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

Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Polaris Healthcare

DATE SURVEY COMPLETED: October 18, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from October 6, 2022 through October 18, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 46. The survey sample totaled 38 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross refer to CMS 2567-L survey completed October 18, 2022: F550, F580, F583, F584, F585, F609, F623, F625, F655, F656, F657, F677, F684, F685, F695, F697, F698, F732, F755, F756 F758, F761, F791, F825, F842, F880 and F887.		

Provider's Signature _____ Title _____ Date 11/16/2022

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3201.6.9.2 3201.6.9.2.4	**Specific Requirements for Tuberculosis** **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. While the requirement for a two step is waived, facilities must complete a one-step TB test upon employment.** Based on interview, review of personnel records, and review of facility policy and procedure, it was determined that the facility failed to ensure that two (E2 and E15) out of 16 sampled employees reviewed had their pre-employment TB screening completed. Findings include: 1. E2 (DON) – E2's first day in the facility was 11/22/21. A copy of E2's first and second steps negative PPD results on file revealed that the tests were done at another facility and the results were dated 2/12/21 and 2/21/21 respectively. The facility failed to ensure pre-employment screening was performed on E2. 2. E15 (CNA) – E15's first day in the facility was 9/15/20. A copy of E15's first and sec-	1. Both employees (E2) and (E15) continue to work in the facility, with no signs or symptoms of TB. The facility had no opportunity to correct the deficient past practice. 2. To address the past deficient practice, the Human Resources/Payroll Manager will complete the New Hire PPD Verification Form for each applicant who we anticipate will be hired as an employee. The Administrator or their designee will review and verify each pre-employment TB screening record information before applicant's first day of employment. 3. The root cause analysis identified the facility failed to follow protocol with TB testing for new employees. The Staff Development RN/designee shall in-service all Department Heads of the facility policy. 4. The facility Infection Control/Staff Development RN or designee will conduct	12/1/22

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	ond steps negative PPD results on file revealed that the tests were done at another facility and the results were dated 6/12/20 and 6/24/20 respectively. The facility failed to ensure pre-employment screening was performed on E15. 10/17/22 2:30 PM – Findings were discussed with E1 (NHA) and E2 (DON). 10/18/22 – Findings were reviewed during the Exit Conference beginning at 9:30 AM.	audits on the newly hired employee's PPD to ensure compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for further audits and/or action plans.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085058	A. BUILDING _____ B. WING _____	C 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS HEALTHCARE AND REHABILITATION CENTER	21 W CLARKE AVENUE MILFORD, DE 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from October 6, 2022 through October 18, 2022. The facility census was forty-six (46) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on interviews and document reviews, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from October 6, 2022 through October 18, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 46. The survey sample totaled 38 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0- 7: Severe impairment; COPD (Chronic Obstructive Pulmonary Disease) - progressive lung disease that makes it hard to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2022

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

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F 000	Continued From page 1 breathe; CNA - Certified Nurse's Aide; CXR - Chest xray; DON - Director of Nursing; DOR - Director of Rehabilitation; FM - Family Member; FSBS - test to determine blood sugar (glucose); ICP - Infection Control Preventionist; IDT - Interdiscplinary Team; LPN - Licensed Practical Nurse; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; MDSC - MDS Coordinator; NHA - Nursing Home Administrator; oxygen saturation - percentage of oxygen in the blood stream; RPh - Pharmacist; pneumonia - lung infection; pulmonary fibrosis - A disease in which the lungs become scarred (fibrosed) and damaged causing difficulty in breathing; RN - Registered Nurse; RT - Respiratory Therapist; UM - Unit Manager.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		12/1/22

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F 550	Continued From page 2 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that residents were treated with respect and dignity for two (R21 and R45) during random observations. Findings include: 1. 10/06/22 12:58 PM - During a random meal observation in the Riverwalk Main Dining room, E19 (CNA) verbalized that her "two remaining are	F 550	Both R21 and R45 remain in the facility and with no opportunity to correct previous deficiency, and their Resident Rights are being protected by staff rounding and resident interviews by the DON/designee.. These residents have been reviewed to determine compliance with their Rights. All residents have the potential to be	

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F 550	Continued From page 3 feeders", where other residents were sitting and could hear the comments. An interview immediately with E19 revealed that R21 was one of the "feeders" referred as R21 needed to be fed her meal. 2. 10/10/22 9:11 AM - During an interview with R45, the residents door was closed to offer privacy and confidentiality. E32 (MD) knocked on the door and immediately opened the door without obtaining permission from R45 to open and enter the room. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 550	affected by this deficient practice. Interviews have been completed by the DON/designee for residents to identify other residents that have been affected. The Staff Development RN / Designee has initiated education to staff on the Resident Rights. The RCA identified that staff failed to follow protocol when identifying residents that are dependent for ADL□s specifically nutrition. Staff failed to follow protocol after knocking then requesting permission to enter. The Director of Nursing or designee will continue random interviews audit for all residents to determine compliance. The audit will be conducted at the rate of 10% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QAI committee will determine the need for further audits and/or action plans.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		12/1/22

