STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING AND REHAB- WILMINGTON	700 FOULK ROAD WILMINGTON, DE 19803

(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 688	Continued From page 98 the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility documentation, it was determined that for two (R26 and R91) out of fifteen(15) residents sampled for accidents, the facility failed to ensure that R26 and R91received adequate supervision and assistance to prevent an accidents. Findings include: 1. Cross refer to F725, example 5 Review of R26's clinical records revealed: 9/15/20 - R26 was admitted to the facility. 9/9/20 (revised 6/13/23) - R26's care plan was developed for falls and risk for falls with the goal to minimize risk for injury related to falls. R26's interventions included but not limited to: activity assessment, administer medication per physician's order, encouraging rest periods when tired during ambulation/wandering episodes, encourage to use wheelchair when tired, frequent safety checks during wandering episodes, head helmet on at all times as tolerated...	F 689	F689 Free from Accidents A. R26 still resides in the facility on 1:1 supervision, R35 still resides in the facility, R41 still resides in the facility, R117 still resides in the facility, R95 still resides in the facility, R116 still resides in the facility, R480 no longer resides in the facility, and R481 no longer resides in the facility. B. DON/ designee completed a 100% audit of all residents with aggressive combative behaviors that have the potential to be affected by this deficient practice of inadequate supervision and physical abuse. Those residents identified with aggressive combative behaviors will have their care plans reviewed to ensure interventions are in place. C. It was determined the root cause of the deficient practice the facility failed provide adequate supervision due to staff lack of understanding for resident with aggressive/ combative behaviors requiring	9/25/23

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F 689	Continued From page 99 6/28/21 (revised 3/31/23) - A care plan was developed for R26's disruptive/compulsive, verbal/physical agitation/aggressive, can be physically aggressive towards other residents, verbally abusive to staff, slams laptop non med cart, putting trash on top of med cart, grabbing and pushing staff, confrontational with peer/staff, roaming into other rooms, smacked another resident on the head, aggressive, hitting, kicking staff who is redirecting him not to sleep in roommate's bed related to cognitive impairment, bipolar - type schizoaffective disorder, pushing another resident unprovoked. R26's interventions included but not limited to 1:1 supervision (one staff person assigned direct supervision of a resident) for safety (created 6/15/22 revised 2/16/23). 11/28/21 - R26 was admitted to the hospital for treatment and evaluation status post fall. 12/13/21 - R26 was readmitted to the facility with diagnoses including pneumonia, dementia and repeated falls. 4/6/23 9:51 AM - An activity note documented that resident (R26) travels on the unit independently and enjoys wandering the halls on the unit...". 4/9/23 7:49 AM - A nurse fall note documented, "Resident (R26) noted coming from the dining room bleeding from his head and nose...laceration noted top of scalp, left eye brow, bridge of nose...steri strips applied to eye brow, bridge of nose, sent to ER (Emergency Room)...Redirection but ineffective".	F 689	1:1. DON/designee will educate staff on 1:1 supervision for residents with aggressive/combative behaviors. D. The DON/ designee will monitor all residents with aggressive/combative behaviors daily to ensure appropriate interventions are in place x 3 days, with the goal of meeting 100% success consecutively. All residents with aggressive combative behaviors will be audited weekly for 4 consecutive weeks until the facility reaches 100% success. Then monitored monthly 100% of all residents with aggressive combative behaviors until the facility reaches 100% success for two consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. These results will be reviewed at the QA meeting monthly x3 months. 2 A. R91 no longer resides at the facility. B. Director of Nursing/designee will audit residents who require 2 person assist for bed mobility to ensure that the identified assistance is provided. C. Root cause analysis determined there was a lack of understanding on the requirement of 2 person assist for bed mobility. DON/designee will educate the nursing staff on Kardex information and where to access bed mobility assistance information. D. The Director of nursing/designee will audit 5 residents with 2 person bed	

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F 689	Continued From page 100 4/9/23 9:00 AM - A facility reported incident submitted to the State incident reporting center documented that on 4/9/23 at 6:30 AM, "Patient (R26) noted walking on hallway with face and scalp covered with blood, patient (R26) assessed and noted with laceration to top of scalp, left eyebrow and bridge of nose. Patient verbalized he fell. Patient has been wandering in the unit during the shift...MD (physician) order to send patient to ER for evaluation and treat". Review of the facility's incident follow up summary documented that R26's "...past medical history includes but is not limited to Alzheimer's disease, delusional disorder, anxiety disorder, schizoaffective disorder, parkinsonism and epilepsy. Resident (R26) is alert and oriented with a BIMS of 6 (severely impaired cognition). R26 has a history of verbal and physical aggression with a care plan in place. Interventions include redirecting resident to take frequent rest periods, psyche referrals, using consistent approaches when giving care, involving resident in 1:1 recreational activity...On 4/9/23 at approximately 4:00 am (morning) resident was asleep in his room. Staff (LPN) had to step out of room momentarily...Upon returning, she saw the resident coming out of his room and heading towards another resident's room. He (R26) was redirected back to the hallway. Around this time, E48 (LPN) informed staff that she needed to begin medication pass and would need assistance watching R26. At approximately 6:00 AM, staff did not see him in the hallway. He was found in an empty bed. Resident easily redirected back into his room. Around 6:30 am, E48 proceeded into the patient's room and didn't see him. Staff member headed toward the dining room, patient was found coming out of the dining	F 689	mobility to verify it is being followed and care plan is updated daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. E Date of completion: 9/25/2023	

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F 689	Continued From page 101 room, blood found on the floor and his face. Upon review of the patient and the environment is suggest (sic) patient may have fallen and gotten back up...Sent ot ED (Emergency Hospital)...following day R26 returned... care plans were reviewed and updated to reflect the preference of an early riser. Medication timing change was made to his Seroquel...Discharge summary from hospital showed a diagnosis of subarrachnoid hematoma...". 7/20/23 9:54 AM - In an interveiw, E7 (LPN) stated that when there is no assigned 1:1 staff for R26 during night shift, she will assign the staff on the unit to take turns watching R26 in his room or assist him and walk with him when R26 starts to wander in the hallways at night. E7 also stated that after 4:00 AM or 5:00 AM when the staff starts doing morning care to their assigned residents, she will keep an eye on R26 from the hallway until she starts her morning medication pass at 6:00 AM. The facility failed to ensure R26 received adequate supervision and assistance when he had a fall on 4/9/23 and obtained laceration on top of his scalp, left eye brow and bridge of his nose and had to be sent out to the hospital for evaluation and treatment. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 2. The following was reviewed in R91's records: 3/29/21 - A physician's order documented, "Transfer with 2 persons assist with Hoyer (mechanical) lift and green pad."	F 689		

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F 689	Continued From page 102 3/29/21- ADL (Activities of Daily Living sheet) documented, "Transfer with Hoyer lift and 2 persons with green sling." Order for turning and repositioning was not located in ADL sheets, MAR (Medication Administration Records) or TAR (Treatment Administration Records.) 3/29/21- R91's fall care plan documented: At risk for falls due to impaired balance/poor coordination, potential medication side effects, immobility. Interventions included bed in low position, encourage resident to transfer and change position slowly. The care plan did not reflect the order for the Hoyer lift transfers. 3/29/21- R91's care-plan for documented, "2 persons assist for turning and repositioning." 4/4/21 - An Admission MDS (Minimum Data Set) documented, "2 persons assist with transfers, 2 persons assist with turning, repositioning, change pads, remove clothing." 7/5/21 - A Quarterly MDS documented, "2 persons assist with transfers, 2 persons assist with turning, repositioning, change pads, remove clothing." 8/18/21- A Significant change MDS documented, "2 persons for bed mobility and transfers." 10/24/21 2: 25 P M - A nursing progress note documented, "Resident fell out of bed while he was receiving incontinent care by the CNA (Certified Nursing Assistant). The resident sustained a hematoma the left side of his forehead and a 1 cm skin tear in the middle of the	F 689		

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F 689	Continued From page 103 hematoma. The Resident was sent to the hospital for evaluation." 10/24/21 - A CNA statement documented, "Turned the patient on his right side in bed while providing incontinence care, then reached my hand behind for a depend that was on the bedside table while holding the patient with the other hand and patient rolled out of bed on his right side." 10/24/21 - Care plan initiated for two persons assist with bed mobility. 10/25/21 - Care plan revised for two persons assist with turning/repositioning in bed. 10/27/21- CNA (hire date 3/9/21) received a "one-on-one" in-service training (provided by the Director of Nursing) titled, "Turning/Repositioning - Reviewed policy on safely turning, providing, incontinence care for a patient in bed." 10/27/21 - Staff members was in-serviced on two persons turning and repositioning. 7/25/23 2:45 PM - During an interview with E26 (Rehab Director) revealed that R91's bed mobility and transfer status is, "Assist of two persons." The facility failed to provide adequate supervision to prevent accidents and as a result R91 fell out of the bed, sustained an injury, and was sent to the hospital. R91 returned from the ER on 10/25/21 at 3 AM with an order to monitor the hematoma. 7/31/23 at 2:00 PM - Findings reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4	F 689		

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F 689	Continued From page 104 (RCD) and E18 (VPO)	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		9/25/23

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F 690	Continued From page 105 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R86) out ___ resident reviewed for bowel and bladder, the facility failed to ensure that R86 received the care and services necessary to restore or maintain bladder function. Findings include: 11/1/19 - The facility's nursing policies and procedures titled "Assessment for Bowel & Urinary Toileting Program included but not limited to: 1. A licensed nurse will perform bowel and/or urinary assessment on admission, readmission, annually and PRN (as needed) using the RAI (Resident Assessment Instrument) process. 2. A licensed nurse will initiate, and CNAs (Certified Nursing Assistants) will implement toileting approaches and encourage the patient to participate. Document Data Collection Trial for Bowel and Urinary Toileting Training Program. The following was reviewed in R86's clinical records: 10/24/22 - R86 was admitted to the facility with diagnoses including Chronic Kidney Disease, Acute Kidney Failure, and weakness/paralysis following a stroke. 10/25/22 - The admission care-plan stated: "Urinary incontinence related to Impaired Mobility, loss of bladder muscle tone and urge. Goals - Will have no complications due to incontinence". Interventions included: adjust toileting times to meet patient needs; encourage patient to wait until scheduled toileting time to urinate; identify voiding pattern and establish toileting program;	F 690	F690 Bowel/Bladder A. R86 still resides at the facility. The nurse completed bowel and bladder assessment and 3-day voiding diary started to determine continence status. Results will be reviewed, and interventions implemented at that time based on results. B. The Director of Nursing/designee will audit residents POC of incontinent episodes and complete 3-day voiding diary and bowel and bladder assessment. Results will be reviewed, and interventions implemented at that time based on results. C. To prevent recurrence of the deficient practice MDS staff will provide residents with a decline in continence to morning clinical meeting, IDT will initiate 3 day voiding diary and will evaluate outcomes for appropriate intervention, DON/designee will educate licensed nurses and certified nursing assistant on the assessment for bowel and urinary toileting program policy and procedure. The root cause of the deficient practice was the lack of knowledge of assessment of bowel and urinary toileting program. D. The Director of nursing or administrative nurse will audit 5 residents daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the	

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F 690	Continued From page 106 inform patient of next scheduled toileting time and place urinal/ bedpan within resident's reach." The care plan failed to include personalized interventions related to R86's toileting plan. There was no evidence of a comprehensive bowel and bladder assessment of a 3-day voiding diary to establish continence patterns. 11/1/22 - An Admission MDS documented no trial toileting program for bladder or current toileting program for bowel and bladder. R86 was documented as "frequently" incontinent of urine, and "always" incontinent of bowel and bladder. 2/6/23 - A Quarterly MDS documented no trial toileting program for bladder or current toileting program for bowel and bladder. R86 was documented as "frequently" incontinent of urine, and "always" incontinent of bowel and bladder. 6/20/23 - R86 was admitted to the hospital, and was diagnoses including an urinary tract infection. 7/9/23 - A Readmission MDS documented no trial toileting program for bladder or current toileting program for bowel and bladder. R86 was documented as "frequently" incontinent of urine, and "always" incontinent of bowel and bladder. 7/21/23 9:30 AM - During an interview R86 stated, "I used the toilet when I was at home but I don't use it here. The aides change me before I get out of bed and change me when I go back to bed." R86 further stated, "I was in the ICU because I was dehydrated and became very sick with a bladder infection." 7/21/23 10:30 - An interview was conducted with	F 690	Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. E. Date of completion: 9/25/2023	

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F 690	Continued From page 107 E62 (CNA) about R86's toileting needs. E62 stated "I don't think anyone here is on a toileting plan or program. I was never told, and I don't see anything in the Kardex. I don't take this resident (R86) to the toilet. I change her when I get her out of bed or put her back to bed." E61 (CNA) also confirmed that R86 was not offered the opportunity to use the toilet and was not aware of any the residents who might be on a toileting plan or program. 7/21/23 8:30 AM - 11:30 AM: R86 was observed in her wheelchair in her room. R86 was not observed being toileted, changed or provided with incontinence care. 7/24/23 8:15 AM - 11:05 AM: R86 was observed in her wheelchair in her room. R86 was not observed being toileted, changed or provided with incontinence care. 7/24/23 9:30 AM - An interview was conducted with E24 (ADON) about bladder and bowel assessments. E24 stated, "The nurse who does the admission does the assessment at the same time. It could be any of the nurses." 7/24/23 10:15 AM - An interview was conducted with E21 (RN MDS Coordinator) about the assessments for the MDS submissions. E21 stated, "I look at the CNA flowsheet and document according to what's on there. The nurses on the floors do the evaluations and assessments for toileting." The clinical record lacked evidence of bowel and bladder assessment. A review of CNA flow sheets from 7/14-7/29/23	F 690		

