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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health **DATE SURVEY COMPLETED: November 1, 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 October 10, 2023 through November 1, 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 seventy (70). The survey sample size was forty (40) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	Cross refer to the CMS 2567-L survey completed 11/1/23: F600, F641, F644, F686, F689, F690, F730, F756, F761 and F812	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey completed 11/1/23: F600, F641, F644, F686, F689, F690,		

Provider's Signature Heather Shea Title NHA Date 12/1/23

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	F730, F756, F761 and F812.		
3201.9.8 **3201.9.8.4** **3201.9.8.4.2**	**Reportable incidents are as follows:** **Significant injuries.** **Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** Based on record review and interview, it was determined that for one (R33) out of six residents reviewed for accidents, the facility failed to report to the State Agency a fall with injury and a transfer to an acute care facility. Findings include: 2/15/19 – R33 was admitted to the facility with Alzheimer's disease. 12/22/22 - R33's care plan included: R33's is at risk for falling r/t impaired mobility, incontinence, medications, cognitive loss, attempts to transfers self, refuses to call for assist, DM. Sometimes refuses to put on socks and shoes even with encouragement. 12/22/22 – Review of R33's physician orders included that R33 was prescribed Plavix and Eliquis (two blood thinner medications). 6/27/23 - Quarterly MDS documented that R33 was extensive assistance of two staff members for transfers and could not walk. 10/7/23 – A facility assessment documented	3201.9.8 3201.9.8.4 3201.9.8.4.2 1 R33 still resides in the facility. State reportable was completed and submitted to the state for the 10/7/2023 fall which resulted in injury and transfer to acute care setting. 2 Current residents residing in the facility who had falls with injuries and were transferred to an acute care setting have the potential to be affected by this practice. All residents who were transferred to an acute care setting as a result of a fall with an injury were reviewed to ensure that a report was completed and submitted to the state. No other residents were identified. 3 A root cause analysis revealed the need for re-education of the DON on section 3201.9.8, 3201.9.8.4 and 3201.9.8.4.2 of the Regulations for Skilled and Intermediate Care Facilities. The DON will be re-educated by the	1.1.2024

Provider's Signature Sabrina Glen Title NHA Date 12/1/23

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	that R33 was at high risk for falling. 10/7/23 6:20 AM – A facility incident report documented "Resident had a fall. The nurse observed on the floor by the RN on duty and was assessed and sent out to (the) the ER via 911 services. Head assessment revealed resident's right eye (with) orbital swelling." 10/17/23 – During an interview E2 (DON) confirmed that R33's fall with injury that required a transfer to an acute care facility was not reported to the State Agency. 10/20/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ED) at the exit conference beginning at 12:30 PM	Administrator/designee on section 3201.9.8, 3201.9.8.4 and 3201.9.8.4.2 of the Regulations for Skilled and Intermediate Care Facilities. 4 DON/designee will conduct an audit of all residents who were transferred to an acute care setting as a result of a fall with injury in the last 12 months to verify that a report was completed and submitted to the state. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% is verified, then monthly X 3 until 100% is verified. Results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	1.1.2024

Provider's Signature [signature] Title NHA Date 12/11/23

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	085032	A. BUILDING _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from October 10, 2023 through Novemeber 1, 2023. The facility census was 70 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 October 10, 2023 through November 1, 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 seventy (70). The survey sample size was forty (40) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Air-filled heel off-loading boots - boots to reduce pressure; BMP - Basic Metabolic Panel; cm - centimeter; CBC - Complete blood (cell) count; CNA - Certified Nursing Assistant; DON - Director of Nursing;	F 000		

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

Electronically Signed | 12/01/2023

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

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F 000	Continued From page 1 ED - Executive Director; e.g. - For example; GM - Gram; HCT - Hematocrit; L - left; LLE - left lower extremity; LNAC - Licensed Nurse Assessment Coordinator; 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; NWB - non-weight bearing; OOB - Out of bed; PRN - As needed; Q - Every; RN - Registered nurse; RNAC - Registered Nurse Assessment Coordinator TID- three times a a day; UM - Unit Manager; Abuse - to hurt, injure or damage OR mental, physical, sexual, involuntary seclusion or misappropriation of resident property); Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Basic Metabolic Panel (BMP) - set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15 Cognitively intact 8-12 Moderately impaired	F 000		

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F 000	Continued From page 2 0-7 Severe impairment; Care Plan - outlines the plan of action that will be implemented during a patient's medical care; Complete Blood Count (CBC) - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia Controlled Ankle Motion Boot/CAM Walker Boot (CAM) - an adjustable device that limits ankle movement that comprises of a flexible liner (which the foot fits into) and a rigid shell (which supports and protects the leg). 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; Conduct - manner in which a person behaves; Culture & Sensitivity (C&S) - laboratory test to identify what bacteria is causing an infection and which antibiotic will effectively kill the bacteria; 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; Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard scab; usually black in color	F 000		

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F 000	Continued From page 3 Extensive assist - means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance. Hematocrit (HCT) - ratio of red blood cells to the total volume of blood; Hemiplegia - paralysis of one side of the body; 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; ICD 10- the International Classification of Diseases, a coding system used for documenting diseases and billing in healthcare; Interdisciplinary Team - professional from different fields and departments who work together with the resident to develop and implement an individualized plan of care; Minimum Data Set (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; Minimum Data Set (MDS) - a standardized assessment form used in nursing homes; Multi Podus Boot - boot or brace that eliminates pressure or friction on the heel to enhance blood circulation and promote healing Nasal cannula - tube placed into nostrils to deliver oxygen; Pressure Ulcers (PUs) - sore area of skin that	F 000		

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F 000	Continued From page 4	F 000		

develops when the blood supply to it is cut off due to pressure;
Prevlon Boot - boots with a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure;
Pseudobulbar Affect - a type of neurological disorder characterized by uncontrollable episodes of crying and laughing;
Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film;
Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated;
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;
Treatment Administration Record (TAR) - list of daily/weekly/monthly treatments to be performed;
Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed);
Ulcer - an open sore on an external or internal surface of the body, caused by a break in the skin or mucous membrane that fails to heal;
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 in patients with suspected urinary tract infection;
1:1 Supervision - one staff person assigned direct

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F 000	Continued From page 5 supervision of a resident.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and 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 three (R71, R68 and R43) out of six residents reviewed for abuse, the facility failed to ensure that R71, R68 and R43 were free of sexual abuse by R16, a resident with a history of sexually inappropriate behavior. The facility's failure to monitor R16 allowed the sexual abuse of R71 on 9/14/22, R68 on 11/16/22 and R43 on 12/16/22. An Immediate Jeopardy (IJ) was identified starting 9/14/22. Due to the facility's corrective measures following the last incident, this is being cited as immediate jeopardy, past non-compliance with an abatement date of 12/16/22. Findings include: A facility policy and procedure titled, "Abuse, Neglect or Exploitation", revised 10/24/22,	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 6	F 600		

documented, "Policy...each resident is provided with a safe environment where they are not subject to mental, physical...and sexual abuse...Objective: Residents are protected from real or perceived abuse...Standard: The facility is committed to ensuring that each resident is free from verbal...or sexual abuse...."

