assist the residents in obtaining routine dental services. Findings include: A facility policy and procedure titled, "OPS160 Dental Services," with last revision of 9/1/22, documented, "Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures."	F 791	A. R7, R16, R20 and R60 were offered dental services on 8/21/2023. B. All current residents have the potential to be negatively impacted by this deficient practice. Social work conducted an audit of all current residents on 8/21/2023, all residents identified as needing dental services were scheduled for dental services on 8/21/2023. C. A root cause analysis was conducted on 09/07/2023 by the interdisciplinary team which determined that social services needs re-education on regulation	

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F 791	Continued From page 73 1. Review of R7's clinical record revealed: 4/17/23 - R7 was admitted to the facility. 4/17/23 - R7's care plan documented that R7 " ...exhibits or is at risk for oral health or dental care problems as evidenced by absence of natural teeth ...." 4/23/23 - The admission MDS assessment documented that R7 had no natural teeth or [having] tooth fragments. 8/14/23 9:57 AM - During an observation and interview, R7 revealed broken and missing teeth. R7 stated she had not seen a dentist yet and had requested staff to see one upon admission. There was lack of evidence of any routine dental consultation since 4/17/23. 2. Review of R16's clinical record revealed: 6/20/19 - R16 was admitted to the facility. 6/20/19 - R16's care plan documented that R16, " ...exhibits or is at risk for oral health or dental care problems as evidenced by no upper teeth." 1/11/21 - R16 was readmitted to the facility. 1/18/22 - The annual MDS assessment documented that R16 had no natural teeth or [having] tooth fragments. 8/15/23 9:28 AM - During an interview, R16 stated they have never been seen by a dentist and has been at the facility for 4 years.	F 791	483.55 Dental Services. NPE/designee will provide re-education on regulation 483.55 Dental Services with a focus on assisting residents with scheduling routine dental services. D. DON/designee will audit all current residents to ensure they are obtaining routine dental service. Audits will occur monthly for three months or until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 14)	

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F 791	Continued From page 74 There was lack of evidence of any routine dental consultation since 6/20/19. 3. Review of R20's clinical record revealed: 11/8/11 - R20 was admitted to the facility. 4/2/22 - R20 was readmitted to the facility. 9/7/22 - The MDS assessment documented that R20 did not have any broken or chipped teeth. 8/14/23 1:42 PM - During an interview, R20 stated they requested directly to the social worker to be seen by a dentist over one year ago and have not seen anyone here. There was lack of evidence of any routine dental consultation since 2/24/17. 4. Review of R60's clinical record revealed: 7/25/19 - R60 was admitted to the facility. 7/25/19 - R60's care plan documented that R60, " ...exhibits or is at risk for oral health or dental care problems as evidenced by missing upper teeth." 8/27/22 - R60 was readmitted to the facility. 9/13/22 - The annual MDS assessment documented that R60 had no natural teeth or [having] tooth fragments. 8/14/23 1:18 PM - During an interview, CG2 (R60's Daughter) stated they have never been asked about routine dental care for R60.	F 791		

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F 791	Continued From page 75 There was lack of evidence of any routine dental consultation since 7/25/19. 8/18/23 1:00 PM - During an interview with E8 (Social Services) regarding R7, R16, R20 and R60, they stated, "There is no routine cleaning by a dentist." 8/21/23 11:00 AM - An interview with E1 (NHA) and E4 (Social Services) regarding R7, R16, R20 and R60, they confirmed routine dental consults are not offered to residents on an annual basis. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 (DON) and E3 (ADON).	F 791		
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; §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	F 803		10/25/23

