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: Milford Center
January 5, 2024

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from December 12, 2023 through December 21, 2023 and January 3, 2024 through January 5, 2024. 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 one hundred and twenty (120). The survey sample size was thirty-two (32) residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**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.	No residents identified. All residents potentially affected. Risk analysis - Root cause is call outs. Daily staffing meetings, use of agency staff, offering incentives to employees to pick up shifts and for attendance. NHA and/or DON monitor daily, Compile Monthly and report to QAPI Committee Completion Date: 2/15/2024	
	This requirement is not met as evidenced by:		
16 Del. code,	Cross refer: E037, F552, F558, F578, F584, F636, F637, F641, F644, F655, F657, F684, F688, F689, F690, F695, F697, F730, F758, F761, F812, F842 and F947.		

Provider's Signature Julie Dee Title NHA Date 2/2/2024

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	Quality, Office of Long-Term Care Residents Protection. The facility was found to be noncompliant with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation submitted for the fourth quarter staffing review, it was determined that two days out of seven days revlewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of the Facility Staffing Worksheets, completed by E1 (Nursing Home Administrator) revealed the following: 11-24-2023 - PPD = 3.22 11-25-2023 - PPD = 2.68 The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature [signature] Title NHA Date 01/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD MILFORD, DE 19963

(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 and complaint survey was conducted at this facility from December 12, 2023 through December 21, 2023 and January 3, 2024 through January 5, 2024. The facility census was 120 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, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		2/15/24

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

Electronically Signed | 02/01/2024

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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E 037	Continued From page 1 least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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E 037	Continued From page 2 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		

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E 037	Continued From page 3 staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,	E 037		

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E 037	Continued From page 4 and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on review of documents, it was determined that for three (E8, E9, and E10) out of seven (7) sampled staff members, the facility failed to ensure that staff received annual Emergency Preparedness training in the previous twelve months. Findings include: - On 11/15/22, E8 (CNA) received the most recently documented Emergency Preparedness	E 037	No specific resident cited. All residents may potentially be affected. Root cause analysis determined that compliance with annual Emergency Preparedness training was not consistently monitored. Employees will receive training regarding Emergency	

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E 037	Continued From page 5 training. - On 10/13/22, E9 (CNA) received the most recently documented Emergency Preparedness training. - On 8/12/22, E10 (CNA) received the most recently documented Emergency Preparedness training. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	E 037	Preparedness on hire and at least annually. Current employees will be trained. Nurse Practice Educator will monitor compliance with annual training. Nurse Practice Educator or designee will monitor compliance with annual Emergency Preparedness raining monthly and report to the QAPI Committee monthly until compliance is 100% for three months.	
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from December 12, 2023 through December 21, 2023 and January 3, 2024 through January 5, 2024. 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 one hundred and twenty (120). The survey sample size was thirty-two (32) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CG - Caregiver; CNA - Certified Nursing Assistant; CO2 - Carbon Dioxide; COPD - Chronic obstructive pulmonary disease; DM- Diabetes; DON - Director of Nursing; GM - Gram; L - Liter;	F 000		

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F 000	Continued From page 6 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; ARD (Assessment Reference Date) - The specific end point of look-back periods in the MDS assessment process; Assessment - an evaluation of a condition or resident Baseline - a minimum or starting point used for comparisons; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges form 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions 8-12: Moderately impaired (decisions poor; cues/supervision required 13-15: Cognitively intact (decisions consistent/reasonable); Catheter - a flexible tube inserted through a narrow opening into a body cavity, for removing fluid;	F 000		

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F 000	Continued From page 7 Continence - control of bladder and bowel function; 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; Elopement - to run away; Gerichair - wheelchair type - one that reclines; Incontinence - loss of control of bladder &/or bowel function; MAR - medication administration record; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Mixing valve - a device that controls the mix of hot and cold water to provide a comfortable and safe temperature; Orientation - ability to accurately identify person, place and time; Pain level- Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain. Parkinson's Disease - A progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking; PASARR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; PRN - as needed; Schizoaffective Disorder - condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations	F 000		

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F 000	Continued From page 8 or delusions and mood disorder symptoms such as mania and depression; Tylenol - the brand name of acetaminophen which is a pain reliever. It is used to treat mild pain and fever; Wanderguard - bracelet worn by residents that are at risk for wandering; alerts staff with audible alarm when resident is near an alarmed door.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R107) out of five residents sampled for medication review. The facility failed to notify R107's representative of a change to R107's treatment plan involving medication. Findings include:	F 552	Representative of Resident R107 was notified of reinstated order for lorazepam on 12/21/2023. Director of Nursing or designee conducted an audit of current residents to ensure	2/15/24

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F 552	Continued From page 9 Review of R107's clinical record revealed: 10/14/22 - R107 was admitted to the facility with a diagnoses of but not limited to anxiety disorder. 10/20/23 - An annual MDS documented R107 as severly cognitively impaired. 12/17/23 - A physician's order to discontinue lorazepam 1 mg one time a day for anxiety. 1/3/24 10:35 AM - During an interview with FM2, it was revealed that the facility did not notify the family regarding the change to R107's medication treatment plan. 1/5/24 1:20 PM - During an interview via telephone with E33 (Psychiatric Nurse Practitioner), it was confirmed that she had discontinued the aforementioned medication without notifying FM2. 1/5/24 2:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 552	that medication changes implemented in the last seven days have been communicated to resident and/or representative. All current residents may be affected. Root cause analysis performed by the interdisciplinary team identified the need for training of licensed nurse and medical staff regarding the requirement to notify resident and/or representative of medication changes to treatment plan. Nurse Practice Educator/designee will re-educate current licensed nurses and medical staff on the requirement to notify resident and/or representative when medication changes are made to treatment plan. Director of Nursing or designee will audit records of current residents who have had medication changes three times a week for one week or until 100% compliance is achieved, then weekly for three weeks, then monthly for three months. Audit results will be reported to QAPI Committee monthly.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		2/15/24

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F 558	Continued From page 10 Based on observation and interview it was determined that for one resident (R114) out of two residents reviewed for accommodation of needs, the facility failed to ensure that the resident had a pull cord for the overhead light. Findings include: A facility policy, last revised 2/1/23, titled Accommodation of Needs stated to "make adaptations of the patient's bedroom ... to ensure the patient can (if able): ...operate room lighting." 12/12/23 3:56 PM - An observation of R114's room revealed a missing pull cord to the overhead light. The resident would have to get up in the dark, to the main doorway of the room, to turn on the main light switch to have light. Repeat observations on 12/13/23, 12/14/23 and 12/15/23 revealed the pull cord to the overhead light was still missing. 12/13/23 10:00 AM - During an observation, R114 demonstrated the ability to reach a pull cord for an overhead light using another overhead light. 12/18/23 8:20 AM - An interview with E5 (RN) confirmed R114 did not have a pull cord for the overhead light. 12/18/23 8:40 AM - An interview with E12 (Maintenance Director) confirmed R114 did not have a pull cord for the overhead light. He stated he had recently changed the switch for the overhead light, which has the pull cord attached. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 558	Resident R114 has a pull cord for overhead light. All residents may be affected. Root cause analysis identified that the Center did not have an adequate supply of pull cords and switches. The Maintenance Director will conduct an inventory of resident rooms to determine that residents have a pull cord to the overhead light within reach. Audits of 20% of resident rooms for pull cords and switches will be conducted monthly until 100% compliance is reached. Results will be reported monthly to the QAPI Committee.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		2/15/24