Review of R16's clinical record revealed:

3/15/21 - R16 was admitted to the facility with diagnoses including depression, anxiety, mood disorder and dementia.

3/21/21 - R16's admission MDS assessment revealed that R16 had severe cognitive impairment. During the seven-day review period R16 was exhibiting behavioral symptoms of the sexual nature directed towards himself. In addition, R16 wandered during the seven-day review period. R16 required supervision and setup help only for transfer and required supervision during walking and locomotion.

2/16/22 - A care plan was developed for R16's inappropriate sexual behaviors related to dementia. R16's interventions included but not limited to monitor and document episodes of behavior, psych evaluation and offer early breakfast.

R16 had physician's orders for:
-2/18/22 behavior documentation every shift for sexually inappropriate behavior.
-2/21/22 psych consult for sexually toward behavior;
-2/23/22 divalproex (Depakote) increased from 125 mg 1 capsule twice a day to 2 capsules twice a day for mood disorder.

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F 600	Continued From page 7 A review of R16's CNA Daily Charting from February through April 2022 revealed that R16 was being monitored by the CNAs every shift from 2/18/22 through 4/25/22. From 4/26/22 through 4/30/22, R16 was monitored by the CNAs hourly and every shift. 4/22/22 7:04 AM - A psychiatry note by P3 revealed that on 4/21/22, R16 was seen for follow up psychotropic medication adjustment - lexapro initiated...monitor and notify provider of any change in condition or ongoing behavior escalation." A. R71 9/1/22 - R71's quarterly MDS assessment revealed that R71 had severe cognitive impairment. R71 required supervision and setup help only during transfer, walking and locomotion. 9/14/22 - A facility incident report submitted to the State Agency documented that, "Staff member observed (R16) with his hands inside the waistband of (R71)'s pants. Per witness it appeared that R16 was attempting to fondle R71. R16 was redirected at which time he removed his hand from R71's pants, he continued to pet her hand and forearm in an affectionate manner. Residents were redirected into separate areas of the unit. (Police) were notified." R16 had a new physician's orders for: 9/14/22 - psychiatry consult for worsened sexual behaviors. 9/14/22 - laboratory CBC, BMP 9/16/22 1:02 PM - A psychiatry note by P3	F 600		

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F 600	Continued From page 8 revealed that on 9/15/22, R16 was seen secondary to staff witnessing R16 inappropriately touching a female resident...."(R16) ... engages easily in conversation...discussed concern with (R16's) inappropriate behavior - touching female residents. (R16) acknowledges behavior and states "ok" when advised not to repeat behavior...No new pharmacological recommendation...." 9/19/22 - A facility follow up report submitted to the State revealed that R16 was cognitively impaired with poor decision making. R16 had a referral for placement in the dementia unit and the female resident (R71) was moved to a different unit. Review of R16's records revealed that R16 was on every 15 minutes checks on 9/14/22 from 10:30 AM until 10:30 PM daily. A review of R16's CNA Daily Charting from 9/1/22 through 9/15/22 revealed that R16 was monitored by the CNAs hourly and every shift. Although the facility had monitoring in place for R16, the facility failed to protect R71 from sexual abuse. B. R68 9/18/22 - R68's quarterly MDS assessment revealed that R68 had severe cognitive impairment. R68 required extensive assist of one staff member for transfer, non-ambulatory and required extensive assist of one staff member for locomotion on the unit. A review of R16's CNA Daily Charting (electronic)	F 600		

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F 600	Continued From page 9 from 9/16/22 through 11/15/22 revealed that R16 was monitored by the CNAs every shift. 11/16/22 - A facility incident report submitted to the State Agency documented that, "Staff witnessed (R16) with his hand inside (R68's) shirt rubbing her breasts as she was sleeping in a chair in a common area TV room. Staff immediately intervened and redirected R16, separating residents...police report filed...." Review of R16's records revealed that the licensed nurses monitored R16: - every 15 minutes check on 11/16/22 from 8:50 AM until 11/17/22 9:00 AM. - every 30 minutes check on 11/17/22 from 10:30 AM until 11:00 PM. - every hour check from 11/17/22 11:00 PM until 11/18/22 7:00 AM. Review of R16's CNA flowsheet revealed that R16 was also monitored by the CNAs hourly from 11/16/23 11:00 PM until 11/17/23 6 PM. R16 had physicians' orders for: -11/16/22 trazodone 50 mg tablet give 1/2 tablet (25 mg) by mouth three times a day for anxiety disorder; -11/16/22 Depakote level in am (11/17/22) notify (psych MD) of result; -11/17/22 psych consult; -11/17/22 referral to psych unit; -11/18/22 laboratory urinalysis to rule out urinary tract infection; -11/18/22 olanzapine 5 mg 1 tablet at bedtime for delusional disorders; -11/16/22 behavioral monitoring every hour and to document sexual inappropriate behavior; -11/25/22 behavioral monitoring and to document	F 600		

