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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

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 and Complaint Survey was conducted at this facility from July 12, 2022, through July 25, 2022. 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 93. The survey sample totaled 42 residents. Abbreviations/definitions used in this state report are as follows: CNA - Certified Nurse Aide; DON -Director of Nursing; LPN - Licensed Practical Nurse; NHA – Nursing Home Administration; NP – Nurse Practitioner; RN – Registered Nurse;	Cross reference plan of correction for CMS 2567 for Annual Survey ending July 25, 2022 F561, F609, F641, F644, F655, F656, F661, F677, F684, F685, F686, F688, F689, F760, F791, F803, F812, F880, and F943	
3201	**Regulations for Skilled and Intermediate Care Facilities**	All residents have the potential to be effected by this deficient practice	9/13/2022
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. Sub-part B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed 7/25/22: F561, F609, F641, F644, F655, F656, F661, F677, F684, F685, F686, F688, F689, F760, F791, F803, F812, F880 and F943.	All current employee, agency and contracted employees will be reviewed to insure there is evidence of tuberculosis screening, criminal background checks, drug testing and adult abuse testing. Those files that do not have evidence of tuberculosis screening, criminal background checks, drug testing and adult abuse testing will have the appropriate checks completed Root cause was determined to be there was no second verification of prn employee, agency and contract staff files to in-	
3201.5.0	**Personnel/Administrative**		

Provider's Signature _____ Title CNA Date 8/26/22

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3201.5.5 3201.5.5.1 3201.5.5.3 3201.5.5.4 3201.5.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:** **Results of tuberculosis screening** **Results of criminal background check** **Results of mandatory drug testing** **Result of Adult Abuse Registry check** This requirement was not met as evidenced by: Based on interview and review of facility documentation provided to the Surveyor, it was determined that for six (E35, E36, E38, E39, E40 and E41) out of twenty-two (22) employees reviewed, the facility's personnel records lacked evidence of tuberculosis screening, criminal background checks, mandatory drug testing an adult abuse registry check. 7/25/22 11:00 AM – During an interview, the Surveyor requested evidence of the above information from E42 (HR) for the following staff: 1. E35 (Agency CNA) was missing evidence of the tuberculosis screening and a recent adult abuse registry check. 2. E36 (LPN) was missing evidence of a recent chest x-ray for tuberculosis screening. The chest x-ray record on file was dated 8/1/07 despite being hired on 4/5/22. 3. E38 (Agency LPN) was missing evidence of an adult abuse registry check and the mandatory drug test during the time he worked in the facility on 10/29/21. The facility provided a negative drug test result dated 3/22/22. 4. E39 (LPN) was hired on 12/07/07 and was missing evidence of a determination letter from the State agency in lieu of a criminal background check. 5. E40 (Agency CNA) was missing evidence of mandatory drug testing an adult abuse registry check.	sure all there was evidence of tuberculosis screening, criminal background checks, drug testing and adult abuse testing. Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. NHA or designee will reinservice all managers on the requirements for testings and screenings as per the State of Delaware regulations 3201.5.5.1-5 To evaluate the success of the systemic changes, NHA or designee will audit the files of all new hires of center, agency employee files and contracted staff member files weekly x's 4 weeks until audits are 100% compliant. Once 100% compliant, audits will be completed monthly x's 3 months to insure the files contain proof of the testings and screenings as per the State of Delaware regulations 3201.5.5.1-5 QAPI committee will review audits and make necessary recommendations	

Provider's Signature _____ Title VAD Date 8/26/22

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	6. E41 (Agency CNA) was hired on 8/8/21 and was missing evidence of a chest x-ray despite completing a tuberculosis annual screening questionnaire on 7/19/21. E41 answered "No" to the question "History of positive TB (tuberculosis) skin test and was missing evidence of a tuberculosis skin test. 7/26/22 2:46 PM – Findings were reviewed in an email correspondence with E1 (NHA) and E2 (DON). **Dementia Training** **Nursing facilities that provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. This section shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** **The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.** Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on dementia care was completed for two (E38 and E41) out of 22 randomly sampled staff members. Findings include: 1. Review of E38's inactive personnel records revealed: The first day of assignment at the facility for E38 (Agency Licensed Practical Nurse) was not determined. 7/25/22 at 12:27 PM - In an interview, E42 (HR) confirmed that E38's agency did not have the information on E38's 2021 dementia care training. 2. Review of E41's personnel records revealed:	All residents have the potential to be effected by this deficient practice All current employee, agency and contracted employees will be reviewed to Insure there is evidence of dementia training. Those employees that do not have evidence of dementia training will have dementia training provided Root cause was determined to be there was no second verification of prn employees, agency and contracted staff files to insure all there was evidence of Dementia training Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. NHA or designee will reinservice all managers on the requirements for dementia training as per the State of Delaware regulations 3201.5.6.1-2 To evaluate the success of the systemic changes, NHA or designee will audit the files of all new hires of center, new agency employee files and new contracted staff member files weekly x's 4 weeks until audits are 100% compliant. Once 100% compliant, audits will be completed monthly x's 3	9/13/2022
3201.5.6 3201.5.6.1 3201.5.6.2			

Provider's Signature _____ Title NHA Date 8/26/22

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	8/8/21 – The first day of assignment at the facility for E41 (CNA) as agency staff. 7/25/22 at 12:27 PM – A written statement from E42 (HR) stated that E41's agency has no information available regarding E41's record of dementia care training. 7/26/22 2:46 PM – Findings were reviewed in an email correspondence with E1 (NHA) and E2 (DON).	months to insure the files contain proof of the dementia training per the State of Delaware regulations 3201.5.6.1-2 QAPI committee will review audits and make necessary recommendations	
	Specific Requirements for Tuberculosis		
3201.6.9.2	**Order of the Department of Health and Social Services Pursuant to the authority established in 16 Del.C. Ch. 11, 16 Del.C. Ch. 30A and 16 Del. C. § 122, Molly K. Magarik, Secretary of the Department of Health and Social Services hereby modifies the following requirements, effective March 1, 2022. This waiver will remain in effect until further notice, but not later than such time as the Governor's Declaration of Public Health Emergency is lifted.**	All residents have the potential to be effected by this deficient practice Root cause was determined to be there was no second verification of prn employees, agency and contract staff files to insure that a one-step TB test or chest x-ray was completed prior to starting employment All current employee, agency and contracted employees will be reviewed to insure there is evidence of a one-step TB test or chest x-ray. Those employees that do not have evidence of a one-step TB test or chest x-ray will have a one-step TB test or chest x-ray provided Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. To evaluate the success of the systemic changes	9/13/2022
3201.6.9.2.4	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** **While the requirement for a two-step test is waived, facilities must complete a one-step TB test upon employment.**		
3201.6.9.2.4.2	**Any person having a positive skin test, but a negative X-ray shall receive an annual evaluation for signs and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).**		

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on interview and review of the facility documentation provided to the surveyor, it was determined that for five (E4, E33, E35, E36 and E41) out of 22 employees reviewed, the facility failed to ensure employees met the minimum pre-employment requirements for tuberculosis screening. Findings include: This requirement was not met as evidenced by: 7/25/22 11:00 AM – During an interview, the Surveyor requested evidence of the above information from E42 (HR) for the following staff: Review of facility documentation provided to the Surveyor on 7/25/22 and 7/28/22 revealed the following staff lacked evidence of a one - step TB test or chest x-ray results prior to starting employment: 1. E4's (RN) first day in the facility was 2/7/22. The facility provided evidence of a first step tuberculosis screening from another facility on 12/22/21 and a second step screening on 3/18/22. 2. E33's (LPN) first day in the facility was 12/14/21. The facility provided evidence of a first step tuberculosis screening dated 12/23/21, after beginning employment. 3. E35's (Agency CNA) first day in the facility was 7/7/22. E35 was missing evidence of a first step tuberculosis screening. 4. E36's (LPN) first day in the facility was 4/5/22. A Tuberculosis Annual Screening Questionnaire was completed on 4/5/22 stating that E6 had a history of positive TB skin test. The last chest x-ray was dated 8/1/07. E36 was missing evidence of the latest chest x-ray on file. 5. E41's (Agency CNA) first day in the facility was 8/8/21. Although a tuberculosis annual screening questionnaire was completed on 7/19/21 and stated no history of a positive TB (tuberculosis) skin test, E41 was missing evidence of a first step TB test or chest x-ray.	NHA or designee will audit the files of all new hires of center, new agency employee files and new contracted staff member files weekly x's 4 weeks until audits are 100% compliant. Once 100% compliant, audits will be completed monthly x's 3 months to insure the files contain proof of a one-step TB test or chest x-ray per the State of Delaware regulations 3201.6.9.2 QAPI committee will review audits and make necessary recommendations All residents have the potential to be effected by this deficient practice	

Provider's Signature _____ Title SC NHA Date 8/26/22

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.8.0 3201.8.4	7/26/22 2:46 PM – Findings were reviewed in an email correspondence with E1 (NHA) and E2 (DON). **Emergency Preparedness** **The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that the required training on emergency preparedness was completed for three (E35, E38 and E41) out of 22 randomly sampled staff members. Findings include: 1. Review of E35's personnel records revealed: 7/10/22 – The first day of assignment at the facility for E35 (CNA) as agency staff. 7/25/22 at 12:27 PM – A written statement from E42 (HR) stated that E35's agency was contacted to request training records as the facility had no other information available regarding E35's record of emergency preparedness training. 2. Review of E38's personnel records revealed: The first day of assignment at the facility for E38 (LPN) was not determined. 7/25/22 at 12:27 PM - In an interview, E42 (HR) confirmed that E38's agency did not have the information on E38's 2021 emergency preparedness training. 3. Review of E41's personnel records revealed: 8/8/21 – The first day of assignment at the facility for E41 (CNA) as agency staff. 7/25/22 at 12:27 PM – A written statement from E42 (HR) stated that E41's agency has no other information available regarding E41's record of emergency preparedness training.	Root cause was determined to be there was no second verification of prn employees, agency and contract staff files to insure all there was evidence of Emergency preparedness training. All current employee, agency and contracted employees will be reviewed to insure there is evidence of emergency preparedness training in their file. Those files that do not have evidence of emergency preparedness training will have emergency preparedness training provided. Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. NHA or designee will reinservice all managers on the requirements for emergency preparedness training as per the State of Delaware regulations 3201.8.0 To evaluate the success of the systemic changes NHA or designee will audit the files of all new hires of center, new agency employee files and new contracted staff member files weekly x's 4 weeks until audits are 100% compliant. Once 100% compliant, audits will be completed monthly x's 3	9/13/2022

Provider's Signature _____ Title NHA Date 8/26/22

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3105 3105.9.0 3105.9.1	7/26/22 2:46 PM – Findings were communicated in an email correspondence with E1 (NHA) and E2 (DON). **Criminal History and Drug Testing for Nursing and Similar Facilities** **Drug Tests** **The BCC provides an electronic conduit through the Delaware Health Information Network (DHIN) to transmit the results of a drug test from a DHIN participating laboratory to the employer. An employer that chooses not to engage a DHIN-participating laboratory will certify that a drug test has been secured by checking a box in the BCC. If the box is checked, it constitutes a representation that a drug test which complies with statutory requirements, 11 Del.C. 1142, has been secured prior to hiring** This requirement was not met as evidenced by: Based on review of facility documentation and staff interviews, it was determined that the facility failed to ensure and certify on the BCC website that fingerprinting and/or drug screening was completed for four (E9, E37, E38 and E40) out twenty-two (22) staff sampled for pre-employment background checks. Findings include: 7/25/21 3:20 PM - During the exit conference with E1 (NHA) and E2 (DON), it was explained that findings are contingent on BCC review of a sample of staff. 1. E9 (Occupational Therapist): 7/25/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E9's first day working in the facility under the new ownership was 12/19/21. 7/25/22 10:00 AM – In an interview, E9 stated that he has been working in the facility since July of 2021 under the old ownership. 7/25/22 10:30 AM – Review of E9's personnel file revealed a drug test result dated, 2/9/22, however, the facility lacked evidence of the pre-employment drug screening.	months to insure the files contain proof of emergency preparedness training the State of Delaware regulations 3201.8.0 QAPI committee will review audits and make necessary recommendations All residents have the potential to be effected by this deficient practice Root cause was determined to be there was no second verification of prn employees, agency and contract staff files to insure all there was evidence of drug test results All current employee, agency and contracted employees will be reviewed to insure there is evidence of drug test results. Those files that do not have evidence of drug test results will have a drug test completed Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. NHA or designee will reinservice all managers on the requirements for drug tests as per the State of Delaware regulations 3105.9.0	9/13/2022

