DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehab Capitol Healthcare

DATE SURVEY COMPLETED: November 8, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Extended Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on October 30, 2023 through November 8, 2023. The facility census on the first day of the survey was one hundred and seven (107). The survey sample size was twenty-nine (29) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed November 8, 2023: E37, F550, F641, F644, F656, F657, F677, F679, F684, F688, F758, F790, F791, F806, F812, F842 F880, and F943.	Please Cross reference electronic POC in epoc systement E37, F550, F641, F644, F656, F657, F677, F679 F684, F688, F758, F790, F791, F806, F812, F842 F880, and F943	01/08/2024

Provider's Signature [signature] Title Administrator 12/07/2023 Date 12/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING ______ B. WING ______	C 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

(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 October 30, 2023 through November 8, 2023. The facility census was 107 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 cited.	E 000		
E 037 SS=E	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 least every 2 years.	E 037		1/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/07/2023

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

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E 037	Continued From page 1 (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 staff, individuals providing services under	E 037		

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E 037	Continued From page 2 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 staff, individuals providing services under	E 037		

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E 037	Continued From page 3 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, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 4 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 record review it was determined that for one (E18) out of twelve (12) sampled employees the facility failed to provide emergency preparedness training at least annually. Findings include: Review of facility records for emergency preparedness training revealed one (1) staff member without evidence of training within the past year:	E 037	1. No resident was negatively impacted by the deficient practice. 2. Transferring staff will complete an initial and an annual emergency preparedness training. All future employees will be protected by taking the corrective action outlined in #3. 3. The facility will conduct an audit of all transferring employees to verify compliance of emergency	

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E 037	Continued From page 5 - E18 (COTA) no record of current emergency preparedness training. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	E 037	preparedness training. A root cause analysis was completed and it was determined that the facility did not have an internal process in place to assure that all transferring employees had the required emergency preparedness training. A facility wide audit was completed and no other employee was found as deficient. 4. DON or designee will audit all new hires for compliance of emergency preparedness training. The audit will be daily until 100% compliance X3 consecutive audits. Then the audits will be weekly until 100% compliance is achieved over 3 consecutive audits. Then another audit will be conducted monthly X3. Once 100% compliance is achieved, the deficient practice will be considered resolved. The results of the audits will be presented and discussed at the facility QA meeting.	
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from October 30 , 2023 through November 8, 2023. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 107. The survey sample totaled 29 residents. CNA - Certified Nursing Assistant; CNO - Chief Nursing Officer;	F 000		

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F 000	Continued From page 6 COO - Chief Operating Officer; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - Occupational Therapist; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager; ADL's - Activities of daily living; Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Arterial duplex scan - a painless exam that uses high-frequency sound waves (ultrasound) to capture internal images of the major arteries in the arms, legs and neck; Arterial wound - A wound due to a reduced arterial blood supply to the leg; Arteries - Are blood vessels that carry blood from the heart to other places in your body; ASHRAE - American Society of Heating, Refrigerating and Air-Conditioning Engineers; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best: 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Bilateral- affecting both sides;	F 000		

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F 000	Continued From page 7 Bipolar Disorder - mood disorder; Care Plan - outlines the plan of action that will be implemented during a patient's medical care; CDC - Centers for Disease Control and Prevention; Cognition - mental process; thinking; Contracture - joint limitations with fixed high resistance to passive stretch of a muscle; Chronic Obstructive Pulmonary Disease - (COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing; Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Delusional disorder - a serious mental illness previously called paranoid disorder, in which a person can't tell real from what is imagined; 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; Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave; Doppler flow - is a type of ultrasound that uses sound waves to measure the flow of blood through a blood vessel; Dorsalis pedia artery - An artery that supplies blood to the foot; Edentulous - lacking teeth; toothless; EPA - Environmental Protection Agency; Extensive Assistance - while the resident	F 000		

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F 000	Continued From page 8 performed part of the activity over the last 7 day period, help was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; OR means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance; Gradual Dose Reduction (GDR) - tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the medications can be discontinued altogether; Hallucinations - something that seems real but does not really exist; Interdisciplinary Team (IDT) - a coordinated group of staff from several different fields who work together towards a common goal or project; Hemiplegia - half of body paralyzed; Insomnia - sleep disorder that is characterized by difficulty falling and/or staying asleep; Legionella - a bacteria found naturally in freshwater environments, which can cause a severe type of lung infection; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations. It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause; MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes;	F 000		

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F 000	Continued From page 9 Multiple Sclerosis - nervous system disease that affects the brain and spinal cord; Non-Alzheimer's Dementia - dementia from another cause other than Alzheimer's, such as vascular or brain damage caused by multiple strokes; Non-pharmacologicial - any intervention (therapy or technique) intended to improve health or well-being that does not involve the use of any drug or medicine; 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; Pathogen - an organism that causes disease; Posterior - back surface of the body; Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Pressure Ulcer Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Psychology - study of behavior and mind; Psychotropic (medication) - any medication capable of affecting the mind, emotions and behavior; QHS - every night; Splint - a rigid or flexible device that maintains in position a displaced or movable part; Tibialis artery - An artery that supplies blood to the lower leg; Urinary incontinence- inability to prevent accidental leakage of urine from bladder.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights	F 550		1/8/24

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F 550	Continued From page 10	F 550		

CFR(s): 483.10(a)(1)(2)(b)(1)(2)

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

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

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

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her

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F 550	Continued From page 11 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R90) out of two residents reviewed for dignity, the facility failed to ensure care was provided in a way that promoted dignity and respect. Findings include: 7/1/22 - R90 was admitted to the facility with degenerative disease of the back. 11/1/23 11:04 AM - During an observation R90 was ambulating in the front hallway of the facility, by the lobby, with E25 (PTA) wearing a night shirt and no pants. R90's upper thighs and incontinence brief was visible to residents, staff and visitors. 11/1/23 11:06 AM - During an interview, E25 (PTA) confirmed that R90's night shirt was bunched up at the waist, and private parts of her body could be seen by others. 11/1/23 11:28 AM - During an interview, E14 (OT) confirmed that she was aware that residents should be appropriately dressed for therapy. E- stated that it would be undignified for a resident to ambulate in the hallway with an "ill-fitting" night shirt exposing their thighs and brief. E14 stated that she and would have noticed and ensured that the resident was appropriately covered. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 550	1. R90 was not negatively impacted by this deficient practice. R90 was offered and declined change of clothing. 2. All residents who are receiving therapy services have the potential to be affected by the deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined in #3. 3. The facility will conduct focused education on resident dignity and respect to include proper dress while in therapy. A facility wide audit was completed and it was determined no other resident was affected by this deficient practice. 4. DOR or designee to perform random observations to ensure that residents are properly dressed 3 X daily for 3 consecutive days, or until 100% compliance is met for 3 consecutive days. 3 observations will then be done 3 times weekly or until 100% compliance is met for 3 consecutive weeks. 3 random observations will then be conducted once per week for 3 consecutive weeks or until 100% compliance is met for 3 consecutive audits. If 100% of	