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F 578	Continued From page 11 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 12 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R16 and R379) out of six residents reviewed for advance directives, the facility failed to assist a resident to enact an advance directive. Findings include: 1. Review of R16's clinical record revealed: 8/1/23 - R16 was admitted to the facility. 8/29/23 - A review of the quarterly MDS revealed R16 had a BIMS (Brief Interview for Mental Status) score of 12. 12/12/23 10:25 AM - An interview with R16 revealed that an advanced directive was not on file and confirmed the want to enact one. 12/13/23 - A review of R16's clinical record lacked evidence of an advanced directive on file or evidence the resident was offered the opportunity to make an advanced directive. 12/15/23 1:31 PM - An interview with E18 (social worker) revealed that the facility requests advance directives on admission to be brought in to file in the chart. E18 confirmed that the facility does not assist or offer new admissions to enact one. 2. Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility.	F 578	Resident R379 has been discharged. Resident R16 advance directive has been initiated. All residents have the potential to be affected. Root cause analysis revealed that the Admission Director and Social Service staff require education regarding the requirement to offer and assist residents in the formulation of an Advance Directive. On admission and at least annually, residents and/or their representative will be provided with written information re: the right to formulate and Advance Directive and the information to do so. Director of Social Service or designee will audit 20% sample of resident medical records for documentation of Advance Directive information provision and offer of assistance on a monthly basis. Audits will continue until all resident records have been reviewed. Then 10% sample will be audited for three months until 100% compliance is achieved for three consecutive months. Results will be reported monthly to QAPI committee. QAPI Committee will then determine the need for additional auditing.	

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F 578	Continued From page 13 12/12/23 9:25 AM - An interview with R379 revealed that an advanced directive was not on file and confirmed the want to enact one. 12/13/23 - A review of R379's clinical record lacked evidence of an advanced directive on file or evidence the resident was offered the opportunity to make an advanced directive. 12/15/23 1:31 PM - An interview with E18 (social worker) revealed that the facility requests advance directives on admission to be brought in to file in the chart, and E18 confirmed that the facility does not assist or offer new admissions to enact one. The facility lacked evidence that new admissions are offered to enact an advanced directive. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 578		
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	F 584		2/15/24

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F 584	Continued From page 14 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 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 one unit out of three units, the facility failed to maintain a clean, comfortable, and homelike environment. The facility failed to provide acceptable water temperatures to provide bathing. Additionally the facility failed to provide adequate lighting in a resident room. Findings include: 1. 12/12/23 9:32 AM - During an observation and interview, R379 stated that the water did not get hot. The surveyor tested the water temperature	F 584	Hot water was restored to the affected areas of the Center on 12/12/2023. Resident R65 was provided with an alternative light source. An inspection of the resident rooms identified the room described. The crack between the wall and baseboard has been repaired, the floor tile replaced and the room was deep cleaned. All residents have the potential to be affected.	

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F 584	Continued From page 15 with her hands and the water was "ice cold". The faucet was on for five minutes and did not warm up. 12/12/23 10:46 AM - During an interview, R12 stated that there was not any hot water this morning. 12/12/23 10:52 AM - During an interview, E12 (Maintenance Director) stated, "the mixing valve was out since last night. The man is here working on it." The surveyor inquired how did the residents receive care without hot water, and he replied, "there was still some warm water available this morning, (and) that it should be fixed soon." E12 stated that they were still "adjusting the mixing valve." E12 stated that there was hot water available in the kitchen and that was close to the units. The CNA's could have gone to the kitchen to fill basins of water to bathe the residents. 12/12/23 11:32 AM - During an interview, E21 (CNA) confirmed the water was cold when she arrived at 8:00 AM. E21 stated, "the only thing that we could do was change the residents." (the resident's incontinence briefs). E21 stated that the residents did not receive any bathing because the water was too cold. 12/13/23 10:33 AM - During an interview, E12 stated that he found out about the hot water situation at about 2 or 2:30 PM (on 12/11/23). 12/21/23 8:42 AM - During and interview, E8 (CNA), E25 (CNA) and E26 (CNA) reported that the facility management did not instruct them on what to do regarding the water being cold and that there was hot water available in other parts of	F 584	Root cause analysis indicated the need for regular scheduled room inspections to maintain a home-like environment. NHA or designee, Maintenance Director and Environmental Services Director will conduct weekly audits of the nursing units on a rotating basis and schedule repairs and corrections as necessary. Audits of the Center for home-like environment will be conducted weekly, on one unit/week, rotating the nursing units. Audits will be conducted for three months, or until three cycles have been completed on each Nursing unit. Results of audits and follow-up repairs and corrections will be reported to the QAPI Committee monthly for three months. QAPI Committee will determine follow-up thereafter.	

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F 584	Continued From page 16 the facility. 2. 12/13/23 8:52 AM - Observation revealed: - A tube of incontinence barrier cream on the floor up against the wall on the right side of the bed. - The floor was smeared with drops of unknown organic matter to the right side of the bed. - In the right corner of the room there was an approximately two-and one-half inch chunk out of the floor tile. - The wall adjacent to the foot of the bed had approximately six inches at one area and two inches at another area of cracks and dirt between the wall and the baseboard. - There was a soiled hospital gown bunched up on the beside dresser. - A Gerichair was visibly soiled with food debris. - A tray table for eating was soiled and had approximately a six by three-inch water-like spill on it. 12/13/23 9:01 AM - During an interview, E8 (CNA) confirmed the room was in disrepair and was not clean nor homelike. E8 stated "housekeeping is terrible." 3. 12/12/23 11:25 AM - During an observation and interview, R65 stated her over the bed light has not worked for "about a month". The Surveyor tested the light, and it did not turn on. R65 stated that the staff had to keep the privacy curtain open to get light from the bed next to her to complete her care at night. 12/12/23 11:28 AM - During an interview, E21 (CNA) confirmed that R65 did not have a working over the bed light and that there was no alternative light source in R65's area in the room.	F 584		

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F 584	Continued From page 17 12/13/23 10:33 AM - During an interview, E12 stated that he was aware that there were over the bed lights that were not working. E12 stated that he had tried a new lightbulb in R65's over the bed light and that every time he put a new bulb in that "they blew". E12 stated that an electrician had been there, and it was the lights themselves that were not working. E12 stated that there were three rooms that the lights were not working. When asked if there was an alternative light source being provided, E12 replied that the facility cannot have lamps related to it was a "fall risk", and that the facility could not have extension cords longer than six feet. When asked if any other alternative solutions for lighting were considered he stated "no." E12 stated that lights were on order. 12/13/23 11:11 AM - During an interview, E24 (UM) stated that she was not aware of R65's light being out "until today." E24 stated that R65 was going to be moved to the other side of the room until the new light came in. 12/13/23 11:13 AM - During an interview, E12 provided the surveyor with a work order which revealed that the new lights would not be arriving until 1/26/24. 12/15/23 9:09 AM During an interview R65 stated that the facility had not provided an alternate lighting source. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		2/15/24