Provider's Signature _____ Title NHA Date 8/26/22

NAME OF FACILITY: Complete Care at Brackenville **DATE SURVEY COMPLETED: July 25, 2022**

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	7/26/22 – Review of the State of Delaware background check database revealed a lack of information of E9's mandatory drug screen results. 2. E37 (Occupational Therapist): 7/22/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E37's first day working in the facility was 12/4/21. 7/25/22 – Review of E37's personnel file revealed a drug test result dated 12/22/21, after beginning employment. 7/26/22 – Review of the State of Delaware BCC database revealed that E37's mandatory drug screen was not received by the BCC. 3. E38 (Agency Licensed Practical Nurse) 11/9/21 – A 5 day follow up submitted by the facility to the State Reporting Agency involving E38 for allegations of abuse and neglect revealed that E38 was not to work at the facility ever again. 7/25/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E38's first day of working in the facility was unknown. 7/25/22 9:30 AM – Review of E38's personnel file revealed a drug test result dated 3/22/22. 7/26/22 – Review of the State of Delaware BCC database revealed that E38's mandatory drug screen was not received by the BCC. 4. E40 (Agency Certified Nurse Assistant) 7/22/22 - Review of the State Agency Personnel Audit Form completed by the facility revealed that E40's first day working in the facility was unknown. 7/25/22 – Review of E40's personnel file revealed E40 was missing the mandatory drug screen result.	To evaluate the success of the systemic changes NHA or designee will audit the files of all new hires of center, new agency employee files and new contracted staff member files weekly x's 4 weeks until audits are 100% compliant. Once 100% compliant, audits will be completed monthly x's 3 months to insure the files contain proof of a drug test per the the State of Delaware regulations 3105.9.0 QAPI committee will review audits and make necessary recommendations	

Provider's Signature _____ Title NHA Date 8/24/22

NAME OF FACILITY: Complete Care at Brackenville

DATE SURVEY COMPLETED: July 25, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/26/22 – Review of the State of Delaware BCC database revealed that E40's's mandatory drug screen was not received by the BCC. 7/26/22 2:46 PM – Findings were reviewed in an email correspondence with E1 (NHA) and E2 (DON).		

Provider's Signature _____ Title NHA Date 8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning July 12, 2022 through July 25, 2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 93. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from July 12, 2022 through July 25, 2022. 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 93. The survey sample totaled 42 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; Boggy - wet, spongy feeling; Braden Scale - standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for	F 000		

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

Electronically Signed | 08/31/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 developing pressure ulcers/injuries; CNA - Certified Nurse's Aide; DON - Director of Nursing; DS - Dining Services; 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. DVT (deep vein thrombosis) - same as a blood clot; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; MDSC - MDS Coordinator; NHA - Nursing Home Administrator; Offload - heel(s) off the bed to reduce the risk of skin breakdown; OT - Occupational Therapist; Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; PRN or prn - as needed; Q - every; RD - Registered Dietician; RN - Registered Nurse; Stage III (3) (PU) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; TD - Therapy Director; UM - Unit Manager; Unstageable (PU) - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed).	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

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F 561	Continued From page 2	F 561		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure for one (R347) out of three (3) residents investigated for choices, that R347's bathing preference was honored. Findings include:	F 561	Facility unable to correct the deficiency for R347 due to the fact that resident R347 was discharged April 10, 2022. All other residents will have their bathing preference review and updated.	9/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707

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F 561	Continued From page 3 Review of R347's clinical record revealed: 2/24/22 - R347 was admitted to the facility. 3/3/22 - The 5 day MDS Assessment documented that it was important for R347 to choose between a tub bath, shower, and bed or sponge bath. In addition, R347 required extensive assistance of staff for bathing. 3/9/22 - The care plan for Activities of Daily Living (ADL) documented that R347 was dependent on staff for bathing and showers. 3/2022 - The Documentation Survey Report, where CNA's documented care and services to R347 indicated that R347 was scheduled for a shower during the 3:00 PM to 11:00 PM shift on Mondays and Thursdays. The report documented that R347 was scheduled for nine (9) showers during this period of time. R347 was showered on 3/3/22 and 3/24/22. For the remainder of the seven (7) scheduled shower days, R347 was given a bed bath for six (6) and refused a shower on 3/28/22. There was lack of evidence that R347's preference for showers twice a week were offered, refused, or declined for six (6) out of nine (9) scheduled showers in 3/2022. 7/25/22 1:15 PM - An interview with E16 (Licensed Practical Nurse, Unit Manager) confirmed the above findings. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing).	F 561	Root Cause was determined to be that staff were not documenting refusals. Nurses will confirm the documentation of any refusals. DON or designee will re-inservice all nursing staff on following the shower schedule and confirming the documentation of refusals. DON or designee will complete random audits to ensure resident are provided showers as scheduled or the resident refusal is documented. Audits will be completed daily x's 7 days until 100%, then, audits will be completed weekly x's 4 weeks until 100% compliant, then, audits will be completed monthly x 3 months until 100% compliance. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation as indicated, it was determined that for one (R18) out of four sampled residents for accidents, the facility failed to report a significant injury of unknown source within the required two hours to the State Agency after R18, a dependent and cognitively impaired resident,	F 609	Facility was unable to correct this deficient practice for R18. Report was already submitted September 23, 2021 for R18 All residents have the potential to be affected by this deficient practice	9/13/22

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F 609	Continued From page 5 was identified with an acute fracture on 8/21/21 at 6:49 PM. Findings include: Cross refer to F689 R18's clinical record revealed: 8/21/21 at 6:49 PM - R18's x-ray result revealed an acute fracture of the left femur (thigh bone). 8/23/21 at 11:08 AM - According to the facility's Incident Report to the State Agency, the facility reported R18's injury of unknown source approximately 39 hours later. The facility documented that R18 "Presented with a change in condition related to swelling noted at right (sic) thigh area with evidence of pain... STAT X-ray... done. Results were femur fracture. Etiology unknown at this time. Investigation has been initiated." 7/25/22 at approximately 11:30 AM - During an interview, finding was reviewed with E2 (DON). The facility failed to report a significant injury of unknown source within the required two hours. 7/25/22 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2.	F 609	Root cause was determined to be that the nursing staff did not report x-ray results to DON immediately for DON to make determination to report within 2 hours Diagnostic results will be communicated to the DON or designee immediately so decision to report can be made within the regulatory timeframe. DON or designee will re-inservice all licensed staff on the protocol for reporting injuries of unknown origin. To monitor the success of the systemic change, DON or designee will audit 24-hour report daily to identify documentation for any injuries of unknown origin that require reporting as per regulation. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R2) out of two	F 641	Resident R2 MDS was corrected August 2, 2022 to indicate impairment is reflected	9/13/22

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F 641	Continued From page 6 sampled residents for position/mobility and one (R60) out of seven sampled residents for unnecessary medications, the facility failed to accurately reflect the residents' status on MDS assessments. Findings include: Cross refer F656, Example 1a and 1b Cross refer F688, Example 2 1. Review of R2's clinical record revealed: a. 10/9/21 - R2 was admitted to the facility. 10/11/21 - The Initial Occupational Therapy (OT) Evaluation documented impaired range of motion (ROM) of bilateral upper (shoulders, elbows, wrists, and hands) and lower (hips, knees, ankles, and feet) extremities. 10/15/21 - The 5 day MDS assessment incorrectly coded that R2 had no impairment of both upper and lower extremities with respect to functional limitation in ROM. b. 2/2/22 - The subsequent Initial OT Evaluation documented impaired ROM of left upper extremity (LUE) and bilateral LE (lower extremity), however, the right lower extremity (RLE) had no impaired functional ROM limitations. 4/14/22 - The Quarterly MDS assessment incorrectly coded that R2 had functional ROM limitation of the RLE. 7/25/22 11:45 AM - An interview with E15 (Minimum Data Set Coordinator) revealed that he/she did not review the above OT Evaluation when completing the above MDS assessments and confirmed the inaccuracies.	F 641	correctly on the MDS as indicated per the Occupational Therapy evaluation All other residents that have ROM impairment will have the MDS section GO4oo A,B, N04500, NO400 A, B data reviewed to ensure the MDS reflects an impairment as per Occupational Therapy evaluation. A communication form has been developed for therapy to communicate with the MDS coordinator the level and location of impaired range of motion, if any. Root cause was determined to be due to the fact that the MDS coordinator did not review the OT evaluation when completing the MDS assessment. DON or designee will audit MDS section G0400 A, B, N04500, N0400 A, B data monthly x4 until 100% compliant and then quarterly x2 until 100% compliant to determine if MDS is coded correctly for impairment as per Occupational Therapy evaluation. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. The MDS for R60 corrected to reflect the appropriate medication and that the physician did document a GDR meeting with no changes on 4/11/2022 All other residents with antipsychotic	

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F 641	Continued From page 7 Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing). 2. R60's clinical record revealed: 11/24/21 - R60 was admitted to the facility with a diagnosis of Bipolar Disorder. R60 was ordered Zyprexa, an antipsychotic medication, daily. a. 1/20/22 - A care plan note documented that a gradual dose reduction (GDR) meeting was held. R60 was stable and there were no recommended changes at this time. 3/1/22 - The quarterly MDS assessment incorrectly coded that a Physician did not document a GDR as clinically contraindicated. b. 4/12/22 - A nursing note documented that a GDR meeting was held. R60 was stable and no (medication) changes were required at this time. 5/24/22 through 5/30/22 - The eMAR documented that R60 received an antipsychotic medication daily. 5/30/22 - The quarterly MDS assessment incorrectly coded that R60 received antianxiety medication for seven days instead of an antipsychotic medication for seven days. In addition, the assessment incorrectly coded that a Physician did not document a GDR as clinically contraindicated. 7/20/22 at 10:55 AM - During an interview, E15 (MDSC) confirmed the findings.	F 641	medication will have the record review to insure the antipsychotic medication is properly coded and that any GDR meeting is reflected in the assessment. The record will be corrected if found that the antipsychotic medication and GDR meeting is not coded correctly Root cause analysis was completed to determine the reason for the deficient practice DON or designee will reinservice the MDS coordinator on the proper coding of antipsychotic medications and GDR meetings on the MDS assessment. DON or designee will audit MDS sections N0410 and N0450 data monthly x4 until 100% compliant and then quarterly x2 until 100% compliant to determine if antianxiety and GDR is coded correctly on the MDS assessment. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 641	Continued From page 8 7/25/22 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R49) out of two sampled residents reviewed for PASARR (Preadmission Screening and Resident Review), the facility failed to refer R49 to the appropriate State - designated authority for a Level II PASARR evaluation and determination after R49 had a new diagnosis and medication that would require or trigger a new PASARR. Findings include: Review of R49's clinical record revealed:	F 644	Resident R49 had his redetermination submitted July 26,2022. All other resident with a diagnosis that requires a level II redetermination will have their charts reviewed to determine is a redetermination was submitted. If it is determined that a redetermination was not submitted, one will be submitted. Root cause was determined to be failure	9/13/22

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F 644	Continued From page 9 3/28/19 - R49 was admitted to the facility with diagnoses including psychomotor deficit (slowing down of mental or physical activities), one of the main features of Major Depressive Disorder (MDD). 3/29/19 - A care plan was developed for R49's risk for complications related to the use of psychotropic drugs for depression with interventions including obtaining psychiatry evaluations as ordered. 4/9/19 - The PASARR Level 1.5 Screen stated that R49 did not require a Level II evaluation due to the absence of a documented serious mental illness. 6/23/20 - On R49's readmission to the facility, the PASARR screening stated that R49 did not have an indication of mental illness. 7/2/20 - R49 was care planned for distressed and fluctuating mood symptoms related to sadness and depression. 12/09/20 - R49 had a physician's order for fluoxetine one time a day for depression. 3/15/21 - R49 was diagnosed with an Unspecified Psychosis Not Due to a Substance or Known Physiological Condition (commonly used if there is inadequate information to make the diagnosis of a specific psychotic disorder). 7/5/21 - A psychiatric consultant note documented that R49 was seen in order to verify original diagnostic impressions. The documentation stated, "... (R49) was initially	F 644	of Social Services a new diagnosis and medication that requires a level II redetermination. Social Services has developed a monitoring system to track PASSR dates. Social Worker/designee will be responsible for completing section A1500 on the MDS to identify the need for redetermination. Social Services or designee will audit all new admissions and readmissions weekly x's 4 weeks to determine if PASRR determinations is necessary and submit accordingly. Once 100% compliant with the weekly audits, the audits will be conducted monthly x's 3 months The QAPI committee will review audits and make recommended provide recommendations to obtain nd maintain compliance.	