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F 600	Continued From page 10 behaviors and any side effects for psychotropic medications: antianxiety, antidepressant, antipsychotic, mood change, crying, withdrawn, target behaviors: wandering, pacing, resisting care, sexually inappropriate behavior, delusions...monitor and document for suicidal ideation; -12/2/22 escitalopram 10 mg dose was decreased back to 5 mg 1 tablet daily. 11/17/22 10:05 PM - R16's nurse progress note by E25 (LPN) documented, "MD (physician) in facility and assessed resident due to...inappropriate behavior, new order received for CMP, progressive UA (urinalysis) and CBC to be done in AM (morning)...psych consult, which was done this day, refer to psyche unit, and if needed, 1:1 supervision, per MD all was discussed with DON and ADON...." 11/21/22 8:54 AM - A psychiatry note by P3 revealed that on 11/17/22, R16 was seen secondary to inappropriately touching a female resident and psychotropic medication use review..."(R16) ...not a great conversationalist today; discussed concern with (R16's) inappropriate sexual behavior - touching female resident earlier in the week. R16 does not elaborate on incident but begins to cry...has exhibited similar behavior in the past - last noted...behavior is impulsive yet resident is typically aware of wrong doing...No new pharmacological recommendation...is a recurrent behavior unfortunately for (R16) likely due to progressing cognitive decline and impulsivity". 11/21/22 - A facility follow up report submitted to the State revealed that R16 had a diagnosis of dementia with behavioral disturbance and	F 600		

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F 600	Continued From page 11 advance impairment in cognition. R16's medications were reviewed and adjusted. R16 was on hourly safety checks and behavior monitoring. Although the facility had monitoring in place for R16, the facility failed to protect R68 from sexual abuse. C. R43 9/22/22 - R43's quarterly MDS assessment revealed that R43's cognition was severely impaired. R43 required extensive assist with one staff member for transfer, walking on unit and locomotion. 12/16/22 - A facility incident report submitted to the State Incident Reporting Center documented that R16 who was confused, placed his hands inside the "upper chest area/clothing" of a female resident (R43) but was immediately redirected. R16 had a physician's order for: -12/16/22 1:1 supervision for sexual inappropriate behavior; -12/19/22 obtain Depakote level in am (12/20/22), then LFT (liver function test) in 2 weeks; -12/19/22 if Depakote level is less than 50, then increase Depakote to 375 mg by mouth two times a day and repeat Depakote level and LFT in 2 weeks; -12/19/22 olanzapine 2.5 mg 1 tablet by mouth every morning - administer only if Depakote level is therapeutic (50-100); -12/19/22 follow up with psych services at next visit to facility. 12/16/22 - Review of R16's care plan	F 600		

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F 600	Continued From page 12 interventions related to his sexually inappropriate behavior included R16 placed on one-to-one supervision and referrals made to psych facilities. 12/20/22 - A facility follow up report submitted to the State revealed that R16 had advanced dementia and had exhibited sexually inappropriate behavior. R43 was immediately removed from the area. R16 was placed on 1:1 supervision 24 hours a day, family members and police were notified...and an order to consult inpatient psych for evaluation and treatment. R16 was transferred to a (psych hospital) on 12/20/22. Although the facility had monitoring in place for R16, the facility failed to protect R43 from sexual abuse. Further review of R16's records revealed that 1:1 supervision continued 24 hours a day upon his readmission to the facility on 1/6/23 through March 2023. From March 2023 through April 2023 R16's 1:1 supervision was decreased to day shifts and evening shifts. From April 2023 to 5/31/23 the 1:1 supervision was decreased to just day shift until 5/31/23. After 5/31/23 R16's monitoring was decreased to hourly monitoring and remains on the hourly monitor through the present. 10/12/23 9:55 AM - In an interview, E5 (LPN) stated, "resident is being monitored hourly for inappropriate sexual behaviors like touching female residents. He used to be in the LTC unit but since his re-admission early this year, they moved him here in the short-term unit. He has been behaving well and there have been no incidents of inappropriate behavior. He has been calm."	F 600		

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F 600	Continued From page 13 10/18/23 8:30 AM - In an interview, E6 (CNA) stated that resident (R16) is currently being monitored hourly and that resident did not have any sexually inappropriate behavior. 10/18/23 11:19 AM - An immediate jeopardy (IJ) was called and reviewed with the facility leadership, including E1 (NHA), E2 (DON) and E24 (Corporate Clinical Nurse Consultant). During this conference, both E1 and E2 confirmed that there had been no other incidents of sexually inappropriate contact by R16 with other residents after the 12/16/22 incident. 10/18/23 - E1 (NHA) presented to surveyor an acceptable documentation of corrective action plan that was fully abated on 12/16/22. The facility's corrective actions at the time of the incident included R16 on 1:1 supervision and then was sent to a psych hospital on 12/20/22. R16 was maintained on 1:1 supervision upon his return to the facility on 1/6/23. This was verified by review of facility documents and interview with facility staff and residents. 10/18/23 11:19 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E24 (Corporate Clinical Nurse Consultant).	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 641	R5 still resides in the facility. R5□s left	2/1/24

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F 641	Continued From page 14 determined that for one (R5) out of forty (40) sampled residents for resident assessment, the facility failed to accurately assess an unstageable pressure ulcer/injury due to an eschar on R5's left lateral heel. Findings include: Review of R5's clinical record revealed: 6/20/23 - R5 was admitted to the facility. 6/26/23 - Review of R5's admission MDS (Minimum Data Set) assessment on skin condition revealed that R5 had one unhealed stage 2 pressure ulcer injury present upon admission, and other wounds and skin problems including a surgical wound and MASD (Moisture Associated Skin Damage). 9/20/23 - Review of R5's Discharge MDS assessment revealed that R5 was discharged to an acute hospital and that R5 had an unhealed stage 2 pressure ulcer injury present upon admission. 10/31/23 - Review of R5's facility Skin Evaluation form dated 9/19/23 documented a pressure injury measuring 4.5 cm in length, 4.0 cm width and 0 cm depth with 100% necrotic/eschar to the left heel. 11/1/23 11:18 AM - In an interview, E22 (RNAC) stated that her review period of gathering clinical data for the discharge MDS was from 9/14/23 through 9/20/223. E22 confirmed and stated, "I looked at the notes that another nurse competed on the skin section of the MDS. I am the one doing the MDS, when I go into the system, I gather the information. I would think all the information in the system is correct. I do not go to	F 641	heel pressure injury was reassessed and accurately documented. Modification MDS was completed to reflect unstageable pressure injury to left heal. Current residents with pressure injuries residing in the facility have the potential to be affected by this practice. MDS records for residents with pressure injuries will be reviewed to ensure that all pressure injuries are coded accurately and correction will be done as necessary. A root cause analysis revealed the need for re-education on the assessment of pressure injuries and MDS coding accuracy. Resident Nurse Assessment Coordinator will be re-educated by the Staff Developer/designee on pressure injury assessment and verifying all information is accurately coded in the MDS. Resident Nurse Assessment Coordinator/designee will conduct an audit of all residents with pressure injury to ensure accurate assessments were done on all skin conditions. Audits will also be conducted on MDS records to ensure coding is accurate for all pressure injuries. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations.	