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F 690	Continued From page 108 revealed two episodes of urinary continence and thirty-two episodes of urinary incontinence. The facility failed to assess and develop an individualized toileting plan for R86. 7/31/23 at 2:00 PM - Findings reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4(RCD), and E18 (VPO)	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of clinical records, facility and other documentation as indicated, it was determined	F 692	F692 Nutrition/Hydration- 1. A. R137 no longer resides at the facility.	9/25/23

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F 692	Continued From page 109 that for three (R86, R135 and R137) out of three residents sampled for hydration, the facility failed to ensure the residents were offered, assisted and monitored for sufficient fluid intake to maintain proper hydration and health, which resulted in harm for all three residents where they required emergent treatment. For R86, the facility's failure to encourage and monitor the resident's fluid intake to ensure adequate hydration resulted in an emergent transfer and hospitalization requiring administration of four liters of intravenous (IV) fluids and treatment for a UTI (urinary tract infection). For R135, the facility failed to ensure that she was offered and assisted with sufficient fluid intake in the setting of daily loose stools as evidenced by her abnormal lab result and a change in condition. For R137, the facility failed to ensure that the resident was monitored for sufficient fluid intake as evidenced by two hospitalizations where her Sodium level was elevated (normal 135-145) at 153 on 10/5/22 and 160 on 10/26/22. Findings include: 11/1/19 - The facility's Hydration Policy and Procedures documented, "Patients will be appropriately hydrated by offering a variety of fluids and encouraging ongoing fluid intake throughout the day. Each patient (except those who are allowed nothing by mouth on fluid restrictions or are on thickened liquids) will have fresh ice and water at least once each shift. The staff will encourage patients to consume all fluids on meal trays and in-between meals supplements/snacks. A licensed nurse will offer patients fluid with each medication pass, CNAs (Certified Nursing Assistants) will be expected to offer fluids periodically each shift...Patients will be monitored for signs and symptoms of dehydration as a part of general provision of care and	F 692	R86 continues to reside at the facility. R86 fluid intake will be reviewed daily by running a look back report from PCC by the DON/designee, hydration status will been evaluated at morning clinical meeting, if R86 is not meeting hydration needs, DON/designee will evaluate R86 and interventions initiated. B. All residents have the potential to be affected by this practice. A 3 day look back report will be run from PCC by DON/designee, at morning clinical meeting for all residents. Residents identified as not meeting hydration needs will be evaluated and interventions initiated by DON/designee. C. Root cause analysis determined that there was not a system to identified residents not meeting fluid needs, to be able to assess and initiate interventions. Regional Director of Clinical Services will in-service the IDT on the look back report in PCC, identifying residents not meeting hydration needs, evaluating the identified residents, and initiating interventions if needed. No policy revision required. D. DON/designee will audit clinical alerts for residents not meeting hydration needs and interventions initiated weekly times 4 weeks until 100%, every 2 weeks times 2 months until 100%, monthly times 2 months until 100%, results will be brought to QAPI for review and further recommendations. 2. A. R135 no longer resides at the facility. B. All residents experiencing diarrhea have the potential to be affected by this practice. DON/designee will review	

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F 692	Continued From page 110 routinely as part to the... MDS (Minimum Data Set) process." 1. Review of R86's clinical record revealed: 10/25/22 - R86's hydration care plan, last revised on 11/1/22, documented, "Risk for alteration in hydration related to constipation and recent hospitalization for sepsis/urinary tract infection...Maintain adequate hydration. Obtain Lab results as ordered and notify physician of results. Report changes related to signs of fluid deficit (tongue furrows, dry mouth etc)." 6/19/23 9:30 PM - A nursing progress note documented, "...Change of condition, patient noted with decreased appetite and confusion. Upon assessment patient noted with slurred speech and slow to respond. Patient was awake and conversant, no respiratory distress or SOB (shortness of breath) noted. Patient has left sided paralysis from previous stroke. Patient hypotensive (low blood pressure) 81/55. On call NP (Nurse Practitioner) notified and new order given to send patient to Wilmington ER (Emergency Room). Patient was sent to the hospital via 911 ambulance at 9:07 PM." 6/20/23 - Review of the hospital records revealed that R86 was administered four (4) Liters of crystalloid fluids (used to treat low fluid volume, sepsis and dehydration) in the ER. In addition, R86 was diagnosed with a UTI and treated. 7/3/23 - The MDS revealed R86 was readmitted to the facility with a BIMS (brief interview for mental status) score of 15 (cognitively intact). R86 did not require assistance with eating or drinking.	F 692	clinical alerts on PCC for residents currently experiencing diarrhea. Identified residents will be reviewed with practitioners for follow-up and will be offered/encouraged additional fluids. C. Root cause analysis determined that the residents experiencing diarrhea hydration status was not evaluated. The Regional Director of Clinical Services will in-service IDT, during morning clinical meeting PCC Clinical Alerts on the dashboard will be reviewed for residents experiencing diarrhea, will have their hydration status evaluated and interventions initiated. No policy revision required. D. DON/designee will audit residents who have experienced diarrhea and evaluation of hydration needs with interventions weekly times 4 weeks until 100%, every 2 weeks times 2 months until 100%, monthly times 2 months until 100%. Results will be brought to QAPI for review and further recommendations. 4. A. R135 no longer resides at the facility. R137 no longer resides at the facility. R86 continues to reside at the facility and will be provided fresh ice and water every shift by CNA□s, offered fluids with med pass by licensed nurses. B. All residents have the potential to be affected by this practice. All residents excluding those NPO, fluid restrictions, or thickened liquid will be provided fresh ice and water every shift by CNA□s. Licensed nurses will offer fluids with each medication pass. Nursing staff will encourage residents to consume all fluids	

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F 692	Continued From page 111 7/3/23 12:33 PM - R86's readmission hydration assessment, completed by E56 (Dietician), documented her fluid requirements to be 1,936 mls per day. Observations during the survey revealed: 7/17/23 8:30 AM - During an interview, R86 stated, "I was in the hospital for almost two weeks. I had a very bad bladder infection because I was not drinking enough." An observation of R86's breakfast tray revealed one 120 ml container of juice and one 120 ml container of milk, totaling 240 mls. No other fluids were observed on R86's meal tray or on the bedside table. 7/17/23 11:15 AM - An observation revealed that R86 did not have any fluids on the bedside table. R86 rang the call bell and requested water from E62 (CNA). E62 returned with a Styrofoam cup of water and gave it to R86. 7/19/23 8:30 AM - An observation revealed that R86 had one 120 ml container of juice and one 120 ml container of milk on the breakfast tray. No other fluids were observed on the tray or on the bedside table. 7/19/23 2:00 PM - An observation revealed that R86 did not have a fresh water cup or any other fluids on the bedside table. 7/19/23 2:30 PM - Two large containers of water were observed on the Dover Unit nursing station. 7/19/23 2:45 PM - Observation of the water containers were still on the Dover Unit nursing	F 692	offered. C. Root cause analysis determined that the residents were not offered fluids due to knowledge deficit. The DON/designee will in-service nursing staff on providing fresh ice and water to residents, excluding residents who are NPO or require thickened liquids, offering fluids with medication pass, and with meal tray service. No policy revision required. D. DON/designee will randomly audit one wing for fresh ice and water provided, fluids offered with med pass and meal tray service, weekly for 4 weeks until 100%, then every 2 weeks times 2 months until 100%, then monthly for 2 months until 100%, results will be brought to QAPI for review and further recommendations. 5. A. R135 no longer resides at the facility. R137 no longer resides at the facility. R86 continues to reside at the facility and will be provided a variety of fluids on the meal trays by dietary staff B. All residents have the potential to be affected by this practice. All residents will be provided with a variety of fluids except residents who are NPO and residents on fluid restrictions will have the ordered amount of fluids, by the dietary staff, C. Root cause analysis determined it was a knowledge deficit related to the fluids provided to the residents on their meal trays. Dietary director will in-service dietary line staff on providing the appropriate amount of fluids on residents meal trays. No policy revisions required. D. Dietary Director/designee will audit random 10% of meal trays to ensure	

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F 692	Continued From page 112 station with the same amount of fluids in them. 7/20/23 8:30 AM - Observation revealed that R86 had one 120 ml container of juice and one 120 ml container of milk on the breakfast tray. A warm undated empty Styrofoam cup was on the bedside table. 7/20/23 11:05 AM - During an interview about how residents receive fluids, E62 (CNA) stated, "I give them water or other fluids when they ask for it." 7/20/23 2:20 PM - E56 (Dietitian) was interviewed about how the residents are monitored to ensure that they receive adequate hydration. E56 stated, "The residents get water with med pass, and fluids on their meal trays. The aides ask them if they want coffee or tea, and if they want water during the day. The ADL sheets record their fluid intake. Fluids are brought up to the units to give to the residents." 7/21/23 2:00 PM - E56 (Dietician) was interviewed on whether R86's fluid intake prior to, post hospitalization, and current intake were reviewed to determine if R86 was meeting the estimated fluid goal. E56 stated, "The intakes were not reviewed." 7/24/23 2:15 PM - R86's fluid intakes from 6/1/23 through 6/19/23 and 7/4/23 through 7/7/23 were reviewed. Despite having a recommended fluid intake goal of 1,936 mls per day, R86's daily fluid intakes did not meet this goal for 23 out of 23 days reviewed (listed below). Daily Fluid Intakes: 6/1/23 - 240 ml	F 692	appropriate amount of fluids are provided, weekly times 4 weeks until 100%, every 2 weeks times 2 month until 100%, monthly times 2 months until 100%, results will be brought to QAPI for review and further recommendations. E. Date of completion: 9/25/2023	

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F 692	Continued From page 113 6/2/23 - 480 ml 6/3/23 - 980 ml 6/4/23 - 1,040 ml 6/5/23 - 740 ml 6/6/23 - 520 ml 6/7/23 - 280 ml 6/8/23 - 580 ml 6/9/23 - 720 ml 6/10/23 - 560 ml 6/11/23 - 1,240 ml 6/12/23 - 960 ml 6/13/23 - 480 ml 6/14/23 - 600 ml 6/15/23 - 480 ml 6/16/23 - 820 ml 6/17/23 - 940 ml 6/18/23 - 1,260 ml 6/19/23 - 410 ml 7/4/23 - 1,122 ml 7/5/23 - 720 ml 7/6/23 - 302 ml 7/7/23 - 500 ml Due to the facility's failure to monitor and encourage R86's fluid intake to ensure adequate hydration, R86 was emergently transferred and hospitalized for low fluid volume, acute kidney injury and UTI. 7/31/23 at 2:00 PM - Findings reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO). 2. Review of R135's clinical record revealed: 11/17/22 at 11:10 AM - R135's lab results revealed her BUN as 21 (normal range 8-23). According to Mosby's Diagnostic and Laboratory	F 692		

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F 692	Continued From page 114	F 692		

Test Reference, Eighth Edition 2007, the BUN measures the amount of urea nitrogen in the blood. It is directly related to the function of the liver and the removal function of the kidneys. Overhydration and underhydration affects its levels.

11/22/22 - An admission MDS (Minimum Data Set) assessment documented R135's BIMS (Brief Interview for Mental Status) score as 9, which reflected moderate cognitive impairment.

11/23/22 at 12:50 PM - R135's BUN lab result was 18.

From 11/25/22 through 11/29/22, R135 was having daily loose stools per the CNA Documentation Survey Report. In addition, R135's clinical record lacked evidence that her hydration was being monitored in the setting of daily loose stools.

11/25/22 - An Occupation Therapy (OT) note documented that "... Pt (Patient) drank juice from a small plastic cup... She drank very slowly, taking very small sips with long pauses between sips...".

11/27/22 - An OT note documented, "Pt seen for self-feeding during lunch today due to visitor concern about pt needing assistance. Pt required therapist assistance to fully bring spoon of food to mouth often placing spoon below chin. Pt acknowledges decreased depth perception. Therapist assisted patient in properly repositioning for optimal function during self-feeding reclined in bed."