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F 644	Continued From page 10 diagnosed with Adjustment Disorder with Depressed Mood... however depression has continued unabated... generally controlled at a mild level via psychotropic medication Fluoxetine and Remeron... depression has become chronic and persistent to the point where a categorization of Adjustment Disorder no longer captures the essence of underlying condition... diagnostic status will be changed to MDD." 3/9/22 - R49 had an additional diagnosis of Mild, Recurrent MDD. 7/13/22 10:21 AM - During an interview, E8 (SW) confirmed that R49 did not have a PASARR Level II screening and determination when R49 started receiving psychoactive medication and after being diagnosed with Unspecified Psychosis and Major Depressive Disorder. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2 (DON).	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		9/13/22

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F 655	Continued From page 11 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R196 and R352) residents, out of one resident reviewed for dialysis and five residents reviewed for pressure ulcers, the facility failed to develop and implement a baseline care plan within 48 hours of a resident's admission that included instructions for	F 655	Facility was unable to correct the deficiency for R352 due to the fact that R352 was discharged July 10, 2021 All residents admitted/readmitted since July 12, 2022 will have their record reviewed to ensure that a baseline	

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F 655	Continued From page 12 person-centered care. Findings include: Review of the facility's policy and procedure titled Care Plans - Baseline, dated 10/2019, stated, "...A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission...". 1. R196's clinical record revealed: 6/8/22 - R196 was admitted to the facility and was receiving outpatient hemodialysis. Record review lacked evidence that a baseline care plan was developed within 48 hours after R196's admission. 7/19/22 12:11 PM - An interview with E8 (Social Services) confirmed that a baseline care plan was not developed within 48 hours after R196's admission on 6/8/22. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing). 2. Cross refer to F686, example 1 R352's clinical record revealed: 6/1/21 - R352 was admitted to the facility for wound care and rehabilitation status post hospitalization for 2nd degree burns to her left front and back of her thigh and her buttocks. Record review lacked evidence that a baseline	F 655	careplan was completed and provided to the resident/responsible party Root cause analysis has been completed to determine the cause of the deficient practice Signature line on new admit review for nurse to sign as proof baseline care plan was provided to family/resident. DON or designee will in-service licensed staff on providing a baseline care plan to resident/resident representative timely. In order to evaluate the success of the systemic change, DON or designee will audit new admissions/readmissions weekly x's 3 weeks to determine if the baseline care plan was completed and provided to the resident/responsible party timely. Once the audits are 100% compliant, the audits will be completed monthly x's 3 months The QAPI committee will evaluated the data and provide recommendations to obtain and maintain compliance.	

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F 655	Continued From page 13 care plan was developed within 48 hours after R352's admission. 7/22/22 at approximately 3:00 PM - During an interview, E2 (DON) confirmed that R352 did not have a baseline care plan. 7/25/22 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		9/13/22

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F 656	Continued From page 14 (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. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to develop and implement comprehensive person-centered care plans for six (R2, R3, R12, R25, R347 and R352) out of 29 residents sampled. Findings include: Cross refer F641, Example 1a and 1b Cross refer F688, Example 2 1. Review of R2's clinical record revealed the following: a. 10/9/21 - R2 was admitted to the facility. 10/11/21 - The Initial Occupational Therapy (OT) Evaluation documented impaired range of motion (ROM) of bilateral upper (shoulders, elbows, wrists, and hands) and lower (hips, knees, ankles, and feet) extremities. 10/15/21 - The 5 day MDS assessment incorrectly coded that R2 had no impairment of	F 656	Resident R2 had her care plan updated 8/11/2022 to include limited range of motion. All other residents that have limited range of motion will have the care plans reviewed to ensure the care plan includes limited range of motion. Care plan will be updated as necessary. Root cause was determined that there was not a system in place for therapy to communicate to nursing/MDS coordinator limited range of motion. A communication form has been developed for therapy to complete and provide to nursing/MDS coordinator indicating what, if any, limitations in range of motion. DON or designee will reeducate the MDS coordinator and therapy staff on	

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F 656	Continued From page 15 both upper and lower extremities with respect to functional limitation in ROM. There was lack of evidence of a comprehensive care plan related to R2's limited ROM and prevention of contractures. b. 2/2/22 - The subsequent Initial OT Evaluation following a referral for a left hand contracture documented impaired ROM of LUE (left upper extremity) and BLE (bilateral lower extremities). The RLE (right lower extremity) had no impairment. 2/7/22 - A physician's order was written to place a rolled up gauze in the palm of R2's left hand to keep fingers extended as much as possible and to remove for hygiene and skin checks. Although R2 was referred for an OT evaluation for a potential left hand contracture, there was lack of evidence of a comprehensive care plan related to limited ROM and/or prevention of contracture. 7/25/22 11:45 AM - An interview with E15 (Minimum Data Set Coordinator - MDSC) confirmed that the above comprehensive care plans were not developed. 2. Review of R347's clinical records revealed the following: 2/24/22 - R347 was admitted to the facility and had no pressure ulcers (PUs). 3/2/22 - The 5 day MDS Assessment stated R347's BIMS was 12, indicating mild cognitive impairment, R347 required limited assistance of	F 656	communication of limited range of motion to ensure it is included in the comprehensive care plan To measure the success of the systemic DON or designee will audit residents on therapy caseload to ensure the care plan was update for limited range of motion The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. Facility was not able to correct the deficiency for R347 due to the fact that R347 was discharged April 10, 2022. All other residents with a pressure ulcer will have their care plan reviewed to ensure that the pressure ulcer is accurately reflected in the care plan. The care plan will be updated as necessary. Root cause was resident passed before care plan could be developed. DON or designee will reeducate nursing management on how to edit care plans and add care plan notes. DON or designee will reeducate nursing management staff on including pressure ulcers in the care plans. To measure the success of the systemic change DON or designee will audit the medical records of all residents with pressure ulcers monthly x's 4 months to	

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F 656	Continued From page 16 one staff for bed mobility, was continent of both bowel and bladder, had no PU, however, R347 was assessed as being at risk for the development of a PUs. There was lack of evidence of the development of a comprehensive care plan for the prevention of PUs. 7/25/22 11:50 AM - An interview with E15 (MDSC) confirmed that the facility failed to develop a comprehensive care plan for the prevention of PUs. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing). Cross refer F677, F688, F791 3. Review of R12's clinical record revealed: a. 7/30/18 - R12 was admitted to the facility with diagnoses including multiple sclerosis (MS). 7/30/18 (revised 12/21/21) - A care plan was developed for R12's risk for alterations in functional mobility related to MS prevention and treatment - no contracture seen at this time. Interventions included monitoring for pain and stiffness. 6/24/22 - A physician's progress note documented R12's stiff extremities and right wrist /hand contracture.	F 656	ensure pressure ulcer is appropriately included in the care plan. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. Resident R12 was seen by the dentist 7/21/2022. All other residents will have an oral assessment completed to identify any further dental follow-up. Those identified will have proper follow-up for dental services. Root cause was due to the covid pandemic hindering follow-up by a dentist and the ability to sign on a Dentist to come to center to see residents. Contract for dental services was signed August 2021. An appointment tracker has been developed to track resident dental visits NPE or designee will reeducate unit managers and unit clerks on the policy for providing or obtaining routine dental needs for residents. DON or designee will conduct weekly audits x 4 weeks to ensure residents receive routine dental services. If the audits are 100% compliant after 4 weeks than the audits will be monthly x 3 months The QAPI committee will evaluate the	

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F 656	Continued From page 17 7/19/22 10:49 AM - Review of R12's June and July 2022 Treatment Administration Record lacked evidence of staff monitoring R12's extremities for stiffness 7/20/22 11:15 AM - In an interview, E23 (RN) confirmed that the facility did not have any documentation in R12's records of staff monitoring R12's extremities, including R12's right hand for stiffness. When asked about R12's contracture to the right hand/wrist, E23 stated that he was not aware and that he would have to check with rehab. There was lack of evidence of a comprehensive care plan related to R12's limited Range of Motion and right wrist/hand contracture. b. 7/30/18 - R12 had a physician's order for a dental consult and treatment as needed for patient health and comfort. 2/14/19 - R12 was care planned for being at risk for oral health or dental care problems with interventions including obtaining a dental consult as ordered. 2/11/20 - R12 was seen by the dentist with recommendations for 3-4 more follow up appointments. 7/20/22 - In an interview, E8 (SW) confirmed that R12 did not have any follow up dental appointments after 2/11/20. The facility failed to implement the care plan intervention to obtain follow up dental appointments for R12 as ordered.	F 656	data and provide recommendations to obtain and maintain compliance. Residents R25 and R3 had their care plans updated to include hearing loss/hearing aides. All other residents that have hearing loss/hearing aides will have the medical record reviewed to ensure that hearing loss/hearing aides is included in the care plan. Root cause was determined to be staff oversight Hearing deficit care plan template will be added in point click care. DON or designee will reeducate unit managers and nursing managers on hearing deficit care plan template To measure the success of the systemic change, DON or designee will audit the records of resident with a diagnosis of hearing loss/hearing aides to ensure that the care plan includes hearing loss/hearing aides. All admissions and readmissions will have care plan audited to ensure that the care plan includes hearing loss/hearing aides. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. The facility was not able to correct the	

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F 656	Continued From page 18 Cross refer F685 4. Review of R25's clinical record revealed: 1/27/22 - R25 was admitted to the facility. 5/16/22 - A physician's progress note documented that R25 was hard of hearing. 7/12/22 10:49 AM - Review of R25's care plan lacked evidence that the facility identified R12's communication problem related to hearing deficit. 7/19/22 11:15 AM - During an interview, E23 (RN) confirmed that the facility did not have a comprehensive care plan related to R25's hard of hearing. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2 (DON). 5. R352's clinical record revealed: 6/1/21 - R352 was admitted to the facility for wound care and rehabilitation. R352's comprehensive person-centered care plan lacked evidence of the following being addressed: - Diagnosis of chronic Atrial Fibrillation and the use of Digoxin, a medication with a narrow therapeutic level, which required close monitoring. The 6/1/21 hospital discharge instructions specified that R352's Digoxin goal level was <1.0.	F 656	deficiency for R352 due to the fact that R352 was discharged from the center on July 10, 2021. All other residents with a foley catheter will have their records reviewed to ensure the foley catheter is included in the care plan. The care plans will be updated as necessary. All other residents with a-fib will have their records reviewed to ensure that a-fib is included in the care plan. The care plans will be updated as necessary. All other residents with cardiac pacemaker have their records reviewed to ensure that pain is included in the care plan. The care plans will be updated as necessary. All other residents with vaginal bleeding will have their records reviewed to ensure that vaginal bleeding is included in the care plan. The care plans will be updated as necessary. All other residents ordered Digoxin will have their records reviewed to ensure that vaginal bleeding is included in the care plan. The care plans will be updated as necessary. Root cause was determined to be that Resident R352 was admitted on the exact day of our ownership transition and we were not on electronic records until ?? Care plan check has been added to a new	