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F 641	Continued From page 15 the floor and check the residents to validate if information is correct". 11/1/23 11:20 AM - In a follow up interview, E22 confirmed that the information on R5's 9/20/23 discharge MDS assessment did not reflect the accurate skin condition to include R5's unhealed and unstageable pressure ulcer/injury due to an eschar. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ED) and E28 (Regional Operational Services) at the exit conference on 11/1/23 starting at 1:05 PM.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		2/1/24

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F 644	Continued From page 16 Based on interview and record review, it was determined that for two (R38 and R10) out of three residents reviewed for PASARR (preadmission screening and resident review), the facility failed to ensure a referral for a PASARR screening was done for a new mental health diagnoses. Findings include: 1. Review of R38's clinical record revealed: 11/12/19 - A PASARR for R38 revealed a Level 1.5 determination. 6/18/20 - R38 was readmitted to the facility with diagnoses including dementia and conduct disorder. Review of R38's records revealed the following diagnosis identified: 9/1/21 - bipolar disorder 1/28/22 - major depressive disorder, recurrent, severe with psych symptoms 1/28/22 - restlessness and agitation 10/18/23 9:40 AM - An interview with E4 (SW) confirmed that an updated PASARR evaluation was not completed for R38. The facility failed to ensure that a referral for a PASARR screening was completed following the new diagnosis of bipolar and major depressive disorders. 2. Review of R10's clinical record revealed: 6/23/22 - Review of R10's PASARR Level I screen outcome documented... 1. No level II required... 2. No SMI (serious mental illness), ID (intellectual disability) or RC (related condition). In	F 644	R38 and R10 still reside in the facility. PASSAR evaluations were completed for both and submitted with response that both R38 and R10 has a dementia MI exclusion. No modifications were recommended. Current residents with a new diagnosis of a mental or neurocognitive disorder have the potential to be affected by this practice. All residents with new psychiatric diagnosis were reviewed to ensure a PASSAR was completed and submitted at the time of the change. No other residents were identified. A root cause analysis revealed the need for re-education of the Social Worker on the completion and referral for PASSAR screening on any resident with a new psychiatric or neurocognitive diagnosis. The Social Worker will be re-educated by the Staff Developer /designee on completing and submitting a PASSAR referral for all residents with a new psychiatric or neurocognitive diagnosis despite a previous dementia MI exclusion. Social Worker/designee will conduct an audit on all residents with new psychiatric and neurocognitive disorders to ensure PASSARs were completed. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and	

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F 644	Continued From page 17 addition, R10's PASARR Level I screen documented R10 did not have a diagnosis and or neurocognitive disorder. 6/28/22 - A review of R10's medical diagnosis sheet revealed R10 was admitted with a diagnosis of psychosis, anxiety, and dementia. 10/18/23 11:07 AM - E4 (SW) was interviewed and stated, "R10 had a PASARR dated 6/23/22 and was admitted on 6/28/22. E4 revealed "I'm not sure if a PASARR Level II was done, I'll need to check." 10/18/23 1:55 PM - E4 presented a preadmission PASARR Level I screen for R10 and stated, "I don't know why another PASARR had not been done, it just slipped off the radar." The facility lacked evidence that R10 a resident with a mental disorder was referred to the state agency for a PASARR Level II evaluation and determination. 10/20/23 12:30 PM - Findings was were reviewed with E1 (NHA), E2 (DON) and E3 (ED) at the Exit Conference.	F 644	recommendations.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/15/24

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F 686	Continued From page 18 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R5 and R36) out two residents reviewed for pressure ulcers (PU), the facility failed to provide necessary treatment and services to promote healing. For R5, the facility failed to remove an orthopedic boot that was identified as a possible cause of preventing the healing of a pressure ulcer. For R36, the facility failed to apply the air-filled heel off-loading boots. Findings include: 1. Review of R5's clinical record revealed: 6/20/23 - R5 was admitted to the facility from an acute hospital for rehabilitation with diagnoses including a left femur (thigh bone) fracture, difficulty walking, disorientation, dementia. On admission, R5's skin evaluation documented that the left heel had a fluid filled blister with blanchable redness to surrounding skin measuring (L) length 4.0 (cm) centimeters, (W) width 2.7 cm, (D) depth 0.0 cm, and pain level zero. The cause of the left heel wound was noted as pressure. 7/10/23 - The Physician's progress note from E11 (Medical Director) documented that R5 had a fall on Friday 7/7/23 and was diagnosed with a left ankle fracture is now non-weight bearing and in a boot. R5 does have a known stage 2 PU on that	F 686	R5 and R36 still residents in the facility. The orthopedic boot was removed from left lower leg of R5. The air-filled off-loading heel boots have been applied to R36 while in bed and wheel chair as tolerated. Current residents in the facility with orthopedic boot who have pressure ulcers and have orders for air filled off-loading heel boots have the potential be affected by this practice. All residents with pressure ulcers and have orders to wear orthopedic boots were reviewed and assessed for the boots potential to cause injury. All residents with pressure ulcers and with physician orders to wear air-filled off-loading boots were reviewed to ensure compliance with physician's orders. No other residents were identified. A root cause analysis revealed to need for re-education of licensed nursing staff on assessment of orthopedic boots and their potential to cause injury. Root cause analysis also revealed the need for re-education of licensed nursing staff on following physicians□ orders for air-filled off-loading boots. The licensed nursing staff will be re-educated by the Staff	