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F 637	Continued From page 18 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R21) out of thirty-two residents reviewed for MDS assessments, it was determined that a significant change MDS assessment was not completed after a decline in status. Findings include: Review of R21's clinical record revealed: 12/16/22 - R21 was admitted to the facility with respiratory failure. 6/23/23 - The quarterly MDS documented R21 was moderately cognitively impaired, had a depressed mood, no behaviors, required extensive assistance of staff for ADL's and was frequently incontinent of bowel and bladder. 9/23/23 - A quarterly MDS assessment documented R21 was not assessed for cognitive status or depression, had a new onset of behaviors (one to three times per week), was dependent on staff for ADL's and was always incontinent of bowel and bladder. The change	F 637	Active current residents' most recent MDS transmitted Significant Change Warning Report will be reviewed, all positive significant change warnings will be brought to Interdisciplinary team to determine if the criteria for a significant change is met. Nurse Management and MDS nurse were re-educated regarding CMS RAI version 3.0 Nabyrak Ictiver 2023 V1.28.22, Chapter 2; Assessments for the RAI 03. Significant Change in Status Assessment (A0310A+4) Page 2-24-29. Audits will be conducted for 100% of the active residents MDS Assessments ARD prior to transmission weekly for four weeks for accurate identification of Significant changes per RAI guidelines. If 100% compliance is achieved, then the audit will be 10% of residents for 100% accuracy for two months. The information will be brought to the monthly QAPI	

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F 637	Continued From page 19 was not identified, nor was the need for a significant change MDS assessment. 12/15/23 12:03 PM - During an interview, E24 (UM) confirmed that R21 did have a significant decline in status, and that a significant change in status MDS should have been completed. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 637	Committee meeting for review and recommendation.	
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 interview and record review, it was determined that for three (R20, R21 and R63) out of thirty-two sampled residents, the facility failed to ensure the MDS assessments accurately reflected the resident's status. Findings include: 1. Review of R21's clinical record revealed: 12/16/22 - R21 was admitted to the facility with respiratory failure. 9/23/23 - A quarterly MDS assessment documented R21 was not assessed for cognitive status or depression. 12/15/23 12:03 PM - During an interview, E24 (UM) stated that the facility did not have a full-time MDS coordinator or a full-time social worker at the time of the survey. E24 stated that it was the full-time social worker who assessed	F 641	Corrections to MDS submissions were submitted for Residents R20, R21 and R63. All active current residents' most recent MDS Assessments transmitted will be reviewed for completion of the BIMS and PHQ-2 to 9 interviews per RAI guidelines. All arrive current residents most recent MDS Assessments transmitted will be reviewed for accuracy of coding of MDS Section L Oral/Dental Status based on information available during the designated lookback period. All active current residents will be reviewed for Hospice payers. All active resident current MDS Assessments for those with active or changes in Hospice enrollment will be audited.	2/15/24

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F 641	Continued From page 20 residents for cognition and depression. E24 confirmed that R21's cognition and depression were not assessed on her 9/23/23 quarterly MDS assessment. E24 confirmed that a resident or staff interview for cognition and depression should have been completed and should not have been documented as "not assessed." 12/15/23 1:22 PM During an interview, E1 (NHA) confirmed R21's cognition and depression had not been assessed on her 9/23/23 quarterly MDS. 2. Review of R20's clinical record revealed: 12/25/18 - R20 was admitted to the facility. 5/4/23 - A dental exam performed by S3 (DDS) documented the following: upper, four roots that are dead and lower, two dead roots and six missing teeth. R20 denied any pain or oral problems. 7/6/23 - An annual MDS Assessment documented that R20 had her natural teeth with no problems noted. 10/6/23 - A quarterly MDS Assessment also documented that R20 had her natural teeth with no problems noted. 12/12/23 at approximately 11:10 AM - During an interview,this surveyor observed that R20 had no front teeth and asked if she had any mouth pain or trouble chewing? R20 replied "no I don't." When asked if she had ever seen a dentist she couldn't remember. 12/18/23 09:54 AM - During an interview E2 (DON) confirmed that R20 did have missing and	F 641	Social Services Department and MDS Nurse were re-educated on the CMS's RAI version 3.0 Manual October 20233 V1.18.11, Chapter 3: C0200-C0500: Brief Interview for Mental Status (MIMS) and D0150: Resident Mood Interview (PHQ-2 to (). MDS Nurse was re0educated on the CMS's Rai Version 3.0 Manual October 2023 V1.18.11, Chapter 3: Section L: Oral/Dental Status. MDS Nurse was re-educated on the CMS's RAI Version 3/0 Manual October 2023 V1.18.11, Chapter 3 page A-5 Coding Tips and Special Populations. Audits will be conducted for 100% of the active residents' MDS Assessments ARD prior to transmission weekly for four weeks for accurate identification of C0200-C0500: Brief Interview for Mental Status (BIMS) and D0150L: Resident Mood Interview (PHQ-2 to 9). per RAI guidelines. If 100% compliance is achieved then the audit will be for 10% or 10 residents, whichever is greater, for 100% accuracy for two months. The information will be brought to the monthly QAPI meeting for review and recommendation. When two consecutive monthly audits are 100% compliant, the concern will be resolved at the QAPI meeting. Audits will be conducted for 100% of the active residents' MDS Assessments ARD prior to transmission weekly for four weeks for accurate identification of MDS Section L oral/Dental Status per RAI guidelines. If 100% compliance is	

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F 641	Continued From page 21 broken teeth and the annual and quarterly MDS assessments were inaccurate. 3. Review of R63's clinical record revealed: 10/14/20 - R63 was admitted to the facility. 4/21/23 - A physician order was written to admit R63 to hospice care with a diagnosis of Alzheimer's. 4/28/23 - A physician order was written to discontinue hospice care. 5/31/23 - A significant change MDS Assessment documented "Hospice - Yes." 8/31/23 - A quarterly MDS Assessment documented "Hospice - Yes." 12/18/23 1:35 PM - This Surveyor asked E22 (LPN) to see R63's hospice binder. E22 replied " he's not on hospice anymore" and confirmed that the order was listed in the active orders as well as the discontinued orders with an end date of 4/28/23. 12/19/23 9:38 AM - During an interview E2 (DON) confirmed the abovementioned findings. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 641	achieved then the audit will be for 10% or 10 residents, whichever is greater, for 100% accuracy for two months. The information will be brought to the monthly QAPI Committee meeting for review and recommendation. When two consecutive monthly audits are 100% compliant, the concern will be resolved at the QAPI meeting. Audits will be conducted for 100% of the residents for active Hospice or changes in Hospice enrollment if the resident is determined to have either enrolled or disenrolled, then we will verify the presence of a significant change MDS with accurate coding for O0110K weekly for four weeks for accurate identification per RAI guidelines. If 100% compliance is achieved then the audit will b for 10% or 10 residents whichever is greater, for 100% accuracy for two months. The information will be brought to the monthly QAPI committee meeting for review and recommendation. When two consecutive monthly audits are 100% compliant, the concern will be resolved at the QASPI meeting.	
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	F 644		2/15/24

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F 644	Continued From page 22 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R86 and R110) out of four residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: 1. Review of R86's clinical record revealed: 7/30/22 - Resident was admitted to the facility. 7/25/2022 - A PASARR Level 1 completed, which reflected "There are no known recent or current mental health symptoms." 9/6/22 - A diagnosis of schizophrenia was added to R86's list of diagnoses. 12/14/23 9:15 AM - E1 (NHA) provided a copy of the above-mentioned PASARR I in response to surveyor's request for all of R86's PASARR's.	F 644	Resident R86 and R110 have current level PASSAR screening documented in medical record. Director of Social Service completed an audit of current residents with mental disorders to ensure that an appropriate referral for PASSAR screening has been made. All residents have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that Social Service staff, Nursing leadership and Clinical Reimbursement Managers needed re-education on policy SS108 to ensure the requirements for PASSAR screening is initiated with a focus on the communication from Clinical Reimbursement staff to Social Service staff upon the addition of a psychiatric	