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F 803	Continued From page 76 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 residents received the selected food from the menu for one (R78) out of ten sampled residents for food investigation. Findings include: 8/16/23 11:40 AM - During a random dining observation of R78's lunch tray, the meal ticket did not match and R78 did not receive a dinner roll or fruit sherbet. 8/16/23 11:44 AM - An interview with E21 (CNA) confirmed that items are often missing from tray and she will walk down and get them. E21 confirmed the dinner roll and sherbet were missing from tray. 8/16/23 11:49 AM - The Surveyor observed E21 providing R78 a dinner roll and a container of fruit sherbet. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 803	A. R78's meal was updated immediately during the survey. B. All residents have the potential to be impacted by this deficient practice. C. A root cause analysis determined R78 changed his meal choice more than once but the meal ticket was not updated to reflect his most current choice. An audit was conducted during the survey to ensure all residents received their meal choices. The Dietary Manager will educate staff regarding resident choice and menu changes by 8/25/2023. D. Dietary Manager/designee will audit meal tickets. Audits will occur daily times three until 100% compliance is achieved, three times a week until 100% is achieved for three weeks, then weekly until 100% compliance is achieved for 3 weeks, then monthly for three months until 100% compliance is achieved. Audit results will be reported to and monitored by the QAPI Committee.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		10/25/23

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F 812	Continued From page 77 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure safe sanitary storage of food, provide the sanitizing solution required for disinfecting food preparation surfaces, and maintain sanitary food preparation areas. Findings include: 8/14/23 10:10 AM - During a kitchen tour, several food items including a container of sliced beets, a large container of a red liquid, a large container of a yellow liquid, and a container of unidentified leftovers were observed with partially open coverings exposing the contents to dust and other debris in the walk-in refrigerator. The reach-in refrigerator contained cartons of thickened juices, sandwiches, and salads, which were missing the date stamp required for safe food storage. 8/14/23 10:20 AM - During a tour of the kitchen,	F 812	A. No residents were negatively impacted by this deficient practice. Deficient practices were corrected on 8/18/2023. B. All current residents have the potential to be impacted by this deficient practice. C. A root cause analysis was conducted to determine why food items weren't date stamped and food surfaces weren't sanitized. The deficient practices identified were corrected on 8/21/2023. The primary factor identified was new current staff members who were still	

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F 812	Continued From page 78 no red sanitizer buckets containing sanitizing solution were available in the kitchen for disinfecting food preparation surfaces. 8/14/23 10:25 AM - Crumbs and other food debris were observed on the floor in the kitchen and food prep surfaces in areas where food prep was not occurring during observation. 8/17/23 8:35 AM - Findings were confirmed with E1 (NHA). 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON).	F 812	learning the kitchen system. The Dietary Director provided additional education (ATTACHMENT Q) on 8/21/2023. D. The Dietary Manager/designee will audit compliance to ensure food items are date stamped, food surfaces are sanitized and the food prep area is kept clean. Audits will occur daily times three until 100% compliance is achieved, three times a week until 100% is achieved for three weeks, then weekly until 100% compliance is achieved for 3 weeks, then monthly for three months until 100% compliance is achieved. Audit results will be reported to and monitored by the QAPI Committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		10/25/23

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F 842	Continued From page 79 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 80 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that the facility failed to ensure, in accordance with professional standards and practices, that medical records for one (R82) out of twenty six (26) of the investigative sampled residents were accurate. Findings include: Review of R82's clinical record revealed: 1/8/23 - R82 was admitted to facility. 6/22/23 3:47 PM - A physician's order was written for Tramadol 50mg give 25 mg by mouth every 6 hours as needed for moderate to severe pain for R82. 8/18/23 - A review of R82's Individual Patient Controlled Record form for Tramadol lacked evidence of staff receiving the drug including date and time. 8/18/23 11:11 AM - An interview with E17 (LPN) and E3 (ADON/UM) confirmed that the facility lacked evidence of completing the Individual Patient Controlled Record for R82's Tramadol. 8/21/23 2:50 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3.	F 842	A. R82□s Patient Controlled Record form was immediately updated to reflect proper documentation. B. All current residents who receive controlled substances have the potential to be impacted by this deficient practice. DON/designee will conduct an audit of all current Patient Controlled Records to ensure proper documentation. C. A root cause analysis conducted on 10/02/2023 by the interdisciplinary team determined that all current licensed nursing staff need re-education on policy for controlled substances with a focus on procedure for receiving and logging controlled substances in Patient Controlled Record. NPE/designee will re-educate all current licensed nursing staff on procedure for receiving and logging controlled substances in Patient Controlled Record. D. DON/designee will conduct an audit to ensure the completion of the individual Patient Controlled Record. Audits will be	