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F 686	Continued From page 19 same heel. Continue with good skin checks and continue with current wound care." 7/18/23 - P2's wound care note documented that "[R5] presented in an CAM boot today." The physical examination showed a wound on the left lateral heel, fully regressed blood-filled blister ...." The analysis was noted as [R5] was status post a fall with left ankle fracture, placed in a CAM per the orthopedic doctor, and the CAM boot did not have heel padding or a cut-out and likely exacerbated the existing partial thickness wound - deterioration of the site was felt to be "unavoidable." 7/25/23 - P2's wound care physical examination revealed a full thickness wound of the left lateral heel intact fully regressed blood-filled blister ... unstageable pressure ulcer/injury of the left lateral heel due to DTI-wound evolving. ...patient was status post a fall with left ankle fracture, was placed in a CAM per the orthopedic doctor, and the CAM boot did not have heel padding or a cut-out and likely exacerbated the existing partial thickness wound - deterioration of the site was felt to be "unavoidable." 8/1/23 - The wound care note from P2 documented "8/1/23 nursing please send wound care note to the orthopedic surgeon-discussed with nursing and rehabilitation. [R5] is non-weight bearing and there is not clinical indication for the CAM boot which has caused a pressure injury on [R5's] skin and is continuing to exacerbate the site, preventing it from healing - recommending substitution of Multi Podus boot with kickstand that has heel cut out for offloading - please consult orthopedics for the okay to make this change."	F 686	Developer/designee on assessment of orthopedic boots and their potential to cause injury. The nursing staff will be re-educated on compliance with physician orders for air-filled off-loading boots. DON/designee will conduct an audit on all residents with orders for orthopedic boots to ensure the boot does not have the potential to cause injury. DON/designee will also conduct an audit on all residents with orders for air-filled off-loading boots to ensure compliance with physicians orders. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations.	

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F 686	Continued From page 20 8/8/23 - The physical examination by P2 revealed the full thickness wound of the left lateral heel measuring 3.8 x 4.1 x 0.0 centimeters, wound base 100% intact dry forming eschar (a slough or piece of dead tissue that sheds off from the surface of the skin after an injury). "Analysis: status post fall with left ankle fracture; orthopedic Dr. put in CAM boot which does not have heel padding or a cut out and likely exacerbated existing partial thickness wound deterioration of site felt to "be unavoidable." 8/8/23 - P2's wound care note documented "per the nursing and rehabilitation staff, orthopedics agreed to the patient only wearing the CAM boot while out of bed; while in bed patient does not need this device and heel can be sufficiently offloaded." Although wound care had presented to the wound team and documented in the note that the CAM boot was likely exacerbating the pressure injury it was 15 days before the facility communicated with orthopedics to change the treatment order to wearing the CAM boot only when out of bed. 2. Review of R36's clinical record revealed: 9/19/17 - R36 was admitted to the facility with diagnoses including CVA (stroke), aphasia (a disorder that affects how you communicate), and spastic hemiplegia (paralysis on one side of the body) affecting the left side. 5/26/20 - A physician order documented that the resident was to wear air-filled heel off-loading boots all the time (in bed and wheelchair as tolerated).	F 686		

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F 686	Continued From page 21 10/15/23 - R36 was care planned for ADL's (activities of daily living)/Functional Status/Rehabilitation interventions including R36 was to wear air-filled heel off-loading boots all the times (in bed and in wheelchair (as tolerated). 10/15/23 - A care plan for R36's skin conditions documented interventions that included air-filled heel protector boots to be worn on both feet at all times as tolerated except for hygiene care. 10/20/23 at 10:13 AM - R36 was observed in bed without air-filled heel protector boots on both feet. 10/20/23 at 10:13 AM - E15 (CNA) confirmed that R36 was not wearing the heel protector boots to both feet. 10/20/23 at 12:30 PM - Findings were reviewed with NHA (E1), E2 (DON) and E3 (ED) at the exit conference. 11/1/23 at 1:05 PM - Findings were reviewed with NHA (E1), E2 (DON) E23 (ADON) and E3 (ED) at the exit conference. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ED) and E28 (Regional Operational Services) at the exit conference on 11/1/23 starting at 1:05 PM.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		2/1/24

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F 688	Continued From page 22 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R57) out of three residents reviewed for range of motion, the facility failed to ensure R57 received services to maintain functional ability and to prevent contractures. Findings include: A facility policy (last revised 2/4/22) titled Restorative Care Program included: "Presbyterian Senior Living Facilities will provide restorative services which prevent slow functional decline and/or maintain the resident highest practicable level functioning in accordance with state and federal regulations. The restorative nursing care program includes ...range of motion program - active and passive." Review of R57's clinical record revealed: 6/9/23 - R57 was admitted to the facility after having a stroke which left him with left-sided hemiplegia.	F 688	R57 still resides in the facility. Active range of motion for fifteen minutes is been provided to the right-side extremity two times per day and passive range of motion is been provided to the left side extremity for fifteen minutes two times per day. Current residents in the facility with orders for active and passive range of motion have the potential to be affected by the deficient practice. All residents with passive and active range of motion orders were reviewed to ensure that this restorative function is being accomplished. A root cause analysis revealed the need for re-education on providing active and passive range of motion for residents with restorative orders. The nursing staff will be re-educated by the Staff Developer/designee on providing active	

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F 688	Continued From page 23 6/29/23 - R57's restorative nursing care plan included: -Active range of motion for fifteen minutes two times a day to right side extremities. -Passive range of motion for fifteen minutes two times a day to left side extremities. 9/15/23 - A quarterly MDS assessment documented that R57 was cognitively intact and had not been rejecting care. 10/10/23 10:31 AM - During an interview, R57 reported that the staff were not providing him with range of motion exercises. R57 stated that staff were "not allowed to do his range of motion yet". Review of the CNA daily charting revealed that the facility lacked evidence that R57 was provided his scheduled range of motion exercises on the following dates and times: -8/31/23, 9/10/23 9/11/21, 9/30/23, 10/7/23, 10/16/23 and 10/17/23 at 7:00 AM; 9/7/23, 9/30/23, 10/9/23, 10/14/23 and 10/17/23 at 3:00 PM. 10/13/23 10:57 AM - During an interview, E12 (Therapy Director) confirmed that the facility has a restorative nursing program and it is the responsibility of the assigned CNA to provide the services. E12 also stated that R57 should be getting range of motion on that (left) hand and that it should be in the care plan for restorative services. 10/13/23 11:25 AM - During an interview with R57 and E12, R57 stated that the nursing staff are not providing him with his range of motion. R57 stated that he feels that "the nurses and aides (CNA's) are not trained to do it".	F 688	and passive range of motion per physician orders. DON/designee will conduct on audit on all residents with orders for active and passive range of motion to ensure that the orders are being followed. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% is verified, then monthly X 3 until 100% is verified. Results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 688	Continued From page 24 10/17/23 11:35 AM - During an interview, E2 (DON) confirmed that the facility lacked evidence of consistent range of motion being provided to R57. 10/18/23 9:40 AM - During an interview, E6 (CNA) stated that he does not do anything with R57's left hand because therapy did not give him any instructions on how to do it (the range of motion). 10/20/23 - Findings were reviewed with E1 (NHA), E2 (DON), and E3(ED) at the exit conference beginning at 12:30 PM.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R368) out of six residents reviewed for accidents, the facility failed to provide adequate supervision during a mechanical lift transfer. Findings include: A facility policy titled "Transferring a Resident" (last approved 5/31/23) included: "Full body mechanical lift - always have 2 staff members when completing a transfer with a full body	F 689	R368 no longer resides in the facility. An investigation was conducted, and as a result, E26 is no longer employed with the facility. Current residents in the facility that require the requires the use of a Hoyer lift for transfers have the potential to be affected. A root cause analysis revealed the need	2/1/24