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F 644	Continued From page 23 12/18/23 9:16 AM - In an email correspondence, S1 (PASARR State Authority) confirmerd that the facility should have submitted a resident review PASARR. 2. Review of 110's clinical record revealed: 1/10/23 - R110 was admitted to the facility. 4/28/23 - A PASARR Level 2 evaluation was completed for R110 with a short term approval period to expire on September 25, 2023. The facility could not provide documentation of a current Level 2 PASARR after September 25, 2023. 12/18/23 7:26 AM - In an email correspondence, S1 (PASARR State Authority) confirmed that a PASARR Level 2 evaluation was required for R110 to be completed prior to the expiration of the previous PASARR. 12/18/23 8:10 AM - An interview with E1 (NHA) confirmed that the facility did not have any Level 2 evaluations for R110 after September 25, 2023. E1 stated, "we probably should have another one for her [R110]." 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).	F 644	diagnosis to ensure that the appropriate level of PASSAR is initiated. Administrator or designee will re-educate Nursing leadership, Social Services and Clinical Reimbursement staff regarding policy SS108 and the process of communicating added psychiatric diagnoses. Clinical Reimbursement Manager or designee will audit records of current residents to ensure that newly added psychiatric diagnoses have the appropriate PASSAR screening weekly for three weeks or unit 100% compliant, then monthly for three months or until 100% compliant. Results will be reviewed an the monthly QAPI Committee meetings.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		2/15/24

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F 657	Continued From page 24 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 interview and record review, it was determined that for eight (R8, R13, R50, R65, R66, R86, R109 and R112) out of thirty-two sampled residents, the facility failed to ensure the required interdisciplinary team members participated at the quarterly care plan meetings. In addition, for R65, the facility lacked evidence that a quarterly care plan conference was completed in March of 2023. Findings include: 1. Review of R50's clinical record revealed: 1/2/20 - R50 was admitted to the facility with schizoaffective disorder.	F 657	Resident R109 no longer resides in the Center. Residents R8, R13, R50, R65, R66, R 86 and R112 - unable to correct past care conference documentation. The Director of Nursing competed an audit of care plan conferences held in the previous two weeks to ensure that attendance of required disciplines was documented. All residents have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that the	

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F 657	Continued From page 25 12/18/23 8:54 AM - A late entry care plan note for a 10/5/23 care plan meeting lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 2. Review of R65's clinical record revealed: 10/28/20 - R65 was admitted to the facility with dementia. 10/20/22 10:22 AM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 1/19/23 12:44 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 1/19/23 - 7/20/23 - The facility lacked evidence of a quarterly care plan conference. 7/20/23 4:33 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/26/23 11:43 PM - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 3. Review of R8's clinical record revealed: 3/25/22 - R8 was admitted to the facility. 12/29/22 - A care plan meeting note lacked	F 657	Social Service employees need re-education on the requirements of regulation 483.21. Nurse Practice Educator or designee will provide education to current Social Service employees regarding regulation 483.21 with a focus on the disciplines who are required to attend care conference meetings and to ensure that all residents have a schedule care conference meeting per the regulation. Director of Nursing or designee will audit care conference meeting documentation to verify that all required disciplines are in attendance weekly for three weeks or until 100% compliance is achieved. Director of Nursing or designee will audit records of newly admitted residents to ensure that care conferences have been scheduled an completed per regulation weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 657	Continued From page 26 evidence that the the attending physician, certified nursing assistant and dietary participated in this meeting. 6/29/23 - A care plan meeting note lacked evidence that that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R8's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023. 4. Review of R13's clinical record revealed: 10/31/14 - R13 was admitted to the facility. 12/29/22 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 6/29/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/5/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R13's clinical	F 657		

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F 657	Continued From page 27 record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023. 5. Review of R66's clinical record revealed: 1/31/19 - R66 was admitted to the facility. 1/26/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 7/27/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R66's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred between October 6, 2022 through July 13, 2023. 6. Review of R86's clinical record revealed: 7/30/22 - R86 was admitted to the facility. 1/26/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 7/27/23 - A care plan meeting note lacked evidence that the attending physician, certified	F 657		

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F 657	Continued From page 28 nursing assistant and dietary participated in this meeting. 7. Review of R109's clinical record revealed: 4/24/23 - R109 was admitted to the facility. 12/22/22 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 10/12/23 - A care plan meeting note lacked evidence that the attending physician, certified nursing assistant and dietary participated in this meeting. 12/18/23 - untimed. A review of R109's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in March, 2023 and July, 2023. 8. Review R112's clinical record revealed: 7/7/23 - R112 was admitted to the facility. 12/18/23 - untimed. A review of R109's clinical record revealed the facility lacked evidence that a quarterly care plan meeting occurred in October, 2023. Additionally, R109's care plan reflected that he has a tracheostomy, but this was removed in August, 2023. 12/21/23 approximately 9:15 AM - Findings regarding care plan meetings were reviewed with E2 (DON). 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2.	F 657		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R107) out of five residents for medication review, the facility discontinued R107's routine anti-anxiety medication in error. In addition, it was determined that for one (R114) out of two residents reviewed for Urinary Cather/UTI, the facility failed to follow the plan of care. Findings include: 1. Review of R107's clinical record revealed: 10/14/22 - R107 was admitted to the facility with a diagnosis that included but was not limited to anxiety disorder. 10/25/23 - A physician order documented lorazepam 1 mg to be given one time a day for anxiety. 11/3/23 (revision date) - A care plan documented R107 has "anxiety, depression with behaviors." 12/17/23 - A physicians order documented to discontinue routine lorazepam 1mg one time a day for anxiety.	F 684	Resident R107 lorazepam order was reinstated on 12/21/203. Resident R114's order was changed to use of large catheter bag. Director of Nursing completed an audit of current residents who have orders to utilize lag bags with indwelling catheters to ensure that appropriate urine collection bags in in place per the order and plan of care. Residents with orders for leg bags with indwelling catheters have the potential to be affected Director of Nursing completed an audit of current residents receiving routine anti-anxiety medications for the previous 30 days to ensure that the medication was not discontinued in error. Current residents who receive routine antianxiety medications have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that current licensed Nursing staff need to be re-educated regarding following	2/15/24

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F 684	Continued From page 30 12/21/23 - A NP progress note for R107 documented "agitation...spouse is requesting that he continue on his previous dose of lorazepam." 1/4/24 9:45 AM - During an interview E4 (NP) stated that R107 was experiencing increased agitation. 1/4/24 1:20 PM - During an interview via telephone, E33 (Psychiatric NP) confirmed that she discontinued the routine dose of lorazepam. As a result R107 missed once a day doses of routine lorazepam on 12/17, 12/18, 12/19 and 12/20, a total of four doses until the medication was re-started on 12/21/23. 2. Review of R114's clinical record revealed: 12/8/23 - A physician order stated a large urinary catheter bag was to be used starting at 8:00 PM and used overnight. The leg catheter bag was to be put back on R114 upon waking for the day at 6:00 AM. 12/13/23 - An interview with F1 revealed on 12/9/23 at 1:30 AM, R114 was laying in bed with the leg catheter bag attached to his leg instead of the large catheter bag. 12/14/23 8:50 AM - An interview with E20 (UM) confirmed that on 12/9/23 at 1:30 AM, R114 was wearing a leg catheter bag instead of the large catheter bag while lying in bed. 12/14/23 9:07 AM - An interview with E32 (LPN) confirmed that on the night of 12/8/23, R114 was wearing a leg catheter bag instead of the large catheter bag. E32 stated that she left the leg	F 684	physicians' orders and that medical providers need re-education on the need to review orders prior to initiating to ensure order accuracy. Nurse Practice Educator or designee will provide re-education to licensed nurses regarding following physician orders with a focus on indwelling catheter orders which including the changing collection bags. The Nurse Practice Educator will re-educate current medical providers regarding ensuring orders are accurate prior to initiation. Director of Nursing or designee will audit medical records of current residents with indwelling catheters who have additional orders to change the collection bag to a leg bag to ensure the appropriate collection bag is in place according to the plan of care daily for three days or until 100% compliant, then three times a week or until 100% compliant, then monthly for three months or until 100% compliant. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 684	Continued From page 31 catheter bag on R114. 12/18/23 10:45 AM - During an interview E2 (DON), stated, if R114 were to get out of bed at night and was redirected back to bed the large catheter bag is to remain on, not the leg catheter bag. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R14) out of three residents reviewed for range of motion, the facility failed to ensure that R14 received treatment and services to prevent further decrease in range of	F 688	Resident R14's hand splint was applied and continues to be applied according to care plan. The Director of Nursing conducted an	2/15/24