11/28/22 - A Speech Therapy note documented,

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F 692	Continued From page 115 "... Pt was in bed asleep. She was noted with pronounced R (right) facial droop and mild dysarthria (slurred speech)...". 11/29/22 at 12:00 Noon - R135's BUN lab result was 60 (abnormal high level). 11/29/22 - A Speech Therapy note documented, "...Pt was asleep upon entry to her room. Her mouth and lips were very dry. She was repositioned for liquid intake. She drank oj (orange juice) and grimaced stating her mouth hurt. Her upper dentures were removed and soaked. Oral care was provided. She was fed ice cream and oj. She demonstrated prompt swallow. She required verbal cues to keep eyes open. She was noted with R (right) facial droop and lean." 11/29/22 at 2:21 PM - A progress note by E68 (NP) documented, "... Therapy requested (R135) to be evaluated for (slurred speech) and R side facial droop... (R135) is very frail and is a limited historian. Per therapy she has been having overall decline for past couple of days... Acute Kidney Injury... BUN 60... Start Hypodermoclysis (method of administering fluids under the skin)... Discussed with patient she does not want to go to ER (Emergency Room). Monitor clinically... patient drank with no issues with swallowing... Monitor closely. Nursing to notify (Physician) with any acute changes...". Despite the physician order, R135 never received the Hypodermoclysis on this date per review of the November 2022 eMAR. 11/29/22 at 6:25 PM - R135 was emergently transferred to the hospital for altered mental status and shortness of breath at the request of a family member present at R135's bedside.	F 692		

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F 692	Continued From page 116 11/29/22 at 6:42 PM - The hospital record documented, "... (R135) extremely dry oropharynx (part of the throat behind the mouth and nasal cavity) and lips...". Additional documentation at 9:55 PM revealed "... patient looks very dehydrated and volume depleted... is tachypneic (rapid and shallow breathing) and lethargic (sleepy)... Patient continues to have persistent hypotension (low blood pressure)... despite 4 L (Liters) normal saline bolus (intravenous fluids)... patient is critically ill...". 7/28/23 at 5:00 PM - During a combined interview with E1 (NHA), E2 (DON) and E4 (RCD), the facility's lack of monitoring R135's hydration while having daily loose stools was reviewed. 7/31/23 at 8:35 AM - Finding was reviewed with E56 (Dietician) regarding how was the facility monitoring of R135's hydration. No further documentation was provided to the Surveyor. 7/31/23 at 2:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO). The facility failed to ensure that R135 was offered and assisted with sufficient fluid intake to maintain proper hydration in the setting of daily loose stools as evidenced by her abnormal BUN lab result of 60 and her change in condition. 3. Review of R137's clinical record revealed: 8/3/18 - R137 was admitted to the facility with diagnoses including, but was not limited to, Multiple Sclerosis (nervous system disease that affects the brain and spinal cord), left hand contracture (joint limitations with fixed high	F 692		

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F 692	Continued From page 117 resistance to passive stretch of a muscle), paraplegia (impairment in motor or sensory function of the lower extremities), urinary ileal conduit (small pouch that holds urine) and recurrent urinary tract infections. 5/8/19 - R137's ADL self care deficit related to physical limitations care plan documented an intervention to assist with eating as needed. 2/11/22 - R137's nutrition care plan documented an intervention to encourage and assist as needed to consume foods and/or supplements and fluids offered. 8/16/22 - The quarterly MDS assessment documented that an interview to assess R137's BIMS was attempted, but revealed that R137 had a change in mentation; and she required supervision with setup help only for eating/drinking. 8/16/22 - A physician note documented that R137 "... was evaluated this AM as follow-up to altered mental status and patient with apparent poor oral intake and labs completed and found to have an elevated sodium of 150 (normal 135-145). I will initiate hypodermoclysis (method of administering fluids under the skin)... for 3 L (liters) and asked staff to encourage PO (oral) intake as well...I have asked nursing to notify clinician of any changes...". 8/22/22 - A physician note documented that R137 was seen for "... elevated sodium, altered mental status... found to have an elevated sodium of 150 and initiated with hypodermoclysis and sodium now stable at 139 patient actually appears at her baseline... PO (oral) intake has improved as	F 692		

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F 692	Continued From page 118 well... Acute hypernatremia: Sodium now stable... encourage PO intake and maintain hydration...". 9/1/22 through 9/30/22 - Review of the CNA Documentation Survey Report revealed that fluids were offered and R137 consumed 81 out of 90 meals and accepted all houseshakes (nutritional supplement). However, the documentation does not capture the amount of fluids R137 consumed for each shift to determine if she was maintaining proper hydration and meeting her fluids needs. The Report documented that R137 received setup help only by staff when the meal tray was delivered 79 out of 90 meals served; and for 72 out of 90 meals served, R137 was independent, where there was no help or staff oversight at any time during her meals. 9/7/22 at 10:42 AM - A nutrition note by E65 (Dietician) documented that R137's "intake more variable than usual, consuming 50-100%. Supplemented with houseshakes TID (three times a day)... which are accepted per documentation... Juven (supplement) currently unavailable due to supply issues...". 10/1/23 to 10/4/23 - Review of the CNA Documentation Survey Report revealed that fluids were offered and R137 refused one out of 12 meals offered and accepted all houseshakes. Again, the documentation lacked evidence of the amount of fluids R137 actually consumed for each shift. The Report documented that R137 received setup help only by staff 11 out of 12 times; and for seven out of 12 meals, R137 was independent, where there was no help or staff oversight at any time during her meals. 10/5/22 at 9:07 AM - R137 was sent to the	F 692		

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F 692	Continued From page 119 hospital due to a change of condition related to a fall. 10/6/23 at 11:52 AM - The hospital record documented a consultation for management of R137's Hypernatremia (high sodium level). The Consultation stated, "... on presentation, patient was found to have sodium level of 153... Patient tells me that she has not been drinking fluids recently... Assessment/Plan: Hypernatremia... This is likely due to poor oral intake and free water deficit...". 10/12/22 - R137 was readmitted to the facility. A physician's order was received for labs, including a BMP (measures sodium level), scheduled for 10/13/22. 10/13/22 at 1:39 PM - A nutrition note by E56 (Dietician) documented that R137 was readmitted to the facility "... following hospitalization for a fall and a urinary tract infection (UTI)... Feeds self post setup... Noted decrease in po (oral) intake 10/1-10/4 prior to hospitalization... IVF (intervenous fluids) administration in hospital for hypernatremia. Good fluid acceptance today... Recommend new BMP to monitor hydration status... Will monitor and f/u (follow-up) prn (as needed). Please refer to the completed assessment for further information." 10/13/22 at 1:39 PM - R137's nutrition assessment by E56 (Dietician) documented, "thin fluids, n/a (not applicable) supplement... Functional Problems Affecting Ability to Eat: contractures, hemiplegia, recent decline in ADLs... recent mental status changes... recent lab Na (sodium) 149... most recent labs obtained from hospital records. Hypernatremia (high	F 692		

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F 692	Continued From page 120 sodium level) treated with IVF in hospital... fluid needs in mls 2018... Recommend new BMP to monitor hydration...". 10/14/22 - R137's BMP lab results were received and showed Na was 144. Despite obtaining a BMP lab result, the facility failed to implement additional interventions to monitor R137's fluid intake and to ensure her fluid needs were being met after being hospitalized. Review of the CNA Documentation Survey Report from 10/12/22 through 10/26/22 revealed that fluids were offered and R137 refused nine out of 40 meals and 6 out of 39 houseshakes. Again, the documentation lacked evidence of the amount of fluids R137 consumed for each shift. The Report documented that she received setup help only by staff 26 out of 41 times; and for 27 out of 41 meals, R137 was independent, where there was no help or staff oversight at any time during her meals. It should be noted that R137 refused: - lunch and dinner meals on Friday, 10/21/22; - breakfast and lunch meals on Saturday, 10/22/22; - breakfast and lunch meals on Sunday, 10/23/22; - breakfast and lunch on Tuesday, 10/25/22; and - breakfast on Wednesday, 10/26/22. There was no evidence in the clinical record that R137's repeated refusals of meals above were acted upon by nursing staff and the Physician/Dietician were notified. 10/26/22 - An acute Progress Note by E3 (Physician) documented that an "... initial call came over of a CODE BLUE (for R137). However	F 692		

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F 692	Continued From page 121 when I entered the room the patient had spontaneous respirations and had a pulse...therefore no need for CPR...found to be tachycardic with a heart rate in the 130s and... tachypneic with a respiratory rate of 30. Based on clinical findings at this time patient most likely with sepsis and does have a history of UTIs and decision made to send to the hospital for further evaluation and treatment..". 10/26/22 at 9:15 AM - The Hospital Record documented R137's Sodium as 160 and "Suspect that the pt (patient) has not had adequate oral intake in the setting of acute illness. She received 2 liters of IVF (intravenous fluids) in the ED (emergency department)...". 7/28/23 at 5:00 PM - During an interview, R137's hydration and two hospitalizations were discussed briefly with E1 (NHA), E2 (DON) and E4 (RCD). 7/31/23 at 8:35 AM - Finding was reviewed with E56 (Dietician) regarding how was the facility monitoring R137's hydration. E56 provided copies of her notes and nutritional assessment to the Surveyor as captured above. The facility failed to ensure that R137 was monitored for sufficient fluid intake to maintain proper hydration as evidenced by two hospitalizations where her Sodium level was 153 on 10/5/22 and 160 on 10/26/22. 7/31/23 at 2:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		9/25/23

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F 695	Continued From page 122 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one out of one resident (R49) reviewed for respiratory/tracheostomy care, the facility failed to provide tracheal suctioning consistent with professional standards of practice. Findings included: The following was reviewed in R49's clinical record: 9/18/22 - R49 was admitted to the facility from an acute hospital with a diagnosis of respiratory failure. 10/29/20 - Per physician's order, "trach care daily and as needed: for disposable: remove and dispose inner cannula. Replace with new inner cannula as needed for reduce risk of infection". 2/21/22 - Per physician's order, "suction every shift and as needed for maintain patent airway". 10/3/22 - Per physician's order, "cool air mist via trach collar at 70% humidification with O2 (oxygen) titrated in at 3 liters to maintain a pulse	F 695	F695 Resp/Trach Care A. R49 still resides at the facility. E66 was educated on facility policy on tracheostomy care suctioning infection control dating of O2 tubing and emptying suctioning canister, additionally E66 was educated on hand hygiene. R49 is receiving O2 at 3 liters per minute as physician orders. B. No residents in facility with tracheostomy, Director of Nursing or administrative nurse will audit residents with oxygen use to verify ordered liters/minute matches what the concentrator is set to and to verify oxygen tubing is dated and labeled. Director of nursing or administrative nurse will audit residents who are suctioned to ensure canister is emptied. C. To prevent recurrence of the deficient practice, the Director of Nursing or Administrative Nurse will educate licensed nurses on performing suctioning tracheostomy care, hand hygiene, oxygen orders and labeling of oxygen tubing. The root cause of the deficient practice was	

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F 695	Continued From page 123 ox greater than 92%. Notify MD if pulse ox is equal to or less than 92%. Every shift". 7/19/23 at 10:40 AM - During observation of preparation to perform tracheal suctioning for R49, E66 (LPN) did not perform hand hygiene. After donning sterile gloves, E66 touched unclean surfaces (the suction canister tubing, outside of the bottle of sterile water, and the inside of the solution receptacle prior to pouring sterile water in it) using both gloved hands interchangeably. E66 was noted to switch between both hands when holding and/or grabbing items used for suctioning, including the suction catheter. During suctioning of R49, part of the suction catheter touched the clean, but unsterile trach dressing before being inserted in the inner cannula. The O2 (oxygen) level was set at 2 liters. The O2 tubing was not dated and labeled. The suction canister had not been emptied after prior use. Hand hygiene not observed being performed by E66 after removing gloves. 7/19/23 at 10:45 AM -During an interview and observation with E66, R49's oxygen was noted to be at 2 liters/minute. E66 stated that the order was for 3 liters/minute and adjusted the setting. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO)	F 695	the lack of knowledge of tracheostomy suctioning, oxygen therapy and hand hygiene. D. The Director of nursing or administrative nurse will audit 5 residents with oxygen therapy for correct liters per minute and labeled tubing daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The Director of nursing or administrative nurse will audit residents with suctioning therapy for correct performance of suction and suction canister being emptied appropriately daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. E. Date of completion: 9/25/2023	
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		9/25/23

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F 697	Continued From page 124 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for four (R38, R113 and R134) out of six residents reviewed for pain the facility failed to monitor and provide interventions for pain. Findings include: The pain management standards were approved by the American Geriatrics Society in 2002 which included: Appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up same quantitative pain scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. 11/1/19 - The facility's Nursing Policies and Procedures titled Pain Management-Pain Management Assessments stated, "Patient will be assessed for acute and chronic pain by licensed nurse and a plan of care will be established." Policy included- 1. Assess all patients for pain as part of the admission nursing assessment. 2. Initiate a pain assessment any time thereafter should a patient experience pain that is not usual for the patient. 3. Administration of pain medication and effectiveness will be documented. 4. Care-plan with specific interventions will be developed based on pain assessment and individual patient needs. 1. Review of R113's clinical record revealed:	F 697	F697 Pain Mgt A. R38 still resides at the facility and R113 still resides at the facility, pain is being evaluated every shift and medicated appropriately. R134 no longer resides at the facility B. All residents who have been coded a 0 for pain are at risk for this practice. Residents with a pain level of 0 will be interviewed to ensure that they are not experiencing pain, by the DON/designee. Those who are experiencing pain will be discussed with their assigned provider for further directions. C. The Director of Nursing/designee will educate licensed nurses on evaluating residents□ pain and appropriate documentation of resident response using the pain scale of 0-10 or if resident is not able to express pain level use of the non-verbal pain scale and treating the pain as ordered. The root cause of the deficient practice was lack of knowledge in the assessment and appropriate documentation of resident response using the pain scale of 0-10 or if resident is not able to express pain level use of the non-verbal pain scale. DON/designee will review pain assessment at morning clinical meeting and that identified pain was addressed appropriately D. The Director of nursing or administrative nurse will audit 5 residents pain score to determine if pain was report and verify follow up was completed x 3	