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F 689	Continued From page 25 mechanical lift (Hoyer lift)." Review of R368's clinical record revealed: 11/30/22 - R368 was admitted to the facility with dementia. 12/6/22 - An admission MDS assessment documented that R368 was cognitively impaired and required assistance of two staff members to be transferred. 1/27/23 - R368 care plan included: "Transfers: total assist x 2 (staff members) with Hoyer (mechanical) lift." 3/5/23 12:45 PM - A facility incident report documented "CNA stated while transferring resident with Hoyer (mechanical lift), (R368) left leg got caught behind wheelchair (there was no other CNA staff present at the time). (R368 sustained a) vertical skin tear measuring 3.6 cm x 6 cm." 3/5/23 12:45 PM - A statement written by E26 (CNA) documented: "Residents left shin was positioned crooked. When shin was straightened, bumped against wheelchair which caused skin tear." 3/5/23 2:42 PM - A nursing progress note documented "Resident skin tear evaluated and noted to be a large skin tear on the left shin with a mostly intact skin flap...Skin tear occurred during transfer..." 3/10/23 - A 5-day follow-up submitted to the State agency documented "Staff member did not follow policy of 2 staff members to use mechanical lift.	F 689	for re-education on the requirement of 2 staff members when conducting a mechanical lift transfer. The nursing staff will be re-educated on the resident transfer policy and ensuring that 2 staff members are present during use of mechanical lifts. DON/designee will conduct an audit of 7 residents who require the use of a mechanical lift for transfers to ensure that 2 staff members are present during the transfer. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4 until 100% is verified, then monthly X 3 until 100% is verified. Results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 689	Continued From page 26 Staff member previously been educated to the policy. Additional staff members were on the unit for assistance, but were not asked. (E26, CNA) Education/Counseled at the time of the incident. Staff member placed on administrative leave until investigation is complete. Staff are being educated on proper use of mechanical lift and policy." 10/20/23 11:05 AM - During an interview, E1 NHA confirmed the unsafe mechanical lift transfer with only one staff member. 10/20/23 - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ED) at the exit conference beginning at 12:30 PM.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		2/1/24

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F 690	Continued From page 27 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R56) out of one resident reviewed for incontinence the facility failed to respond to or provide services to restore bladder continence after a decline in bladder continence was identified. Findings include: The facility policy for bowel and bladder training last updated 5/31/23 indicated, "...Determine eligibility for retraining program using the bowel and bladder evaluation. Upon completion of the bowel and bladder evaluation is reviewed to determine if voiding diaries are needed in order to ascertain resident toileting plans." Review of R56's clinical record revealed: 6/23/23 - A quarterly MDS assessment documented R56 as mentally intact, requiring extensive assistance of one staff member for toileting and frequently incontinent of bladder with no toileting plan.	F 690	R56 was evaluated for eligibility for retraining program using the 3-day voiding diary. All residents have the potential to be affected. An audit was conducted of all residents with a bladder function decline to ensure that an intervention was implemented to restore bladder continence. No other resident residents were identified as a result of this audit. A root cause analysis revealed the need for re-education for the Nursing Assessment Coordinators (RNAC and LNAC) and all licensed nursing staff for initiating voiding diary upon admission, quarterly and with any change in the residents□ voiding pattern. The re-education will be conducted the Staff Developer (RN).	

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F 690	Continued From page 28 6/29/23 - R56's care plan for continence issues was reviewed with no revisions since the 10/8/22 revision. 8/1/23 - A toileting plan was created for R56. The clinical record lacked evidence a voiding diary or similar tool was completed to assist in creating a personalized toileting plan for R56. 9/23/23 - An annual MDS assessment documented R56 as mentally intact, requiring extensive assistance of one staff member for toileting and always incontinent of bladder. This assessment identified a decline in bladder continence for R56. 9/26/23 - R56's care plan for continence issues was revised to include a raised toilet seat. Review of R56's clinical record lacked evidence of completion of a voiding diary or similar tool to determine changes and patterns of R56's continence. R56's toileting plan was not revised to include any modifications related to R56's decline in continence from occasionally to always incontinent of bladder. During an interview on 10/16/23 at 11:56 AM R56 was asked whether her bladder continence has declined and R56 responded, "It's changed a lot. I used to tell them when I had to go. It depends on how much staff whether they help you and take you." R56 then confirmed that she is aware of when she needs to be toileted, and stated, "They just let me urinate in the brief. They don't ask if I want to go to the bathroom during the day. Only E6 (CNA) ask's me when I need to go and takes me." R56 also reported that staff at night will offer	F 690	The DON/designee will conduct a Change in Bladder Continence audit to ensure that any continence changes/decline result in an intervention to restore bladder continence. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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F 690	Continued From page 29 a bed pan for toileting. R56 denied knowledge of staff attempting to assess habits and patterns for using the bathroom. During an interview on 10/13/23 at 2:41 PM E6 (CNA) confirmed that R56 has had a decline in continence. E6 explained that R56 ask to be toileted, uses the bathroom when toileted and that E6 also offers toileting. During an interview on 10/13/23 at 2:52 PM E16 (NC) confirmed that the facility did not complete additional assessments such as a voiding diary, nor make modifications to R56's toileting plan following the residents decline in bladder continence from frequently to always incontinent of bladder between the most two recent MDS assessments. E16 stated the facility did not respond because they implemented a toileting plan in August. E16 stated, "We could have done another bladder diary" following R56's decline captured on the most recent MDS assessment. 10/20/23 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ED).	F 690		
F 730 SS=D	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:	F 730		2/1/24