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F 688	Continued From page 32 motion. Findings include: Review of R14's clinical record revealed: 9/25/20 - R14 was admitted to the facility with Parkinson's Disease and dementia. 6/7/22 - R14's care plan for splinting included a goal to prevent further contractures and maintain skin integrity. 9/4/23 - An annual MDS assessment documented that R14 was severely cognitively impaired and had bilateral upper and lower extremity limited range of motion. 11/1/23 7:00 AM - A physician's order included "Apply resting hand splint to R (right) hand after AM (morning) care and ROM (range of motion)." The following dates and times R14 was observed without a right hand splint: 12/14/23 10:23 AM, 12/15/23 11:26 AM, 12/15/23 2:46 PM,12/18/23 11:22 AM and 12/20/23 10:58 AM. 12/20/23 11:05 AM - E27 (CNA) confirmed R14 was not wearing his right hand. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 688	audit of current residents with orders for hand splints to ensure that each resident's hand splint is available and applied per care plan/order. Current residents with orders for hand splints have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that current nursing staff need re-education regarding the importance of applying hand splints per physician order with the goal of preventing further decline in activities of daily living. The Director of Nursing or designee will audit current residents with orders for hand splints to ensure that splints are applied according to the order three times a week for three weeks or until 100% compliance is achieved, then weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	
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	F 689		2/15/24

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F 689	Continued From page 33 §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 observation, interview and record review, it was determined that for two (R8 and R50) out of five residents reviewed for accident hazards, the facility failed to follow the plan of care. For R8 and R50 the facility failed to accurately /implement or obtain physician's orders for their wanderguards. In addition, the facility lacked evidence that R8 and R50 were adequately assessed for elopement risk. Findings include: A facility policy effective 6/1/96 (last revised 10/24/22) titled Elopement of a Patient included: Patients/Residents will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition as part of the clinical process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Security system checks will be conducted routinely and documented to ensure the function of...trigger bracelets (wanderguards)... 1. Review of R50's clinical record revealed: 1/2/20 - R50 was admitted to the facility with schizoaffective disorder. 3/7/20 - A care plan included that R50 was at risk for elopement related to a diagnosis of paranoid schizophrenia, impulsive, hearing voices that others do not hear as evidenced by attempt to leave the building without an escort (States "I'm not doing good and I want out of here").	F 689	Residents R8 and R50 have current elopement assessments and functioning wanderguards in place. Each resident has current orders for wanderguards and updated expiration dates. The Director of Nursing completed an audit of current residents to ensure that each resident received an elopement assessment according to policy and that residents identified as an elopement risk who require wanderguards have a functioning and unexpired wanderguard in place. All residents have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that licensed nursing staff require re-education regarding policy OPS111. Nurse Practice educator or designee will re-educate current Nursing staff regarding policy OPS111. Director of Nursing or designee will audit 10% of current resident population to ensure that elopement assessments are completed per policy weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved.	

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F 689	Continued From page 34 12/27/21 1:41 PM - An elopement evaluation documented that R50 had a history of actual or attempted elopement, a history of wandering that places the patient at significant risk of getting to a potentially dangerous place and has expressed the desire to leave. R50 was not assessed for elopement on admission or quarterly thereafter. 6/27/23 11:00 PM - A physician' order included, "Wander Guard/Wander Elopement Device due to poor safety awareness every shift for elopement check the placement of the device and in supplemental documentation document the location and every night shift for elopement until 09/30/2023 00:00 check function and document in supplemental documentation Expiration date: 9/30/23 (update the order with the new date when the bracelet is changed)." 9/16/23 6:35 PM - A progress note documented, "I was standing in hall way around 1630 (4:30 PM), around room 201, I heard the front alarm go off and saw a person go out the door. The secretary at the front desk said she let him out not knowing that he was ours [a resident of the facility]. As I was headed outside I saw a CNA [name] in the parking lot assisting another resident, and asked for her assistance. Pt (patient) kept going towards highway, I slowly approached pt and he said he was going home. I asked him to stop and to talk to me. Pt raised his right arm as to hit me, glared at me and said he was going home and continued to walk towards highway. At that time I asked the CNA to go get help. [E29] (CNA) came out to assist, and pt started to walk faster, and became more agitated. I asked [E29] to call the cops for assistance in case he became violent or went towards the	F 689		

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F 689	Continued From page 35 highway. Pt sat on the railing to the right of Marvel rd (road) entrance. A male CNA [E30], came out to assist. Male CNA was able to talk pt into coming back into the facility. CNA tried to call back 911 and cancel the 1st call. Primary Nurse of pt updated with incident. Cops did show up to facility to make sure everything was ok with resident. I explained situation and thanked them for checking in on pt. Pt safely went back to room with big grin on his face." Review of R50's September, October, November and December's 2023 treatment records revealed that the wanderguard order remained the same as above. The facility lacked evidence that the wanderguard was changed or checked for function until a new physician's order (while the surveyors were onsite) to check for function dated 12/18/23. 12/18/23 3:15 PM - During an observation, R50's wanderguard was in place to his left ankle. 12/18/23 3:17 PM - During an interview, E24 (UM) stated that the facility knows when a wanderguard is expired because they are checked routinely every week. 12/18/23 3:21 PM - During an interview E24 (UM) confirmed R50's order for the wanderguard was 6/27/23, the expiration was 9/30/23, the facility failed to update the order and the facility lacked evidence that R8's wanderguard had been changed. 12/18/23 3:24 PM - During an observation and interview, E31 (LPN) showed the surveyor the device to check a wandergaurd's function, and stated that nursing was supposed to check	F 689		

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F 689	Continued From page 36 resident wanderguards for function. 12/18/23 3:39 PM - During an observation and interview, E24 (UM) and E31 (LPN) utilized the testing device on R50's wanderguard and it did not read as activated. E31 was going to put a new device on R50, but the surveyor identified that the new wanderguard was also expired related to it had to be activated by 12/2/23 and it was now 12/18/23. E31 confirmed the expired wanderguard. 12/18/23 3:46 PM - E31 (LPN) returned with another wanderguard which would not expire until April 2024. 12/18/23 3:49 PM - During an observation, E31 (LPN) cut the expired wanderguard from R50's ankle, presented the expired wanderguard to the surveyor, and applied the new one (expiration date April 2024) to R50's ankle. 12/18/23 3:55 PM - During an observation and interview, E31 (LPN) accompanied the surveyor to the front door of the facility (with the 9/30/23 expired wanderguard), opened the door, and confirmed the alarm failed to sound. During an additional observation, E31 tested the wanderguard at the exit to the smoking area and confirmed the alarm also failed to sound when the door was opened. 12/18/24 4:47 PM - An elopement evaluation was completed at the time of the survey which included R50 had a history of elopement at home and in the facility, verbally expressed the desire to go home (packed belongings to home or stayed near an exit door) and R50 wandered.	F 689		