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CADIA REHABILITATION CAPITOL	**1225 WALKER ROAD DOVER, DE 19904**

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F 550	Continued From page 12	F 550	compliance is achieved, the deficiency will be considered resolved. The findings will be reviewed with the QAPI committee.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R98 and R417) out of twenty-nine residents reviewed for resident assessment, the facility failed to accurately complete MDS assessments to reflect resident status. Findings include: 1. Review of R98's clinical record revealed: 5/9/23 - R98 was readmitted to the facility with dementia. 5/10/23 1:00 AM - A provider progress note documented that R98 was, "referred from home to Cadia for LTC (long term care) due to progressive dementia." 5/11/23 - R98's care plan included that R98 had impaired cognitive function or impaired thought process related to dementia. 5/17/23 - R98's admission MDS assessment did not include R98's diagnosis of dementia. 5/31/23 12:42 PM - A psychiatric progress note documented that R98 had a diagnosis of dementia with behavioral disturbances.	F 641	641-R98 1. No resident was negatively impacted by this deficient practice. R98 MDS was immediately corrected upon discovery. 2. All residents with the diagnosis of dementia have the potential to be affected by the deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below. 3. The facility will conduct a focus audit of all residents with dementia to ensure proper coding on the MDS. A facility wide audit was conducted and no other dementia diagnoses were omitted. The facility RNAC will be educated by the corporate RNAC to ensure proper understanding of the importance of ensuring the MDS assessment accurately reflects the residents□ status. 4. Corporate RNAC/Designee will conduct random audit MDS assessments to	1/8/24

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F 641	Continued From page 13 8/15/23 1:00 AM - A provider progress note documented a history of dementia. 8/17/23 - R98's quarterly MDS assessment did not include R98's diagnosis of dementia. 11/7/23 10:44 AM - During an interview, E26 (RNAC) confirmed that R98's admission and quarterly MDS assessments failed to include R98's MDS diagnosis of dementia. 2. Review of R417's clinical record revealed: 7/30/22 - R417 was admitted to the facility after a stroke affecting his left side. 8/5/22 - R417's MDS assessment documented that R417 did not have any pressure ulcers. 8/12/22 12:17 PM - A nursing progress note documented that R417 had 2 new "open areas" to his buttocks. 8/13/22 3:11 PM - A nursing progress note documented that R417 "has a open stage 2 wound on outer left ankle." 8/17/22 - R417's discharge MDS assessment documented that R417 had one stage 2 pressure ulcer that was present on admission and one unstageable pressure ulcer present on admission. R417 did not have any pressure ulcers on admission. Review of R417's clinical record was not consistent with the MDS data. 11/7/23 1:30 PM - During an interview, E3 (CNO) confirmed the R417's 8/17/22 MDS assessment was inaccurate based on the the initial 8/5/22	F 641	ensure assessments accurately reflect the resident status. The audit will be conducted daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed with the facility QA committee. F641-R417 1. No resident was negatively impacted by this deficient practice. R98 MDS was immediately corrected upon discovery. 2. All residents with the diagnosis of a wound have the potential to be affected by the deficient practice. Residents will be protected from this deficient practice by taking the corrective actions outlined below. 3. The facility will conduct a focus audit of all residents with wound to ensure proper coding on the MDS. A facility wide audit was conducted and no other wounds were omitted. The facility RNAC will be educated by the corporate RNAC to ensure proper understanding of the	

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F 641	Continued From page 14 admission assessment. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 641	importance of ensuring the MDS assessment accurately reflects the residents□ status. 4. Corporate RNAC/Designee will conduct random audit MDS assessments to ensure assessments accurately reflect the resident status. The audit will be conducted daily until 100% compliance is achieved for five consecutive audits. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed with the facility QA committee.	
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		1/8/24

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F 644	Continued From page 15 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for four (R30, R38, R40 and R74) out of five residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed following a new diagnosis of psychotic disorder which was not listed on the previous PASARR. Findings include: 1. Review of R30's clinical record revealed: 3/7/18 - R30 was admitted to the facility. 3/6/18 - A review of R30's medical record revealed that R30 had a PASARR level I that indicated R30 had a documented serious mental illness (mood disorder with depressive features) and demonstrated a full level II was not indicated at that time. 9/17/18 - A review of R30's medical record revealed that R30 had a PASARR level I.5 that indicated R30 had a documented serious mental illness (mood disorder with depressive features) and demonstrated a full level II was not indicated at that time. 9/7/22 - A review of R30's medical record revealed that R30 has the following new diagnoses: major depressive disorder, delusional disorder, hallucinations, and adjustment disorder	F 644	644 R30 1. Resident R30 was not affected by this deficient practice. All residents with a diagnosis of dementia have the potential to be affected by this deficient practice. 2. An audit of diagnoses records for current residents will be conducted by the Social Worker (SW)/designee to ensure all residents with PASSR level II criteria are screened appropriately. 3. A root cause analysis was conducted, and it was determined that the social worker was not being informed of residents newly assigned diagnoses prompting the need for a new PASSR review. A facility-wide audit was conducted and no further issues with PASSR updates were identified. The Psych NP will be educated to update the DON on all diagnosis changes so that the social worker can collaborate with the PASSR team any changes needed for an updated PASSR. 4. SW will conduct daily audit X3, weekly X3, and monthly X3 until 100% compliance is achieved, and at that time the issue will be	

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F 644	Continued From page 16 with depressed mood. 11/1/23 1:58 PM - An interview with E7 (social worker) confirmed that a PASARR level II was never requested for R30. 11/7/23 8:40 AM - An email correspondence with, S3 (PASARR State Authority) revealed that, "...The facility should have submitted a status change or another resident review PASARR at that time of or timely discovery that the Level 1.5 (Notice Date 9/7/18) was not an accurate reflection of (R30) mental health status and new diagnoses." 2. Review of R40's clinical record revealed: 2/7/17 - R40 was admitted to the facility. 5/19/17 - A review of R40's medical record revealed that R40 had a PASARR level I that indicated R40 had a documented serious mental illness (bipolar, major depressive disorder, and anxiety) and demonstrated a full level II was not indicated at that time. 10/1/22 - A review of R40's medical record revealed that R40 had the following new diagnoses: adjustment disorder with depressed mood, dementia with agitation, delerium, and delusional disorder. 5/14/23 - A review of R40's MDS revealed anxiety, bipolar, depression, psychotic disorder, and non-alzheimer's dementia were documented. 11/1/23 1:58 PM - An interview with E7 (social worker) confirmed that a PASARR level II was never requested for R40 when new diagnoses	F 644	considered resolved. The findings will be reviewed with the QAPI committee. F 644 R38 1. Resident R38 was not affected by this deficient practice. All residents with a diagnosis of dementia have the potential to be affected by this deficient practice. 2. An audit of diagnoses records for current residents will be conducted by the Social Worker (SW)/designee to ensure all residents with PASSR level II criteria are screened appropriately. 3. A root cause analysis was conducted, and it was determined that the social worker was not being informed of residents newly assigned diagnoses prompting the need for a new PASSR review. A facility-wide audit was conducted and no further issues with PASSR updates were identified. The Psych NP will be educated to update the DON on all diagnosis changes so that the social worker can collaborate with the PASSR team any changes needed for an updated PASSR. 4. SW will conduct daily audit X3, weekly X3, and monthly X3 until 100% compliance is achieved, and at that time the issue will be considered resolved. The findings will be reviewed with the QAPI committee. F 644 R40 1. Resident R40 was not affected by this deficient practice. All residents with mental disorder	

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F 644 Continued From page 17
were identified.

11/7/23 8:40 AM - An email correspondence with, S3 (PASARR State Authority) revealed that, "...The facility should have submitted a status change or another resident review PASARR at that time of or timely discovery that the Level 1 (Notice Date 5/19/17) was not an accurate reflection of (R40) mental health status and new diagnoses."

3. Review of R38's clinical record revealed the following:

2/3/16 - R38 was admitted to the facility.