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F 730	Continued From page 30 Based on interview and review of facility documentation, it was determined that the facility failed to ensure that a performance review was completed at least every 12 months for three (E8, E9 and E10) out of five sampled employees. Findings include: 1. E8 (CNA) had a hire date of 2/21/17. A record review revealed that the last annual performance was completed on 10/17/23. There was a lack of evidence of a performance evaluation from the past year. 2. E9 (CNA) had a hire date of 1/22/19. A record review revealed that the last annual performance was completed on 10/11/23. There was a lack of evidence of timely completion of current performance evaluation. 3. E10 (CNA) had a hire date of 5/5/14. A record review revealed that the last annual performance was completed on 5/20/22. There was a lack of evidence of timely completion of current performance evaluation. 10/19/23 9:05 AM - The above findings confirmed in interview with E1 (NHA). 10/20/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ED) during the exit conference starting at 12:30 PM.	F 730	The performance reviews for E8, E8, and E10 were completed and reviewed with each nurse aide. All nursing aides currently employed have the potential to be affected. An audit was conducted of all nurse aid performance reviews for timeliness and, where possible, all performance reviews have been completed and presented to the nurse aides. A root cause analysis revealed the need for re-education for the Director of Nursing (DON) regarding the requirement for the nurse aide performance reviews to be completed at least once every 12 months the provision of regular in-service education based on the outcome of these reviews. The NHA/designee will provide this re-education to the DON. The NHA/designee will conduct a Performance Review audit to ensure that the nurse aide performance reviews are completed at least every 12 months and provide regular in-service education based on the outcome of the reviews. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		1/15/24

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F 756	Continued From page 31 §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 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.	F 756		

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F 756	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it has been determined that for two (R10 and R21) out of five residents sampled for unnecessary medication review, the facility failed to ensure the physician reviewed and signed the consultant pharmacist communication. In addition, the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Reviews) that included time frames for different steps in the MRR process. Findings include: 1. Review of R10's clinical record revealed: 6/28/22 - R10 was admitted to the facility with diagnosis of depression, vascular dementia, psychosis, and repeated falls. 5/17/23 - A consultant pharmacist communication to the physician documented... "1. Per CMS guidelines, all PRN (as needed) psychotropic medications require a stop date... 1. Please provide a stop date for PRN clonazepam order... 2. Note order was updated May 9 but no stop date was included." Further review of the communication to the physician lacked a required response and physician signature. 6/20/23 - A consultant pharmacist communication to the physician documented... "1. Per CMS guidelines, all PRN (as needed) psychotropic medications require a stop date... 1. Please provide a stop date for PRN clonazepam order... 2. Note order was updated May 9 but no stop date was included." Further review of the communication to the physician lacked a required response and physician signature.	F 756	The consultant pharmacist communication for R10 and R21 were reviewed by the Medical Director and medication order adjustments and/or documentation was updated in the clinical record. The Medication Regimen Review (MRR) policy has been updated to include time frames for the different steps in the MRR process. All residents who are included in the consultant pharmacist report(s) have the potential to be affected. A review of the prior 12 months consultant pharmacist reports was conducted to ensure all recommendations were addressed/documented by the physician. There we no other pharmacy consultant recommendations found without physician documentation and/or medication order adjustments. A root cause analysis revealed the need for the Medication Regimen Review (MRR) policy to be updated to include time frames for the different steps in the MRR process. Additionally, the root cause analysis revealed the need for re-education with the Medical Director and DON on the MRR policy. The NHA/designee will re-educate the DON and Medical Director regarding the MRR policy revision/update which includes the requirement for the physician signature. The Director of Nursing/designee will	

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F 756	Continued From page 33 7/17/23 - A consultant pharmacist communication to the physician documented ..... "1. I am required to review patients experiencing falling episodes for contributing medications... 2. Receives multiple medications which may increase risk for falls... 3. Please evaluate potential role in falls on June 23 and July 4... 4. Assess for dose reductions... clonazepam 0.5 mg (Milligrams) three times a day... 5. risperidone 0.25 mg... 6. sertraline 75 mg daily... 7. trazadone 50 mg at bedtime (also gabapentin and ropinirole may increase fall risk) consider assessment for orthostatic hypotension. Further review of the communication to the physician lacked a required response response and physician signature. 10/18/23 12:01 PM - During an interview, E11 (MD) said, "I am the medical director, my partners are responding to the consultant pharmacist communications." 10/18/23 12:32 PM - During an interview E1 (NHA) revealed "the consultant pharmacist had emailed R10's recommendations to E1, E2 (DON) and E11 (MD). In addition, E11 confirmed "the consultant pharmacist's communication to the physician had been emailed directly to E11." 10/18/23 12:45 PM - During another interview E11 confirmed the consultant pharmacist communication to the physician for R10 needed a response and signature from the attending and or primary care provider for 5/17/23, 6/20/23 and 7/17/23. 10/18/23 12:57 PM - During an interview E2 said, "I was not aware that the physician was required to document a response and signature on R10's consultant pharmacist communication to the	F 756	conduct a Medication Regimen Review (MRR) audit to that all pharmacy consultant recommendations are addressed through physician documentation in the clinical record or medication order adjustment. As well, the pharmacy consultant report will be signed upon review. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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F 756	Continued From page 34 physician." 2. Review of R21's clinical record revealed: 4/21/23 - R21 was admitted to the facility with a diagnosis of diabetes, major depressive disorder, and hypertension. 5/16/23 - A consultant pharmacist communication to the physician documented... "1. Novolog Flex pen (Insulin Pen) order reads twice daily before meals and at bedtime but is listed as four times a day... 2. Please clarify the frequency and times for novolog." Further review of the communication to the physician lacked a required response and physician signature. 5/16/23 - A consultant pharmacist communication to the physician documented... "1. Please review current labs and renal function to assess appropriate dose for Eliquis... 2. Renal dosing of 2.5 mg twice a day is recommended of serum creatinine is less than 1.5 and patient is 80 years (sic) or weighs less than 60 kg (kilograms)... 3. Note increased bleeding with Eliquis plus SSRI (Selective Serotonin Reuptake Inhibitor)... 4. Please evaluate escitalopram dose of 20 mg (Milligrams) daily and consider dose reduction when appropriate." 10/18/23 12:01 PM - During an interview E11 (MD) said, "I am the medical director, my partners are responding to the consultant pharmacist communications." 10/18/23 12:32 PM - During an interview E1 revealed "the consultant pharmacist had emailed R21's recommendations to E1 (NHA), E2 (DON) and E11 (MD). In addition, E11 confirmed "the	F 756		