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F 689	Continued From page 37 12/20/23 11:11 AM - During an interview, E1 (NHA) confirmed the status of the elopement assessments for R50 and that they had not been completed as required. E1 stated that that elopement assessment should be completed at least annually, and that "some (residents) had not been done." E1 confirmed R50's risk for elopement, and that their orders could allow their wanderguards to be expired and fail to function. 2. Review of R8's clinical record revealed: 3/25/22 - R8 was admitted to the facility with back issues and was later diagnosed with dementia. An elopement evaluation was not completed on admission. 3/31/22 - R8's admission MDS documented that R8 had moderate cognitive impairment. 9/16/22 - An elopement evaluation documented that R8 had a history of actual or attempted elopement and of wandering that placed the resident at significant risk of getting to a potentially dangerous place. 9/23/22 - R8's care plan included, "Resident/Patient is at risk for elopement related to cognitive loss/dementia as evidenced by attempt to leave the building without an escort. Utilize and monitor security bracelet (wanderguard) per protocol." 5/18/23 - A physician's order included that R8 was to wear a wanderguard due to poor safety awareness and that the wanderguard expiration date was 8/18/23 (update the order when changed). The facility lacked evidence that the wanderguard was changed and that the order	F 689		

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F 689	Continued From page 38 was updated to include a new expiration date. 9/2023 - The facility lacked evidence that a yearly elopement evaluation had been completed. 9/30/23 - R8's quarterly MDS documented that R8 was severely cognitively impaired. 10/24/23 10:00 PM - A care plan evaluation note included that R8 had wandered eighteen out of thirty days. 12/18/23 4:47 PM - R8's reassessment elopement evaluation was completed which indicated a risk for elopement and was not completed until the surveyor inquired. 12/20/23 11:11 AM - During an interview, E1 confirmed the status of the elopement assessments for R8 and that they had not been completed as required. E1 stated that that elopement assessment should be completed at least annually, and that "some (residents) had not been done." E1 confirmed R8's risk for elopement, and that their orders could allow their wanderguards to be expired and fail to function. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	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	F 690		2/15/24

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F 690	Continued From page 39 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R379) out of one resident reviewed for bowel and bladder, the facility failed to ensure that appropriate assessments and services were rendered to maintain bowel and bladder continence. Findings include: A policy titled "Continence Management" revised	F 690	Resident R379 was discharged on 12/26/2023. The Director of Nursing completed an audit of current residents to ensure that a bowel and bladder assessment has been completed and that those residents identified as incontinent of bowel and bladder have a plan in place to maintain	

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F 690	Continued From page 40 on 6/15/22 stated "patients will be assessed for the need for continence management as part of the nuring assessment process. ..... Identify patient's continence status and need for continence management by conducting a nursing assessment." Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility. R379 was alert and oriented to person, place, and time. 12/8/23 2:37 PM - A review of R379's clinical admission assessment lacked evidence that bowel and bladder continence was assessed by nursing. 12/8/23 - A review of the CNA task flow sheet revealed that R379 had two continent episodes out of two opportunities using a urinal with staff assistance. The CNA task flow sheet marked R379 as a set up for toileting and requiring max assistance from staff. 12/9/23 - A review of R379's baseline careplan lacked evidence of how to provide care to assist with toileting for R379. The baseline careplan was pre-populated text that required staff to edit to personalize per residents needs, and the baseline careplan was not personalized to reflect R379's toileting needs. 12/9/23 - A review of the CNA task flow sheet revealed that R379 had three incontinent episodes out of three opportunities. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/10/23 - A review of the CNA task flow sheet	F 690	bowel and bladder continence. All current residents who are assessed as incontinent have the potential to be affected. Root cause analysis was completed by the interdisciplinary team and determined that current licensed Nursing staff have the need for re-education regarding policy NSG211. Nurse Practice Educator or designee will re-educate licensed nursing staff regarding policy NSG 211. Director of Nursing or designee will perform audits of medical records of newly admitted residents to ensure that bowel and bladder assessments have been completed and the care plan is updated to reflect the most current bowel and bladder assessment and a plan is in place for those residents identified as incontinent to maintain continence three times a week for one week or until 100% compliance is achieved, then weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 690	Continued From page 41 revealed that R379 had three incontinent episodes out of three opportunities. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/11/23 - A review of the CNA task flow sheet revealed that R379 had one continent using the toilet with staff assistance episode out of three opportunities. The CNA task flow sheet marked R379 as indepent, dependent and requiring max assistance from staff for toileting. 12/12/23 - A review of the CNA task flow sheet revealed that R379 had one continent episode using the toilet with staff assistance out of three opportunities. The CNA task flow sheet marked R379 as indepent, dependent and requiring max assistance from staff for toileting. 12/12/23 9:29 AM - An interview with R379 revealed that he started having problems with incontinence related to the stroke and required assistance with toileting. R379 also revealed that staff would tell him to urinate in his brief. 12/13/23 - The CNA task flow sheet revealed that R379 was marked for incontinence twenty four episodes out of twenty four opportunities from 12/13 to 12/21/23. The CNA task flow sheet marked R379 as dependent and requiring max assistance from staff for toileting. 12/20/23 8:30 AM - An interview with E16 (unit clerk) revealed that the facility does not complete voiding diaries on new admissions. 12/20/23 9:15 AM - An interview with E14 (CNA) confirmed that R379 stated he was continent and able to use a urinal upon admission.	F 690		

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F 690	Continued From page 42 12/20/23 9:25 AM - An interview with E15 (RN) confirmed that R379 lacked a bowel and bladder assessment upon admission. E15 stated the admitting nurse was responsible to complete this assessment with the admission assessment. The facility failed to initiate a plan to assist R379 in maintaining urinary continence. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 690		
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 one (R58) out of one sampled residents for respiratory care, the facility failed to maintain oxygen as ordered. Findings include: Review of R58's clinical record revealed: 1/7/21 - R58 was admitted to the facility with a diagnoses of COPD and chronic respiratory failure.	F 695	Resident 85's O2 tubing was changed and labeled. Director of Nursing completed an audit of current residents receiving order for O2 tubing verifying labels and dates. All current residents with orders for O2 have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined that current Nursing staff need re-education on	2/15/24

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F 695	Continued From page 43 1/8/21- A physician order was written to administer oxygen continuously at 3 L/min (liters per minute) using a nasal cannula to maintain O2 (oxygen) saturation above 90%, change oxygen tubing weekly and label each component with date and initials. 12/12/23 10:23 AM - Upon screening residents, this Surveyor observed R58 sitting in her wheelchair and there was a portable oxygen tank hanging on the back. The oxygen tubing was connected and the tank was set at 3L/min. There was also an oxygen concentrator in the room and neither tubing was labeled. 12/12/23 10:30 AM - During an interview, E23 (Director of the memory care unit) confirmed that neither tubing was labeled. 12/12/23 10:46 AM - During an interview, E22 (LPN) also confirmed that the tubing connected to the oxygen tank and the concentrator was not labeled. E22 stated that the tubing is changed on Tuesday's and was due to be changed that night. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 695	the procedure of Oxygen delivery. Nurse Practice Educator or designee will re-educate licensed Nursing staff regarding procedures for delivering Oxygen via tubing. Director of Nursing or designee will audit current residents receiving O2 to ensure that the tubing is labeled and dated weekly for three weeks or until 100% compliant then monthly for three months or until 100% compliant. Results of the audits will be reviewed in the monthly QAPI meeting.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		2/15/24