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F 697	Continued From page 125 1/6/23 - R113 was admitted with a diagnosis of Dementia and Osteoarthritis. 1/6/23 - A physician's order written for R113 included Tylenol 650 mg. (milligrams) by mouth every 6 hours as needed for mild to moderate pain not to exceed greater than three grams in twenty-four hours. 1/9/23 - Review of R113's care plan for "Pain related to Arthritis and Right Upper Arm dislocation revised 2/14/23 documented...1. Will express that pain management is within acceptable limits with a goal of 0 report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. 2. Administer pain medication per physicians' orders." 2/11/23 11:53 AM - A progress note documented..."noted bruise light/blue/purple and swelling to the right upper arm. Complained of pain, as needed Tylenol given, (E3 MD) made aware. New order for x-ray two views to arm. (E64 RP) had been present and aware of the bruising, swelling and x-ray ordered." 2/11/23 11:17 PM - A progress note documented..."The x-ray provider called the facility and stated that they were unable to perform the patient's right upper arm x-ray today because of staffing issues and would do the x-ray in the morning. (E3 MD) and (E64 RP) were aware." 2/12/23 - Review of R113's MAR revealed R113's pain level had been 5. Further review of R113's MAR and progress notes lacked evidence R113	F 697	days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. E. Date of completion: 9/25/2023	

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F 697	Continued From page 126 had been administered Tylenol for mild to moderate pain. 2/12/23 11:30 AM - Record review of R113's x-ray of the right upper arm results documented..."There is a shoulder joint dislocation with fracture of the upper right arm, likely chronic." Conclusion shoulder joint dislocation with a bony defect at the head of the right upper arm. Additionally, the x-ray report documented R113's results were reported 2/12/23 at 12:16 PM. 2/14/23 8:38 AM - A progress note documented..."notified by staff that the resident's right upper arm was swollen and had a purple bruise, resident complained of pain with ROM (range of motion)...(E57 RN) called the x-ray provider for R113's x-ray results, resident had a dislocation on the upper arm per report given. (E3 MD) made aware and ordered a sling on the right arm and send the patient to the emergency room." The facility evaluated the resident's pain on 2/12/23 and did not administer pain medication as ordered by the physician for mild to moderate pain. There was lack of evidence of a pain assessment and treatment on 2/12/23, despite a x-ray report for a dislocated upper arm. 2. Review of R134's clinical record revealed: 8/4/21 - R134 was admitted to the facility with a diagnosis of chronic pain. 8/4/21 - R134 was ordered oxycodone (a pain medication).	F 697		

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F 697	Continued From page 127 8/4/21 - R134's admission assessment documented that she had frequent pain, and at the time of the assessment R138 expressed that her pain level was an eight out of ten. Review of R 134's medication administration record revealed: 8/4/21 8:30 PM - R134 was administered pain medication for a pain level of nine out of ten. The post pain medication assessment was documented as "E" (effective) and did not include a numerical score. 8/5/21 - R134 was administered pain medication at 1:25 AM for a pain level of six out of ten, 10:10 AM for a pain level of five out of ten and only documented as effective. In addition, R134 was administered pain medication at 5:55 PM for a pain level of seven out of ten and only documented as "U" ineffective. R134 was then transferred to the hospital. 7/26/23 1:09 PM - During an interview E4 (Regional Clinical Director) confirmed R134's medication administration record lacked evidence of a numerical post pain medication administration numerical assessment. 3. The following was reviewed in R38's clinical record: 12/10/22 8:35 PM - R38 was readmitted to the facility with a surgical incision after a broken right hip. 12/10/23 9:47 PM - R38's nursing readmission pain assessment for patients in advanced dementia (PAINAD) assessment documented	F 697		

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F 697	Continued From page 128 pain score of 6 (moderate pain.) R86 had occasional moan or groan, facial grimacing, rigid, fists clenched, and knees pulled up 12/14/22 - R38's Pain care plan stated, "Pain related to arthritis, low back pain, fracture, right hip.... Goals: Pain or analgesia will not affect participation in activities of choice or daily care. Interventions: Administer pain medication per physician orders. Notify physician if pain frequency/ intensity is worsening or if current analgesia regimen has become ineffective. Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Therapy evaluation and treatment per orders." 12/15/22 11:16 AM - A nursing progress note documented, "Therapist stated while was about to initiate therapy noted right lower extremity internally rotated, resident grimacing when moving or touching right leg, resident noted laying on her left side, when attempted to repositioning, grimacing and screaming." R38's MAR (Medication Administration Record) documented that Roxanol (narcotic used to treat moderate pain) given per PRN (as needed) order with relief of pain. 12/19/22 - R38's MDS for Significant Change pain assessment documented, "Yes" for facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw). 12/23/22 15:11 PM - E3 Medical Director's progress note documented, "She keeps attempting to stand up, noted facial grimacing. E3 documented on plan "Acute Pain: Change Morphine Sulfate (Concentrate) Oral Solution 20	F 697		

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F 697	Continued From page 129 MG/ML (Morphine Sulfate) Give 0.25 ml by mouth every 12 hours for pain for 7 days, then start every six hours as needed, also on Tylenol for mild pain..." 12/29/22 - R38's pain assessment for the 7-3 shift was not documented on the MAR per the MD's order. 1/9/23 12:45 PM - E3 (MD) ordered a supplemental pain order, " Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML - Give 0.25 ml by mouth every 4 hours as needed for pain." 1/15/23 4:00 AM - R38's MDS pain (PAINAD) assessment was done with a pain score of "0" (no pain). 1/1/23 through 7/27/23 - R38's daily pain assessment was documented in the MAR as "0" (no pain). 1/24/23 3:23 PM - R38's MDS pain was assessment documented a pain score of "0" (no pain). 1/30/23 5:27 PM - R38's MDS pain assessment documented a pain score of "0" (no pain). 5/9/23 10:05 PM - A nursing progress note documented; "R38 noted with unstageable pressure ulcer to right medial heel, measuring 3 X 3 cm, painful to touch. PRN Tylenol 325 mg (2 tablets) administered for pain." Despite R38' being documented as having pain to wound site, staff continued to assess "0" (no pain).	F 697		

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F 697	Continued From page 130 5/19/23- 5/29/23: E3 ordered; "Morphine 20/ml 0.25 ml (5 mg) daily at 8 AM (for 10 days) then discontinue." 5/20/23 8:00 AM - E3 ordered; "Tylenol 325 mg 2 tablets by mouth daily." 7/12/23 - R38's sacral wound was debrided by the Wound Care Nurse Practitioner with the use of topical anesthesia and lidocaine prior to procedure. There were no changes to pain management or updates to pain care plan. 7/21/23 8:40 AM - R38 was observed with facial grimacing when repositioned by E28 (LPN) prior to being fed breakfast. E28 stated; "She always does that when she sits up." R38 did not receive any PRN pain medications. Although R38 displayed symptoms of pain during repositioning the facility documented the daily pain assessment as "0", and failed to assess and treat the pain. 7/24/23 7:07 AM - A nursing progress note documented, "New wound on sacrum." 7/28/23 - E3 ordered, "Pain assessment every shift." R38's MAR documented that Morphine 20/ml 0.25ml (5 mg) was given with relief of pain. 7/28/23 10:25 AM - E21 (RN MDS Coordinator) documented in R38's progress notes: "Patient alert up in her Geri-chair and eating breakfast .....periodically, patient would gasp and wince suddenly (not related to eating). Unable to understand what patient was saying but interpreted as pain. Informed nurse to patient's	F 697		

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F 697	Continued From page 131 episodic sharp-seeming pain." There was no documentation of PRN pain medication given or non-pharmacological interventions documented or implemented for this report of pain. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO).	F 697		
F 725 SS=K	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		9/25/23

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F 725	Continued From page 132 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of clinical records and other facility documentation, it was determined that the facility failed to ensure there were sufficient nursing staff to administer critical medications to meet the needs of the residents during the 7:00 AM to 3:00 PM shift on Friday, 7/21/23. For three residents (R22, R51 and R630) on the Dover Unit that were ordered Humalog insulin to be administered with breakfast (scheduled at 7:35 AM), revealed the following: - R22 was never administered insulin with breakfast. - R51 was administered insulin at 10:48 AM and 10:50 AM, approximately 3.5 hours later. - R630 was administered insulin at 9:56 AM and 9:57 AM, approximately 2.5 hours later. For one resident (R631) on the Heritage Unit that was ordered Humalog insulin with breakfast revealed that R631 never received the ordered insulin. The lack of available nurses to administer medications timely had the potential to cause a serious adverse outcome or death. An Immediate Jeopardy (IJ) was called at 2:50 PM on 7/21/23. The IJ was abated at 9:00 AM on 7/24/23. Additionally, two previous night shifts (11:00 PM to 7:00 AM), specifically 7/1/23 to 7/2/23 and 7/15/23 to 7/16/23, failed to have sufficient nursing staff where the residents in the two units were not administered medications, provided treatments and lacked monitoring/supervision by a nurse. Findings include: 1. Cross refer to F760, example 1	F 725	F725 Abatement Statement of IJ regarding F725 Corrective Action for those residents found to be affected by the alleged deficient practice E-4 was given PCC login 9:27am on 7/21/2023 Nurse Manager 1 was assigned to front hall of Dover on 7/21/2023 Nurse Manager 2 assignment was split front of Arcadia (dementia unit) and the front of New Castle on 7/21/2023 AD-HOC QAPI meeting was held to determine and review root cause analysis and corrective actions were implemented on following of sufficient licensed nursing staff to ensure ordered medications are administered. on 7/21/2023 Corrective Actions taken for residents with potential to be affected by alleged deficient practice Staff scheduler with VPO, DON and Administer immediately reviewed 7/21/2023, 7/22/2023, 7/23/2023, 7/24/2023 staffing levels of licensed nursing staff to ensure medication administration on 7/21/2023 Staff will call out to supervisor using the number 667-335-5995 Management staff will review licensed nursing staff 2 hours prior to shift change identifying any needs. If the levels fall below 6 licensed nurses on 7-3, 6 licensed nurses on 3-11, 4 licensed	

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F 725	Continued From page 133 7/21/23 at 9:12 AM - Review of the daily Staff Posting posted at the second floor nurse's station revealed two blank spots for a second nurse's name assigned to the Dover Unit and a second nurse's name assigned to the Heritage Unit. 7/21/23 at 9:15 AM - An observation on the Dover Unit (rooms 226-244) noted two medication (med) carts: the first med cart with no nurse present and the second med cart with E36 (Agency LPN) waiting next to it. During an interview, E36 stated that she was still waiting for her PointClickCare (PCC) login to start the morning medication pass for 22 residents in her assigned area (rooms 234 to 244). E36 stated that this was her first day on the floor and she asked for her PCC login multiple times this morning. When asked who was working the other med cart in the unit, E36 stated that she did not know and she did not see anyone passing medications from that med cart. Review of the Dover Unit revealed three residents (R22, R51 and R630) with physician orders for Humalog insulin to be administered with breakfast. 7/21/23 at 9:20 AM - An observation on the Heritage Unit (rooms 200-225) revealed two nurses passing medications. It was noted and confirmed that E37 (LPN/Wound Care) was reassigned to a med cart on this unit as the daily Staff Posting lacked evidence of a second nurse assigned to the Heritage Unit. Review of the Heritage Unit revealed one resident (R631) with a physician order for Humalog insulin to be administered with breakfast.	F 725	nurses on 11-7, the following plan will be initiated: " A list of current employed licensed nurse with contact numbers will be provided " A list of current agencies utilized by the facility o Trinity o Oculus o Samba o American " An Agency orientation package will be place at the nursing stations on each floor that will contain agency orientation check list that will include information on how to obtain PCC login with contact information of HR manager who is available 24/7, if there is an issue with obtaining login within 15 minutes, and the HR manager, will obtain PCC login " Manager will follow the below plan if there are any needs identified: o Notification of on call nurse to come in for staffing need o The manager on duty will place calls to current licensed employees o Then call agencies if needs are not filled o Then call to Administrator and Director of Nursing to have Nurse Management team fill in the needs o Staff will be mandated to stay until relieved " Manager will call supervisor 15 minutes after shift has started to confirm staffing. If there is a no show the supervisor will assume the cart and ensure that the blood glucose levels are obtained and insulin is administered as	