9/26/17 - A PASARR Level I Screen was completed, which stated, "Individual does not require additional evaluation due to the following determination and needs can be met at a NF (nursing facility): The individual does have a documented serious mental illness ... and the individual needs can be met in a NF without further evaluation ..."

10/30/23 2:20 PM - A review of R38's diagnoses in his clinical record revealed the following diagnoses were added on 12/1/22: adjustment disorder with depressed mood; major depressive disorder, recurrent, severe with psychotic symptoms; anxiety disorder, unspecified; delusional disorders; suicidal ideations; persistent mood (affective) disorder, unspecified.

11/1/23 1:58 PM - During an interview, E7 (SW) stated the State PASARR contractor will tell the facility that an updated PASARR Level II was not needed, but she would check. She provided a list of residents currently being considered for a

F 644

diagnosis have the potential to be affected by this deficient practice.
2. An audit of diagnoses records for current residents will be conducted by the Social Worker
(SW)/designee to ensure all residents with PASSR level II criteria are screened appropriately.
3. A root cause analysis was conducted, and it was determined that the social worker was not
being informed of residents newly assigned diagnoses prompting the need for a new PASSR
review. A facility-wide audit was conducted and no further issues with PASSR updates were
identified. The Psych NP will be educated to update the DON on all diagnosis changes so that
the social worker can collaborate with the PASSR team any changes needed for an updated
PASSR.
4. SW will conduct daily audit X3, weekly X3, and monthly X3 until 100% compliance is
achieved, and at that time the issue will be considered resolved. The findings will be reviewed with the QAPI committee.
F 644-R74
1. Resident R74 was not affected by this deficient practice. All residents with a diagnosis of
dementia have the potential to be affected by this deficient practice.
2. An audit of diagnoses records for current residents will be conducted by the Social Worker

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Continued From page 18

PASARR Level II and R38's name was not included.

11/3/23 approximately 1:50 PM - E3 (CNO) provided a report dated 11/3/23 from the State PASARR contractor confirming that a PASARR Level II was needed for R38.

11/8/23 9:00 AM - During an interview, E3 and E2 (DON) confirmed additional mental health diagnoses had been added to R38's diagnoses, but no PASARR Level II was completed. They confirmed that E7 will coordinate the PASARR Level II evaluation for a representative to meet with R38 to conduct a face-to-face PASARR Level II evaluation.

11/8/23 2:42 PM - E3 advised the survey team that the PASARR team coming on 11/9/23 to evaluate the four residents who need a level II PASARR.

4. Review of R74's clinical record revealed:

10/15/20 - R74's preadmission PASARR documented that R74 was exempt for a level II PASARR.

1/15/21 - R74 was admitted to the facility including, but not limited to a diagnosis of dementia.

8/21/22 - R74 had a new diagnosis of persistent mood (affective) disorder.

8/23/22 - R74 had a new diagnosis of post-traumatic stress disorder.

11/2/23 9:53 AM - During an interview, E7 (SW) confirmed that R74 only had one PASARR

F 644

(SW)/designee to ensure all residents with PASSR level II criteria are screened appropriately.

3. A root cause analysis was conducted, and it was determined that the social worker was not being informed of residents newly assigned diagnoses prompting the need for a new PASSR review. A facility-wide audit was conducted and no further issues with PASSR updates were identified. The Psych NP will be educated to update the DON on all diagnosis changes so that the social worker can collaborate with the PASSR team any changes needed for an updated PASSR.

4. SW will conduct daily audit X3, weekly X3, and monthly X3 until 100% compliance is achieved, and at that time the issue will be considered resolved.The findings will be reviewed with the QAPI committee.

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F 644	Continued From page 19 completed three months prior to his 1/15/21 admission, and had not been referred to [State PASARR contractor] for any further review with his new diagnoses. E7 stated that she would submit another level 1 PASARR to [State PASARR contractor] for further review with his new diagnoses. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		1/8/24

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F 656	Continued From page 20 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (3) (R40, R89, and R514) out of twenty nine residents reviewed for care plans, the facility failed to develop and implement a comprehensive person-centered care plan for an identified need. Findings include: 1. Review of R40's clinical record revealed: 2/7/17 - R40 was admitted to the facility. 2/26/21 - A comprehensive care plan was initiated for R40's verbally aggressive behavior with the following interventions: allow 10-15 minutes to calm down then reapproach; explain all procedures; and identify triggers that cause outbursts.	F 656	F656-R40 1. Resident R40 was not negatively impacted by this deficient practice. Care plan related to the dementia diagnosis has been put in place. 2. All residents with Dementia diagnosis have a potential to be affected by the deficient practice. 3. A root cause analysis was conducted, and the facility failed to have a care plan in place for the diagnosis of dementia. The facility wide sweep was conducted, and no further residents were affected by this deficient practice. The corporate RNAC will educate the	

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F 656	Continued From page 21 10/1/22 - A review of R40's medical diagnoses revealed a diagnosis of dementia unspecified severity with agitation. 5/14/23 - A review of R40's MDS revealed that R40 had a diagnosis of non-alzheimers dementia. 11/1/23 10:25 AM - A review of R40's progress notes revealed R40 was receiving services from psychology related to dementia and bipolar disorder. 11/3/23 2:03 PM - An interview with E21(LPN) revealed that care and interventions are based on a care plan and if a resident does not have one to notify the unit manager to update. 11/3/23 2:12 PM - An interview with E13 (LPN UM) confirmed that R40 did not have a comprehensive person centered care plan related to dementia. 2. Review of R514's clinical record revealed: 7/6/23 - R514 was admitted to the facility with a diagnosis of COPD. Review of R514's physician orders revealed: Respiratory inhaler for COPD. 11/1/23 10:52 AM - An interview with R514 confirmed the use of a respiratory inhaler. 11/1/23 11:11 AM - During an interview, E10 (LPN) confirmed that R514 was administered his respiratory inhaler every morning. 11/1/23 11:14 AM - During an interview, E11	F 656	facility RNAC/LNAC of the proper Care planning process based on diagnosis. 4. The SSD /designee will conduct daily audits times three until 100% compliance. The weekly X three until 100% compliance. Then monthly times 3 until 100% compliance. Once this is achieved the deficient practice will be considered resolved. The findings will be reviewed with the QAPI committee. F 656-R89 1. Resident R89 was not negatively impacted by this deficient practice. Care plan related to the dementia diagnosis has been put in place. 2. All residents with Dementia diagnosis have the potential to be affected by the deficient practice. 3. A root cause analysis was conducted, and the facility failed to have a care plan in place for the diagnosis of dementia. The facility wide sweep was conducted, and no further residents were affected by this deficient practice. The corporate RNAC will educate the facility RNAC/LNAC of the proper Care planning process based on diagnosis. 4. The SSD /designee will conduct daily audits times three until 100% compliance. The weekly X three until 100% compliance. Then monthly times 3 until 100% compliance. Once this is achieved the deficient practice will be	