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F 656	Continued From page 19 - Presence of a cardiac pacemaker. - Foley catheter use and care: R352 was admitted with an indwelling foley for wound healing. - At risk for bleeding: R352 was ordered a blood thinning medication. 7/25/22 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (DON) and E2 (NHA). 6. R3's clinical record revealed: 5/1/21 - R3's Activities of Daily Living (ADL) care plan listed an intervention that R3 desired to care of her own hearing aides. 1/27/22 - R3's annual MDS assessment documented that her hearing was highly impaired and she wore hearing aides. R3's clinical record lacked evidence of a comprehensive person-centered care plan for her hearing deficit and use of hearing aides. 7/20/22 at 12:22 PM - During an interview, E16 (LPN) confirmed the finding. The facility failed to develop a hearing deficit care plan. 7/25/22 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 656	admit review when there is a change in condition. Don or designee will re-inservice nursing management on the proper way to create a care plan? To measure the success of the systemic change, DON or designee will complete audits of medical records monthly to ensure care plans include foley catheters, a-fib, cardiac pacemaker's, digoxin, and vaginal bleeding. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. R3 had their care plans updated to include hearing loss/hearing aides and her desire to manage the hearing aides in her own. All other residents that have hearing loss/hearing aides and wish to manage the hearing aides on their own will have the medical record reviewed to ensure that hearing loss/hearing aides is included in the care plan. Root cause was determined to be staff oversight Hearing deficit care plan template will be added in point click care. To measure the success of the sysetemic change, DON or designee will audit the records of resident with a diagnosis of hearing loss/hearing aides and the desire	

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F 656	Continued From page 20	F 656	to manage the hearing aides to ensure that the care plan includes hearing loss/hearing aides. All admissions and readmissions will have care plan audited to ensure that the care plan includes hearing loss/hearing aides. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661		9/13/22

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F 661	Continued From page 21 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R350 and R353) out of four residents reviewed for discharge, the facility's discharge summary failed to accurately capture and document each residents post-discharge plan of care. Findings include: 1. Review of R353's clinical records revealed the following: 9/9/21 - R353 was admitted to the facility from the hospital. 10/11/21 - R353 was discharged home with a family member. 10/11/21 - Review of the form titled "Physician/Mid-Level Provider Discharge Summary" incorrectly documented R353's admission date as "3/31/22." Additionally, under the "Final Diagnoses" section, E17 (Nurse Practitioner) documented diagnoses numerical codes and not narrative diagnoses. For the following three (3) sections, Pertinent Physical and Laboratory Findings, Course of Treatment, and Condition on Discharge, the facility documented "See Note." In reviewing the undated Discharge Note by E17, there was lack of recapitulation of the residents stay, that included course of illness/treatment and therapy services. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM,	F 661	Resident R352 was discharged July 10, 2021, R353 was discharged October 11, 2021, R350 was discharged November 8, 2021. All other residents have the potential to be effected by this deficient practice. Paper discharge summary will be eliminated. Discharge summary will continue to be documented in point click care. DON or designee will re-inservice the nurse practitioners and physicians on documenting a proper recapitulation of stay. DON or designee will audit all discharges weekly x's 4 weeks to ensure the nurse practitioner or physician has documented a proper recapitulation of stay. Once audits are 100% compliant than audits will be completed monthly x's 3 months. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 661	Continued From page 22 with E1 (NHA) and E2 (DON). 2. Review of R350's clinical records revealed the following: a. 10/13/21 - R350 was admitted to the facility from the hospital. 10/11/21 - Review of the form titled "Physician/Mid-Level Provider Discharge Summary" revealed lack of documentation of R350's admission date. The discharge was documented as "11/18/21." Additionally, under the "Final Diagnoses" section, E17 (Nurse Practitioner) documented diagnoses numerical codes and not narrative diagnoses. "Brief Section" was without any documentation. For the following three (3) sections, Pertinent Physical and Laboratory Findings, Course of Treatment, and Condition on Discharge, the facility documented "See Note." In reviewing the Discharge Note dated 11/18/21 by E17, there was lack of recapitulation of the residents stay, that included course of illness/treatment and therapy services. 11/8/21 - A nurse progress note documented that R350 was discharged to home with a family member. b. 10/14/21 - R350 had a dietary order for consistent carbohydrate, regular texture, thin consistency and low potassium diet with no salt packets. 11/8/21 - Review of the facility form titled "Discharge Plan Documentation" revealed R350's recommendation for a regular diet. 7/25/22 11:17 AM - In an interview, E6 (RD)	F 661		

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F 661	Continued From page 23 stated that R350's diet recommendation upon discharge on 11/8/21 continued to be consistent carbohydrate, regular texture, thin consistency and low potassium with no salt packets. 7/25/22 11:27 AM - In an interview, E3 (ADON) stated that during the actual discharge, the resident or family member affix their dated signature to acknowledge receipt of the Discharge Plan Documentation. When asked if R350 or his family received the correct prescribed dietary order instruction on discharge, E3 confirmed that the facility lacked evidence that the correct prescribed dietary order was given to R350 or his family upon discharge on 11/8/21.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Cross refer F656 ex. 3a & b Cross refer F688 2. Review of R12's clinical records revealed the following: 7/30/18 (revised) 4/30/21) - A care plan documented that R12 required assistance and was dependent for ADL (Activities of Daily Living) care in bathing, grooming, and personal hygiene related to Multiple Sclerosis with a goal to anticipate and meet R12's ADL care needs. R12's interventions included shaving R12's face on shower days (Wednesdays) and upon request.	F 677	Resident R12 had her facial hair and nails trimmed on July 27, 2022. All other residents will be assessed for grooming to include nail care and facial hair grooming. Root cause was determined that staff were reluctant to shave resident due to her skin reaction and resident was reluctant to have certain staff provide facial hair grooming. Resident requires to be shaved 2 plus	9/13/22

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F 677	Continued From page 24 7/12/22 11:28 AM - During screening, R12 was observed with facial hair and long fingernails on her left hand. R12 stated that she wants her facial hair shaved and her fingernails trimmed short and further stated, "They (staff) are not doing them. I will be getting a shower tomorrow (Wednesday) and I hope that they will shave my facial hair and trim my fingernails." 7/18/22 - An Annual Minimum Data Set assessment coded R12 as totally dependent with one staff person for bathing and extensive assist with one staff person for personal hygiene and grooming. 7/21/22 9:00 AM - Review of the CNA (Certified Nurse Assistant) flowsheets revealed that R12 had a shower/bathing schedule for Wednesdays and Saturdays on day shift with nail care and to shave R12's face on Wednesdays. Further review of R12's July 2022 CNA flowsheets revealed that R12 received a shower on 7/16/22 (Saturday). There was no documentation of nail care provided to R12. On 7/20/22, R12 was showered, but lacked evidence that R12's facial hair was shaved and that R12's fingernails were trimmed. 7/21/22 11:15 AM - A follow up observation revealed that R12 still had unshaved facial hair and the fingernails on her left hand remained long and untrimmed. 7/21/22 11:20 AM - During an interview, R12 stated that she received showers the past Saturday and Wednesday. R12 further stated, "The aide did not trim my fingernails and also did not shave my facial hair."	F 677	times per week and requests to only be shaved once per week. DON or designee will re-inservice all nursing staff on providing proper grooming and trimming of nails and documenting any refusals. NHA or designee will audit all residents weekly x 4 weeks until 100% compliant, then monthly x3 until 100% compliant. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 677	Continued From page 25 7/21/22 11:26 AM - In an interview, E24 (CNA) stated that the Nurse told her earlier in the shift to shave resident's facial hair and to trim the fingernails. E24 confirmed that R12's facial hair was growing long and R12's fingernails were long with debris. 7/25/22 10:00 AM - An interview with E9 (OT) revealed that E9 came to see R12 last week to assess the range of motion of R12's right hand and E9 noticed the long untrimmed fingernails. E9 further stated that he notified nursing that R12's fingernails needed clipping. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2 (DON).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R6 and R98) out of ** sampled residents for _____, the facility failed to ensure that each resident received treatment and care in accordance with their comprehensive person-centered care plans and professional standards of practice. For R98, the	F 684	Facility was unable to correct the deficiency for R98 due to the fact that Resident R98 was discharged on April 17, 2022. All other diabetic patients have the potential to be affected by this deficient	9/13/22

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F 684	Continued From page 26 facility failed to notify the Physician when R98 had a blood sugar level below the physician ordered parameters and when she continued to have behaviors even after being treated for a urinary tract infection (UTI). For R6, the facility failed to complete a U/A C&S lab per the care plan. Findings include: 1. R98's clinical record revealed: 3/17/2020 - R98 was admitted to the facility with diagnoses of Diabetes, Major Depressive Disorder and Anxiety Disorder. 3/22/22 at 12:15 PM - A physician progress note documented that R98's blood sugars fluctuate and that nursing reports no new concerns. 3/23/22 at 2:54 PM - R98 had a new physician's order to perform accuchecks (fingersticks to assess blood sugar) every morning (timed for 6:00 AM) and at bedtime (timed for 5:00 PM) and to notify the provider if her blood sugar level was less than 90 or greater than 350. 4/3/22 at 1630 - A nursing note documented that R98 was very confused and hallucinating. A new physician's order stated to obtain labs and a urine analysis. 4/4/22 at 12:23 - A progress note by E31 (NP) documented that R98's hallucinations have stopped and she was back to baseline now. If lab/urine results are positive for infection, E31 will treat R98. 4/11/22 at 10:12 AM - A progress note by E31 (NP) documented that R98 continued to have hallucinations and the urine analysis was positive	F 684	practice. Root cause was determined to be that the nurse failed to follow the residents individualized intervention per physician's order to report blood sugar outside parameters. All licensed nurses will be re-inserviced on the policy to notify the physician or nurse practitioner when blood sugar readings are outside the specified parameters. DON or designee will audit all diabetic resident records daily x 7 days to ensure that the physician or nurse practitioner has been notified of any blood sugar readings outside specified parameters. Is audits are 100% compliant, audits will be completed weekly x 4 weeks. If weekly audits are 100% then audits will be completed monthly x 3 months QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. All orders for UA for resident R6 since July 1, 2022 have been reviewed to ensure that the UA was completed. All other residents that had a urinalysis ordered since July 1, 2022 will have their record reviewed to determine if the UA was completed. If the UA was not completed or discontinued by the doctor, the doctor will be asked if he/she would like to order a new UA.	

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F 684	Continued From page 27 for a urinary tract infection (UTI). E31 was ordered an antibiotic twice a day for five days. 4/16/22 at 9:00 AM - The eMAR documented that R98 received her last dose of antibiotic for a UTI. 4/17/22 at 6:53 AM - E27 (LPN), the night shift nurse, checked R98's blood sugar level and documented the level as 84 on the eMAR. The clinical record lacked evidence that E27 notified the provider when her blood sugar was less than 90, as per R98's 3/23/22 physician's order. 4/17/22 at 8:00 AM - CNA documentation of R98's breakfast consumption was blank. 4/17/22 at 9:12 AM - E28 (LPN), the day shift nurse, administered R98's three (3) diabetic medications: Levemir insulin 18 units, Metformin 500 mg (milligrams) tablet and Tradjenta 5 mg tablet. 4/17/22 at 9:18 AM - E28 documented that R98's vital signs were within normal limits. 4/17/22 at 11:03 AM - E28 (LPN) documented on R98's eMAR under behaviors for psychotherapeutic medication use that "Resident was trying to throw herself out of the bed multiple times. Screaming for help even after we had been in the (sic) 2 minutes earlier." Despite having completed treatment the prior day for a UTI, there was no evidence that the Physician was notified of R98's continued behaviors. 4/17/22 at 2:15 PM - A nursing note, by E28 (LPN), documented that R98 "Took all medications as ordered this AM, but kept trying to get out of bed and we were concerned that she	F 684	Root cause was determined to be that practitioner did not discontinue UA order after offering alternative treatments. DON or designee will re-inservice all licensed nurses on the protocol for urinalysis and culture orders. DON or designee will audit all orders for urinalysis and culture daily x 7 days to ensure that there was follow through on the order and results were obtained. If audits are 100% then audits will be completed weekly x 4 weeks. If weekly audits are 100% compliant, then audits will change to monthly x 3 months. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 684	Continued From page 28 was going to end up falling so we put her in the chair to keep her safe. She wasn't talking much, but was responding appropriately this AM. Around 1:30 PM CNA caring for the resident asked me to check her because she was breathing funny...". 7/21/22 at 3:45 PM - During an interview, E30 (CNA) confirmed that she assisted R98 with lunch. E30 stated that R98 did not eat breakfast that morning. E30 stated that R98 typically can eat by herself, but on this day (4/17/22) she was assisting R98 to eat lunch. E30 stated that R98 ate about 25% of her lunch and was attempting to get out of the geri-chair (recliner type chair), but then stopped moving and eating. E30 stated that R98 did not look right and E30 called E28 (LPN) into the resident's room. 7/21/22 at 4:03 PM - During an interview, E29 (CNA) confirmed that she was R98's assigned CNA on 4/17/22 day shift. E29 stated on the morning of 4/17/22, R98 was very confused and that normally the resident could feed herself. E29 stated that R98 refused to eat breakfast and when E29 offered R98 something to drink (juice/coffee), R98 refused. E29 stated that she told E28, the day shift nurse, that R98 did not eat breakfast. E29 stated that she was assigned to cover the dining room during lunch and E30 assisted R98 with lunch. 7/21/22 at 4:24 PM - During an interview, E28 (LPN) stated she could not remember if E27 (LPN), the night-shift nurse, informed her of R98's blood sugar level of 84 on the morning of 4/17/22. When asked if R98's CNA told her that the resident did not eat breakfast, she could not remember. E28 stated that R98 became unresponsive during lunch and the CNA told her.	F 684		