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F 580	Continued From page 4	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility policy and procedure, it was determined that for one (R100) out of four residents reviewed for respiratory services, the facility failed to ensure immediate consultation with the resident's attending physician when R100 had a significant change in condition, as evidenced by R100's oxygen saturation decreasing to 90%. Findings include: Cross refer F695, Example #1. Review of R100's clinical records revealed the following: 6/24/22 - R100 was admitted to the facility from the hospital with diagnoses including pneumonia, chronic obstructive pulmonary disease, and pulmonary fibrosis. 6/24/22 - The admission Physician's Orders were written for the facility to administer oxygen via nasal cannula, as needed to maintain oxygen saturation of 92% or above. 6/29/22 9:38 AM - The Weight and Vitals Summary documented that R100's oxygen saturation was 90% on room air. 6/29/22 7 AM to 3 PM - The Medication Administration Record (MAR) documented by E9 (LPN, UM) that the oxygen saturation was 90% and that oxygen at 2 l/minute via NC was being administered. 6/29/22 10:36 AM - An Alert Note by E25 (LPN, UM) documented, "Resident discharged from	F 580	Resident R100 no longer resides in the facility, there was no opportunity to correct alleged deficiency. Nursing documentation is reviewed daily by the DON/designee in morning clinical meeting to determine compliance with MD/RP notification. All residents have the potential to be affected by this deficient practice. Audits have been completed by the DON/designee to identify no other resident have been affected. A root cause analysis determined further education is necessary on notification of change in condition. The Staff Development RN/ designee shall provide education to licensed nurses on facility policy Change in Residents Condition, Physician Notification related to decline in oxygen saturation . The Director of Nursing or designee will continue audits of resident progress notes and MD/RP notification related to change in condition. to determine compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QAI committee will determine the need for further audits and/or action plans.	

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F 580	Continued From page 6 facility against medical advise, resident's daughters in facility to pack up belongings...LOA (Leave of absence) 1033 (10:33 AM)..." There was lack of evidence that the facility identified R100's significant change in condition when R100's oxygen saturation decreased to 90%, as documented on the above clinical records. 10/13/22 beginning at 2:40 PM - An interview with E25 confirmed there was lack of evidence that R100's attending physician was immediately consulted when R100's oxygen saturation decreased to 90% on 6/29/22 at 9:38 AM. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		12/1/22

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F 583	Continued From page 7 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on a random observation and interview, it was determined that for one (R22) resident, the facility failed to secure her confidential medical records. Findings include: During an observation on 10/12/22 from 4:22 PM to 4:44 PM. E24 (RN) failed to ensure personal privacy and confidentiality when R22's electronic Medication Administration Record was displayed on top of the medication cart and information not secured when E24 left the medication cart in the hallway until 4:44 PM. An interview immediately after this observation with E24 confirmed that she failed to ensure that R22's private and confidential information was not secured. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 583	Resident R22 remains in the facility, the facility had no opportunity to correct previous deficiency. The DON/designee are completing observation rounds during Medication Pass to ensure privacy is being maintained. E24 has been educated on Privacy/Confidently of medication records. All resident have the potential to be affected by this deficient practice. The DON/designee have completed observation audits during Medication Administration to ensure compliance with privacy of medical records. The root cause analysis identified the protocol of protection/privacy of medical records was not followed. The Staff Development RN/designee shall in-service licensed nursing staff on facility policy protection/privacy of medical	

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F 583	Continued From page 8	F 583	records The Director of Nursing or designee will continue audits on protection/privacy of medical records to determine compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QAI committee will determine the need for further audits and/or action plans.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		11/30/22

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F 584	Continued From page 9 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed anc bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified n §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on random observation and interview it was determined that the facility failed to keep temperatures at a comfortable level in the facility. Findings include: 10/6/22 1:30 PM - During an interview with R106, it was reported that "I am freezing my [a$%] off too cold to get out of bed for therapy". 10/17/22 10:15 AM - An observation of R201 with a blanket over the upper bocy while sitting in the wheelchair in the common a-ea near the activities/dining room (where the large fish tank is located). An unidentified visitor that was sitting next to R201 stated that it was cold and suggested that R201 return to his room where it may be warmer and R201 returned to his room.	F 584	Tag: 584 Safe/Clean/Comfortable/Homelike Environments 1. A] R106 □ [Room 207] Resident was cold. Temperature was taken was below 71F. Maintenance adjusted temperature in room. Resident□s room was check again and temperature was in range between 71-81F. Patient was satisfied and no room change requested. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature	

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	085058	A. BUILDING _____ B. WING _____	C 10/18/2022

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F 584	Continued From page 10 10/17/22 12:30 PM - During an interview R110 revealed that she was cold and that she had reported to the nurse that she was cold. 10/17/22 at approximately 12:35 PM - During an interview and observation, R200 in 214 reported that it felt like it was 65 degrees. R200 was observed to have on a sweatshirt and pointed out the gloves that she uses to keep her hands warm. 10/17/22 - During an interview in the afternoon around 2:00 PM, E37 (Agency Nurse) revealed that if a resident complains of being cold that E37 would get them a blanket. E37 further revealed that there "were problems going on with temperatures." 10/17/22 1:05 PM - 1:10 PM - During observations and interview with E36 (Maintenance Director) it was confirmed that the following temperature in Room 205 was 69.5 degrees and in 214 the air temperature coming from the vent was 63 degrees and 65.3 degrees at the thermostat. It was further revealed that facility has a maintenance system to submit maintenance issues and if the temperatures need adjusting a message can be submitted and it will be addressed. Maintenance can adjust the temperatures remotely. Immediately following the interview maintenance was checking all the temperatures. 10/17/22 - A review of the maintenance log from September to October 17, 2022 it revealed the following: -9/14/22 Administrative offices reported it was so cold. Temperature was turned up to make it warmer.	F 584	range issue to maintenance. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. 2. A] R201 [Room 208] was sitting in the common area of Reserve and a visitor stated that it was cold and returned to his room. Resident room was checked for range in temperature and found to be in appropriate range. Hallway temperature reading was in appropriate range. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3	