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F 656	Continued From page 22 (RN,UM) confirmed that R514 had a diagnosis of COPD and physician orders for respiratory interventions. A record review lacked evidence of a person-centered care plan for R514's respiratory status that included interventions for COPD. 3. Review of R89's clinical record revealed: 4/13/22 - R89 was admitted to the facility. 4/11/23 1:32 PM - R89's weight was documented as 172.8 pounds. 8/24/23 - R89's significant change MDS assessment documented a significant weight loss of 5% in one month or 10% loss in six months, and was not on MD (doctor) prescribed weight loss program. 10/12/23 11:56 AM - A quarterly nutrition assessment documented, "Decline in overall meal intakes and unplanned weight loss noted this review period." 10/23/23 11:18 AM - R89's weight was documented as 158.2 pounds (an 8.45 % weight loss since 4/11/23). 11/02/23 2:18 PM - During an interview, E22 (RD) confirmed that although R89 had a significant weight loss, R89's nutrition care plan was not initiated until 10/30/23. E22 stated that it "fell through the cracks." 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference	F 656	considered resolved.The findings will be reviewed with the QAPI committee. F656 R514 1. Resident R514 was not negatively impacted by this deficient practice. care plan related to the COPD diagnosis has been put in place. 2. All residents with COPD diagnosis have the potential to be affected by the deficient practice. 3. A root cause analysis was conducted, and the facility failed to have a care plan in place for the diagnosis of COPD. The facility wide sweep was conducted, and no further residents were affected by this deficient practice. The corporate RNAC will educate the facility RNAC/LNAC of the proper Care planning process based on diagnosis. 4. The SSD /designee will conduct daily audits times three until 100% compliance. The weekly X three until 100% compliance. Then monthly times 3 until 100% compliance. Once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	

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F 657	Continued From page 23	F 657		
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 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 four (R7, R20, R56, and R87) out of twenty-nine residents reviewed for care plans, the facility failed to ensure the care plan was revised to reflect current care needs. For R7 and R20, the facility failed to have the required members present for the IDT (interdisciplinary	F 657	657 R56 1. Resident R56 was not negatively impacted by this deficient practice The care plan has been updated to reflect the classification of the wound. 2. All residents with DTI wounds have the	1/8/24

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F 657 Continued From page 24
team) meeting. Findings include:

1. Review of R56's clinical record revealed the following:

11/22/21 - R56 was admitted to the facility.

A care plan for R56 was documented for having a potential/actual impairment impaired mobility with a goal of [R56] "will have no complications r/t (related to) DTI (deep tissue injury of the second tow through the review date" was initiated on 9/29/22 and revised on 10/21/22.

6/12/23 at 2:52 PM - A nurse's note revealed the following: "Resident was noted to have an open area on left foot second toe. Measurement 1.50cm X 0.6cm. Area was measured, dressed and NP and unit manager was informed."

7/24/23 - Bilateral arterial duplex scans completed and revealed "no doppler flow detected in left posterior tibialis artery and right dorsalis pedis artery."

8/1/23 - E17 (NP) note for wound assessment documented a wound to the right second toe on the right leg.

10/30/23 9:59 AM - During an interview, R56 stated he has a "wound on my toe" and "it has to be amputated."

11/7/23 12:18 PM - Interview with E3 (CNO) at which time the care plan was reviewed with him. Although the care plan problem was revised on 10/13/23, it refers to a DTI (deep tissue injury) and not an arterial wound. It also did not address R56's current situation. E3 stated he will ensure

F 657 (Plan of Correction)

potential to be affected by the deficient practice.
3. DON conducted a facility wide audit of all residents with deep tissue injuries for proper classification on the care plan. The DON/designee will conduct an in-service on
the correct wound identification/designation on the care plan to the Unit Managers and
Facility RNAC/LNAC.
4. DON/designee will conduct daily audits times three until 100% compliance. Then weekly times three until 100% compliance and then monthly times three until 100% compliance once this this achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.
F657-R87
1. Resident R87 was not negatively impacted by this deficient practice. The care plan
and the Cna task in Point Click Care has been updated to reflect current order for the
resident to be out of bed for lunch.
2. All residents with an order to be out of bed for meals have the potential to be affected by this deficient practice.
3. The DON/Designee conducted a facility audit and determined no other residents have been affected by this deficient practice. A root cause analysis was conducted, and
it was determined that the facility did not have a process in place to assure that residents who had an intervention to get out of bed for meals were offered to be

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F 657	Continued From page 25 that the care plan is updated. 2. Review of R87's clinical record revealed: 3/7/22 - R87 was admitted to the facility. 3/14/22 - A careplan for R87 was initiated for ADL self care performance deficit related to limited mobility. 12/8/22 - A physicians order was written for R87 to get out of bed for lunch daily. 11/2/23 9:17 AM - A review of R87's care plan revealed that current interventions did not include R87 to get out of bed for lunch daily. 11/7/23 10:42 AM - An interview with E15 (CNA) confirmed that the CNA task sheet and care plan did not include R87's intervention of getting out of bed daily for lunch. The facility failed to update R87's careplan to reflect the current needs of R87. The facility's policy on "Care Planning" revision date 1/12/2023 documented,"A comprehensive care plan must be prepared by an interdisciplinary team, that includes... - The attending physician; - A nurse with responsibility for the resident; - A nurse aide with responsibility for the resident; - A member f the food and nutrition services staff; - To the extent practicable, the participation of the resident and the resident's representative; - Other appropriate staff as determined by the resident's needs or as requested by the resident." 3. Review of R7's clinical record revealed: 7/6/23 - R7 was admitted to the facility.	F 657	out bed for meals. 4. The DON/Designee will conduct daily audits times three until 100% compliance is achieved. Then weekly audits times three until 100% compliance. Then monthly audits times three until 100% compliance once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee. F657 -R07 1. Resident R07 was not negatively impacted with this deficient practice of not having MD or CNA involvement in care plan meeting. The care plan meeting will include all members of the IDT. 2. All residents have the potential to be impacted by this deficient practice. 3. The RCA concluded that the facility failed to have a process to assure the provider and CNA were involved in the quarterly care plan meetings. A new document was developed to gain input from the MD and CNA that are impactful for resident care (care conference participation form). 4. The SW/designee will conduct weekly audits times three until 100% compliance. Then monthly times three until 100% compliance once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI	

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F 657	Continued From page 26 7/22/23 3:27 PM - A review of R7's comprehensive person-centered care plan conference notes revealed the physician and CNA were not present. 11/2/23 2:08 PM - A review of R7's comprehensive person-centered care plan conference notes revealed the physician and CNA were not present. 4. Review of R20's clinical record revealed: 6/12/23 - R20 was admitted to the facility. 6/22/23 10:53 AM - A review of R20's comprehensive person-centered care plan conference notes revealed the physician and CNA were not present. 9/19/23 1:46 PM - A review of R20's comprehensive person-centered care plan conference notes revealed the physician and CNA were not present. 11/7/23 11:18 AM - During an interview, E7 (SW) confirmed there was no physician or their designee in attendance at the meetings. E7 stated "they never attend the meetings, I didn't think they had to." E7 also confirmed there wasn't a CNA in attendance at any of the meetings. 11/7/23 12:33 PM - During an interview, E3 (CNO) confirmed that neither the physician, designee or CNA attended or provided input at the meetings. The facility lacked evidence that the post-admission care plan conference meetings	F 657	committee. F567-R20 1. Resident R20 was not negatively impacted with this deficient practice of not having MD or CNA involvement in care plan meeting. The care plan meeting will include all members of the IDT. 2. All residents have the potential to be impacted by this deficient practice. 3. The RCA concluded that the facility failed to have a process to ensure the MD and CNA to be involved in the quarterly care plan meetings. A new document was developed to gain input from the MD and CNA that are impactful for resident care (care conference participation form). 4. The SW/designee will conduct weekly audits times three until 100% compliance. Then monthly times three until 100% compliance once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	