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F 725	Continued From page 134 7/21/23 at 9:25 AM - An observation of the two units on the first floor revealed only one nurse on each unit, New Castle and Arcadia (locked dementia unit). At 9:35 AM, E22 (LPN/UM) arrived on the New Castle Unit and start the morning medication pass. During an interview, E22 stated that she "did not know her assignment" and confirmed that she did not pass any medications on the assigned split med cart for the New Castle unit (rooms 126-130) and Arcadia unit (rooms 100-106) this morning. Review of the New Castle Unit revealed one resident (R1) with a physician order for Humulin N insulin scheduled for 8:00 AM, but was administered at 11:52 AM, approximately 4 hours later. Humulin N insulin was an intermediate-acting insulin that starts to work within 2 to 4 hours after injection, peaks in 4 to 12 hours, and does not require administration with meals. 7/21/23 at 10:31 AM - E2 (DON) informed the Surveyor that the facility had a census of 132 residents. Review of nursing staff timecards for the 7:00 AM to 3:00 PM shift on 7/21/23 revealed: On the Dover Unit: -E36 (Agency LPN) clocked in at 6:52 AM, assigned to a med cart on the Dover Unit. -E40 (RN/Staff Development) clocked in at 7:00 AM. She was reassigned to the second med cart on the Dover Unit. On the split med cart covering New Castle Unit and Arcadia Unit: - E22 (LPN/UM) - clocked in at 7:54 AM, and clocked out at 2:49 PM.	F 725	ordered Director of Nursing/ Administrator and Medical Director will review residents, who missed medications due to staffing insufficiency to identify further interventions needed. on 7/21/2023 Administrator/Director of Nursing/Staffing Coordinator were educated by the Regional Director of Clinical Services on ensuring the staffing needs of the facility are met and reviewed at least daily 7/21/2023 Administrator/designee will audit staffing every shift x 3 days until 100%, then daily x 3 days until 100%, then weekly x 2 weeks until 100% then every 2 weeks x 2 months until 100%, then monthly for 2 months until 100%. Results will be brought to QAPI for review and further recommendations. Date of completion: 9/25/2023	

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F 725	Continued From page 135 Despite the day shift hours for facility nursing staff were 7:00 AM to 3:00 PM, E22 arrived almost one hour after the day shift started and left 10 minutes before the end of the shift. 7/21/23 at 11:31 AM - During an interview, E41 (LPN) stated that she just finished med pass in the New Castle Unit and will continue to pass meds to the following five residents in rooms 100-103 (R19, R44, R55, R70 and R92) in the Arcadia Unit. 7/21/23 at 12:31 PM - During a follow-up interview, E41 (LPN) stated that she was working a double (shift) as she had the New Castle Unit on night shift and this morning she was assigned the second med cart in the New Castle Unit. E41 stated that she performed the narcotic count with E22 (LPN/UM). 7/21/23 at 12:57 PM - During an interview, E30 (Agency LPN) stated that she received shift report and performed the narcotic count for her assigned residents in the Arcadia Unit. E30 also stated that she administered meds to some of the Arcadia residents who were assigned to the split med cart. 7/21/23 at 1:03 PM - During an interview, E22 (LPN/UM) stated that she checks the schedule at the nurse's station. E22 also stated that she already performed a narcotic count, but she doesn't believe that she signed the narcotic count book for today (7/21/23). 7/21/23 at 1:50 PM - During a follow-up interview, E22 (LPN/UM) stated that she received shift report from E41 (LPN). E22 stated that two other nurses (E41 and E30) assisted in administering	F 725		

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F 725	Continued From page 136 meds in the Arcadia Unit today as she was administering meds in the New Castle Unit. 7/21/23 at 2:00 PM - During an interview, E40 (RN/Staff Development) stated that she was working with orientees this morning when E2 (DON) alerted her that she would need to work on the floor. E40 was assigned a med cart in the Dover Unit. E40 stated that she received shift report from E2 (DON) and performed a narcotic count with a nurse from the Heritage Unit. 7/21/23 at 2:15 PM - During an interview, E36 (Agency LPN) stated that she arrived at 7:00 AM and received shift report and performed a narcotic count with the offgoing nurse in the Dover Unit. 7/21/23 at 2:18 PM - During a follow-up interview, E22 (LPN/UM) was asked if she received shift report this morning. E22 stated that "sometimes not much report is given because oncoming staff arrives late and the departing staff gets tired of waiting." 7/21/23 at 2:45 PM - During an interview, E37 (LPN/Wound Care) stated that she was reassigned to a med cart on the Heritage Unit. E37 stated that did not receive shift report nor did she perform a narcotic count at the start of her shift. 7/21/23 at 2:50 PM - Based on observations, interviews and review of facility documentation, an Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA), E2 (DON), and E4 (RCD). 7/21/23 at 9:50 PM - E1 (NHA) submitted an	F 725		

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F 725	Continued From page 137 acceptable Abatement Plan signed, dated, and timed. 7/24/23 at 9:00 AM - The facility's Immediate Jeopardy was abated at this time. Further observations of facility staffing and timely insulin administration revealed that the IJ was abated on 7/24/23 at 9:00 AM based on the verification of the facility's immediate corrective actions: - staffing was reviewed for 7/21/23, 7/22/23, 7/23/23, 7/24/23; - staffing agencies added for additional support; - implementation of a staffing agency orientation package and location in the nurse's stations; - process in place to address call outs and no call no shows to ensure sufficient staffing; - completed education with NHA, DON and Staffing Coordinator; - observations of blood glucose checks and timely insulin administrations; - review of the residents' clinical records; and - observations of facility staffing over the weekend and 7/24/23 by two Surveyors. 2. Cross refer to F684, example 1a Review of the facility's Staff Posting for the 11:00 PM to 7:00 AM shift on Saturday, 7/1/23, to Sunday, 7/2/23, revealed that there was no nursing supervisor listed, no nurse assigned to the Arcadia Unit (locked dementia unit) with 34 residents, and no CNA assigned to 1:1 supervision for R26, a resident with known aggressive behaviors. The Staff Posting listed two CNAs in the Arcadia Unit for this shift: E5 and E6.	F 725		

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F 725	Continued From page 138 The facility's timecards for nurses on the 11:00 PM to 7:00 AM shift on Saturday, 7/1/23, into Sunday, 7/2/23, revealed: - E43 (RN) clocked in at 3:57 PM and clocked out at 9:02 AM, assigned to the Dover Unit. - E44 (LPN) clocked in at 10:48 PM and clocked out at 7:30 AM, assigned to the Heritage Unit. - E41 (LPN) clocked in at 11:01 PM and clocked out at 9:29 AM, assigned to the New Castle Unit. Review of the July 2023 eMARs and eTARs for 34 residents in the Arcadia Unit (first floor) revealed that E43 (RN), assigned to the Dover Unit on the second floor, administered and signed off medications, treatments and monitoring at the beginning of the night shift. Further review revealed that 15 residents were not administered medications or provided treatments at the end of the shift. 7/28/23 at 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 3. Cross refer to F684, example 1b, and F760, example 2 Review of the facility's Staff Posting for 11:00 PM to 7:00 AM shift on Saturday, 7/15/23, into Sunday, 7/16/23, revealed that there was no nurse assigned to the New Castle Unit with 37 residents and E43 (RN) was listed as the night shift Supervisor and also assigned to a med cart on the Dover Unit. The Staff Posting listed two CNAs in the New Castle Unit for this shift: E46 and E47. The facility's timecards for nurses on the 11:00 PM to 7:00 AM shift on Saturday, 7/15/23, into Sunday, 7/16/23, revealed:	F 725		

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F 725	Continued From page 139 - E48 (LPN) clocked in at 3:19 PM and clocked out at 7:30 AM, assigned to the Arcadia Unit. - E44 (LPN) clocked in at 10:43 PM and clocked out at 7:47 AM, assigned to the Heritage Unit. - E43 (RN) clocked in at 3:47 PM and clocked out at 7:47 AM, assigned to the Dover Unit. Review of the July 2023 eMARs and eTARs for 37 residents in the New Castle Unit revealed that 36 residents did not receive medications, treatments and monitoring during the night shift due to no assigned New Castle unit nurse on the night shift. 7/28/23 at 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 4. The following was reviewed in R284's clinical record: 9/3/21 11:10 PM - R284 was admitted to the facility with diagnoses including a stroke with right sided weakness. 9/4/21 - R284's admission baseline care plan documented that R284 had urinary incontinence related to R284's limited ability to move. A care plan intervention included to provide incontinence care as needed to R284. 9/14/21 - A progress note documented that R284 left the facility AMA (Against Medical Advice) with the assistance of R284's wife (FM3) because FM3 was not happy with the care that the facility provided to her husband. 7/19/23 12:20 PM - During a telephone interview, FM3 stated that she had not been happy with the care that her husband received while he was a	F 725		

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F 725	Continued From page 140 resident at the facility. FM3 stated that her husband was not kept clean while he was a resident at the facility, and that he was often left for lengthy periods of time in wet briefs. 7/20/23 - A review of the 9/3/21 CNA Documentation Survey Report for R284 documented that toileting care was not provided to R284 on the 11-7 shift. 7/20/23 - During an interview, E60 (CNA) stated that a blank section for documentation on a documentation survey report means that the task was not done. 7/27/23 - A review of employee timecards for 9/3/21 revealed that six CNAs called out for 9/3/21. Based on an analysis of the CNA timecards and the locations of work for CNAs on 9/3/21, the unit that R284's room was located had one CNA for the 11-7 shift, and the other unit on the same floor had no CNA timecard entries for the 11-7 shift. 7/27/23 - During an interview, E16 (HR) stated that the 9/3/21 timecard documentation does not reflect that Agency CNAs that may have worked, but E16 said that there was no way to produce a staffing sheet for 9/3/21. 7/31/23 -- During an interview, E61 (CNA) stated that a blank section for documentation on a documentation survey report means that the task was not done. Cross refer to F689, example 1 5. Review of R26's clinical record revealed the following:	F 725		

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F 725	Continued From page 141 12/13/21 - R26 was readmitted to the facility with diagnoses including but not limited to repeated falls. A care plan was developed for R26's (created on 6/28/21 and revised 3/31/23) disruptive/compulsive behaviors including, roaming into other residents' rooms. R26's interventions included but not limited to 1:1 supervision (one staff person assigned direct supervision of a resident) for safety (created 6/15/22 revised 2/16/23). 4/9/23 - A facility investigation report documented that R26 had an unwitnessed fall. R26 was noted in the hallway with blood on the face and scalp. The report further documented that R26 had been wandering in the unit during the shift and was also noted with laceration on top of scalp, left eye and bridge of nose. 7/28/23 - Review of the facility Weekend Staffing sheet dated 4/9/23 on the 11:00 AM - 7:00 AM shift lacked evidence that a staff person was assigned to R26 for the 1:1 supervision for safety as the care plan indicated. The facility failed to ensure there were sufficient nursing staff to meet the needs of R26 during the 11::00 PM to 7:00 AM shift on Sunday, 4/9/23 that resulted to R26's fall with injuries and transfer to the hospital. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO). 8/14/23 11:13 AM - Findings were communicated in an email correspondence with E1 (NHA), E2	F 725		

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F 725	Continued From page 142 (DON) and E3 (RDC).	F 725		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		9/25/23

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F 756	Continued From page 143 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R3, R26, R101 and R129) out of eight residents sampled for medication review, the facility failed to act on irregularities identified during Medication Regimen Reviews (MRRs) by the Pharmacist. Findings include: A review of facility policy "Medication Regimen Review" dated 8/2020, stated that "recommendations are acted upon by the facility staff and/or the prescriber." The facility's policy and procedure for MRR lacked evidence of the timeframes when the facility would respond. 1. Review of R3's clinical records revealed: 10/7/22 8:44 AM - A Medication Regimen Review note by P4 (Pharmacy Consultant) documented the recommendation for R3's semi annual dose reduction evaluation for the use of divalproex sodium (Depakote) 125 mg by mouth three times a day for mood disorder. 4/14/23 - A Consultant Pharmacist Recommendations to Nursing Staff recommended to update the AIMS (Abnormal Involuntary Movement Scale) for R3 as she was on Seroquel, an antipsychotic medication without a current AIMS on the electronic chart. There was no response by the Physician found in	F 756	F756 Drug Regimen Review A. R3 still resides at the facility, R26 still resides at the facility, R101 still resides at the facility, R129 no longer resides at the facility. The last Medication Regimen Review will be reviewed for each resident identified to determine if any recommendations exist and verify, they were followed. If recommendations were given and not followed, they will be reviewed with the in-house provider. B. The Director of Nursing or Administrative Nurse will audit Medication Regimen Review for current residents for the last 30 days. Any recommendations will be reviewed with the in-house provider. C. The Director of Nursing or administrative nurse will educate Nurse Manager(s) (unit manager, ADON and house supervisors) on Medication Regiment Review and completion of recommendations after physician approval. The DON/designee will review the daily/monthly pharmacy reviews and assign them to residents□ provider. The assigned provider will review and submit recommendations within 5 business days. The Administrator/designee will educate Residents□ provider to have the Medication Regiment Review with response within 5 business days of receiving the recommendations. The root cause of the deficient practice was lack of	