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F 584	Continued From page 11 -9/19/22 temperature on Riverwalk was turned down all the way. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 584	patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. 3. A] R110 [Room 205] Resident reported to surveyor that they were cold and had reported to nurse. Room 205 temperature was below range. Resident was offered room 216 and accepted and satisfied with change. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance. It was also determined that the HVAC controller for this room had locked up and was unable to maintain the appropriate ranges. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. HVAC controller was replaced and working properly. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly	

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F 584	Continued From page 12	F 584	until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. 4. A] R 200 [Room 214]] Resident was cold and wore a sweatshirt to keep warm. Temperature was taken and vent temperature was below range. Maintenance adjusted temperature in room. Resident□s room was check again and temperature in range and patient was satisfied and no room change requested. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. 5. A] Agency staff was asked to explain what she would do if a resident complains that they are cold and responded that she	

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F 584	Continued From page 13	F 584	would get resident a blanket. Agency staff stated that she was aware of problems with temperatures on Reserve unit. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance work order system. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. . D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. 6. A] Maintenance Director assessed temperature in RM 205 and 214 and determined both rooms were below 71F. Maintenance Director immediately check all the temperatures. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that	

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F 584	Continued From page 14	F 584	the nurse did not report the temperature range issue to maintenance work order system. Maintenance was not aware of temperature issues. Maintenance reviewed the maintenance log and did not locate a work order containing an issue of temperature in the resident area. Maintenance checked Room 204 and 205 found the controllers for these rooms were locked up. Controllers have been replaced and room temperatures are maintaining a temperature range between 71 to 81F. Review of policy no edits required. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		11/30/22

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F 585	Continued From page 15 respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 585		

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 17 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, it was determined that the facility failed to make the information available to residents regarding how to file a grievance or complaint anonymously. Findings include: The facility policy titled, "Grievances/Complaints, Filing" revised April 2019, stated, "...#5. Grievances and/or complaints may be submitted orally or in writing, and may be filed anonymously..." Review of the Resident Council meeting minutes from October 19, 2021 through October 4, 2022, lacked evidence that there was a process or information on how to file a grievance anonymously was discussed with residents. 10/10/22 2:30 PM - During the Resident Council meeting, in response to the question,"'Do you know how to file a grievance including filing a grievance anonymously?", nine residents who attended the meeting responded "no". 10/11/22 9:42 AM - An observation of the facility bulletin boards on the first and second floors lacked the required posted information on how to file a complaint or grievance anonymously with the facility.	F 585	1. A] Resident Council meeting minutes lacked evidence that there was a process or information on how to file a grievance anonymously was discussed with residents. Residents were not aware of how to file grievances anonymously. B] All residents have the potential to be affected. All residents and resident representatives receive this notice at the time of admission and notices are posted. Grievance Office educated residents on how to file an anonymous grievance at the Resident Council meeting on November 8, 2022. C] Root Cause Analysis was conducted and found residents currently utilize the complaint/concern form to communicate. Council meeting minutes did not provide evidence that the facility or Ombudsman covered the option to file a grievance anonymously during the Resident Council meeting. Grievance Officer reviewed how to file a grievance anonymously at the November 8, 2022 Resident Council meeting. Grievance Office/Designee will mail/email Grievance/Concern information to resident representative on or by November 18. 2022. Review of the facility policy and procedure-posting □ no edits required. Grievance Officer and Activities	

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F 585	Continued From page 18 10/13/22 8:50 AM - During an interview, E5 (Social Service) confirmed the process and information for filing a grievance anonymously was not posted in the facility. The facility failed to have a process for residents to file grievances or complaints anonymously. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 585	Director were educated on the recording of accurate minutes of Council Meeting and the various way residents may file grievances on October 19, 2022. All staff will be educated by Grievance Officer/Designee that the facility must notify residents through posting in prominent locations throughout the facility of the right to file grievances anonymously and the contact information of the grievance official by November 30, 2022. D] A tracking form will be utilized to collect data. The grievance officer will attend the next 4 monthly resident council meetings to introduce self, explain the grievance policy and how to anonymously file a grievance or concerns. Ongoing, the Activities Director will announce who the grievance officer is and how to file an anonymous concern or grievance at the beginning of Resident Council Meeting quarterly. Activities Director /designee will conduct a random audit of residents by asking residents who the grievance officer is and how and where to file a grievance unit 100% for 4 consecutive weeks, the 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. All reports of grievances will be reported through the QA Process. 2. A] Facility bulletin boards on the 1st and 2nd floor have the required posted information on how to file a complaint or grievance anonymously with the facility. A review of posting in the facility indicate two notices are posted in display cabinets: Grievances/Concerns notice listing Grievance Officer and how to file with the Compliance Officer is posted in the large	

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F 585	Continued From page 19	F 585	display cabinet at the entrance into the facility and along corridor in another display case. Grievances and Concern Notice contents contains, □&the grievance can either be: in person, telephone (302) 503 7650, In writing: Polaris Healthcare, 21 W. Clarke Ave., Milford, DE 19963, by email: lpillman@polarishealthcarerehab.com or anonymously. The Compliance: Compliance & Ethics Hotline poster contains an 800 telephone number that is toll free/24 hours a day/7 days a week/anonymous/confidential, the name of the Compliance Officer for reportable violations that includes but is not limited to violations of resident□s rights and inadequate quality of care. B] All residents have the potential to be affected. All residents and resident representatives receive notice at the time of admission and notices are posted. Grievance Office educated residents on the locations of the posting throughout the building that contain information on how to file an anonymous grievance during the November 8, 2022 Resident Council meeting. C] Root Cause Analysis was conducted and found residents were aware and currently utilize the complaint/concern form to communicate and did not know that they could file grievances anonymously. Grievance Officer reviewed where the notices were posted and how to file a grievance anonymously at the November 8, 2022 Resident Council meeting. Additional postings were added to each unit by Administrator/designee on	