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F 657	Continued From page 27 included Physician input and CNA input with responsibility for the resident. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 and E4 (COO) during the exit conference.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one, (R7), out of three residents reviewed for (ADLs) for activities of daily living, the facility failed to ensure that residents who are unable to carry out ADLs received the necessary services to maintain good grooming. Findings include: 1. 4/3/23 - R7 was admitted to the facility following a stroke. 4/8/23 - An admission MDS documented R7 as needing one person extensive assistance with grooming. 10/30/23 approximately 10:00 AM - During an observation and subsequent interview, R7's fingernails were long and he was unshaven. R7 stated that he would like to have his finger nails trimmed and to be shaved. 11/2/23 1:06 PM - During an interview, at R7's bedside E12 (CNA) confirmed that finger nails on	F 677	677 1. R7 was not negatively impacted by this deficient practice. While R7 did get assistance with his nails, he was not shaved resident due to refusing. 2. All residents who require assistance with activities of daily living have the potential to be affected by this deficient practice. 3. RCA was conducted and it was determined that the facility did not have a process in place to assure that nails and facial hair trimming is completed during the resident□s shower days. A facility wide audit was completed on all dependent residents to assure proper grooming and nail care was completed. CNAs will receive education on providing ADL care to offer nail trimming and facial hair during scheduled shower	1/8/24

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F 677	Continued From page 28 both hands were long and R7 would like them trimmed. E12 stated, "I'll trim them, and I'll shave him." E12 also confirmed that grooming was part of providing care. 11/2/23 through 11/6/23 - Multiple observations of R7 revealed that his finger nails had not been trimmed and he was unshaven. 11/6/23 1:15 PM - During an observation R7's finger nails were not trimmed and he was still unshaven, a follow up interview R7 revealed he still wanted to have his finger nails trimmed and to be shaved. 11/6/23 1:23 PM - During an interview, E11 (RN, UM) confirmed that R7's nails had not been trimmed and still remained unshaven. E11 stated that he would, "take care of it." 11/7/23 2:55 PM - Observation of R7 revealed his finger nails were trimmed but was still unshaven. Despite shaving being a part of providing grooming to a resident, R7 was not shaved. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 677	days to dependent residents and to include documentation for care refusals. 4. The Don/Designee will conduct daily audits to ensure all residents are receiving the required assistance with ADLs and that all refusals of care are reported to the nurse to intervene and document. The DON/designee will conduct random audits of 5 residents until 100 % compliance. Then weekly times three until 100 % compliance. Then monthly times three until 100 % compliance then the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		1/8/24

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F 679	Continued From page 29 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that, for one (R87) out of one resident sampled for activities, the facility failed to ensure that R76 was provided their activity of interest. Findings include: Review of R87's clinical record revealed: 3/7/22 - R87 was admitted to the facility. 3/11/22 - A review of R87's care plan revealed that R87 preferred to have little involvement with activities and chooses not to participate. 11/7/23 10:31 AM - An interview with R87 revealed that R87 wants to participate in bingo when available and wishes to get out of bed to attend this activity. 11/8/23 9:27 AM - A review of R87's activity task log dated 10/24/23 to 11/18/23, revealed R87 attended one bingo out of four bingo activities offered. 11/8/23 9:41 AM - An interview with E20 (Activities Director) confirmed that R87 attended one bingo activity out of four offered in the last sixteen days. E20 confirmed activities were offered but staff are not getting R87 out of bed to attend activities. The facility failed to provide R87 with activity of	F 679	679 1. R 87 was offered to go to bingo yet refused to get out of bed. R87 will continue to be offered to attend activities of her choice. R87 was care planed for occasional refusal. 2. All residents that want to attend activities have the potential to be negatively impacted by this deficient practice. A RCA was conducted, and it was determined that the facility failed to appropriately care plan R87 for activity refusals. 3. Activity Director will complete a facility wide sweep of all dependent residents that their preferences are documented and that participation and or refusals are documented appropriately. A RCA was conducted and it was determined that the facility failed to appropriately care plan R87 for activity refusals. 4. The activities director/designee will conduct random audits of 5 residents daily x three until 100 % compliance. Then weekly times three. Then monthly times three until 100 % compliance once this is achieved	

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F 679	Continued From page 30 choice. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 679	the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	
F 684 SS=E	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 observation, interview and record review, it was determined that for two (R58 and R87) out of twenty-nine (29) residents reviewed for quality of care, the facility failed to follow physician orders. Findings include: 1. Review of R58's clinical record revealed: 8/8/22 - R58 was admitted to the facility with dementia. 9/15/23 12:29 AM - A nursing progress note documented, "Resident [R58] in roommate's bed hitting him, trying to make him get out of his bed. Staff attempted to redirect resident to his bed, however, resident punched and kicked staff." 9/15/23 11:24 AM - A Physician order included: "Resident (R58) placed on 1:1 (one to one)	F 684	F684 1. R58 was not negatively impacted by this deficient practice. 2. All residents placed on 1:1 supervision have the potential to be affected by the cited deficient practice. Residents will be protected by this deficient practice by taking the corrective actions outlined in #3. 3. No residents currently in the facility require 1:1 supervison at this time. All residents with an ordered 1:1 supervision will be reviewed to ensure evidence to support the order is in place. Staff educator will provide training to nurses to have the proper documentation of the 1:1 supervision when ordered. 4. The DON/Designee will audit all	1/8/24

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F 684 Continued From page 31
supervision."

11/1/23 3:35 PM - During an interview E3 (CNO) confirmed the facility lacked evidence of one-to-one supervision implemented following a resident-to-resident altercation.
2. Review of R87's clinical record revealed:

3/7/22 - R87 was admitted to the facility.

12/8/22 - A physician's order was written for R87 to get out of bed daily at lunch time.

5/31/23 - A quarterly MDS revealed that R87 is totally dependent for transfer with hoyer lift.

11/01/23 12:38 PM - An observation of R87 in bed during lunch.

11/02/23 12:22 PM - An observation of R87 in bed during lunch.

11/07/23 10:42 AM - An interview with E15 (CNA) revealed that the CNA flow sheet did not reflect the physician's order to get R87 out of bed for lunch daily and confirmed that the CNA's were not aware of this order.

11/07/23 10:52 AM - An interview with E16 (UM) confirmed that nurses will transcribe orders into the electronic records and update the CNA flow sheets to reflect new orders.

The facility lacked evidence of following a physician's order for R87 to get out of bed daily for lunch.

11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO)

F 684

in-house residents with a 1:1 order to ensure the
order is being followed. The audit will be conducted daily times three until 100% compliance. Then weekly until 100% compliance is achieved for three consecutive
audits. Then monthly times three until 100% compliance once this is achieved the
deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.
F684
1. R 87 was not negatively impacted by this deficient practice.
2. All residents with orders to be out of bed for meals have the potential to be negatively
impacted by this deficient practice.
3. RCA was conducted and it was determined that the order to be out of bed was not
tasked to the CNA flow sheet in PCC. A facility wide sweep was completed for all residents to be out of bed to assure the task was assigned to the CNA flow sheet. Staff D
to complete an education for nurses to properly task orders to the CNA flowsheet.
4. The audit will be conducted daily times three until 100% compliance. Then weekly until
100% compliance is achieved for three consecutive audits. Then monthly times three
until 100% compliance once this is achieved the deficient practice will be considered

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F 684	Continued From page 32 during the exit conference.	F 684	resolved.The findings will be reviewed with the QAPI committee.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R66) of four residents reviewed for ROM/mobility, the facility failed to provide appropriate services, equipment, and assistance to maintain function/mobility. Findings include: Review of R66's clinical record revealed: 2/8/21 - R66 was admitted to the facility with left sided hemiplegia due to a stroke. 7/22/23 - The annual MDS assessment	F 688	688 1 R66 was not negatively impacted by this deficient practice. 2. All residents who have an order for a splint have the potential to be negatively impacted. 3. A facility wide sweep was completed to assure that the splints are donned and doffed as per the schedule that is tasked to the Cna in the medical record . The facility DOR to educate the CNAs performing the splint wearing schedule to assure	1/8/24