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F 756	Continued From page 144 the clinical record for the pharmacy recommendation on 10/7/22. There was no response from Nursing found in the clinical record for the pharmacy recommendation on 4/14/23. 7/27/23 12:50 PM - In an interview, E4 (RCD) confirmed that the 10/7/22 Medication Regimen Review and the 4/14/23 Consultant Pharmacist Recommendations to Nursing Staff did not have a copy of the signed and dated facility response on file. 2. Review of R26 's clinical records revealed: 6/8/22 11:32 AM - A Medication Regimen Review note by P4 (Pharmacy Consultant) documented the following recommendations: Quetiapine 25 mg tablets are not scored and should not be cut in half, discontinue quetiapine (Seroquel) 12.5 mg po two times a day, 100 mg (milligrams) by mouth at bedtime and new order: Quetiapine 25 mg po every morning, 100 mg by mouth at bedtime. 9/7/22 2:23 PM - A Medication Regimen Review note by P4 (Pharmacy Consultant) documented the recommendation to reevaluate the following medications: "...metoclopramide: may increase risk of EPS (extrapyramidal syndrome) symptoms, especially when used in conjunction with an antipsychotic medication. Additionally , may increase risk of tremors or seizures (resident receiving primidone)", an anticonvulsant..."quetiapine: may increase risk of falls - particularly when combined with motoclopramide, primidone and lorazepam".	F 756	knowledge on the Medication Regimen Review process. D. The Director of nursing or administrative nurse will audit 5 residents Medication Regimen Review to determine if recommendations were made and follow up was completed x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. E. Date of completion: 9/25/2023	

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F 756	Continued From page 145 There was no response by the Physician found in the clinical record for the pharmacy recommendations on 6/8/22 and 9/7/22. 7/27/23 12:54 PM - In an interview, E4 (RCD) confirmed that the 6/8/22 and 9/7/22 Medication Regimen Reviews did not have a copy of the signed and dated facility responses on file. 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 3. Review of R101's clinical record revealed: Cross refer F758 8/3/22 - R101 was admitted to the facility. 9/8/22 9:34 AM - A review of the MRR revealed a recommendation to consider a dose reduction or discontinue to Risperidone 0.75mg by mouth at bedtime. 7/27/23 11:00 AM - A review of the Physicians order sheet for R101 revealed that the above recommendation for Risperidone had not been acknowledged. 4. Review of R129's clinical record revealed: 8/18/21 - R129 was admitted to the facility. 4/6/22 - A review of the MRR revealed a recommendation to reevaluate the use of triple antidepressant therapy and consider dose reduction or discontinue one of the medications: Sertaline 50 mg, Trazadone 25 mg, and Remeron 7.5 mg. The MRR was not signed by the Physician.	F 756		

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F 756	Continued From page 146 5. Review of R179's clinical record revealed: 2/18/21 - R179 was admitted to the facility. 7/27/23 11:30 AM - A review of R179's MRR revealed the facility lacked evidence that the MRR's were completed for the following months: March 2023, April 2023, May 2023, and June 2023. 7/27/23 12:30 PM - An interview with E4 (Corporate) confirmed there was no record of MRR's completed for March, April, May, or June 2023. The facility failed to consistently act on irregularities or recommendations identified on MRR by the Pharmacist. The facility also failed to complete the monthly MRR for R179. 7/27/23 2:45 PM - Findings reviewed with E1 (NHA) and E4 (Corporate consultant). 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO)	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		9/25/23

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F 758	Continued From page 147 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 148 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R3) out of seven residents reviewed for unnecessary medications, the facility failed to monitor side effects of a psychoactive medication. Findings include: 1. Review of R3's clinical record revealed: 5/12/21 - R3 was admitted to the facility. 9/2/22 - R3 had an active physician's order for seroquel 50 mg (milligrams) by mouth three times a day for restlessness and agitation and unspecified psychosis. 5/12/23 - A Consultant Pharmacist Recommendations to Nursing Staff documented an AIMS (Abnormal Involuntary Movement Scale) completed on 4/24/23 showing a score of 7, with abnormal movements identified in many categories. R3 did not have a prior assessment in the electronic health record. The recommendation was to compare this AIMS assessment to the prior assessment and if there has been an increase in abnormal movement, to let medical (physician) know so they can reassess her Seroquel therapy. 5/16/23 - A facility response from the nursing staff documented, "Repeat AIMS". 7/28/23 2:00 PM - Further review of R3's record revealed a lack of evidence of a completed baseline AIMS when she was first started on seroquel in 9/2/22. In addition, the facility lacked evidence that a repeat AIMS was done for R3 up to date.	F 758	F758 Free from Unnecessary Psychotropics A. R3 still resides at the facility. An AIMS assessment was completed. B. The Director of Nursing or Administrative Nurse will audit residents on anti-psychotic medication for AIMS completion. If no AIMS was completed within the last 3 months, one will be completed. Any identified side effects will be reviewed with the provider. C. The Director of Nursing or administrative nurse will educate licensed nurses on AIMS assessment and completion of assessment. New admissions with antipsychotic orders, residents a new order or increased dosage of antipsychotic will be reviewed at morning clinical meeting to ensure an AIMS test has been completed and/or scheduled. The root cause of the deficient practice was lack of knowledge on the AIMS process. D. The Director of nursing or administrative nurse will audit 5 residents on anti-psychotic medication to determine if AIMS were completed appropriately x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. E. Date of completion: 9/25/2023	

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F 758	Continued From page 149 7/28/23 2:41 PM - In an interview, E4 (RCD) confirmed that, "...The only AIMS on file was the one done on 4/24/23. There was no AIMS done for the resident (R3) before that and no follow up AIMS test was done for for her up to date." 7/31/23 8:30 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO).	F 758		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and reviews of clinical records and other documentation as indicated, it was determined that for four (R22, R51, R630 and R631) out of seven residents reviewed in three hallways, the facility failed to ensure these residents received timely administration of insulin due to no staff being available to provide the medication. The facility's failure placed the residents at risk for a serious adverse outcome, hypoglycemia and hyperglycemia. Due to this failure, an Immediate Jeopardy (IJ) was called at 3:40 PM on 7/21/23. The IJ was abated on 7/24/23 at 9:00 AM. Additionally, R80 was not administered physician ordered insulin on 7/16/23 at 6:00 AM due to no staff being available on the night shift. Findings include:	F 760	F760 Abatement Statement of IJ regarding F760 Corrective Action for those residents found to be affected by the alleged deficient practice R22, R51 and R626 had no adverse effects from failure to obtain blood glucose levels, Dr. Janney was made aware of the missed blood glucose levels, physician will assess identified residents for further interventions. 7/21/2023 R1, R51, R22, R360, R631, and R629, had no adverse effects from missed administration of insulin, Dr. Janney was made aware of the missed administration	9/25/23

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F 760	Continued From page 150 The manufacturer's instructions documented, "...Humalog is a...fast-acting insulin used to control high blood sugar... for Use of Humalog insulin for subcutaneous use, last revised on 7/2023, documented, "... Humalog starts acting fast, so give... injection within 15 minutes before or right after you eat a meal." According to the facility's Food Cart Delivery Schedule, dated 3/8/22, estimated breakfast delivery times for the following units were: Heritage Unit - 7:20 AM; and Dover Unit - 7:35 AM. 1. Cross refer to F725, example 1 7/21/23 at 9:12 AM - Review of the daily Staff Posting posted at the second floor nurse's station lacked evidence of a second nurse assigned to the Dover Unit and a second nurse assigned to the Heritage Unit. 7/21/23 at 9:15 AM - An observation on the Dover Unit noted only one nurse, E36 (Agency LPN) present with two med carts. During an interview, E36 stated that she was still waiting for her PointClickCare (PCC) login to start the morning medication pass as she had asked multiple times since her arrival this morning. There was no nurse present on the other med cart. Review of E36's timecard for 7/21/23 revealed that E36 clocked in at 6:57 AM and had been waiting for approximately 2.25 hours with no PCC login access to start the medication pass. 7/21/23 at 9:20 AM - An observation on the Heritage Unit revealed that E37 (LPN/Wound Care) was reassigned to a med cart on this unit	F 760	of medication, physician will assess identified residents for further interventions 7/21/2023 AD-HOC QAPI meeting was held to determine and review root cause analysis and corrective actions were implemented on following of missed administration of insulin. 7/21/2023 Corrective Actions taken for residents with potential to be affected by alleged deficient practice Residents ordered blood glucose levels have been reviewed for missed blood glucose level, any identified missed levels will be called into physician for further directions 7/21/2023 Residents receiving insulin have been reviewed for missed insulin administration. Any missed insulin administration will be called into physician for further directions 7/21/2023 Staff scheduler with VPO, DON and Administer immediately reviewed 7/21/2023, 7/22/2023, 7/23/2023, 7/24/20 staffing levels of licensed nursing staff to ensure insulin administration and obtaining blood glucose levels 7/21/2023 Director of Nursing/ Administrator and Medical Director will review residents, who missed medications due to staffing insufficiency to identify further interventions needed. 7/21/2023 Systemic Changes put into place to ensure the alleged deficient practice does not recur. Administrator/Director of Nursing/Staffing	

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F 760	Continued From page 151 as the daily Staff Posting lacked evidence of a second nurse assigned to the Heritage Unit. 7/21/23 at 10:00 AM - The facility provided a list of all residents in the facility that receive diabetic medications, including insulin, per the Surveyor's request. Review of four residents' clinical records that had current insulin physician orders revealed: Dover Unit: - R22 had a physician order for Humalog insulin 9 units scheduled at 7:30 AM and at 11:30 AM to be given at breakfast and lunch. On 7/21/23, R22's eMAR lacked evidence of a blood glucose check at 7:30 AM and administration of Humalog insulin 9 units for 7:30 AM. The eMAR had an "X" marked in the spot where R22's blood glucose level (number) should have been documented. R22's blood glucose check was 113 and administration of the 11:30 AM Humalog insulin was signed off as administered at 12:57 PM by the E40 (RN/Staff Development). - R51 had physician orders for Humalog insulin 7 units scheduled at 7:30 AM and Humalog insulin per the sliding scale at 7:30 AM to be given before meals. On 7/21/23, R51's scheduled 7:30 AM blood glucose check was recorded in the clinical record under blood sugars as 253 at the same times of the administrations of Humalog insulin 7 units plus 4 units (sliding scale). E40 (RN/Staff Development) signed off both at 10:48 AM and 10:50 AM, approximately 3.5 hours later. - R630 had physician orders for Humalog insulin	F 760	Coordinator were educated by the Regional Director of Clinical Services on ensuring the staffing needs of the facility are met and reviewed at least daily 7/21/2023 Nursing schedule will be reviewed in a week in advance by the Director of Nursing and Administrator to identify the needs of the facility to address any identified needs and put interventions in place 7/21/2023 Weekly re-education by QA/ICP and/or Administrator to the Director of Nursing/scheduler on the staffing needs of the facility 7/21/2023 Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Regional Director of Clinical Services will audit monthly 25% of insulin administration and obtaining blood glucose levels x 90 days. The results of these audits will be presented to the Quality Assurance Committee during their monthly meeting for review and comment. 7/21/2023 DON/Designee will audit residents' MAR for medications not administered weekly x 2 weekly until 100% then every 2 weeks x 1 one month until 100%, then monthly x 2 months until 100%. Results will be brought to QAPI for review and further recommendations. Date of completion 9/25/2023	

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F 760	Continued From page 152 6 units scheduled at 7:30 AM and Humalog insulin per the sliding scale at 7:30 AM to be given before meals. On 7/21/23, R630's scheduled 7:30 AM blood glucose check was recorded in the clinical record under blood sugars as 106 at the same times of the administrations of Humalog 6 units plus 2 units (sliding scale). E36 (Agency LPN) signed off both at 9:56 AM and 9:57 AM, approximately 2.5 hours later Heritage Unit - R631 had a physician order for Humalog insulin 6 units scheduled at 7:30 AM for DM breakfast. On 7/21/23, R631's eMAR lacked evidence of a blood glucose check and administration of Humalog insulin 6 units for 7:30 AM. The eMAR had an "X" marked in the spot where R631's blood glucose level (number) should have been documented. 7/21/23 at 3:29 PM - Based on observations and review of facility documentation, an Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA), E2 (DON) and E4 (RCD). 7/21/23 at 10:30 PM - E1 (NHA) submitted an acceptable Abatement Plan signed, dated, and timed. 7/24/23 at 9:00 AM - The facility's Immediate Jeopardy was abated at this time. Further observations of facility staffing, timely insulin administration and reviews of the residents' clinical records revealed that the IJ was abated on 7/24/23 at 9:00 AM based on the verification of the facility's following immediate	F 760		

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F 760	Continued From page 153 corrective actions: - staffing was reviewed for 7/21/23, 7/22/23, 7/23/23, 7/24/23; - staffing agencies added for additional support; - implementation of a staffing agency orientation package and location in the nurse's stations; - process in place to address call outs and no call no shows to ensure sufficient staffing; - completed education with NHA, DON and Staffing Coordinator; - observations of blood glucose checks and timely insulin administration; - review of the residents' clinical records; and - observations of facility staffing over the weekend and 7/24/23 by two Surveyors. 2. Cross refer to F725, example 3 Review of R80's clinical record revealed: 7/20/22 - R80 had a physician's order for NPH Insulin inject 4 units subcutaneously in the morning for diabetes diagnosis. 7/16/23 at 6:00 AM - Review of the July 2023 eMAR revealed that R80 was not administered NPH Insulin because there was no assigned nurse on night-shift (11:00 PM to 7:00 AM) in the New Castle Unit. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E15 (VPO)	F 760		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		9/25/23