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F 585	Continued From page 20	F 585	November 8, 2022. All residents and resident representative will be provided a copy via email of the Grievance / Complaint notice. Review of the facility policy and procedure-posting □ no edits required. D] A tracking form will be utilized to collect data. The Grievance Officer will tour of building to ensure a supply of blank grievance forms located at each unit and posting are posted on each unit grievance until 100% for 4 consecutive weeks, the 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. All reports of grievances will be reported through the QA Process. 3. A] Employee E5 [Social Services] was aware of Facility bulletin boards on the 1st and aware of the 2nd floor that contained the required posted information on how to file a complaint or grievance anonymously with the facility. During the tour with surveyor E5 become nervous and walked past the cabinet containing the notices and shortly after showed surveyor the posting in the display cabinet location on Reserve unit. B] All residents have the potential to be affected. All residents and resident representatives receive notice at the time of admission and notices are posted. C] Root Cause Analysis was conducted and found residents were aware and currently utilize the complaint/concern form to communicate and did not know that they could file grievances anonymously. A review of posting in the facility indicate two notices are posted in display cabinets: Grievances/Concerns	

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F 585	Continued From page 21	F 585	notice listing Grievance Officer and how to file with the Compliance Officer is posted in the large display cabinet at the entrance into the facility and along corridor in another display case. Grievances and Concern Notice contents contains, □&the grievance can either be: in person, telephone (302) 503 7650, In writing: Polaris Healthcare, 21 W. Clarke Ave., Milford, DE 19963, by email: lpillman@polarishealthcarerehab.com or anonymously. The Compliance: Compliance & Ethics Hotline poster contains an 800 telephone number that is toll free/24 hours a day/7 days a week/anonymous/confidential, the name of the Compliance Officer for reportable violations that includes but is not limited to violations of resident□s rights and inadequate quality of care Administrator and Grievance Officer [E5] confirmed current locations of posting on October 18, 2022. Addition posting will be posted on each unit on or by November 8, 2022. Grievance Officer reviewed where the notices were posted and how to file a grievance anonymously at the November 8, 2022 Resident Council meeting. Review of the facility policy and procedure-posting □ no edits required. D] A tracking form will be utilized to collect data. The Grievance Officer will tour of building to ensure a supply of blank grievance forms located at each unit and posting are posted on each unit grievance until 100% for 4 consecutive weeks, the 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. All reports of grievances will be reported	

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	085058	A. BUILDING _____ B. WING _____	C 10/18/2022

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F 585	Continued From page 22	F 585	through the QA Process.□ Tag: 584 Safe/Clean/Comfortable/Homelike Environments 1. A] R106 □ [Room 207] Resident was cold. Temperature was taken was below 71F. Maintenance adjusted temperature in room. Resident□s room was check again and temperature was in range between 71-81F. Patient was satisfied and no room change requested. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process. Tag: 584 Safe/Clean/Comfortable/Homelike Environments 2. A] R201 [Room 208] was sitting in the	

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F 585	Continued From page 23	F 585	common area of Reserve and a visitor stated that it was cold and returned to his room. Resident room was checked for range in temperature and found to be in appropriate range. Hallway temperature reading was in appropriate range. B] All residents have the potential to be affected. Resident□s rooms that are above or below appropriate temperature range, a work order will be entered. Appropriate measures will be taken to correct air temperatures. C] A root cause analyses determined that the nurse did not report the temperature range issue to maintenance. All staff will be educated on contacting maintenance staff by DON/designee by November 30, 2022. Policy review □ no edits required. D] Audit will be performed and documented on collection tool 3 times daily by maintenance staff. Air temperature testing will be performed in 3 patients room for each unit and hallways to determine if the temperature range is between 71 to 81F until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks and, then PRN to maintain compliance. Reported findings will be discussed through the QA process.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		12/1/22

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F 609	Continued From page 24 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility policy, it was determined that for one (R8) out of one resident reviewed for abuse, the facility failed to report an allegation of abuse immediately within 2 hours to the State Agency. Findings include: The facility's policy entitled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating", revised April 2021, stated that if an alleged abuse is suspected, the suspicion must be reported immediately to the administrator and State licensing agency within two hours of an allegation involving abuse or result in serious	F 609	Resident R8 and R29 remain in the facility and there was no opportunity to correct deficient practice. The DON/designee has completed audits on allegations to determine the need for reporting. There have been no further altercations. Any allegation of Abuse shall be investigated within 2 hours and report timely to the appropriate state agency. The root cause analysis identified that the DON failed to report and allegation of abuse to the state agency in the appropriate time frame. . The Staff	

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F 609	Continued From page 25 bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of R8's clinical record and facility documents revealed the following: 10/9/22 3:30 PM - The facility's incident/accident statement by E24 (RN) stated that R8 had a back and forth disagreement between her and and another male resident (R29). During the altercation, R29 grabbed both of R8's forearms and left bruises. 10/11/22 10:32 AM - It was reported to the State Agency two days after the resident to resident altercation. 10/14/22 3:57 PM - During an interview with E2 (DON), it was confirmed that the facility failed to report an allegation of abuse on 10/9/22 in a timely manner to the State Survey Agency. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 609	Development RN/designee shall provide education to the DON and licensed nursing staff on facility policy Abuse investigation and Reporting . The Director of Nursing or designee will continue audits on reported allegation of abuse and timely reporting to the state agency, to determine compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for further audits and/or action plans.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		11/30/22

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F 623	Continued From page 26 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623		