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F 684	Continued From page 29 E28 stated that she checked R98's blood sugar and administered glucagon twice to increase her blood sugar, however, she passed away. 7/21/22 at 10:36 AM - During an interview, E31 (NP) was asked if she was notified the morning of 4/17/22 of R98's blood sugar level of 84. E31 stated that she would check the call log to see if the facility nurse called the service that morning to report R98's blood sugar level taken at 6:53 AM. No further information was received by the Surveyor. While R98 had an acute medical change of condition during the afternoon of 4/17/22, the facility missed opportunities for interventions when nursing staff failed to notify and consult the Physician regarding her blood sugar level below the physician ordered parameters, her refusal to eat breakfast when diabetic medications were administered and her continued behaviors and confusion despite completing treatment for UTI the prior day. 7/25/22 at 3:20 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). 2. Review of the facility policy for lab and diagnostic tests, last updated 1/2022, indicated in the assessment section, "The physician will identify and order diagnostic and lab testing based on the residents diagnostic monitoring needs. The staff will process the test requisitions and arrange for test." Review of R6's clinical record revealed:	F 684		

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F 684	Continued From page 30 A care plan for Foley catheter care, last updated 6/4/21, had an intervention that included to monitor for signs and symptoms of infection and report to physician. A care plan for history of [and] or risk factors for sepsis, last updated 6/4/21, included the intervention to obtain labs/cultures/x-rays as ordered and report results to physician as indicated. 11/10/21 - An order for Hiprex, a medication to prevent UTI's [urinary tract infections] was started for R6. 11/18/21 1:38 PM - A progress note in R6's clinical record documented, "The resident was seen today for a complaint of burning with urination." 11/19/21 2:03 PM - A progress note in R6's clinical record documented, "Follow up complaint of burning with urination. According to nursing report, resident complains of burning with urination." 11/19/21 2:45 PM - A progress note in R6's clinical record documented, "Resident complain of dysuria [difficulty urinating] to this nurse... Resident states... he wants a urinalysis and culture done... Order placed for U/A C&S [urine test to check for infection] ... Urine to be collected on next shift." 11/19/21 - A laboratory order was written for "Urinalysis and Culture one time only for dysuria." 11/19/21 - An order for Pyridium to treat dysuria was started for R6.	F 684		

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F 684	Continued From page 31 Review of R6's laboratory results revealed the absence of a urinalysis from the 11/19/21 order. 11/24/21 4:24 PM - A progress note in R6's clinical record documented, "Resident complain of pain above his penis...". 11/24/21 6:00 PM - A progress note in R6's clinical record documented that R6 "Complained of bladder spasms with urination." 11/27/21 5:12 PM - A progress note in R6's clinical record documented, "Resident complained of pain to his groin and penis, pain medications were provided and resident complained the medications were not effective and requested to be discharged to the hospital... The resident was transferred out to the ER... ". 11/28/21 1:42 AM - A progress note in R6's clinical record documented, "Resident returned from ER with an indwelling Foley catheter and an order for [antibiotic] with a diagnosis of UTI...". During an interview on 7/12/22 at 1:38 PM, R6 stated, "That was a one time occurrence. I had a UTI. I don't think they realized. So I went to the hospital, they fixed it right away. I haven't had any problems since. I had a bladder full of blood and the hospital fixed it under in 8 hours they gave me the antibiotics." During an interview on 7/19/22 at 1:23 PM, E20 (RN) confirmed that R6's order for a U/A C&S was not completed. E20 explained that the order was not placed in the eMAR orders so staff would be aware to obtain the U/A C&S.	F 684		

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F 684	Continued From page 32 During an interview on 7/21/22 at 10:07 AM, E2 (DON) reported she was the Infection Control Nurse in November 2021. E2 confirmed that R6's ordered U/A C&S was not completed. When asked whether R6 presented signs and/or symptoms of infection, E2 stated, "The only thing I can remember at the time was he was treated [for a UTI] the month before. R6 had a Foley and he had just finished antibiotics and we didn't want to put him on [an] antibiotic so she [E17 (NP)] tried Pyridium then she tried Hiprex instead." R6 experienced delayed treatment and services for a UTI due to failure to obtain ordered laboratory tests. Findings were reviewed during the exit conference on 7/25/22 at 3:20 PM with E1 (NHA) and E2 (DON).	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Cross refer F656 Ex. 4	F 685	Resident R25 had care plan updated to	9/13/22

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F 685	Continued From page 33 Based on record review and interview, it was determined that for one (R25) out of one sampled resident reviewed for hearing/vision, the facility failed to ensure that R25 received proper treatment and an assistive device to maintain hearing abilities. Findings include: Review of R25's clinical record revealed: 4/28/22 - A nurse progress note documented that R25 went to (clinic) "hearing department" and had a hearing evaluation. R25 had a hearing aid ordered and was to return in 5 weeks for a fitting. 5/16/22 - A physician's progress note documented that R25 was recently fitted for a right hearing aid. 6/2/22 - A review of the Report of Consultation revealed "...New hearing aid and right ear fitting today... moderate hearing loss in right ear." 6/2/22 - A nurse progress note documented that R25 "...returned from ear dr (doctor) with new hearing aids...". (The resident had only one hearing aid). 7/12/22 11:05 AM - R25 was observed in the hallway ambulating with the use of a rolling walker outside of her room holding a piece of a hearing aid and calling out for staff asking, "Where is everybody? I need help!" R25 approached the Surveyor and asked the Surveyor if she could apply the hearing aid on her ear as she was pointing the hearing aid to her right ear. 7/12/22 11:06 AM - The Surveyor intervened and notified the nurse regarding R25 who needed	F 685	reflect that she needed assistance from nursing to put hearing aides in place. All other residents that have hearing loss/hearing aides will have the medical record reviewed to ensure that hearing loss/hearing aides is included in the care plan. Root cause was determined to be that resident is capable of placing hearing aide in ear independently but prefers to have a specific staff member place hearing aide. Hearing deficit care plan template will be added in point click care with the option to individualized interventions. DON or designee will audit the records of resident with a diagnosis of hearing loss/hearing aides monthly x's 4 months to ensure that the care plan includes hearing loss/hearing aides. All admissions and readmissions will have care plan audited weekly x's 4 weeks to ensure that the care plan includes hearing loss/hearing aides. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 685	Continued From page 34 assistance with her hearing aid. 7/12/22 11:10 AM - Review of R25's physician orders lacked a physician's treatment order to ensure R25's hearing aid placement to her right ear. 7/12/22 11:21 AM - R25 had a physician order which stated , "Pt (patient) and family prefer hearing aid be kept at bedside. Check every shift to make sure that pt has hearing aid in her room." 7/12/22 11:30 AM - Review of R25's careplan and CNA (Certified Nurse Aid) Kardex revealed no information regarding R25's use of the hearing aid. 7/19/22 11:15 AM - During an interview, E23 (RN) stated R25 has been wearing the hearing aid since she got fitted in June of this year. E23 confirmed that a physician's order was not written until 7/12/22 when the Surveyor intervened and notified nursing of R25's need for assistance with hearing aid placement. The facility failed to ensure that applying R25's right ear hearing aid was in place to help address R25's communication problem related to her hearing deficit. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2 (DON).	F 685		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		9/13/22

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F 686	Continued From page 35 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R57 and R352) out of five sampled residents reviewed for pressure ulcer (PU), the facility failed to ensure PU care, treatment and services, consistent with professional standards of practice, were provided to the residents. For R352, a newly admitted resident who was at risk for developing PUs, the facility failed to ensure that R352 received care to prevent a new left heel PU from developing. R352's left heel PU was identified on 6/25/21 by F1 (R352's POA) and subsequently worsened, which required R352 to be evaluated in the Emergency Room (ER). R352 was admitted to the hospital and diagnosed with a left heel Deep Tissue Injury (DTI), resulting in harm. For R57, the facility failed to assess R57's sacral PU from 5/20/22 - 6/1/22. Findings include: 10/2019 (revision) - The facility's policy and procedure entitled Pressure Ulcers/Skin Breakdown - Clinical Protocol stated: "Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk	F 686	The center can no longer assess the wound of Resident R57 because the center was able to successfully heal the wound of R57. Facility was not able to correct the deficient practice for R352 due to the fact that R352 was discharged from the facility on 7/10/21. Root cause analysis was completed to determine the cause of the deficient practice Audit of entire facility conducted and residents identified with actual/potential skin breakdown will have a plan of care to include individualized interventions for prevention and/or treatment. All nursing staff will be re-educated by the Nurse Practice Educator/designee on Policy: Prevention of Pressure Ulcers/Injuries.	

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F 686	Continued From page 36 factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses ...". 1. Cross refer F655 Review of R352's clinical record revealed: 6/1/21 - R352 was admitted to the facility for wound care and rehabilitation status post hospitalization for burns with diagnoses that included, but were not limited to, Peripheral Vascular Disease (PVD) and Diabetes Mellitus (DM). 6/1/21 (untimed) - The facility's admission nursing assessment documented: - R352 was alert and oriented to person and place; - no redness, maceration or breakdown of R352's heels were observed; - a Braden assessment documented R352's score was a 14, which documented that she was a moderate risk for developing a pressure ulcer. 6/1/21 (untimed) - The facility's admission Skin Check documented that R352 had skin breakdown, specifically burns on her left thigh and buttocks. There were no PUs identified.	F 686	Audits will be conducted weekly x4 until 100% compliant, and then monthly x3 months until 100% compliant. The DON will report monthly to the QAPI committee any variances in the data collected. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 686	Continued From page 37 6/1/21 (untimed) - The facility's Bed Rail Evaluation documented that R352 was unable to turn and reposition herself. 6/1/21 through 6/8/21 - Review of R352's clinical record revealed that the facility failed to develop a baseline care plan to address her immediate care needs. 6/8/21 - The admission MDS assessment documented that R352 had burns and no pressure ulcers, but she was at risk of developing pressure ulcers. The facility checked the following skin treatments: pressure reducing device for chair and bed; turning and repositioning. R352 required extensive assist of one staff person physical assistance for bed mobility. R352 was dependent with two staff person physical assist for transfers. 6/8/21 - R352 had two care plans initiated: 1. Actual skin breakdown related to scold burns. Interventions included: -assess site of impaired tissue integrity and its condition; -consult C1 (Wound Care Consultant Physician); -monitor site of impaired tissue integrity daily and prn (as needed) for color changes, redness, swelling, warmth, pain, or other signs of infection; -provide skin tissue care as needed. 2. At risk for skin impairment related to advanced age and decreased mobility. Interventions included: -assist with general hygiene and comfort measures; -encourage to offload (heels off bed to reduce risk of skin breakdown) heels;	F 686		

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F 686	Continued From page 38 -monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD (Medical Doctor); -skin will be assessed on a weekly basis on scheduled bath day and document findings on a weekly skin assessment; -report any skin redness/impaired integrity areas to the nurse; -use a draw sheet or lifting device to move resident; -use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Although the 6/8/21 at risk care plan stated to "encourage R352 to offload heels", the facility lacked individualized interventions on how nursing staff could assist with offloading the resident's heels as a preventative measure. R352 required extensive assist of one staff person for bed mobility. 6/10/21 at 9:00 AM - A skin check noted no new pressure ulcers. 6/17/21 at 9:00 AM - A skin check noted no new pressure ulcers. 6/19/21 at 4:45 PM - A nurse's note documented that R352's heels were offloaded. 6/24/21 at 1:28 PM - A skin check noted no new pressure ulcers. 6/25/21 at 11:17 AM - The CNA Documentation Survey Report documented that R352 received a scheduled bed bath.	F 686		