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F 697	Continued From page 44 Based on record review and interview, it was determined that for one (R397) out of three residents sampled for pain the facility failed to provide pain management according to professional standards of practice . R397, a resident with chronic pain, was not assessed for pain and not scheduled timely for a pain management consult. Findings include: Review of R379's clinical record revealed: 12/8/23 - R379 was admitted to the facility with a history of chronic pain managed by a pain management specialist. 12/8/23 11:30 AM - A review of hospital discharge summary records revealed that R379 has a history of chronic pain and to "defer to discretion of pain management" regarding medication regimen. R379 was discharged with no active pain medication orders and recommended to follow up with pain management. 12/8/23 2:37 PM - A review of R379's clinical admission assessment lacked evidence that a pain assessment was completed. 12/10/23 - A review of R379's baseline care plan failed to include R379's acceptable pain level or a baseline pain level. 12/12/23 - An interview with R379 revealed a pain level of 8 out of 10 (pain is identified between 0 and 10, with 10 being the worst pain imaginable and 0 being no pain.) R379 received tylenol (pain medication) with post pain assessment marked as "effective" on MAR. The facility failed to use the same pain scale to assess pre and post pain.	F 697	Resident R379 was discharged from the Center on 12/26/2023. Director of Nursing performed an audit of current residents with diagnosis of chronic pain to ensure that pain is being assessed according to professional standards of practice and to determine if a resident is identified as their pain not being managed, then they are scheduled for a pain management consultation timely. Current residents with diagnosis of chronic pain have the potential to be affected. Root cause analysis completed by the interdisciplinary team determined the need for re-education to Licensed Nursing staff on policy NSG227. Nurse Practice Educator or designee will re-educate Licensed Nursing staff on policy NSG227 for pain management. Director of Nursing or designee will audit residents with diagnosis of chronic pain to ensure that pain assessments are being conducted per professional standards of practice and those residents identified as not having their pain managed are scheduled for a pain management consultation timely - weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 697	Continued From page 45 12/12/23 - An interview with R379 revealed a pain level of 8 out 10 post tylenol administration. R379 confirmed the medication is not effective for his pain. 12/14/23 11:19 AM - An interview with R379 revealed a pain level of 8 out of 10. 12/14/23 11:25 AM - An interview with E17 (LPN) revealed that she was unaware of R379's pain level. The MAR lacked evidence of pain medication administration and monitoring of pain level. 12/15/23 10:07 AM - An interview with E16 (unit clerk) revealed that a physician saw R379 this morning and requested R379 to follow up with pain management for chronic pain. E16 stated a call has been placed to schedule appointment. 12/18/23 10:02 AM - An interview with E3 (UM/ADON) revealed that when a resident is admitted to the facility a pain assessment is completed and that determines the acceptable pain level. The admitting nurse and nurse responsible for chart check are responsible to update care plan and ensure all assessments are completed upon admission. E3 confirmed the initial pain scale was not completed and acceptable pain level was not updated. It was also confirmed that the resident is not being monitored every shift for pain level as that standing order was not initiated. E3 stated she is following up with pain management today for a course of action regarding pain management. 12/18/23 10:38 AM - An interview with E17 revealed that R379 had a pain management appointment scheduled for 12/19/23.	F 697		

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F 697	Continued From page 46 12/20/23 9:10 AM - An interview with E4 (NP) revealed that she does not review discharge paperwork until the resident arrives to the facility and she discussed scheduling R379 for pain management with E16 on 12/15/23. It is unclear based on interview why the pain management appointment was not made sooner. 12/21/23 12:00 PM - Findings were reviewed with E1(NHA) and E2 (DON).	F 697		
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: Based on record review and interview, it was determined that for five (E6, E8, E9, E10 and E11) out of five certified nursing assistants reviewed, the facility failed to complete an annual evaluation. Findings include: 12/15/23 approximately 1:15 PM - E1 (NHA) provided documentation regarding CNA evaluations for the following employees and stated that no annual evaluations had been completed: E6 with a hire date of 8/30/22; E8 with a hire date of 11/8/22; E9 with a hire date of 10/22/22;	F 730	No residents were cited. No residents are affected. Root cause analysis revealed the need for a tracking system to ensure that annual evaluations are completed for CNAs. Tracking system was put into place by HR designee and is monitored for accuracy and completion by Administrative Assistant. Audit of completion of CNA annual evaluations will be completed by HR designee monthly for a minimum of three	2/15/24

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F 730	Continued From page 47 E10 with a hire date of 8/9/22; E11 with a hire date of 7/5/22. 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).	F 730	months. When 100% compliance is achieved, the QAPI committee will evaluate the need for continuance	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		2/15/24

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F 758	Continued From page 48 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R72 and R107) out of five residents sampled for medication review, the facility failed to re-evaluate the need for a PRN medication for anxiety every fourteen days. Findings include: 1. Review of R72's clinical record revealed: 8/27/20 - R72 was admitted to the facility with a diagnoses of dementia with other behavioral disturbance and anxiety disorder. 10/21/22 - A physician order was written for lorazepam 0.5 mg to be given every six hours as needed for signs and symptoms of increased anxiety. 7/27/23 - A quarterly MDS assessment documented no adverse behaviors.	F 758	Resident R72 discharged 1/1/2024. Resident R107 received a psychotherapeutic medication evaluation on 12/21/2023 which determined the need to remain on the PRN Lorazepam related to R107 Representative states that R107 gets anxious while she is visiting, and Representative believes that R107 is always anxious. Psychiatric Nurse Practitioner reinstated Lorazepam for anxiety. Director of Nursing conducted an audit of current residents who received PRN anti anxiety medication prescribed in the last 30 days to ensure that after 14 days there is a psychotherapeutic medication evaluation to determine the continued need for the medication. Current residents on newly prescribed PRN antianxiety medications have the potential to be	

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F 758	Continued From page 49 10/1/23 through 12/21/23 - Review of MAR revealed no adverse behaviors and no use of the above mentioned medication. 10/27/23 - An annual MDS assessment documented no adverse behaviors. Record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate continued use of the PRN medication. 2. Review of R107's clinical record revealed: 10/14/22 - R107 was admitted to the facility with a diagnoses of dementia without behavioral disturbance and anxiety disorder. 7/20/23 - A quarterly MDS assessment documented physical behaviors directed towards others and behavioral symptoms not directed towards others occurred 4-6 days. 10/1/23 through 12/21/23 - Review of MAR revealed no adverse behaviors. 10/20/23 - An annual MDS assessment documented no adverse behaviors. 10/25/23 - A physician order was written for lorazepam 0.5 mg to be given every eight hours as needed anxiety. Record review lacked evidence of the attending physician or prescribing practitioner's reason for the appropriate continued use of the PRN medication. 12/21/23 12:00 PM - Findings were reviewed with	F 758	affected. Root cause analysis performed by the interdisciplinary team determined that the current Licensed Nursing staff need re-education on 3.8 psychotropic medication use. Nursing Practice Educator or designee will re-educate current licensed nursing staff on 3.8 psychotropic medication use with a focus on re-evaluating continued need for PRN anti-anxiety medication after 14 days. Director of Nursing or designee will audit current residents who received new orders for PRN antianxiety medication to ensure that there is a psychotherapeutic medication evaluation after 14 days to determine the continued need for the medication weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 758	Continued From page 50 E1 (NHA) and E2 (DON).	F 758		
F 761 SS=E	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 three out of six medication carts and in two out of three medication rooms reviewed. In addition, the facility failed to monitor refrigerator temperatures in one medication fridge on the Central Unit.	F 761	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.	2/15/24