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F 623	Continued From page 27 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 28 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R50 and R103) out of two residents reviewed for hospitalization the facility failed to provide notice of the transfer to the Ombudsman. Findings include: 1. Review of R50's clinical record revealed: 8/9/22 - R50 was admitted to the facility. 8/24/22 3:02 PM - A progress noted documented R50 was transferred to the hospital. Review of R50's clinical record lacked evidence of notification of the transfer to the Ombudsman. During an interview on 10/11/22 at 11:11 AM E1 (NHA) and E5 (SW) confirmed the findings. 2. Cross Refer F625 Ex. # 3 Review of R103's clinical record revealed: 3/2/22 - R103 was admitted to the facility. Review of R103's nurse progress notes revealed that R103 was transferred to the hopsital on 3/27/22, 4/27/22, 5/27/22 and 7/26/22. 10/13/22 2:30 PM - Review of R103's clinical	F 623	1 A] Transfer or Discharge Notice Policy was not followed: Facility must provide Notice of Transfer to Ombudsman. R50 did not return from the hospital stay at family□s request and went to another facility closer to family. Resident was discharged from the facility 8/24/22. Therefore, a notice could not be sent. No evidence of transfer notice to Ombudsman. The resident was not harmed. B] All residents have the potential to be affected. On October 18, 2022 an audit was conducted by the Administrator to determine if there were any resident at the hospital whom the Ombudsman was not notified of transfer. All residents are in house and no hospitals leave. C] A root cause analysis by the Director of Social Services, ADON and DON found that the notification to the Ombudsman had not been utilized as the Dir. Of Social Services was not aware of the notification log. On 10/19/22, the Director Of Social Services, DON, ADON and Business Office Manager were educated by Administrator on notice before transfer and its contents. Policy reviewed, no edits needed. Director of Social Services will notify Ombudsman of discharge/transfers and record same on Transfer Log and	

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F 623	Continued From page 29 record lacked evidence of notification of transfer to the Ombudsman for the transfers on 3/27/22, 4/27/22, 5/27/22 and 7/26/22 . 10/13/22 5:11 PM - In an email correspondence, E5 (SW) confirmed the findings. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 623	send log to the Office of the State Ombudsman by the 15th of the following month. All resident transfers for the last 30 days will be audited by the Director of Social Services/designee by November 30, 2022, for evidence that the Ombudsman was notified of the transfer. Any discrepancies/concerns noted during this review will be clarified and correct at that time. D] Performance Improvement Tool has been initiated that will check the facility roster for transfer/discharges. Compliance with this corrective action will be monitored through the facility Quality Assurance Performance Improvement Program. The Administrator or designee will be responsible for completion of the QAPI Audit Tool related to Discharge/Hospital transfer daily for 4 weeks and then monthly until 100% compliance is achieved for two consecutive months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. 2 A] Transfer or Discharge Notice Policy was not followed: Facility must provide Notice of Transfer to Ombudsman. R103 has discharge form the facility 7/26/22. Resident family transferred resident to another facility from hospital. Therefore, a notice could not be sent. The resident was not harmed. B] All residents have the potential to be affected. On October 18, 2022 an audit was conducted by the Administrator to	

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F 623	Continued From page 30	F 623	determine if there were any resident at the hospital whom the Ombudsman was not notified of transfer. All residents are in house and no hospitals leave. C] A root cause analysis by the Director of Social Services, ADON and DON found that the notification to the Ombudsman had not been utilized as the Dir. Of Social Services was not aware of the notification log. On 10/19/22, the Director Of Social Services, DON, ADON and Business Office Manager were educated by Administrator on notice before transfer and its contents. Policy reviewed, no edits needed. Director of Social Services will notify Ombudsman of discharge/transfers and record same on Transfer Log and send log to the Office of the State Ombudsman by the 15th of the following month. All resident transfers for the last 30 days will be audited by the Director of Social Services/designee by November 30, 2022, for evidence that the Ombudsman was notified of the transfer. Any discrepancies/concerns noted during this review will be clarified and correct at that time. D] A performance Improvement Tool has been initiated that will check the facility roster for transfer/discharges. Compliance with this corrective action will be monitored through the facility Quality Assurance Performance Improvement Program. The Administrator or designee will be responsible for completion of the QAPI Audit Tool related to Discharge/Hospital transfer daily for 4 weeks and then monthly until 100% compliance is achieved for two	

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F 623	Continued From page 31	F 623	consecutive months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		12/2/22

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F 625	Continued From page 32 by: Based on record review and interview it was determined that for three (R50, R52 and R103) out of three residents reviewed for hospitalization the facility failed to ensure the resident/representative was provided with a bed hold notice. Findings include: The facility policy on bed holds and returns last updated March 2022, indicated that, "Residents/representatives would be provided written information regarding the bed-hold policies ...at the time of transfer or if emergent within 24 hours". 1. Review of R52's clinical record revealed: 6/28/22 - R52 was admitted to the facility. 7/18/22 8:43 AM - A progress note documented R52 was transferred to the hospital. Review of R52's clinical record lacked evidence that a bed hold notice was provided to the resident/responsible party. During an interview on 10/11/22 11:45 AM E1 (NHA), confirmed the absence of documentation that R50 and R52 were provided with bed hold notices following their transfers to the hospital. 2. Review of R50's clinical record revealed: 8/9/22 - R50 was admitted to the facility. 8/24/22 3:02 PM - A progress noted documented R50 was transferred to the hospital. Review of R50's clinical record lacked evidence	F 625	1 A] Notice of Bed Hold and Returns and Transfer or Discharge Notice policies were not followed: Facility must provide Bed Hold and Return Policy and Notice of Transfer to Resident/Resident□s representative before a facility transfer a resident to a hospital. R50 has discharge form the facility 8/24/22. Therefore, a notice could not be sent. No evidence of transfer notice or bed hold policy given to resident/resident□s representative. The resident was not harmed. B] All resident have the potential to be affected. On October 18, 2022 an audit was conducted by the Administrator to determine if there were any resident at the hospital who did not receive the Bed Hold policy. All residents in house and no hospital leaves. C] Bed hold policy is given by nursing at the time of discharge and sent with resident to the hospital but no copy of evidence in resident□s chart. A nursing in-service will be conducted by the DON/designee on or before December2, 2022. This education will include the facility policy related to of providing a copy of the Bed Hold Policy to resident or resident□s representative at the time of Transfer. Staff will forward this to Medical Records Department to scan into patients□ chart. DON/designee will be responsible for review of all Discharge/Hospital Transfer. The Director Of Social Services/designee will be responsible for review of all Discharge and/or Hospital Transfer to ensure Bed Hold Policies and Transfer Notices to all	