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F 688	Continued From page 33 documented R66 cognitively intact with an impairment on one side for the upper extremities and the lower extremities for her functional range of motion. The MDS also documented R66 required extensive assistance of one staff for dressing. 9/28/23 - An active Physician's order for R66 for a left modified resting hand splint. 10/25/23 - R66's care plan documented the potential for contractures from decreased functional mobility. The interventions for the R66 included to use a left modified resting hand splint. 10/30/23 1:52 PM - During an interview, R66 stated she did not have her splint on yet today and it usually gets put on in the morning and stays on for 7 to 8 hours. She stated she can take the split off herself but is not able to put it on herself. The splint was observed in her lower side table drawer. Observations made of R66 without left resting splint on for 10/30/23, 10/31/23, 11/1/23 and 11/2/23. 11/3/23 9:16 AM - During an interview, E15 (CNA) stated that the day shift (7 am to 3 pm) puts the splint on and the evening shift (3 pm to 11 pm) will remove the splint. 11/3/23 9:20 AM - During an interview with R66 and E13 (UM), R66 stated, "I have not had my splint on anytime this week." E13 confirmed R66 did not have her splint on and stated she will "look into this." 11/3/23 10:45 AM - During an interview E14 (OT)	F 688	the schedule is followed per the Therapy order. 4. The audit will be conducted daily times three until 100% compliance. Then weekly until 100% compliance is achieved for three consecutive audits. Then monthly times three until 100% compliance once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	

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F 688	Continued From page 34 stated the splint was used to keep R66's hand from getting in the clenched position. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 688		
F 758 SS=E	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	F 758		1/8/24

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F 758	Continued From page 35 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R58) out of six residents reviewed for unnecessary medications, the facility lacked evidence of a gradual dose reduction (GDR) and qualifying diagnosis for R58's physician prescribed antidepressant. Findings include: A facility policy (effective 6/23, last revised 4/29/21 and reviewed on 1/20/23) documented, "It is the policy of Cadia Healthcare that residents receive only those psychoactive medications, in the doses and the duration that is clinically necessary to treat the resident's condition." 1. Review of R58's clinical record revealed: 8/8/22 - R58 was admitted to the facility with dementia.	F 758	1. . R58 was not negatively impacted by the deficient practice. R 58□s trazodone□s diagnosis was clarified and updated. 2. All residents on Trazodone have the potential impacted by this deficient practice. 3. A facility wide sweep for all residents on Trazodone to assure a proper diagnosis was conducted. No other residents were identified with conflicting diagnosis. Staff D to educate Unit Managers and supervisors on assuring proper diagnosis for residents on trazadone. 4. The DON/Designee will conduct a random audit of 5 psychotropic medications daily times three until 100% compliance. Then weekly times three until 100 %	

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F 758	Continued From page 36 7/19/23 - A pharmacy recommendation to the Physician documented, "This resident [R58] is receiving therapy with Trazadone 50 mg QHS (an antidepressant at bedtime) for insomnia since 11/11/22. Federal guidelines require periodic dose reduction trials in an attempt to minimize or discontinue medications that are unnecessary. Please consider a trial dose reduction." The Physician response was to decrease the medication. 7/26/23 - A Physician's order included to decrease R58's Trazadone to 25 mg at bedtime for insomnia. 11/02/23 12:34 PM During an interview E3 (CNO) confirmed R58 did not have a GDR attempt for his Trazadone from 11/11/22 to 7/17/23 as noted in the pharmacy review. 2. Review of R58's clinical record revealed: 11/11/22 - R58 had a Physician's order for Trazadone 50 mg at bedtime for insomnia. 9/27/23 11:45 PM - A psychiatric progress note documented, "Chief Complaint: staff reports increased anxiety and agitation... consider increasing Trazadone if behavior persists." While the medication was ordered for insomnia, this note reflects that it is being used for anxiety, agitation and/or behaviors. 11/1/23 1:35 PM - During an interview, E24 (RN, UM) stated that R58 was receiving Trazadone for his behaviors and "rarely has insomnia since his room was changed." 11/1/23 2:54 PM - During a phone interview E23	F 758	compliance. The monthly times three until 100% compliance once this is achieved then the deficient practice will be considered resolved. The findings will be reviewed with the QAPI committee.	

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F 758	Continued From page 37 (PNP) confirmed R58's order identified insomnia as the diagnosis for R58's prescribed Trazadone. E23 stated, "The diagnosis for the prescribed Trazadone should be anxiety and agitation with behavioral disturbance. You can use it for insomnia, but it is definitely for his agitation." 11/1/23 3:35 PM - During an interview, E1 (NHA), E2 (DON) and E3 (CNO) confirmed the discrepancies in diagnoses for R58's Trazadone. The facility failed to identify the specific condition for R58's prescribed Trazadone. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those	F 790		1/8/24

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F 790	Continued From page 38 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R56) out of one sampled resident for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include: A facility policy titled, "Dental Services Available to Residents" last revised on 1/20/23 states, as follows: "It is the policy of Cadia Healthcare to ensure that residents have access to contracted Dental Services ... Dental Services are coordinated for each resident as needed and requested and include routine and emergent dental care." Review of R56's clinical record revealed the following:	F 790	1. R 56 was not negatively impacted by the deficient practice. R56 was offered a dental referral and has declined at this time. 2. All LTC residents have the potential to be affected by the deficient practice. 3. The RCA was conducted, and it was determined that the facility did not have a process in place to offer annual dental evaluation. The social services evaluation was updated to include offering a resident/POA a dental visit annually. 4.SW/designee will conduct audits daily times three until 100% compliance. Then weekly times three until 100% compliance. Then monthly times three once this is achieved	

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F 790	Continued From page 39 11/22/21 - R56 was admitted to the facility. 11/25/21 - The admission MDS assessment documented that R56 had no natural teeth or tooth fragment(s) (edentulous). 11/29/21 - A dental care plan was revised, as follows, "[R56] has potential for oral health problems r/t being edentulous (without teeth), poor nutrition, poor oral hygiene .... Coordinate arrangements for dental care, transportation as needed/as ordered." 10/30/23 9:51 AM - During an interview, R56 stated he was without dentures. He stated that he had them at home, but they are now gone because his house and belongings were sold. He stated he has tried to make a dental appointment, but "nothing happened." 11/1/23 untimed - Surveyor requested R56's dental reports. 11/1/23 at approximately 12:00 PM - E3 (CNO) advised that there were no dental reports for R56. 11/2/23 at approximately 9:13 AM - During an interview, E7 (SW) stated she contacts a dental contractor to schedule appointments based on recommendations from the provider. She does not assess the residents and relies on nursing/providers to tell her which residents need to be seen. E7 stated she is not aware of any dental complaints by this resident. 11/7/23 9:35 AM - During an interview, E3 confirmed that residents within the facility have not been offered an annual dental assessment.	F 790	the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	

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F 790	Continued From page 40 E3 stated he will make changes to ensure residents are offered a dental exam annually and that their responses are documented. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 790		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 791		1/8/24