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F 761	Continued From page 51 Findings include: 12/19/23 12:30 PM - During a medication storage review of the Central unit medication room, the following was observed inside: 1. Expired on 8/23, two epinephrine (medication to treat allergic reactions) injection pens. 2. The Emergency Medication box was unsealed. 12/19/23 12:35 PM - A review of the temperature log for the medication refrigerator revealed that the facility failed to monitor temperatures. 12/19/23 12:50 PM - An interview with E28 (RN) confirmed medications were expired, the emergency medication box was unsealed and the temperature log had five missed log days out of 18 days documented. 12/19/23 1:38 PM - During a medication storage review of the East unit medication room, the following was observed inside: 1. Expired on 11/2023 two boxes of Chewable calcium supplements. 2. Expired on 8/19/23 four bags of Cefazolin (antibiotic) medication. 3. Expired on 3/14/23 Pneumovax (vaccine against pneumonia) injection solution. 4. Multidose Tuberculin (skin test to determine tuberculosis) solution vial: opened and dated 9/20/23. 12/19/23 3:16 PM - An interview with E24 (UM) and E31 (LPN) confirmed medications were expired and/or undated. 12/20/23 2:03 PM - During a medication storage	F 761	Director of Nursing conducted audit of all medication cars and medication rooms to ensure that no further biologicals were outdated. Director of Nursing conducted an audit of all refrigerators to ensure temperatures were obtained. All current residents have the potential to be affected. A root cause analysis was performed by the interdisciplinary team and determined that current licensed nursing staff need re-education on the policies and procedures for storage of drugs and biologicals and the policy for obtaining refrigerator temperatures to ensure proper temperatures controls. Nurse Practice Educator or designee will re-educate licensed nursing staff on policy 5.3 storage and expiration dating of medications and biologicals and the policy for refrigerator temperatures. Director of Nursing or designee will audit the facility medication rooms and medication carts to ensure that there are no outdated biologicals and that the refrigerators have documentation of obtained temperatures -weekly for three weeks or until 100% compliance is achieved, then monthly for three months or until 100% compliance is achieved. Results of the audits will be reviewed at the monthly QAPI meetings.	

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F 761	Continued From page 52 review of the Central unit medication cart 1, the following was observed inside the medication cart: 1. Expired on 3/2023 a bottle of zinc supplement tablets with an opened date of 8/21/23. 2. Expired on 11/2023 a bottle of multi-vitamin tablets with an opened date of 3/9/23. 3. Two insulin Lispro (medicine for diabetes) injection pens: opened with no open date. 4. Two Advair discus metered dose inhalers: opened with no open date. 5. Anoro metered dose inhaler: opened with no open date. 6. Fluticasone propionate nasal spray: opened with no open date. 7. Deep sea nasal spray: opened with no open date. 12/20/23 2:24 PM - An interview with E15 (RN) confirmed medications were expired and/or undated. 12/20/23 2:36 PM - During a medication storage review of the Homestead unit medication cart 1, the following was observed inside the medication cart: 1. Expired on 10/2023 an unopened vial of olanzapine (an antipsychotic medication). 2. Advanced antacid magnesia: opened with no open date. 12/20/23 2:54 PM - An interview with E3 (ADON) and E22 (LPN) confirmed medications were expired and/or undated. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 761		

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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 that food was stored, prepared, and served in a manner that prevents foodborne illness to the residents. Findings include: 1. 12/12/23 8:57 AM - During the initial tour of the kitchen, the surveyor observed seven rectangular plastic food storage canisters from the refrigerator containing various food items with the following "use by" dates: 10/23, 11/15, 11/21, 11/21, 11/29, no date and no date, on the counter. E7 (Dietary Manager) stated that the items were on the counter to be discarded as part of the weekly food management procedure. Interview with E7 revealed that these items had been on a	F 812	No residents were cited. All residents have the potential to be affected. Root cause analysis identified the need for education of Dietary staff regarding proper labeling, dating and covering of food. Temperature logs have been revised for better compliance. Daily inspections will be completed by the Dietary manager or designee to verify compliance with labeling, dating and covering of food, and completion of temperature logs. Sanitizer levels will be checked by the Cook each shift.	2/15/24

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F 812	Continued From page 54 top shelf and were missed in previous refrigerator cleanings. 2. 12/12/23 10:39 AM - During a tour of the kitchen, there was significant ice build-up on the plastic flaps in the doorway of the walk-in freezer, and what appeared to be water damage to the ceiling area of the door frame of the walk-in freezer. 3. 12/12/23 11:03 AM - A one pound stick of butter was partially unwrapped, preventing protection from dust, debris, and other contaminants, and a rectangular plastic food storage canister containing peeled pears in juice had no date label. 4. 12/12/23 11:06 AM - Kitchen cloths used for sanitizing food prep surfaces were left on the counter more than forty-five minutes. 5. 12/12/23 1:35 PM - E13 (District Dining Manager) was observed testing the sanitizer level of the solution in two red sanitizing buckets. When E13 tested the sanitizing solution, the test strips from both buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 6. 12/12/23 2:43 PM - During a review of the food temperature logs, the facility kitchen records had no food temperatures recorded for one-hundred seven (107) meals out of two-hundred sixteen (216) meals sampled. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare	F 812	Damaged flaps have been removed from the freezer. Door will be securely closed. Ice buildup will be monitored and cleared as necessary. Repairs made to door frame. Buckets are now placed on each table for ease of access. Audits will be conducted weekly for one month, monthly for three months until 100% compliance is consistently achieved. Results will be reported to QAPI Committee monthly.	

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F 812	Continued From page 55 it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F), and cold ready to eat foods must be held below forty-one (41) degrees (F) to maintain food safety. 12/12/23 2:15 PM - Findings were confirmed with E1 (NHA). 12/21/23 12:00 PM - Findings were reviewed with E1 and E2 (DON).	F 812		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (E8, E10 and E11) out of five Certified Nursing Assistants (CNA)	F 947	No residents were cited. No residents are affected.	2/15/24

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F 947	Continued From page 56 reviewed, the facility failed to ensure that these employees had the mandatory twelve hours of annual in-service training. Findings include: 12/15/23 approximately 12:15 PM - The surveyor received documentation regarding staff training hours. Review of this documentation revealed the following: E8 (CNA) with a hire date of 11/8/22 had only 4 hours of training; E10 (CNA) with a hire date of 8/9/22 had only 2 hours of training; E11 (CNA) with a hire date of 7/5/22 had only 4.45 hours of training. The facility lacked evidence that these employees completed the mandatory twelve hours of annual in-service training. 12/19/23 approximately 12:00 PM - During an interview, E1 (NHA) and E2 (DON) stated they will review additional records to provide confirmation of training's. 12/19/23 2:41 PM - In an email correspondence, E1 confirmed that the facility has no additional information regarding the training and that it was not completed by E8, E10 and E11. 12/21/23 12:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 947	Root cause analysis identified need for implementation of a tracking system to ensure that CNAs receive the mandatory twelve hours of inservice training. An audit will be conducted of CNA annual inservice training completion. CNAs who have not completed annual training will be scheduled to complete the training. Mandatory inservice training completion will be tracked by the Nurse Practice Educator. Appropriate follow-up action will be taken to address non-compliance. Audits will be conducted monthly for compliance for 10 months. Results will be reported to QAPI Committee.	