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F 625	Continued From page 33 that a bed hold notice was provided to the resident/responsible party. During an interview on 10/11/22 11:45 AM E1 (NHA) confirmed the absence of documentation that R50 and R52 were provided with bed hold notices following their transfers to the hospital. 3. Cross Refer F623 Ex. # 2 Review of R103's clinical record revealed: 3/2/22 - R103 was admitted to the facility. R103's progress notes documented that the resident was transferred to the hospital on 3/27/22, 4/27/22, 5/27/22 and 7/26/22. Review of R103's clinical record lacked evidence that a bed hold notices were provided to the resident/responsible party when R103 was transferred to the hospital on those above dates. 10/17/22 2:00 PM - In an interview, E1 (NHA) confirmed the absence of documentation that R103 or her resposible party was provided with bed hold notices following her transfers to the hospital. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 625	parties have been completed as evidence in the resident□s clinical chart. Policy review and no edits needed. D] A performance Improvement Tool has been initiated that will check the facility roster for transfer/discharges. Compliance with this corrective action will be monitored through the facility Quality Assurance Performance Improvement Program. The Dir of Social Service/designee will be responsible for completion of the QAPI Audit Tool related to Discharge/Hospital transfer daily for 4 weeks and then monthly until 100% compliance is achieved for two consecutive months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. 2 A] Notice of Bed Hold and Returns and Transfer or Discharge Notice policies were not followed: Facility must provide Bed Hold and Return Policy and Notice of Transfer to Resident/Resident□s representative before a facility transfer a resident to a hospital. R52 was discharge directly home with hospice from the hospital and discharge from facility on 7/18/22. Therefore, a notice could not be sent. No evidence of transfer notice or bed hold policy given to resident/resident□s representative. The resident was not harmed. B] All resident have the potential to be affected. On October 18, 2022 an audit was conducted by the Administrator to determine if there were any resident at the	

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F 625	Continued From page 34	F 625	hospital who did not receive the Bed Hold policy. All residents in house and no hospital leaves. C] Bed hold policy is given by nursing at the time of discharge and sent with resident to the hospital but no copy of evidence in resident□s chart. A nursing in-service will be conducted by the DON/designee on or before November 30, 2022. This education will include the facility policy related to of providing a copy of the Bed Hold Policy to resident or resident□s representative at the time of Transfer. Staff will forward this to Medical Records Department to scan into patients□ chart. DON/designee will be responsible for review of all Discharge/Hospital Transfer. The Director Of Social Services/designee will be responsible for review of all Discharge and/or Hospital Transfer to ensure Bed Hold Policies and Transfer Notices to all parties have been completed as evidence in the resident□s clinical chart. Policy review and no edits needed. D] A performance Improvement Tool has been initiated that will check the facility roster for transfer/discharges. Compliance with this corrective action will be monitored through the facility Quality Assurance Performance Improvement Program. The Dir of Social Service/designee will be responsible for completion of the QAPI Audit Tool related to Discharge/Hospital transfer daily for 4 weeks and then monthly until 100% compliance is achieved for two consecutive months. If threshold of 90% is not met, an action plan will be	

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F 625	Continued From page 35	F 625	developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up. 1 A] Notice of Bed Hold and Returns an Transfer or Discharge Notice policies were not followed: Facility must provide Bed Hold and Return Policy and Notice of Transfer to Resident/Resident□s representative before a facility transfer a resident to a hospital. After R103 transfer to the hospital on 7/26/22, the resident transferred directly to another facility at the family□s request and did not return to facility. Therefore, a notice could not be sent. No evidence of transfer notice or bed hold policy given to resident/resident□s representative. The resident was not harmed B] All resident have the potential to be affected. On October 18, 2022 an audit was conducted by the Administrator to determine if there were any resident at the hospital who did not receive the Bed Hold policy. All residents in house and no hospital leaves. C] Bed hold policy is given by nursing at the time of discharge and sent with resident to the hospital but no copy of evidence in resident□s chart. A nursing in-service will be conducted by the DON/designee on or before December2, 2022. This education will include the facility policy related to of providing a copy of the Bed Hold Policy to resident or resident□s representative at the time of Transfer. Staff will forward this to Medical Records Department to scan into patients□ chart. DON/designee will be	

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F 625	Continued From page 36	F 625	responsible for review of all Discharge/Hospital Transfer. The Director Of Social Services/designee will be responsible for review of all Discharge and/or Hospital Transfer to ensure Bed Hold Policies and Transfer Notices to all parties have been completed as evidence in the resident□s clinical chart. Policy review and no edits needed. D] A performance Improvement Tool has been initiated that will check the facility roster for transfer/discharges. Compliance with this corrective action will be monitored through the facility Quality Assurance Performance Improvement Program. The Dir of Social Service/designee will be responsible for completion of the QAPI Audit Tool related to Discharge/Hospital transfer daily for 4 weeks and then monthly until 100% compliance is achieved for two consecutive months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		12/1/22