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F 842	Continued From page 81	F 842	conducted three times a week for three weeks until 100% is achieved, then weekly for three weeks or until 100% compliance is achieved, then monthly for three months until 100% compliance is achieved. Audit results will be presented to the QAPI committee for review. (AUDIT 15)	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §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: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		10/25/23

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F 868	Continued From page 82 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure attendance of required members at the quarterly quality assurance and performance improvement (QAPI) meetings. Findings include: Review of the facility's QAPI plan, last updated 1/6/21, indicated, " ...Meets at least 10 times annually ... is composed of ... The Infection Preventionist, or designee ...." 8/21/23 - A review of the QAPI Meeting Sign-in Sheets revealed that the Infection Preventionist or designee was not present during the 10/20/22, 11/22/22, 12/22/22, 1/19/23, 2/23/23, 3/23/23, 4/27/23, 5/15/23, or the 7/27/23 meetings. 8/21/23 10:45 AM - During an interview with E1 (NHA) and E2 (DON), it was confirmed that E20 (Infection Preventionist) had been in that role with the facility for more than one year and was not in attendance during the quarterly QAPI meetings. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 868	A. No residents were negatively impacted by this deficient practice. B. All current residents have the potential to be impacted by this deficient practice. C. A root cause analysis conducted on 10/03/2023 to determine the cause of the deficiency identified current staff absences during QAPI meetings as the primary cause. NHA/designee has provided current staff education on the F868 regulation (ATTACHMENT R) on 8/21/2023. The process has been implemented where Current staff who are out of the office can call into the meeting or attend via Zoom. Remote participation will be documented and verified by the NHA. D. NHA/designee will audit QAA Committee meetings to ensure compliance. Audits will occur monthly following each QAA Meeting for 4 months to ensure 100% Compliance is achieved.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/25/23

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	085015	A. BUILDING _____ B. WING _____	C 09/07/2023

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F 880	Continued From page 83 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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:	F 880		

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F 880	Continued From page 84 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections. Findings include: The manufacture's instructions for cleaning and disinfecting, with a revision of March 2015, indicated cleaning and disinfecting of the	F 880	A. E12 was immediately re-educated on manufacturer recommended wipes for use on the glucometer. B. All current residents who have orders to receive accuchecks have the potential to be impacted by this deficient practice. C. A root cause analysis completed on 10/03/2023 by the interdisciplinary team	

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F 880	Continued From page 85 glucometer needs to be completed after each resident use. 8/16/23 9:44 AM - During medication administration observation, E12 (LPN) used an alcohol pad before and after performing fingerstick blood sugar testing. 8/16/23 11:04 AM - During medication administration observation, E12 (LPN) used an alcohol pad before and after performing fingerstick blood sugar testing. 8/17/23 10:48 AM - During medication administration observation, E24 (RN) used an alcohol pad before and after performing fingerstick blood sugar testing. 8/21/23 10:23 AM - During an interview E22 (RN) stated she uses an alcohol pad to clean the glucometer, "they don't have any more germicidal wipes." 8/21/23 10:40 AM - During an interview E12 (LPN) stated she uses an alcohol pad to clean the glucometer. 8/21/23 10:53 AM - During an interview E23 (Supplies) stated there is an adequate supply of germicidal wipes and proceeded to show this surveyor, there were at least twelve containers on the shelf. E23 stated that the "Cavi-wipes that staff are used to using have been discontinued" thus E23 had to order from another supplier. E23 then proceeded to say " Every Friday I re-stock both units." 8/21/23 11:20 AM - During an interview E12 confirmed that there should be a container of	F 880	and determined that licensed nursing staff need to be re-educated on manufacturer recommendations on the type of disinfecting wipes to use on the glucometers. NPE/designee will provide re-education to all current licensed nursing staff on manufacturer recommended wipes for use on glucometers. D. DON/designee will conduct random audits via observation three times a week for 3 weeks or until 100% compliance is achieved to ensure licensed nursing staff is using proper product to clean glucometers. Audit results will be presented to the QAPI committee for review. (AUDIT 16)	

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F 880	Continued From page 86 germicidal wipes on each med cart. 8/21/23 2:50 PM - Findings were reviewed with E1, E2 and E3 (ADON).	F 880		