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F 686	Continued From page 39 6/25/21 at 8:00 PM - A eINTERACT SBAR Summary for Providers note documented a change in condition ... "Resident's (POA) reported that she has noticed a blister on resident's left heel ... Provider ... recommendations: apply skin prep to blister." R352's clinical record lacked evidence of a description/characteristics of R352's left heel blister and surrounding skin and an immediate intervention to offload the resident's heels. 6/26/21 at 10:35 AM - A physical therapy treatment note documented that R352 was seen at the bedside and noticed R352's left heel blister. The therapist documented that she made nursing aware and to "offload BLE (bilateral lower extremities)...". There was no evidence that an individualized intervention for nursing staff to assist offloading R352's heels was added to the care plan and consistently implemented. 6/26/21 at 4:45 PM - A nursing note documented that R352's had bilateral lower extremity pitting edema. Despite facility nursing staff being notified of R352's left heel blister by F1 (R352's POA) during the evening shift of 6/25/21 and then during day shift of 6/26/21 by the physical therapist, the facility failed to do a thorough assessment of R352's left heel blister. 6/28/21 - R352's Occupational Therapy Discharge Evaluation documented that she had no functional improvement while on therapy caseload and remained maximal assistance for bed mobility. 6/28/21 at 11:14 AM - A physical therapy	F 686		

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F 686	Continued From page 40 treatment note documented that R352 had a left heel blister and the resident's heels were offloaded. 6/28/21 at 2:50 PM - A progress note by E26 (NP) lacked evidence of an assessment and plan for R352's new left heel blister identified on 6/25/21. 6/29/21 at 9:45 AM - A progress note by E26 (NP) documented that R352 was seen for a left heel blister and "the blister now has a darker appearance and is fluid filled. R352 complained of some tenderness when the skin prep is applied... Increased in size overnight. C1 (Wound Care Consultant Physician) following. Monitor and continue with skin prep." 6/29/21 at 11:33 AM - A nurse's note documented "Resident was noted with a big blister on her left heel. E14 (Wound Care Consultant Physician) was consulted about the blister and orders were received to send pt (patient) to ED (Emergency Department) for vascular eval (evaluation). E26 (NP) was notified also F1 (R352's POA)." 6/29/21 at 5:45 PM - The hospital record documented that R352 had a left ankle/heel blister and consulted WOC (wound, ostomy and continence nurse). 6/29/21 at 6:02 PM - The hospital record documented that R352 had a doppler ultrasound of her legs, groin and ankles. R352's diagnostic results revealed her left lower extremity had full compression and no blood clots. 6/30/21 at 11:31 AM - The hospital record WOC consult documented that R352 had a "left heel DTI presenting as ruptured blister with intact roof.	F 686		

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F 686	Continued From page 41 DTI may evolve into open wound. Boggy darker discolored area noted over bony prominence. Patient states that she has not been very mobile for the past month ... Skin Care Recommendations: Suspend heels with pillow or Heelzup, Inspect bony prominences & under devices at least Q8hr & PRN, Maintain dry and clean skin, Turn and reposition at least Q2H, Limit sitting intervals to a maximum of 2 hours, Patient unable to shift own weight in chair, reposition Q1H, Elevate head of bed <(less than) 30 degrees unless contraindicated, Maintain sling under patient to move & reposition patient, Pillows between knees to prevent skin to skin contact, Elevate legs, Meplix for prevention ...". R352's clinical record from her admission on 6/1/21 until her discharge to the hospital on 6/29/2 lacked evidence of offloading the heels until after R352 developed a left heel PU on 6/25/21 and lacked evidence of turning and repositioning for ten (10) shifts, specifically eight (8) night shifts and two (2) evening shifts. 7/2/21 - R352 was readmitted to the facility. 7/2/21 at 6:27 PM - A nursing note documented that R352 had an open area on the left heel and heels were inspected. R352's clinical record lacked evidence of further description/characteristics of her left heel PU upon readmission to the facility. In addition, R352's care plan lacked individualized interventions to address the new left heel PU and for facility staff to assist the resident with offloading the heels. 7/3/21 (untimed) - The facility's Skin Integrity Report documented that R352's left heel was an	F 686		

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F 686	Continued From page 42 Unstageable PU, measuring 2.0 cm x 3.0 cm x utd with deep purple/maroon surrounding tissue. 7/7/21 at 8:00 PM - A nursing note documented that R352's heels were offloaded. 7/8/21 - A progress note by E26 (NP) documented that when R352 was recently hospitalized, Hematology was consulted, but not Vascular as they felt it was a blister related to DTI. 7/8/21 at 2:23 PM - A nursing note by E3 (ADON) documented that R352 was seen by C1 (Wound Care Consultant Physician). "Wound to left heel assessed, per E14 (Wound Care Consultant Physician) wound presents more as acute vascular injury vs. pressure, resident recently hospitalized for blood clot. Wound measures 6.4 x 7.1 x utd (unable to determine) and is 100% intact purple tissue. Continue skin prep and foam dressing as well as to offload." Despite having been diagnosed with a left heel DTI pressure ulcer and a care plan for being at risk of PUs, R352's clinical record from her readmission on 7/2/21 until her discharge on 7/10/21, lacked evidence of nursing staff providing assistance to offload the heels as R352 required extensive assistance of one staff person with bed mobility. 7/25/21 at 10:16 AM - During an interview, E3 (ADON) and the Surveyor reviewed R352's clinical record and the lack of care plan interventions, specifically offloading the resident's heels. E3 was unable to provide evidence of an initial assessment on 6/25/21 when R352's left heel blister was identified.	F 686		

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F 686	Continued From page 43 7/25/21 at 3:20 PM - Finding was reviewed with E1 (NHA) and E2 (DON) during the Exit Conference. 2. The facility policy on pressure ulcer protocol, last updated 10/2019, indicated in the assessment section, "The nurse shall describe and document/report the following: full assessment of the pressure sore including location, stage, length, width and depth, presence of exudates or necrotic (dead) tissue." Review of R57's clinical record revealed: 6/24/21- A Braden scale assessment to determine risk of pressure ulcer development was completed that resulted in a score of 16 indicative of mild risk. The clinical record lacked evidence of subsequent Braden scale assessment completions. 6/6/22 - A quarterly MDS assessment documented R57 was at risk for pressure ulcer development and as having a stage three pressure ulcer. An undated care plan for actual skin breakdown, stage three pressure ulcer to the sacrum [tailbone], included the intervention to complete weekly wound assessments. 7/15/22 1:39 PM - The facility provided wound care documentation of assessments of R57's wound from the initial reopening on 5/11/22 - 7/7/22. The wound care documentation lacked evidence of an assessment from 5/20/22 - 6/1/22. During an interview on 7/18/22 at 9:49 AM, E3	F 686		

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F 686	Continued From page 44 (ADON) stated the wounds were expected to be assessed at least weekly. During an interview on 7/18/22 at 10:22 AM, E3 (ADON) confirmed the findings of absent documentation from 5/20/22 - 6/1/22. Findings were reviewed during the exit conference on 7/25/22 at 3:20 PM with E1 (NHA) and E2 (DON).	F 686		
F 688 SS=E	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 record reviews, interviews and review of facility documentation, it was determined that for two (R2 and R12) out of four sampled residents with limited ROM (Range of Motion) and limited mobility, the facility failed to ensure	F 688	R12 Has been re-evaluated by Physical Therapy and has a splint in use. Nursing staff placed gauze roll in R2's hand on 7/19/22.	9/13/22

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F 688	Continued From page 45 appropriate treatment, equipment and services were provided to prevent further decrease in range of motion when R12's resting hand splint was not applied on her right hand for five months from February 2022 through July 2022. For R2, the facility failed to ensure that a rolled up gauze was placed in the palm of R2's left hand to keep the fingers extended. Findings include: Cross refer F656 Ex, 3a & 3b Cross refer F671 1. Review of R12's clinical record revealed the following: 7/30/18 - R12 was admitted to the facility with diagnoses including Multiple Sclerosis (MS). 7/30/18 (revised 12/21/21) - R12 was care planned for being at risk for alterations in functional mobility related to MS. Interventions included PROM (Passive Range Of Motion) to bilateral (both sides) upper and lower extremities two times daily for fifteen minutes each time. 12/19/21 - R12's transitional evaluation and plan of care developed by occupational therapy (OT) revealed a long term goal of precautions for R12's right hand contracture and to establish RNP (Restorative Nursing Program) with patient (resident) and patient's caregiver in preparation for discharge. 2/1/22 - R12 was discharged from skilled OT services as she had reached the highest functional level. R12 was placed on a RNP for R12 to wear a resting hand splint on her right hand daily for six hours during the day.	F 688	All other residents have the potential to be effected by this deficient practice Root cause was completed to determine the cause of the deficient practice Audit of all residents with splint orders was conducted and plan of care updated to include individualized interventions. DON or designee will reeducate all nursing staff individualized interventions and required documentation. DON or designee will conduct audits weekly x 4 until 100% compliant, and then monthly x 3 months until 100% compliant. The DON will report monthly to the QAPI committee any variances in the data collected. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 688	Continued From page 46 7/12/22 11:25 AM - R12's right hand was observed in a closed fist. R12 stated that she could not open her right hand and extend her fingers. R12 also stated that the staff used to put something on her right hand to keep it from closing but "They stopped doing it. I don't know why." 7/19/22 10:00 AM - Review of R12's clinical record lacked evidence that she received restorative services, specifically application of the resting hand splint on her right hand daily for six hours during the day. 7/19/22 11:15 AM - During an interview, E23 (RN UM) confirmed the findings. The facility failed to provide R12, a resident with limited ROM, with appropriate treatment and services for her upper extremities to increase the ROM and/or to prevent a further decrease in ROM. 7/21/22 11:02 AM - In an interview, E24 (CNA) stated that she was not aware that R12 was supposed to have a splint applied on her right hand. 7/25/22 10:00 AM - When interviewed, E9 (OT) confirmed that he received a referral from nursing on 7/21/22 to assess and evaluate R12's decreased right hand ROM and to re-establish a splint wearing schedule with R12 and R12's caregivers (nursing). 7/25/22 11:10 AM - Findings were reviewed with E2 (DON). Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2.	F 688		

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F 688	Continued From page 47	F 688		

Cross refer F641, Example 1a and 1b
Cross refer F656, Example 1a and 1b

2. Review of 2's clinical record revealed the following:

10/9/21 - R2 was admitted to the facility.

10/11/21 - The Initial Occupational Therapy (OT) Evaluation documented impaired range of motion (ROM) of bilateral upper (shoulders, elbows, wrists, and hands) and lower (hips, knees, ankles, and feet) extremities.

2/2/22 - The subsequent Initial OT Evaluation following a referral for a left hand contracture documented impaired ROM of the left upper extremity and bilateral lower extremities. The right lower extremity had no impairment.

2/7/22 - A physician's order was written to place a rolled up gauze in the palm of the left hand to keep fingers extended as much as possible and to remove for hygiene and skin checks.