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F 655	Continued From page 37 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R100 and R105) out of three residents reviewed for baseline care plans	F 655	Resident R100 no longer resides in the facility and there was no opportunity to correct deficient practice, R105 plan of	

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F 655	Continued From page 38 the facility failed to develop a baseline care plan. Findings include: 1. Review of R100's clinical record revealed: 6/24/22- R100 was admitted to facility. 10/12/22 - Record review lacked evidence that a baseline care plan was developed within 48 hours after R100' s admission. 10/13/22 3:46 PM - An interview with E2 (DON) confirmed that the facility was unable to provide evidence that a baseline care plan was developed within 48 after R100's admission. 2. Review of R105's clinical record revealed: 9/21/22 - R105 was admitted to the facility. During an interview on 10/6/22 at 12:29 PM FM4 answered "no", to receiving a copy of R105's care plans and stated, "It's hard to get any information". Review of R105's TAR revealed an unmarked/blank section in the space designated for completion of the baseline care plan. During an interview on 10/10/22 at 2:15 PM, E25 (RN) confirmed that a baseline care plan was not completed for R105. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 655	care has been reviewed with the resident and RP by the DON/designee and he has been given a copy. All new residents have the risk to be affect by this deficient practice. Current and new resident charts are being reviewed by the DON/designee to determine compliance with Baseline Care Plans. The root cause analysis determined that the facility failed to follow protocol related to Baseline Care Plans. The Staff Development RN/designee shall provide in-service for licensed nursing staffand ICO team on facility policy Care Plans Baseline. The Director of Nursing or designee will continue audits on development of base line care plans for new admission residents to determine compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for further audits and/or action plans.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		12/1/22

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F 656	Continued From page 39 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 40 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (R22, R33, R45, R101 and R107) out of 25 residents reviewed for care plans, the facility failed to develop and implement a comprehensive person centered care plan. Findings include: 1. Cross refer F695, Example #2. Review of R45's clinical records revealed the following: 7/31/20 - R45 was admitted to the facility. 9/23/22 - A Physician's Order was written for oxygen at 3 liters per minute via nasal cannula. There was lack of evidence of a respiratory care plan for oxygen administration. 2. Review of R33's clinical record revealed: 8/25/22 R33 was admitted to the facility. 8/31/22 - An admission MDS assessment documented R33 received special treatments such as oxygen, suctioning and tracheostomy care. On 9/25/22, the same assessment was modified to add ventilator use. 10/10/22 3:08 PM - Review of R33's clinical record lacked evidence of a care plan for the care of the resident's tracheostomy and mechanical ventilator.	F 656	Residents R 101 and R107 no longer reside in the facility the facility had no opportunity to correct the deficient practice.. Resident R22□s care plan has been updated to reflect her hearing difficulty, R33□s care plan has been updated to reflect respiratory needs. and R45□s care plan has been updated to reflect her respiratory needs. All current and new residents have the potential to be affected by the deficient practice. Current residents with respiratory diagnosis and hearing difficulties care plans have been audited by the DON/designee to identify other residents that have been affect by the deficient practice. Any residents identified have been reviewed by the ICP team and care plans have been updated as necessary. The root cause analysis identified that the facility failed to follow protocol on development of comprehensive care plans . The Staff Development RN/designee shall in-service the ICP team on facility policy Comprehensive Care Plan. The Director of Nursing or designee will continue audits of comprehensive care plans to determine compliance. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is	

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F 656	Continued From page 41 10/20/22 - After the surveyor inquired about the care plans they were created for R33's use of mechanical ventilation, tracheostomy care, and potential for respiratory distress. 3. Review of R101's clinical record revealed; 12/8/21 - R101 was admitted to the facility. 12/14/21 - An admission MDS assessment documented R101 required limited assitance of two people for hygiene. 12/8/21 - R101's care plan for ADL's was created with the following interventions, assist resident to pick out own clothes, assist to attend activities of choice, assist with meal tray: opening items and set up as needed. PT/OT to evaluate and treat as indicated. Toileting schedule as resident allows. The care plan lacked evidence of interventions for R101's assistance with hygiene. 4. Review of R107's clinical record revealed: 9/22/22 - R107 was admitted to the facility with multiple diagnoses including seizure disorder, and diabetes. 9/28/22 - An admission MDS assessment documented R107 as receiving the following medications: antipsychotics, antidepressants, and anticoagulants. 10/20/22 - Review of R107's clinical record lacked evidence of care plans regarding the residents use medications to manage a seizure disorder, diabetes and use of antipsychotics,	F 656	achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QA committee will determine the need for further audits and/or action plans.	

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F 656	Continued From page 42 antidepressants, and anticoagulants. 10/11/22 - After the surveyor inquired about the care plans they were created for R107's use of anticoagulant therapy, antidepressant therapy, diabetes and seizure disorder. 5. Cross Refer F685 Review of R22's clinical records revealed the following: 1/18/22 - R22 was admitted to the facility. R22's admission MDS and quarterly MDS dated 2/5/22 and 5/5/22 revealed that R22 had adequate hearing with no difficulty in normal conversation. 8/7/22 - Review of R22's quarterly MDS revealed that R22 had minimal difficulty with hearing meaning difficulty in some environment for example, when person speaks softly or setting is noisy. 10/6/22 9:45 AM - In an interview, R22 stated that she could not hear very well out of her right ear. There was lack of evidence that a care plan was developed to address R22's hearing difficulty. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		12/1/22