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F 806	Continued From page 154 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that for one (R100) out of one residents sampled for preferences, the facility failed to provide the resident's food preference for breakfast. Findings include: 7/24/23 at 8:50 AM - During an interview at the centralized nurse's station on the second floor, R100 stated to the Surveyor, in the presence of E56 (Dietician), that he did not receive eggs for breakfast this morning and it was listed on his meal ticket. E56 asked R100 if he still wanted eggs and R100 replied "no too late". The Surveyor observed R100's meal tray and meal ticket, which stated "scrambled eggs... Tray Notes:... LIKES EGGS...". R100 stated that other residents on the Dover hallway were served eggs. 7/31/23 at 2:00 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 806	F806 Resident Allergies A. R100 still resides at the facility. Resident is currently receiving his food preference. B. The dietitian will audit current residents who have food preference(s) on their meal ticket and verify tray includes food preference(s) listed. C. Dietitian/designee will educate food service staff on following of food preference(s) on meal tickets. The root cause of the deficient practice was lack of knowledge on food preference(s) and including them on trays. D. The dietitian or food service manager will audit 5 residents with food preferences on tray tickets and confirm tray matches preferences daily x 3 days until 100% consecutively and then 5 residents weekly for 4 consecutive weeks until facility reaches 100% success. Then 5 residents monthly until the facility reaches 100% success for 2 consecutive months. E. Date of completion: 9/25/2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		9/25/23

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 812	Continued From page 155 §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 interviews, it was determined that the facility failed to provide and store food in accordance with professional standards for food service safety. Findings include: The following were observed during the initial kitchen tour on 7/13/23 from 8:45 AM through 10:00 AM. - The kitchen lights covers were in disrepair in the dry storage, food prep, and dish washing area; - The walls in the areas near the entrance, and dish washing room in were disrepair; - There were water pooling on the floor in the walk-in.	F 812	F812 Food Procurement A. The kitchen light covers have been replaced/repaired in the kitchen area. The walls near the entrance and dish washing room were cleaned from debris. The water pooling on the floor in the walk-in was repaired. B. All residents have the potential to be affected. C. The Administrator re-educated the Maintenance Director and Dietary Director on ensuring that the kitchen environment must be kept in good working conditions. D. The Administrator, Maintenance Director, and Dietary Director will round the kitchen on a weekly basis x 90days to observe any environmental issues that	

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F 812	Continued From page 156 Findings were reviewed and confirmed by E77 (FSD) on 7/13/23 at approximately 10:00 AM. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 812	require immediate attention. Data collected from the audit will be presented to the QAPI team for review. E. Date of completion: 9/25/2023	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		9/20/23

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F 868	Continued From page 157 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on a review of facility documentation, it was determined that the facility failed maintain a quality assessment and assurance committee consisting of the required minimum members. Findings include: 8/31/22 - Quarter 3 2022 Quality Assurance and Performance Improvement Committee Meeting Attendance record documented that the Director of Nursing (DON) was not present at the meeting. 5/25/23 - Quarter 2 2023 Quality Assurance and Performance Improvement Committee Meeting Attendance record documented that the Director of Nursing (DON) was not present at the meeting. Findings were reviewed with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO) at the Exit Conference on 7/31/23 at 2:00 PM.	F 868	F868 QAA Committee A. There were no residents impacted by this deficient practice. B. All residents have the potential to be impacted by this deficient practice. C. To prevent reoccurrence, the RDCS re-educated the Administrator and DON on the importance of ensuring that all key team members attend the QAA meeting as expected. A record of attendees will be documented during each meeting held. The RDCS will review the most recent QAA attendance record during her monthly visit to the center to ensure compliance with the regulation. The root cause of this deficient practice was nonadherence to attendance expectations. D. In addition to the RDCS reviewing the most recent QAA attendance record during her monthly visit to the center, the RDCS will also attend one QAA meeting per quarter to ensure compliance with attendance. If repeated noncompliance is observed, a facility action plan will be implemented. E. Date of completion: 9/20/2023	
F 880 SS=E	Infection Prevention & Control	F 880		9/25/23

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F 880	Continued From page 158 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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	F 880		

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F 880	Continued From page 159 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review of the facility's Infection Surveillance Monthly Report, it was determined that the facility failed to provide an ongoing system of surveillance designed to identify possible communicable diseases and infections. Findings include: Review of the following months of surveillance data for residents treated for urinary tract infections revealed:	F 880	F880 Infection Prevention A. There were no residents negatively impacted by this deficient practice. B. All residents with an active infection and/or communicable disease have the potential to be impacted. An audit was conducted on all current residents to identify those that have an active infection/communicable disease. All	

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F 880	Continued From page 160 February 2023 - for three residents signs and symptoms were lacking; for seven residents the facility lacked data on name of organism, and culture dates and results were not provided. March 2023 - for three residents signs and symptoms were lacking, for five residents the facility lacked data on name of organism, for four residents culture dates and results were not provided; and for one resident reference was made to a laboratory report but organism name, culture dates or results were not provided. April 2023 - for three residents organism name, culture dates and results were not provided. May 2023 - for one resident signs and symptoms were lacking; for ten residents organism name and culture dates and results were not provided. June 2023 - for one resident signs and symptoms were lacking; for six residents name of organism, and culture dates and results were not provided; for two residents antibiotic names and doses were lacking. July 2023 - as of 7/17/23 there were no urinary tract infections. Documentation for surveillance of residents with Urinary Tract Infections was incomplete as evidenced by a lack of organism names, culture results and date of cultures on the report. 4. The Healthcare Professional Operator's Manual for the EvenCare G3 blood glucose monitoring system, dated 2017, stated, "... Cleaning and Disinfecting... The EvenCare G3	F 880	residents identified have been added to the surveillance log. C. The DON re-educated the nursing staff how to prevent, identify, report, and investigate infections/communicable diseases among residents, staff, and visitors. A revised surveillance log which includes symptoms, organism, culture date and results was provided by the RDCS to be used going forward. The acting IP was trained on how to input data and maintain an accurate surveillance log. The root cause word for this deficient practice was lack of knowledge on how to identify, report, investigate and track infection process. D. The Surveillance log will be reviewed and discussed during the At-risk meeting for accuracy weekly x 2 weeks until 100%, then every 2 weeks for 1 month until 100%, then monthly x 2 months until 100%. A monthly infection control summary will be submitted to QAA committee monthly for review and further recommendations. Ftag 880 (2) A. There were no residents impacted by this deficient practice. B. All residents subjected to a glucose check utilizing the Evencare G3 glucometer has the potential to be affected. C. The Staff Development nurse re-educated E43 on the proper procedure to disinfect the glucometer device after use and between patients and which products were acceptable for disinfecting.	

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F 880	Continued From page 161 Meter should be cleaned and disinfected between each patient... The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: -Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8); -Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning wipes with Alcohol (EPA Registration Number: 59894-10); -Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12); -Medline Micro-Kill Bleach Germicidal Bleach Wipes (EPA Registration Number: 69687-1)...". Observation of medication administration on the Dover Unit revealed: 7/26/23 at 4:25 PM - Observed E43 (RN) perform a blood glucose check using the device, EvenCare G3, on R360 in her room. E43 noted as he went to throw something in the trashcan that there were no trashcan liners in the one trashcan located in R360's room. E43 returned to the med cart, used hand sanitizer and obtained a clear plastic liner from one of the drawers in the med cart and returned back into R360's room. E43 went into the resident's bathroom to wash his hands, and there was no trashcan in the resident's bathroom where E43 could dispose of his used paper towels. The Surveyor held the bathroom door open for E43 so he could dispose his used paper towels in the trashcan he just put the plastic liner into. E43 returned to the med cart and placed the EvenCare G3 device back into the top right drawer, without disinfecting it. 7/26/23 at 4:49 PM - During an interview, the Surveyor reviewed the observation of E43 placing	F 880	The Staff Development nurse re-educated all licensed nurses on the proper procedure in which to disinfect the glucometer device after use and between patients and which products were acceptable for use. The root cause of this deficiency was lack of knowledge of the protocol for disinfecting of equipment and the frequency. D. The DON will conduct random observations daily with focus on proper disinfection of the glucometer between and after use weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100% then month for 2 months until 100%. All findings will be reported to QAA committee for review and further recommendations. Ftag 880 (3) A. There were no residents impacted by this deficient practice. B. There were no residents impacted by this deficient practice. C. The VPO met with the Administrator to ensure that the facility always has enough trash cans and liners available, especially in the patient care areas. The Administrator educated the housekeeping supervisor on ensuring that trash cans and liners are always available in the resident room and bathroom. The root cause for this deficient practice is facility failure to ensure enough trash cans and liners were made available in the patient care areas. D. The housekeeping supervisor will round the units daily to ensure enough trash can liners are available. The	

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F 880	Continued From page 162 the EvenCare G3 device back in the med cart drawer without disinfecting it after use. E43 was asked what does he use to disinfect the device after it is used on a resident. E43 replied, "alcohol swab" while picking one up that was in the drawer. In addition to not disinfecting the Glucometer, the facility failed to ensure trashcan liners in a resident's room are routinely replaced for residents and staff to throw away trash and have a trashcan in the resident's bathroom to throw away paper towels after handwashing. 7/26/23 at approximately 5:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (RCD). 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 880	Administration will conduct rounds in the facility and observe 10 resident room/bathroom to ensure trash can and liners are always available weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All concerns identified will be addressed immediately. The housekeeping supervisor will report to QAA committee monthly X 3 months. E. Date of completion: 9/25/2023	
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the	F 882		9/20/23

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F 882	Continued From page 163 facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and interview, it was determined that the facility failed to have an Infection Preventionist (IP) responsible for the facility's IPCP (Infection Prevention and Control Program) that had completed specialized training in infection prevention and control prior to assuming the role of the IP. Findings include: The facility's policy on, "Infection Preventionist," last revised November 17, 2020, reads, " ...The IP must: Possess knowledge of infection surveillance, prevention and control of infections and has completed specialized education on infection prevention and control ...". 6/12/23 - E24 (former ADON/IP) provided the facility with a formal notification of resignation from the position. 7/13/23 - In response to documentation requests during the Survey's Entrance Conference, the facility provided evidence of specialized infection prevention and control training of E24 as the facility's IP. 7/21/23 - E24's last day as ADON/IP at the facility. 7/26/23 11:52 AM - During an interview, E40 (RN/Staff Development) stated that she took over the IP role after E24 left the facility on 7/21/23. E40 confirmed that she did not complete her	F 882	F882 IP Qualifications A. There were no residents impacted by this deficient practice. B. All residents and staff have the potential to be affected by this deficient practice. C. The facility is actively interviewing to fill the IP position with a nurse that has completed specialized training in infection control practices. The interim IP will complete the CDC training by_(9/19/23)_ The facility has adopted the MFA Infection prevention & control policies and procedure manual. This manual has been reviewed and updated effective 06.27.22 The root cause of this deficient practice is the IP had submitted his resignation prior to the start of the survey. His last day employed with center was 07.21.23 D. The RDCS will validate that the interim IP has completed the required specialized training by _9/19/23__ E. Date of completion: 9/20/2023	

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F 882	Continued From page 164 specialized training in infection prevention and control. 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 882		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain required kitchen equipment to prepare food for residents were in safe working order. Findings include: The following were observed during the initial kitchen tour on 7/13/23 from 8:45 AM through 10:00 AM: - The dishwasher food grinders were out of service and unable to dispose of food waste; - The ovens in the food preparation area are not functional. Findings were reviewed and confirmed by E77 (FSD) on 7/13/23 at approximately 10:00AM. Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (Corporate Nurse), and E18 (Vice President of Operations) on 7/31/23, at approximately 2:00 PM.	F 908	F908 Essential Equipment A. The dishwasher food grinder was repaired and is in good working condition. The ovens that are not function are not being utilized and there are other ovens that are in good working condition that is used to bake/cook foods. B. Other residents have the potential to be affected. C. The Administrator re-educated the Maintenance Director and Dietary Director on ensuring that the kitchen equipment must be kept in good working conditions. D. The Administrator, Maintenance Director, and Dietary Director will round the kitchen on a weekly basis x 90days to observe equipment issues that require immediate attention. Data collected from the audit will be presented to the QAPI team for review. E. Date of completion: 9/25/2023	9/25/23
F 923 SS=D	Ventilation CFR(s): 483.90(i)(2)	F 923		9/25/23

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F 923	Continued From page 165 §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on interview and observation, it was determined that the facility failed to ensure adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two in the Arcadia unit. Findings include: 7/21/23 3:00 PM - EHS (Environmental Health Specialist) toured the Arcadia unit. 7/21/23 3:45 PM - During an interview with E39 (Director of Maintenance), it was stated that Arcadia's hall AC unit was out of service and the facility was waiting on a back ordered part to have replaced. 7/21/23 3:50 PM - E39 confirmed poor ventilation on the Arcadia unit. Findings were reviewed with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO) at the Exit Conference on 7/31/23 at 2:00 PM.	F 923	F923 Ventilation A. New air conditioning unit was installed for adequate ventilation. B. All residents have the potential to be affected. C. The Administrator has provided re-education to Maintenance Staff on adequate outside ventilation. D. The Maintenance Director will audit unit for adequate outside ventilation on a weekly basis x 90 days. Data collected from the audit will be presented to the QAPI team for review. E. Date of completion: 9/25/2023	
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training	F 940		9/25/23