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F 688	Continued From page 48 7/1/22 through 7/14/22 - CNA documentation lacked the above intervention for the rolled up gauze to be placed in R2's left hand. 7/1/22 through 7/14/22 - The Treatment Administration Record (TAR) revealed that the assigned nurses documented that the intervention of the rolled gauze to the left palm was implemented. 7/12/22 11:27 AM to 7/14/22 2:40 PM - Multiple observations of R2's left hand revealed that R2 did not have the rolled gauze in the palm of her left hand, although the TAR documented that the intervention was in place during the Surveyor's observations. 7/14/22 11:56 AM - An interview with E10 (Certified Nurse's Aide- CNA) revealed that E10 was uncertain of any device for the left hand to be placed by the CNA. 7/14/22 2:45 PM - A subsequent interview with E10 (CNA) revealed that the CNA checks the facility's EMR system related to care needs of the residents. A joint observation of the EMR system with E10 was conducted and E10 stated "It is there now", referring to the intervention of placing the rolled up gauze in the palm of the left hand to keep fingers extended as much as possible and to remove for hygiene and skin checks. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing).	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		9/13/22

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F 689	Continued From page 49 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and review of facility documentation as indicated, it was determined that for one (R18) out of four residents sampled for accidents, the facility failed to ensure that R18, a dependent resident, was transferred using a hoyer lift with the assistance of two staff members on 8/19/21 as per her plan of care and the facility's hoyer lift policy and procedure. As a result of this incident, R18 was diagnosed with a femur fracture on 8/21/21, resulting in harm to the resident. In response to this incident, the facility implemented corrective actions. Based on the facility's corrective actions, interviews of floor staff and confirmation that no further incidents involving hoyer lifts were identified up to and at the time of the current survey, this deficiency was past non-compliance. Findings include: 5/2021 (last revision) - The facility's policy and procedure entitled, Lift, Mechanical (Hoyer), stated, "Purpose: To enable two employees to lift and move a resident safely ... Procedure: ... 9. One employee stays with and guides resident, other employee moves the lift ...". Cross refer to F609	F 689	Past Non-compliance	

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F 689	Continued From page 50 R18's clinical record revealed: 8/6/15 - R18 was care planned for being totally dependent for Activities of Daily Living (ADL) care. One of the interventions was that the resident required two person assist for transfers. 5/6/20 - R18 had a physician's order for comfort measures only per family request (No labs, IV's, x-rays). 8/2/21 - The quarterly MDS assessment documented R18 with severe cognitive impairment, a diagnosis of dementia and R18 was dependent on two person assist for transfers. 8/20/21 at 7:16 AM - A nursing note documented, "This AM resident presents with swollen R (sic) lateral upper thigh; no redness or elevated temp (temperature) noted from area, resident denies pain except for when leg is moved certain positions...". 8/20/21 at 12:00 Noon - A nursing note documented that R18's thigh was assessed noting swelling. Resident denied any pain or discomfort. 8/20/21 at 2:00 PM - A nursing note documented that R18's thigh was assessed. The nurse noted swelling and firmness, but no evidence of pain, redness or elevated temperature to the area. R18 denied any pain. 8/21/21 at 6:49 PM - R18's x-ray result revealed an acute fracture of the left femur (thigh bone). 8/21/21 at 10:34 PM - A late entry nursing note	F 689		

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	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

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F 689	Continued From page 51 documented, "On 8/20/21, at the change of shift, 11-7 nurse notified this nurse of the change to resident's (L) (left) thigh. Site noted with edema, no s/s (signs or symptoms) of pain or discomfort noted. No other changes reported throughout the shift. On 8/21/21, 7-3 shift nurse notified this nurse that a change was noted to the site. Upon assessing the site, redness, warmth and a lump was felt. There was evidence of pain r/t (related to) resident's facial expression. This nurse notified the POA... of the change and if it will be ok to X-ray the site. (POA) (sic) to this nurse that she was in the facility on 8/20/21, she did not notice any changes. She said resident was able to lift both legs with no problem. POA ok to obtain X-ray. Spoke to on call NP... order obtained, Hospice also notified and a nurse was requested to come in and evaluate resident. X-ray ordered STAT. (Name) RN from hospice came in to assess resident, new order to start resident on Roxanol PRN, script was faxed to facility by hospice MD. X-ray done, results shows acute fracture of (L) (left) femur. (POA) was notified of result, POA told this nurse not to send resident out to the hospital. This nurse attempted to convince POA to send resident out because the fracture is acute and appeared painful... POA told this nurse to keep resident in the facility and keep her comfortable and administer pain medication as ordered by MD. On call NP (Name) notified of resident's (sic) response and X-ray result. NP told this nurse to honor POA wishes. Hospice also notified of X-ray result and POA's response. PRN Roxanol was administered." 8/23/21 at 11:08 AM - The facility reported R18's injury of unknown source to the State Agency. The facility documented that R18 presented with a change in condition related to swelling noted at	F 689		

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F 689	Continued From page 52 right (sic) thigh area with evidence of pain... STAT X-ray... done. Results were femur fracture. Etiology unknown at this time. Investigation has been initiated." The facility failed to report an alleged violation of injury of unknown source to the State Agency within the required two hours after receiving the x-rays results on 8/21/21 at 6:49 PM. The facility conducted a thorough investigation, which included interviewing and obtaining statements from the staff who worked from 8/18/21 to 8/21/21. There was only one staff person's statement that deviated from R18's plan of care, which was a two staff person assist with a hoyer lift transfer: (undated and untimed) - E32 (agency CNA) documented, "On 8/19/21, I (E32's name) came in on 3-11... When I got to R18's (name) room it was about 9 PM. I started to get R18 undressed in the wheelchair. I went out into the hallway to see if I can (sic) get help with the transfer. No one was around so I waited and went in did another resident and came back. No one was still around... Now it's about quarter to 10 PM so I started to set up the transfer using a hoyer lift. Once, I hooked up all four straps I asked R18 was she ok. R18 said yes so I started the transfer... The transfer was over I unhooked the straps...". Based on the facility's thorough investigation, they identified that R18 was transferred by one staff member, an agency CNA (E32), using a hoyer lift. R18 was later diagnosed with a significant injury, a femur fracture. In response to R18's investigation, the facility implemented the following corrections: -Immediately reported E32's (agency CNA)	F 689		

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F 689	Continued From page 53 actions to her employer and removed her from returning to work in the facility. -On 9/1/21, in-serviced staff and agency CNAs on the facility's Mechanical Lift policy requiring two staff members. -On 9/24/21, updated the agency orientation document where agency CNAs were required to read and sign the attached copy of the facility's Mechanical Lift policy and procedure. The Agency Orientation document emphasized that "ALL mechanical lifts require 2 staff members to operate. No exceptions." -Assigned all staff CNAs an educational video that demonstrated how to use the (mechanical) lifts. 7/21/22 at 1:12 PM - During an interview, E2 (DON) confirmed that there have not been any further incidents involving a hoyer lift with other residents since the 8/19/21 incident with R18. Based on review of the facility's corrective measures, interviews with floor staff during the current survey and confirmation of no further incidents occurring with residents involving hoyer lifts since 8/19/21, it was determined that this deficiency was past non-compliance. 7/25/22 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		9/13/22

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F 760	Continued From page 54 by: Based on interview and record review, it was determined that for one (R352) out of five residents reviewed for pressure ulcers, the facility failed to ensure that R352 was free from a significant medication error when she was readmitted after being newly diagnosed with a blood clot in her right leg and prescribed Eliquis, a blood thinner, for treatment. Findings include: R352's clinical record revealed: 7/2/21 at 12:46 PM - The hospital's Interagency Discharge Orders documented that R352 had a blood clot in her right leg and that her blood thinning medication was changed to Eliquis. The specific order to treat R352's blood clot was Eliquis 10 mg (milligrams) twice daily for one week through 7/8 and then 5 mg twice daily long term. 7/2/21 - R352 was readmitted to the facility and her physician's orders were transcribed as: - Eliquis 5 mg tablet - Give 2 tablets (10 mg) by mouth two times a day for DVT until 7/8/21 at 11:59 PM. - Eliquis 5 mg tablet - Give 1 tablet by mouth one time a day for DVT (to start on 7/9/21). The facility failed to accurately transcribe R352's Eliquis medication order to treat her newly diagnosed blood clot as the order was for twice daily, not one time a day. R352's July 2021 eMAR revealed that she only received one dose of Eliquis 5mg on 7/9/21 before being discharged to the hospital for an unrelated reason on 7/10/21 at approximately 3 PM.	F 760	Facility was unable to correct the deficient practice for R352 due to the fact that resident R352 was discharged from the facility on 7/10/21. All other residents on Eliquis will have the order for Eliquis reviewed to make sure the order is accurately transcribed. A root cause analysis will be completed to determine the cause of the deficient practice All Licensed Nursing staff will be reeducated by NPE/Designee on Policy: Medication and Treatment Orders. New medication orders will be audited weekly x4 weeks to ensure medication orders were transcribed accurately until 100% compliant, and then monthly x3 months until 100% compliant. The DON will report monthly to the QAPI committee any variances in the data collected. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 760	Continued From page 55 7/25/21 at 3:20 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 760		
F 791 SS=D	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 led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		9/13/22

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F 791	Continued From page 56 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: Cross Refer F656, Ex. 3a & 3b Cross Refer F677, F688 Based on observation, interview, and record review, it was determined that for one (R12) out of two sampled residents reviewed for dental, the facility failed to assist R12 in obtaining follow up dental services. Findings include: Review of R12's clinical record revealed the following: 6/2/20 - R12 had a dental consult recommendation for crowns and for an impression for a full lower denture and R12 needed 3-4 follow up appointments. According to Cleveland Clinic's website, dental impressions are imprints of the teeth, gums and surrounding oral structures. They are used to create diagnostic models of the mouth as well as dental restorations. Dental crowns are caps placed on top of damaged teeth. 7/12/22 11:42 AM - R12 was observed with missing upper teeth and no bottom teeth. When interviewed, R12 stated that she would like to see	F 791	Resident R12 was seen by the dentist 7/21/2022. All other residents will have an oral assessment completed to identify any further dental follow-up. Those identified will have proper follow-up for dental services. Root cause was due to the covid pandemic hindering follow-up by a dentist and the ability to sign on a Dentist to come to center to see residents. Contract for dental services was signed August 2021 An appointment tracker has been developed to track resident dental visits. NPE or designee will re-inservice the licensed staff and unit clerks on the policy for providing or obtaining routine dental needs for residents. DON or designee will conduct weekly audits x 4 weeks until 100% compliant to ensure residents receive routine dental	

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F 791	Continued From page 57 the dentist again to follow up on her dentures. R12 added that the last time she saw the dentist was back in 2020. 7/18/22 - An Annual MDS (Minimum Data Set) assessment revealed no dental concerns. 7/20/22 12:10 PM - In an interview, E8 (SW) revealed that R12 was last seen by the dentist on 2/11/20 and confirmed that R12 was not seen by the dentist for follow up appointments after the 2/11/20 visit. 7/22/22 8:30 AM - During an interview, E2 (DON) stated that R12 was seen by the dentist "yesterday" (7/21/22). The facility failed to assist in obtaining follow up dental services for R12's crowns and impression for a full lower denture since 2/11/20 until the Surveyor intervened. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (Nursing Home Administrator) and E2 (Director of Nursing).	F 791	services. If the audits are 100% compliant after 4 weeks than the audits will be monthly x 3 months until 100% compliant. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		9/13/22

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F 803	Continued From page 58 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to ensure a planned menu item was substituted with an item of the same nutritional value for four (4) randomly sampled residents (R70, R77, R78, and R196). Findings include: A random lunch observation was conducted on 7/18/22, beginning at approximately 12:40 PM and concluding at approximately 12:52 PM, revealed the following: 1. R77's meal ticket (a form used by the facility where residents make meal selections) stated dinner roll/bread with margarine, however, these items were not on the tray. A comparison of R77's lunch tray and R77's meal ticket did not match. 2. R78's meal ticket stated dinner roll/bread with	F 803	The facility was unable to correct the deficient practice due to meal service ended for R70, R77, R78 and R196. All other residents have the potential to be affected by this deficient practice. The root cause was that there was no quality review of supplies for upcoming meals and review of the tray line. New equipment will be implemented to return to the traditional style tray line service system. Food Service Director or designee will reeducate all dietary staff on ordering proper foods per menus and communicating when an item is not available. Communicating when a	