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F 756	Continued From page 35 consultant pharmacist's communication to the physician had been emailed directly to E11." 10/18/23 12:45 PM - During another interview E11 confirmed the consultant pharmacist communication to the physician for R21 needed a response and signature from the attending and or primary care provider for 5/16/23. 10/18/23 12:57 PM - During an observation and interview E2 said, "I was not aware that the physician was required to document a response and signature on R21's consultant pharmacist communication to the physician." 3. May 2018 - A review of the facility's policy titled "Consultant Pharmacist Services Provider Requirements", lacked information of the facility's time frame to respond to the pharmacy recommendations based on identified irregularities. 10/16/23 1:30 PM - In an interview, E1 (NHA) stated that the facility completes a Monthly Medication Review (MRR) for each resident. The pharmacy will submit the recommendations and the MD will review it. E1 further revealed that the facility follows the consultant pharmacy's procedure for findings and recommendations to be acted upon by the facility at least monthly. E1 reviewed the policy and confirmed that the policy lacked information on timeframes for the steps of the MRR process. 10/29/23 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ED) at the Exit Conference.	F 756		

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F 761	Continued From page 36	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that medications were stored and labeled properly in two out of three medication carts reviewed. Finding's include: The facility policy on storage of medications, last updated May 2018 indicated, "...Medications and biologicals are stored safely, securely, and	F 761	The opened medications in the 200 hallway medication cart, the laxative and vial/pen of insulin, were immediately disposed of and new medications ordered to replace. No residents were affected. When received and opened, the new medications were dated. The opened medications in the 400 hallway medication cart, three vials/pens	1/15/24

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F 761	Continued From page 37 properly, following manufacturers' recommendations or those of the supplier...". 10/16/23 12:14 PM - During a medication storage review of the 200 hall the following was observed inside the 200 hallway medication cart: - One opened bottle of laxative with no open date. - One opened vial/pen of insulin labeled 'discard unused after 28 days' with no open date. 10/16/23 12:24 PM - E14 (LPN) confirmed the findings. 10/16/23 12:39 PM - During a medication storage review of the 400 hall the following was observed inside the 400 hallway medication cart: - Three vials/pens of opened insulin with no open dates. - Two nasal inhalers in use with no open date. E13 (LPN) immediately confirmed the finding. 10/20/23 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ED).	F 761	of opened insults and two nasal inhalers, were immediately disposed of and new medications ordered to replace. When received and opened, the medications were dated. All residents physician orders for laxative and insulin vial/pen have the potential to be affected. No residents were determined to be affected. All medications stored in the medication carts have the potential to be affected. An audit of all medication carts will be conducted to ensure that all medications that are opened are labeled and dated appropriately. All medications were labeled and dated appropriately. A root cause analysis revealed the need for re-education of all licensed nursing staff regarding proper medication labeling and dating. The Staff Development Director/designee will provide re-education on the Medication Storage Policy to all licensed nursing staff. The Director of Nursing/designee will conduct a Medication Cart audit to ensure all medications stored in the medication carts are properly labeled and dated. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	

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F 812	Continued From page 38	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure safe, sanitary storage of food and maintain food preparation equipment in a sanitary and safe operating condition. Findings include: 10/10/23 8:26 AM - During a kitchen tour, several food items in the reach-in refrigerator including numerous individual portions of peach pie and individual servings of chocolate pudding were missing the date stamp required for safe food storage. Several condiments including grape jelly and strawberry flavored syrup were missing the required date stamp for food safety. The reach-in refrigerator contained several plastic	F 812	The peach pie, chocolate pudding, condiments and orange slices were immediately discarded. The ice scoop was immediately removed from the top of the ice machine, sanitized, and placed in the proper holding area. Maintenance removed the ice machine and replaced it with a new ice machine that does not drip water and the front panels properly secured with no wiring exposed. The outdated fruit cups were immediately removed from the snack refrigerator located behind the counter in the dining area.	1/15/24

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F 812	Continued From page 39 cups of orange slices with expired use by dates. 10/10/23 9:48 AM - The ice scoop was stored on top of the ice machine, there was a large puddle of water under the ice machine, the door of the ice machine remained open more than twenty (20) minutes, and one of the front panels of the ice machine was missing exposing the wiring behind it. 10/10/23 9:52 AM - Outdated fruit cups were discovered in the snack refrigerator located behind the counter in the dining area. 10/10/23 11:42 AM - A large, dried spill was noted on the bottom shelf to the left of the door in the dry storage room. 10/10/23 11:56 AM - A significant amount of rust was observed on all of the shelving in the walk-in refrigerator. 10/19/23 2:35 PM - Findings were confirmed with E19 (Director of Dining Services). 10/20/23 12:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (ED).	F 812	The dried spill was immediately cleaned in the dry storage room. The walk-in refrigerator shelving was removed and replaced with new shelving that has no rust. All residents have the potential to be affected. All food items in the reach-in refrigerator have the potential to be affected. No other items were identified. All ice machines and ice scoops have the potential to be affected. No other ice machine or ice scoop was identified to have an issue. All snack refrigerators have the potential to be affected. No other snack refrigerator was identified with outdated snacks. All dry storage areas have the potential to be affected. No other dry storage/dry storage shelving was identified with a dried spill. All shelving in the walk-in refrigerator have the potential to be affected. The walk-in refrigerator shelving was deemed to be replaced. A root cause analysis revealed the need for re-education of the Dietary staff regarding safe, sanitary food storage and maintenance of food preparation equipment in a sanitary and safe operating condition. The Director of Dining Services will re-educate the Dietary staff regarding covering, labeling, dating, and checking for outdating food items in the walk in refrigerator; proper placement/storage of ice scoop and machine functioning requirements to be	

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F 812	Continued From page 40	F 812	reported through our work order system, checking for outdated food items in the snack refrigerators, checking the dry storage shelving for spills to be cleaned, and checking the walk-in refrigerator shelving for rust. The Director of Dining Services/designee will conduct an audit of the reach-in refrigerator and snack refrigerators to ensure all food items are covered, labeled, dated and not expired. Additionally, the audit will include the ice machine scoop for proper placement and ice machine equipment in proper working order. The audit will also include the dry storage area to be free from spills and the walk-in refrigerator shelving to be free from rust. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	