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F 791	Continued From page 41 led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for four (R5, R39, R40 and R66) out of six sampled residents for dental services, the facility failed to assist the residents in obtaining routine dental services. Findings include: A facility policy and procedure titled, "Dental Services Available to Residents," with last reviewed of 1/20/23, documented, "Routine dental care includes, but is not limited to, initial evaluation of the resident's dental needs; consultation with the resident, family, responsible party, staff, guardian and dental consultant as needed." A facility policy titled, "Dental Services Available to Residents" last revised on 1/20/23 documented, "It is the policy of Cadia Healthcare to ensure that residents have access to contracted Dental Services ... Dental Services are coordinated for each resident as needed and requested and include routine and emergent dental care."	F 791	F791-R5 1. R5 was not negatively impacted by the deficient practice. 2. All LTC residents have the potential to be affected by the deficient practice. 3. The RCA was conducted, and it was determined that the facility did not have a process in place to offer annual dental evaluation. The social services evaluation was updated to include offering a resident/POA a dental visit annually. 4. SW/designee will conduct audits daily times three until 100% compliance. Then weekly times three until 100% compliance. Then monthly times three. Once this is achieved the deficient practice will be considered resolved. And the results will be presented to the QAPI committee. F791-R39 1. R39 was not negatively impacted by the deficient practice. 2. All LTC residents have the potential to	

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F 791	Continued From page 42 1. Review of R5's clinical record revealed the following: 3/30/22 - R5 was admitted to the facility. 3/30/22 - The admission MDS assessment documented that R5 had obvious or likely cavity or broken natural teeth. 8/2/22 - A dental care plan was revised, as follows, [R5] has p/f (potential for) oral/dental health problems - [R5] has 2 teeth on the bottom/ broken/carious teeth noted .... Coordinate arrangements for dental care, transportation as needed/as ordered." 10/30/23 11:09 AM - In an interview, R5 stated she needs dentures. 10/31/23 3:07 PM - After surveyor requested R5's dental visit records, in an interview, E3 (CNO) confirmed there were no such records for this resident. 11/2/23 at approximately 9:13 AM - During an interview, E7 (SW) stated she contacts a dental contractor to schedule dental appointments based on recommendations from the provider. She does not assess the residents and relies on nursing/providers to tell her which residents need to be seen. 11/7/23 9:35 AM - During an interview, E3 confirmed that residents have not been offered an annual assessment. He stated he will make changes to ensure residents are offered a dental exam annually and that their responses are documented.	F 791	be affected by the deficient practice. 3. The RCA was conducted, and it was determined that the facility did not have a process in place to offer annual dental evaluation. The social services evaluation was updated to include offering a resident/POA a dental visit annually. 4. SW/designee will conduct audits daily times three until 100% compliance. Then weekly times three until 100% compliance. Then monthly times three. Once this is achieved the deficient practice will be considered resolved. And the results will be presented to the QAPI committee. F 791-R40 1. R40 was not negatively impacted by the deficient practice. 2. All LTC residents have the potential to be affected by the deficient practice. 3. The RCA was conducted, and it was determined that the facility did not have a process in place to offer annual dental evaluation. The social services evaluation was updated to include offering a resident/POA a dental visit annually. 4. SW/designee will conduct audits daily times three until 100% compliance. Then weekly times three until 100% compliance. Then monthly times three. Once this is achieved the deficient practice will be considered resolved. And the results will be presented to the QAPI committee. F 791-R66 1. R66 was not negatively impacted by the deficient practice.	

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F 791	Continued From page 43 2. Review of R39's clinical record revealed the following: 12/14/17 - R39 was admitted to the facility. 12/20/17 - The admission MDS assessment documented that R39 had no natural teeth or tooth fragment(s) (edentulous). 9/23/20 - A dental care plan was initiated and revised, as follows, "P/F (potential for) alteration in oral/dental status [R39] is edentulous and has upper and lower dentures. Coordinate arrangements for dental care, transportation as needed/as ordered." 3/16/21 - A Dental Exam and Treatment/Exam revealed the following, "Visit for denture try on. Went in to try on patient's denture wax set up and patient stated he had found his dentures. F/S discontinue denture 'c__se' (writing not legible)." Review of R39's clinical record did not reveal any additional dental visits. 10/30/23 9:30 AM - In an interview, R39 stated that his dentures do not fit well. R39 stated he does not know if he can see dentist and that the last time that he saw one was eight years ago, prior to coming to the facility. R39 does not think anyone has asked if he wants to see a dentist. 11/2/23 at approximately 9:13 AM - During an interview, E7 (SW) stated she contacts the dental contractor to schedule dental appointments based on recommendations from the provider. She does not assess the residents and relies on nursing/providers to tell her which residents need to be seen.	F 791	2. All LTC residents have the potential to be affected by the deficient practice. 3. The RCA was conducted, and it was determined that the facility did not have a process in place to offer annual dental evaluation. The social services evaluation was updated to include offering a resident/POA a dental visit annually. 4. SW/designee will conduct audits daily times three until 100% compliance. Then weekly times three until 100% compliance. Then monthly times three. Once this is achieved the deficient practice will be considered resolved. And the results will be presented to the QAPI committee.	

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F 791	Continued From page 44	F 791		

11/7/23 9:35 AM - During an interview, E3 confirmed that residents have not been offered an annual dental assessment. He stated he will make changes to ensure residents are offered a dental exam annually and that their responses are documented.
3. Review of R40's clinical record revealed:

2/7/17 - R40 was admitted to the facility.

8/14/23 - A quarterly MDS revealed R40 had no missing or broken teeth.

10/30/23 10:25 AM - An interview with R40 revealed that dental services have not been received since admission. R40 stated that an outside dentist provided dental care prior to admission to the facility.

11/01/23 9:21 AM - A review of the clinical record revealed no evidence of R40 receiving dental services. R40 had routine oral evaluations quarterly by staff.

11/01/23 9:35 AM - An observation of R40 revealed that R40 has no natural upper teeth and broken or missing lower teeth. R40 denies pain but would like to receive services to obtain dentures.

11/01/23 12:03 PM - An interview with E3 (CNO) confirmed R40 did not have routine visits with a dentist or physicians orders to receive dental services.
4. Review of R66's clinical record revealed:

2/8/21 - R66 was admitted to the facility with left sided hemiplegia.

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F 791	Continued From page 45 7/22/23 - The annual MDS assessment documented that R66 did not have any broken or chipped teeth. 10/30/23 - During an interview, R66 stated that they have partial dentures and asked a nurse to see a dentist over one year ago. She stated she hasn't seen a dentist yet. There was lack of evidence of any routine dental consultation since admission on 2/8/21. 11/3/23 11:27 AM - During an interview with E7 (SW), stated there are no routine dental services provided to residents every 12 months. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 and E4 (COO) during the exit conference.	F 791		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R34) out of three residents reviewed for food preferences,	F 806	F806 1. R34 was not negatively impacted by this deficient practice.	1/8/24

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F 806	Continued From page 46 the facility failed to accommodate R34's food preferences or choices. Findings include: Review of R34's clinical record revealed: 7/7/23 - R34 was admitted to the facility with stroke and multiple sclerosis. 10/12/23 - A quarterly MDS documented R34 had a BIMS score of 14/15, revealing an intact cognitive state. 10/30/23 10:47 AM - During an interview, R34 stated she did not have her menu brought up to make her food choices for this current week. She did not get her menu choices for 10/29/23 and she was served whatever option the kitchen had put on her tray for the day. She said she had spoke to E8 (Food Service Director) about it. 11/3/23 1:17 PM - During an interview, E8 confirmed the menus go from Sunday to Saturday. The menu for the next week is brought up to residents on Thursdays so the residents can make their choices. R34 needs assistance where a dietary aide will circle her choices for her at the bedside. E also confirmed if a menu gets missed then they will bring it the next day. 11/3/23 1:42 PM - During an interview with R34, E8 and E9 (dietary aide), E9 stated she completed the menu choices for R34 on 10/31/23. R34 denied having her menu choices taking by E9. Observations for breakfast and lunch meals for R34 on 10/30/23, 10/31/23, 11/1/23 and 11/2/23 were meals the resident did not choose from a provided menu.	F 806	2. All residents have the potential to be affected by this deficient practice. 3. A completed facility wide sweep demonstrated no other residents were affected by this deficient practice. A RCA was conducted and it was determined that R34 did not receive the weekly menu. The registered dietician/Food service director will have a copy of the menu for the resident to keep and will keep own record to audit which resident did or did not receive a menu. If audit reveal that a resident did not receive a menu, Dietician/food service director would revisit the resident and document the outcome. 4. The RD/Designee will conduct a random of 5 audits weekly times three until 100% compliance is achieved. When 100% compliance is achieved, the deficiency will be considered resolved and results will be presented to the QAPI committee.	