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F 940	Continued From page 166 necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training for new and existing staff was completed for one (E53) out of five staff for the Facility Assessment. Findings include: 2/22/23 - (E53) was hired for the housekeeping position. 8/9/23 - The facility was provided a list of five randomly selected staff members for facility assessment training and instructed to provide documentation of the required training requirement for new and existing staff. 8/9/23 3:45 PM - During an interview with E16 (HRD) revealed E53 (CNA) "had not completed all required trainings." A copy of E53's orientation check list was requested during the interview. Additionally, E16 said, "the general orientation check list would be different for the housekeeper position." Further review of documentation revealed a general orientation check off list for E53 had not been provided. 8/11/23 12:12 PM - E2 (DON) documented in an email correspondence "E53 had not been due for other educational items until 8/31/23." The facility failed to provide a general training requirement which is required for all direct and indirect care staff.	F 940	F940 Training Requirements A. There were no residents affected by this deficient practice. B. All residents could be negatively affected by this deficient practice. C. Employee E53 has completed all required training that was due at time of hire as it relates to his/her job role. An audit was conducted by the Director of HR on all employees newly hired in the past 90 days to ensure that all training required at the time of onboarding as it pertains to each individual job role has been completed. Any staff member not in compliance was notified immediately. A facility wide training has been conducted by the leadership team on the following; resident rights, abuse and neglect, Dementia, QAPI, compliance and ethics, and behavioral health on (9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the training requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required trainings timely. All active employees will be up to date with all required training by 09/20/23 The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training in	

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F 940	Continued From page 167 8/10/23 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the Exit Conference to the extended survey.	F 940	Relias has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly to ensure compliance with the required trainings that are consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. All audits conducted by the Director of HR will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
F 942 SS=D	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by:	F 942		9/25/23

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F 942	Continued From page 168 Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training for Resident Rights was completed for one (R53) out of five staff. Findings include: 2/22/23 - (E53) was hired for the housekeeping position. 8/9/23 - The facility was provided a list of five randomly selected staff members for Resident Rights training and instructed to provide documentation of the required training. 8/9/23 3:45 PM - During an interview with E16 (HRD) revealed E53 (CNA) "had not completed all required trainings." A copy of E53's orientation check list was requested during the interview. Additionally, E16 said, "the general orientation check list would be different for the housekeeper position." Further review of facility documentation revealed, "Residents Right training for E53 had not been provided." 8/11/23 12:12 PM - E2 (DON) documented in an email correspondence that "E53 had not been due for other educational items until 8/31/23." The facility failed to provide training for Resident Rights which is required for all direct and indirect care staff. 8/10/23 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the Exit Conference to the extended survey.	F 942	F942 Resident Rights Training A. There were no residents impacted by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Employee E53 was educated on resident rights by the Staff development nurse on 7/24/23. An audit was conducted by the Director of HR on 09/19/23 of all active employees to assure that all required training on resident rights has been completed. A facility wide training has been conducted by the Staff Development nurse on resident rights on 9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required trainings timely. All active employees will be up to date with all required trainings by __(09/19/23)___ The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly to ensure compliance with the required training that are consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active employee is found not in compliance, the	

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F 942	Continued From page 169	F 942	employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. HR Director/designee will audit 5 newly hired staff weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Director of HR/designee will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
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	F 943		9/25/23

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F 943	Continued From page 170 §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, it was determined that the facility failed to ensure that the required training on abuse, neglect, exploitation and misappropriation of resident property was completed for three (E32, E53 and E54) out of 11 randomly sampled staff members. Findings include: 1. Review of E32 (LPN) personnel records revealed: 2/20/18 - The date of E32's most recent abuse and neglect training. 12/9/22 - E32's last date of employment at the facility. 7/24/23 11:00 AM - A verbal confirmation from E16 (HR) was provided that E32's most recent abuse training was 2/20/18. 2. Review of Review of E53 (Housekeeping) personnel records revealed: 2/22/23 - E53's date of facility hire. 7/24/23 - E53's personnel file did not have evidence of abuse and neglect training. 7/24/23 11:10 AM - E16 provided verbal confirmation that E53 did not have abuse training and neglect training upon hire. 3. Review of Review of E54 (CNA) personnel	F 943	F943 Free from Abuse Training A. There were no residents affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. C. Employee E53, and E54 was educated on abuse and neglect on 7/24/23 E32 is no longer employed with the facility. An audit was conducted by the Director of HR on 09/19/23 of all active employees to assure that all required training on abuse and neglect has been completed. A facility wide training has been conducted on abuse and neglect by the DON on 9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required trainings timely. All active employees will be up to date with all required trainings by __(09/19/23)___ The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training in Relias has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly	

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F 943	Continued From page 171 records revealed: 2/20/18 - The date of E54's most recent abuse and neglect training. 7/24/23 11:15 AM - A verbal confirmation from E16 was provided that E54's most recent abuse training was 2/20/18. E54 is a current employee of the facility. Findings were reviewed with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO) at the Exit Conference on 7/31/23 at 2:00 PM.	F 943	to ensure compliance with the trainings that are consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. HR Director/designee will audit 5 newly hired staff weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Director of HR/designee will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
F 944 SS=D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		9/25/23

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F 944	Continued From page 172 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training for QAPI (Quality Assurance and Performance Improvement) was completed for one (R53) out of five staff. Findings include: 2/22/23 - (E53) was hired for the housekeeping position. 8/9/23 - The facility was provided a list of five randomly selected staff members for QAPI training and instructed to provide documentation of the required training. 8/9/23 3:45 PM - During a brief interview with E16 (HRD) revealed E53 (CNA) "had not completed all required trainings." A copy of E53's orientation check list was requested during the interview. Additionally, E16 said, "the general orientation check list would be different for the housekeeper position." Further review of facility documentation revealed "QAPI" training for E53 had not been provided. 8/11/23 12:12 PM - E2 (DON) documented in an email correspondence "E53 had not been due for other educational items until 8/31/23." The facility failed to provide training for QAPI which is required for all direct and indirect care staff. 8/10/23 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the Exit Conference to the extended survey.	F 944	F944 QAPI Training A. There were no residents affected by this deficient practice. B. All residents can be affected by this deficient practice. C. Employee E53 was educated on QAPI process by the Staff development nurse on 7/24/23. A facility wide training has been conducted by the Admin on the QAPI process on 9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required training timely. All active employees will be up to date with all required training by 09/20/23 The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training in Relias has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly to ensure compliance with the required training that is consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to	

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F 944	Continued From page 173	F 944	the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. All audits conducted by the Director of HR will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
F 946 SS=D	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training for Compliance and Ethics was completed for one (R53) out of five staff. Findings include:	F 946	F946 Compliance and Ethics Training A. There were no residents affected by this deficient practice. B. All residents have the potential to be affected by this deficient practice. HR	9/25/23

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F 946	Continued From page 174 2/22/23 - (E53) was hired for the housekeeping position. 8/9/23 - The facility was provided a list of five randomly selected staff members for Compliance and Ethics training and instructed to provide documentation of the required training. 8/9/23 4:00 PM - During a brief interview with E16 (HRD) revealed E53 (CNA) "had not completed all required trainings." A copy of E53's orientation check list was requested during the interview. Additionally, E16 said, "the general orientation check list would be different for the housekeeper position." Further review of facility documentation revealed "Compliance and Ethics" training for E53 had not been provided. 8/11/23 12:12 PM - E2 (DON) documented in an email correspondence "E53 had not been due for other educational items until 8/31/23." The facility failed to provide training for Compliance and Ethics which is required for all direct and indirect care staff. 8/10/23 3:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the Exit Conference to the extended survey.	F 946	director/designee will audit employee files to identify missing compliance and ethics training. Those identified employees will be provided the compliance and ethics training by HR/designee. C. Employee E53 was educated on Compliance and ethics by the Staff development nurse on 7/24/23. An audit was conducted by the Director of HR on _(date)_ of all active employees to assure that all required training on compliance and ethics has been completed. The Administrator conducted a facility wide training on compliance and ethics on 09/20/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required trainings timely. All active employees will be up to date with all required training by 09/19/23 The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training in Relias has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly to ensure compliance with the required training that are consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active	

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F 946	Continued From page 175	F 946	employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. HR Director/designee will audit 5 newly hired staff weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Director of HR will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as	F 947		9/25/23

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F 947	Continued From page 176 determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to provide required in-service training (12 hours per year) for five out of five CNAs reviewed. Additionally, the facility failed to ensure E15, E74, and E76 had training on dementia management, care of the cognitively impaired, abuse and neglect. Findings include: The facility was provided a list of five names selected at random and instructed to provide documentation of the required 12 hours per year of in-service training. 7/28/23 3:00 PM - During a brief interview E16 (HRD) revealed, "she thought continuing education units submitted for CNA renewal (Certified Nursing Assistant) met the required 12 hours per year of in-service training." 7/31/23 8:30 AM - Review of facility documentation submitted for staff training had not met the required in-service training's for E15, E54, E74, E75 and E76. The facility failed to provide 12 hours of annual in-service training's as required for five out of five staff CNA's.	F 947	F947 Required In-Service Training for Nurses□ Aides A. There were no residents impacted by the deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Employee E15, E74, and E76 has completed the required Dementia training effective _(09/19/23)_ An audit was conducted by the Director of HR on 09/20/23 of all existing CNAs to assure that the 12hr annual training to include Dementia training has been completed for all CNAs who have been employed at the center greater than 1 year. The DON conducted a facility wide training on Dementia on 9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the trainings requirements as set forth by CMS. All existing CNAs employed greater than 1 yr were notified in writing of the need to complete all required annual trainings timely. This training will be completed by 09/20/23 The Director of HR in collaboration with	

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	085028	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 947	Continued From page 177 7/31/23 at 2:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E4 (RCD) and E18 (VPO).	F 947	the Staff development nurse will ensure that all CNAs will complete the assigned training in Relias according to the set schedule. The Director of HR will audit 10 CNA files weekly to ensure compliance with the required 12hr training for those employed greater than 1 year.. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any CNA fail to adhere to the training schedule, the employee, the DON and the Administrator will be notified. Failure of the CNA to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. HR Director/designee will audit 5 newly hired staff and 5 current staff weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Director of HR will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health.	F 949		9/25/23

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F 949	Continued From page 178 A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the required training for Behavioral Health Training was completed for one (R53) out of five staff. Findings include: 2/22/23 - (E53) was hired for the housekeeping position. 8/9/23 - The facility was provided a list of five randomly selected staff members for Behavioral Health training and instructed to provide documentation of the required training. 8/9/23 3:45 PM - During a brief interview with E16 (HRD) revealed E53 (CNA) "had not completed all required trainings." A copy of E53's orientation check list was requested during the interview. Additionally, E16 said, "the general orientation check list would be different for the housekeeper position." Further review of facility documentation revealed "Behavioral Health" training for E53 had not been provided. 8/11/23 12:12 PM - E2 (DON) documented in an email correspondence "E53 had not been due for other educational items until 8/31/23." The facility failed to provide training for Behavioral Health which is required for all direct and indirect care staff. 8/10/23 3:15 PM - Findings were reviewed with	F 949	F949 Behavioral Health Training A. There were no residents affected by this deficient practice. B. All residents have the potential to be affected by the deficient practice. C. Employee E53 received training on behavioral health by the Director of Social Work on 7/24/23. An audit was conducted by the Director of HR on 09/19/23 of all active employees to assure that all required training on behavioral health has been completed. The Director of Social services conducted a facility wide training on behavioral health on 9/8/23 The Director of HR and Staff development nurse was educated by the Administrator on ensuring that all new and existing staff meet the training requirements as set forth by CMS. All active employees were notified in writing of the need to complete all required trainings timely. All active employees will be up to date with all required training by 09/19/23 The Director of HR in collaboration with the Staff development nurse will ensure that all newly hired staff do not assume their job role until all onboarding training has been completed as required. The Director of HR will audit 10 existing and 3 newly hired employee files weekly to ensure compliance with the required	

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F 949	Continued From page 179 E1 (NHA), E2 (DON) and E3 (ADON) at the Exit Conference to the extended survey.	F 949	training that are consistent with their expected role and the facility assessment. The Director of HR will generate a report monthly to validate adherence to the training requirements. If any active employee is found not in compliance, the employee, the DON and the Administrator will be notified. Failure of staff to adhere to the expected requirements will be subjected to progressive discipline. The root cause of this deficiency is the facility did not have a process in place in which to track and monitor adherence to required staff training. D. HR Director/designee will audit 5 newly hired staff weekly x 2 weeks until 100%, then every 2 weeks x 1 month until 100%, then monthly x 2 months until 100%. All audits conducted by the Director of HR will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of completion: 9/25/2023	