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F 803	Continued From page 59 margarine, however, these items were not on the tray. A comparison of R78's lunch tray and R78's meal ticket did not match. 3. R70's meal ticket stated dinner roll/bread with margarine, however, these items were not on the tray. A comparison of R70's lunch tray and R70's meal ticket did not match. 4. R196's meal ticket stated dinner roll/bread with margarine, however, these items were not on the tray. A comparison of R196's lunch tray and R196's meal ticket did not match. 7/18/22 12:55 PM - An interview with E6 (Registered Dietician - RD) confirmed that the above residents lunch trays did not match their meal tickets, as it relates to the dinner roll/bread with margarine. 7/18/22 12:59 PM - An interview with E7 (Dining Services) in the presence of E6 (RD) was conducted. The Surveyor advised E7 of the above lunch observations in which the lunch trays and meal tickets did not match and the residents did not receive a dinner roll/bread with margarine. E7 stated that the facility did not receive a supply of dinner rolls and bread with butter was to be provided. 7/19/22 9:40 PM - An interview with E6 (RD) confirmed that when the dinner roll with margarine was not available, the facility failed to ensure that bread with margarine was offered as a substitute, providing nutritional adequacy. Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1(Nursing Home Administrator) and E2	F 803	replacement item is necessary, Dieticians involvement when there is a replacement item on the menu for a specific meal Food Service Director or designee will audit the tray line daily x 7 days to ensure trays delivered to the floor contain the appropriate items as posted on the menu. If audits are 100% compliant, audits will be completed weekly x 4 weeks. When weekly audits are 100% compliant, audits will be completed monthly x 3. The QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 803	Continued From page 60 (Director of Nursing).	F 803		
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 observations and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: 1. The following were observed on 7/12/22 during the initial kitchen tour from 9:45 AM through 11:00 AM: - There was a lot of stagnant water on the floor of the facility near the walk-in refrigerator, the dishwashing machine, and the 3 compartment	F 812	All residents have the potential of being affected by this deficient practice. Root cause was there were several leaks coming from the garbage disposal and the plumbing connected to the garbage disposal. These issues were not reported in our electronic system until pointed out by the surveyor. Water by the freezer door and back sink was due to the closer not working properly on the freezer door resulting in	9/13/22

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F 812	Continued From page 61 sink; - The fume hood above the cooking stove was not serviced and had significant oil build up; - The east wing dining room hand washing sink did not have soap. Findings were reviewed and confirmed with E7 (Food Service Director) on 7/12/22 at approximately 11:00 AM. 2. During a dining observation of the 300 hall on 7/12/22 at 12:48 PM, E19 LPN was observed removing a food item from packaging with bare hands. E19 then placed the food item on the tray for the resident to eat and walked out of the residents room. E19 immediately confirmed the finding, returned to the resident's room and discarded the food item. Findings were reviewed during the exit conference on 7/25/22 at 3:20 PM with E1 (NHA) and E2 (DON).	F 812	condensation developing on the door and running down to the floor. The garbage disposal was replaced and the plumbing was repaired. The closer on the freezer door was repaired. Maintenance Director or designee will re-inservice the dietary staff on reporting maintenance issues utilizing our TELS system. Food Service Director or designee will complete kitchen audits for maintenance issues weekly x 4 weeks until 100% compliant to identify areas that need reporting. Once the audits are 100% compliant, the audits will be completed monthly x 3 months until 100% compliant. QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. All residents have the potential to be effected by this deficient practice Root cause was determined to be that the hood requires more frequent checking by both maintenance and dietary. The hood filters will be checked weekly by maintenance and cleaned weekly as necessary. Maintenance Director or designee will audit the hood weekly x 4 weeks until	

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F 812	Continued From page 62	F 812	100% compliant to ensure there is no oil dripping from the hood. Once audits are 100% compliant, the audits will be completed monthly x 3 months until 100% compliant. QAPI committee will evaluate the data and provide recommendations to obtain and maitain compliance. All residents have the potential to be affected by this deficient practice. Root cause was the lack of regular checks of soap dispensers for proper placement and proper function. Whole house audit of soap dispensers was completed July 15, 2022. Checking of soap dispensers will be added as a weekly task x4 weeks until 100% compliant and then monthly x3 until 100% compliant. Audits will be documented in TELS system, or maintained on paper audit. Maintenance Director or designee will reinservice all staff on reporting non-functioning soap dispenser to Maintenance to repair or replace Soap dispensers will be audited weekly x□s 4 weeks for proper placement and proper function. If audits are 100% than audits will be monthly. QAPI committee will review audit results and make necessary recommendations	

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	085042	A. BUILDING _____ B. WING _____	C 07/25/2022

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F 812	Continued From page 63	F 812	All residents have the potential to be effected by this deficient practice Root cause was determined to be that the staff member required reservicing on proper handling of food New equipment will be implemented to return to the traditional style tray line service system Dietician or designee will re-inservice all nursing staff and management team members on the proper handling of food when serving in the dining room or in a resident room Dietician or designee will complete random audits/observations of staff handling of food during meal service. Audits will be conducted weekly for all three meals weekly x 4 weeks. When audits are 100% compliant, audits will be completed monthly x 3 months The QAPI committee will evaluate the data and provide recommendation to obtain and maintain compliance.	
F 880 SS=F	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	F 880		9/13/22

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F 880	Continued From page 64 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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	F 880		

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F 880	Continued From page 65 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two (R47 and R196) the facility failed to ensure adherence to infection control practices for glucometer use and insulin administration. Additionally, the facility failed to ensure the laundry room adhered to standards of practice to prevent infection. Findings include: The facility policy on hand hygiene, last revised 5/2021, indicated, "If hands are not visibly soiled, use an alcohol based hand rub for routinely decontaminating hands before putting on clean gloves, after contact with residents skin, after contact with medical equipment, after removing gloves." The facility policy for glucometer cleaning, last revised 5/2021, indicated, "It is the policy of this	F 880	The employee involved in the deficient practice for R47 and R196 was immediately inserviced on the Facility protocol for cleaning glucometer and proper hand hygiene while checking blood sugar and administering insulin All residents that require fingers sticks and insulin administered have the potential to be affected by this deficient practice. Root cause of the deficient practice was that agency staff member did not follow policy for cleaning glucometer and proper hand hygiene while administering insulin. Nurse Educator has reeducated all nurses	

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F 880	Continued From page 66 facility that glucometer's that are shared between more than one resident are disinfected between each resident use. If one resident use, clean per protocol after each use... Disinfect the glucometer after each use even if there is no visible blood." The facility policy on insulin administration, last updated 10/2019, indicated, "Step one in the procedure, wash hands.... dispose of the needle in a designated container, wash hands." 1a. During a medication observation on 7/20/22 at 11:07 AM, E18 (RN) was observed retrieving a glucometer from the medication cart, then entering R196's room. E18 donned gloves and obtained R196's blood sugar. E18 then removed the gloves, discarded them and placed the glucometer in the right pocket of her uniform. E18 was not observed cleaning the glucometer prior to or after using it to obtain R196's blood sugar. E18 did not perform hand hygiene at any time during the observation. 1b. At 11:11 AM, E18 was observed retrieving the glucometer from her pocket, entering R47's room, donning gloves and obtaining R47's blood sugar. E18 then removed the gloves, placed the glucometer in the right pocket of her uniform and returned to the medication cart. E18 was not observed cleaning the glucometer prior to or after using it to obtain R47's blood sugar. E18 did not perform hand hygiene at any time during the observation. 2a. During a medication observation on 7/20/22 at 11:15 AM, E18 (RN) returned to R196's room to administer insulin to the resident. E18 donned gloves at the door, administered the insulin, then removed the gloves and exited the room. E18 did	F 880	on protocol for cleaning glucometer. Nurse Educator or designee will educate newly hired nurses on glucometer cleaning protocol. All nurses will be re-inserviced on proper hand hygiene while checking blood sugar and administering insulin. Competencies will be completed for all nurses. Staff development or designee will audit nurses daily for one week observing proper cleaning of glucometers while checking blood sugar and proper hand hygiene when administering insulin. If audits are 100% than audits will occur weekly x 3 weeks. If the weekly audits are 100% then audits will occur monthly x 4 months QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. All residents have the potential to be effected by this deficient practice. Root cause revealed that there was not proper ventilation to provide positive airflow from the clean linen room and negative airflow in the soiled room. Additional exhaust system has been installed to generate positive airflow from clean linen room. Areas around the dryers were sealed to assist in the positive airflow for the clean linen room.	

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F 880	Continued From page 67 not perform any hand hygiene during any point prior, during or after the administration. 2b. At 11:17 AM E18 entered R47's room to administer insulin to the resident. E18 donned gloves at the door, administered the insulin, removed the gloves and exited the room. E18 did not perform any hand hygiene during any point of the observation. After administering insulin to both residents, E18 returned to the medication cart, removed the glucometer from her pocket and placed it in the drawer of the medication cart without cleaning the glucometer. During an interview on 7/20/22 at 11:21 AM, E18 (RN) confirmed the findings. E18 stated that she cleans the glucometer "Once a day at the start of my shift" and answered "No" when asked whether cleaning the glucometer between residents was indicated. During the same interview, E18 confirmed that no hand hygiene was performed during the observations. Findings were reviewed during the exit conference on 7/25/22 at 3:20 PM with E1 (NHA) and E2 (DON). 3. The following were observed during the laundry room observation on 7/18/22 from 11:00 AM to 11:45 AM: - The soiled linen room did not have hand washing soap in the soap dispenser; - The soiled linen room did not have adequate negative pressure in the room to prevent contaminants from leaving the room.	F 880	Checking of airflow will be added as a task in the TELS maintenance task system. Maintenance Director or designee will audit for proper airflow weekly x 4 weeks. If audits are 100%, audits will be monthly thereafter to check for proper airflow QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance. All residents have the potential to be affected by this deficient practice. Root cause was the lack of regular checks of soap dispensers for proper placement and proper function. Whole house audit of soap dispensers was completed July 15, 2022. Checking of soap dispensers will be added as a weekly task x 4 weeks until 100%, then monthly x3 until 100% compliant, and documented in TELS. Maintenance Director or designee will re-inservice all staff on reporting non-functioning soap dispenser to maintenance to repair or replace Soap dispensers will be audited weekly x 4 weeks for proper placement and proper function. If audits are 100% than audits will be monthly x3.	

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F 880	Continued From page 68 The facility lacked adequate ventilation and pressurization in the laundry facility to ensure infection control. Findings were reviewed and confirmed by E22 (Facility Maintenance Director) on 7/18/22 at approximately 11:45 AM.	F 880	QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	
F 943 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that required training on abuse, neglect, exploitation and misappropriation of resident property was completed for two (E38 and E41) out of 22 randomly sampled staff members. Findings include:	F 943	All residents have the potential to be affected by this deficient practice. All staff, including agency and contracted staff will have their records reviewed to ensure that proper abuse Training documentation is included in the file. For those identified as not having the proper proof of Abuse Training, Abuse Training	9/13/22

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F 943	Continued From page 69 1. Review of E38 (LPN) personnel records revealed: 10/29/21 - E38, an agency Nurse was assigned to work in the facility. 10/29/21 - E38 was involved in a facility reported incident for allegations of abuse and neglect to a resident (R19). 11/9/21 - A 5 day follow up submitted by the facility to the State Reporting Agency revealed that E38 was not to work at the facility again. 7/25/22 at 11:00 AM - Review of E38's employee file revealed lack of evidence of E38's 2021 abuse, neglect and exploitation training. 7/25/22 at 12:45 PM - A written statement from E42 (HR) stated that E38's agency owner has no other information available regarding E38's 2021 abuse, neglect and exploitation training. The facility was unable to provide evidence of E38's 2021 abuse, neglect and exploitation training. 2. Review of E41's (CNA) personnel records revealed: 8/8/21 - The first day of assignment at the facility for E41 (CNA) as agency staff. 7/25/22 at 12:45 PM - A written statement from E41 (HR) stated that the facility had no available information regarding E41's record of abuse, neglect and exploitation training.	F 943	will be provided and proof maintained in the file. Root cause was determined to be there was no second verification of prn employee, agency and contract staff files to insure all there was evidence of adult abuse training. Policy for maintaining and auditing of contracted and agency staff members will require a second level review to be completed by the Human Resource Manager or designee. DON or designee will in-sevice staff educator, scheduling manager and human resource manager on the protocol for maintaining proper documentation for all staff on abuse training. All new hires, agency and contracted staff will have their records audited to ensure proper abuse training was completed and documentation is included in their file. All employee files will be audited to ensure the facility is maintaining proper documentation for all staff on abuse training upon hire and annually QAPI committee will evaluate the data and provide recommendations to obtain and maintain compliance.	

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F 943	Continued From page 70 Findings were reviewed during the Exit Conference on 7/25/22, beginning at 3:20 PM, with E1 (NHA) and E2 (DON).	F 943		