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F 806	Continued From page 47 R34 did not have her food menu choices for 15 of 21 meals served for the menu week 10/29/23 to 11/4/23. The facility lacked evidence of the resident receiving her menu choices for the meals provided from 10/29/23 to 11/2/23. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 806		
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 document review, it was determined that the facility failed to ensure	F 812	F812 1. No residents were negatively impacted	1/8/24

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F 812	Continued From page 48 safe sanitary storage of food, maintain food preparation equipment and kitchen area in a sanitary condition, and maintain food temperature logs. Findings include: 10/30/23 9:53 AM - A build up of dried food residue was discovered around the cutting surface of the stationary can opener. 10/30/23 10:03 AM - The ice scoop was stored on top of the ice inside of the ice machine and a tomato based frozen entrée was discovered with a large portion of the foil lid peeled back exposing the frozen food to contamination from dirt and other debris. 10/30/23 10:15 AM - Significant amounts of dust and other debris were noted inside and suspended from the openings in the air vents located in the kitchen ceiling. 10/30/23 11:57 AM - During a review of the food temperature logs, forty-three (43) meals out of two hundred seventy-six (276) reviewed for temperatures had no temperatures recorded. 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 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. 10/30/23 12:16 PM - The temperature in the nourishment refrigerator on the Magnolia wing was noted to be 46 degrees Fahrenheit (F).	F 812	by this deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. RCA conducted revealed the need to develop and conduct effective sanitation audit. The new audit tool will ensure that the can opener is clean, the ice scoop is put back on its holder, the dietary staff keeps the food temperature logs current and up to date, and temperature for the nourishment refrigerator is maintained. The air vents located in the kitchen ceiling have been cleaned to rid of off all dust and other debris. 4. The RD/designee will audit daily times until 100% compliance. Then weekly times three until 100% compliance, then monthly times three until 100% compliance. Once 100% compliance is achieved, this deficient practice will be considered resolved and the result will be presented to the QAPI committee.	

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F 812	Continued From page 49 10/30/23 11:45 PM - Findings were confirmed with E8 (Director of Dining Services). 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		1/8/24

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F 842	Continued From page 50 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined	F 842	F842 1. R66 was not negatively impacted.	

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F 842	Continued From page 51 that the facility failed to ensure, in accordance with professional standards and practices, that medical records for one (R66) out of twenty nine (29) of the investigative sampled residents were accurate. Findings include: Review of R66's clinical record revealed: 2/8/21 - R66 was admitted to the facility with left-sided hemiplegia due to a stroke. 7/22/23 - The annual MDS assessment documented R66 was cognitively intact with an impairment on one side for the upper extremities and the lower extremities for her functional range of motion. The MDS also documented R66 required extensive assistance of one staff for dressing. 9/28/23 - An active Physician's order for R66 for a left modified resting hand splint. 10/25/23 - R66's care plan documented the potential for contractures from decreased functional mobility. The interventions for the R66 included to use a left modified resting hand splint. Observations made of R66 without left resting splint on for 10/30/23, 10/31/23, 11/1/23 and 11/2/23. A review of the CNA documentation task records revealed the task for the left resting hand splint was being marked as "Done" for 10/30/23, 10/31/23, 11/1/23 and 11/2/23. 11/3/23 9:20 AM - During an interview, E13 (UM) confirmed the splint was being signed off as completed even though the splint was not placed	F 842	2. All residents with splints have the potential to be impacted 3. It was determined that two CNAs were not documenting properly and were educated immediately. DOR to educate all CNAs on delivering and documenting splint care accurately. A facility wide sweep was conducted to assure splints wearing schedules are occurring and are documented properly. 4. The audit will be conducted daily times three until 100% compliance. Then weekly until 100% compliance is achieved for three consecutive audits. Then monthly times three until 100% compliance once this is achieved the deficient practice will be considered resolved.The findings will be reviewed with the QAPI committee.	

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F 842	Continued From page 52 on R66. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		1/8/24

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F 880	Continued From page 53 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on document review, it was determined that the facility failed to have acceptable measures in place to prevent the growth of Legionella and other opportunistic waterborne	F 880	F880 1. No resident was impacted negatively by this deficient practice. 2. All residents have the potential to be	

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F 880	Continued From page 54 pathogens. Findings include: 11/6/23 9:22 AM- Document review revealed that the facility did not have a comprehensive water management plan based on nationally accepted standards (e.g., ASHRAE, CDC, or EPA), including a flow diagram with narrative text depicting areas where Legionella and other opportunistic waterborne pathogens could grow and spread, facility specific measures to prevent the growth of opportunistic waterborne pathogens in the building's water system, methods the facility uses to monitor the prevention measures that are in place, and established steps to intervene when control limits are not met. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 880	affected by this deficient practice. 3. The facility has developed a Water Management plan based on nationally accepted standards with a flow diagram that shows areas where legionella and other waterborne pathogens can grow and how. With this plan, the facility will have preventive measures to monitor and intervene when control limits are not met. 4. The Maintenance Director/Designee will see to it that the plan meets its objective and will review with the fire committee and present to the QAPI committee.	
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention.	F 943		1/8/24

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F 943	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (E18) out of twelve staff being sampled for abuse training, the facility failed to ensure that E18 received the annual abuse training. Findings include: 11/2/23 1:54 PM - Surveyor requested that E1 (NHA) and E3 (CNO) complete the Annual Training/Vaccination Form. 11/3/23 untimed - Results received and reviewed by surveyor. 11/3/23 12:45 PM - In an interview, E3 stated that E18 (COTA) was a transfer from another facility. Her last training had occurred in August 2022 and, as such, is overdue for 2023. 11/3/23 approximately 3:00 PM - E3 provided updated abuse training documentation, which was completed by E18 on 11/3/23. 11/8/23 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (CNO) and E4 (COO) during the exit conference.	F 943	943 1. No residents were negatively impacted by this deficient practice. 2. All new hires and transfers will receive annual abuse education. All future employees will be protected from this deficient practice by taking the corrective actions as outlined in #3. 3. The facility has conducted a focus audit to review all employees files to assure that all employees have completed annual abuse training. 4. The DON or designee will audit all new hires for compliance of Abuse training. An audit will be completed daily until 100% compliance is achieved for three consecutive audits. Then the audit will be completed weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be completed monthly until 100% compliance is achieved for three consecutive audits the deficient practice will be considered resolved. Results of the audits will be discussed with the facility QAPI committee.	