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F 657	Continued From page 43 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited tc-- (A) The attending physician (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resicent. (iii)Reviewed and revised by the interdisciplinary team after each assessmer t, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R45 and R5) out of 25 residents reviewed care plans, the facility failed to conduct an IDT (Interdisciplinary Team) care plan meeting for R45. For R5, the facility failed to review and revise the fall care plan. Findings include: 1. The following was reviewed in R45's clinical record:	F 657	Resident R5 and R 45 both remain in the facility, the facility had no opportunity to correct the deficient practice. Resident R5□s care plan has been reviewed by the ICP team in interventions have been updated as necessary to reflect the residents current level of care as related to falls. . Resident R45 has had an ICP team meeting to review her plan of care. All residents have to potential to be affected by this deficient practice. The	

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F 657	Continued From page 44 7/31/20 - R45 was admitted to the facility. On 11/20/21 and 2/20/22 - Quarterly MDS Assessments were completed. There was lack of evidence that an IDT Care Plan Meeting was held after the completion of the above assessments. 8/23/22 - An Annual MDS Assessment was completed. There was lack of evidence that an IDT Care Plan Meeting was held after the completion of the above assessment. 10/12/22 10:29 AM - An interview with E5 (Social Services) confirmed that the facility was not able to provide evidence that IDT Care Plan meetings were held following the above MDS Assessments. 2. The following was reviewed in R5's clinical record: 3/9/22 - R5 was admitted to the facility 4/5/22 - A care plan was implemented for potential for (actual) fall related to decreased mobility with a goal that R5 would not sustain or be injured from a fall. 7/27/22 - R5 experienced a fall without injury. To prevent similar incident occurrence, the facility implemented a new intervention in which a signage was placed on R5's door for staff to knock and open door slowly when entering the room.	F 657	Social Service director has completed an audit to determine no other residents have missed the ICP team meetings to review their plan of care. The DON/designee has audited residents fall care plans to determine compliance with appropriate/recommended interventions. . The root cause analysis identified that facility ICP team failed to update care plans in a timely manor and failed to have residents invited to ICT care plans meetings. The staff Development RN/designee shall provide education for the facility ICP team on policy Comprehensive Care Plan, and IDT care conference meetings. The Director of Nursing or designee will continue audits on residents fall care plans to to determine compliance with timely updating of interventions. The Social Service Director will continue to audit quarterly and annual care meetings to determine compliance with invitations. . The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. . The QA committee will determine the need for further audits and/or action plans.	

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F 657	Continued From page 45 There was lack of evidence that the facility reviewed and revised the above fall care plan to include the intervention for signage to be posted on R5's door to her room. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutr tion, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for two (R45 and R101) out of five sampled residents reviewed for activities of daily living the facility failed to maintain good oral hygiene and bathing. Findings include: 1. Review of R45's clinical records revealed the following: 7/31/20 - R45 was admitted to the facility. 8/23/22 - The Quarterly MDS Assessment indicated that R45 was independent in daily decision making and required extensive assistance of two plus staff to complete personal hygiene which included oral care. 10/10/22 9:10 AM - An interview with R45 revealed that she has not brushed her teeth following this morning's breakfast and that she	F 677	Resident R45 remains in the facility and is receiving oral care per facility policy . R101 no longer resides in the facility. The facility had no opportunity to correct the deficient practice. All residents are at risk of the deficient practice. Residents care rounds are being completed by the DON/designee to identify no other residents have been affect by the deficient practice. The root cause analysis identified the staff failed to follow protocol to provide ADL care to the identified residents. The Staff Development RN/designee shall in-service nursing staff on facility policy ADL Support. The Director of Nursing or designee will continue rounds to determine compliance with ADL□s. The audit will be conducted at the rate of 20% weekly until 100% compliance is achieved for three	12/1/22

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F 677	Continued From page 46 was waiting on staff to provide her the toothbrush and toothpaste. 10/10/22 11:19 AM - During a subsequent interview with R45, she stated that she has not brushed her teeth today. 10/10/22 11:23 AM - During an interview with R45's assigned CNA (E17) revealed, it was her understanding that R45 used toothettes (disposable, single-use oral care sponges attached to a stick used for oral care) proceeded to enter into R45's room in an attempt to locate the toothettes. R45 verbalized that "my toothbrush is in the bag back there" and pointed to her night stand. E17 indicated that she was unable to locate the toothbrush and proceeded to leave R45's room. 10/10/22 1:15 PM - During a follow-up interview, R45 stated she was able to brush her teeth after the 11:23 AM interview. The facility failed to ensure that oral care was provided to R45 who was dependent on staff to perform this activities of daily living. 2. Review of R101's clinical record revealed: 12/8/21 - R101 was admitted to the facility. 12/14/21 - An admission MDS assessment documented R101 required limited assitance of two people for hygiene/hair washing. 12/8/21 - R101's care plan for ADL's lacked evidence of interventions for R101's assistance with hygiene.	F 677	consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. . The QA committee will determine the need for further audits and/or action plans.	

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F 677	Continued From page 47 Review of R101's CNA documentation report, a record of care received, revealed R101 was to receive a bath/shower/hair washing Wednesdays and Saturdays during the 3-11 PM shift. R101 did not receive bath/shower/hair washing: December 2021 -three out of seven opportunities January 2022- one out of nine opportunities February 2022-three out of eight opportunities March 2022 -one out of four opportunities The missed dates were not documented as resident refusals. During an interview on 10/14/22 10:30 AM, E2 (DON) reported resident hair is to be washed during showers and documented in the shower slot on the CNA documentation report. During an interview on 10/14/22 at 11:55 AM, E33 MDS coordinator confirmed the findings. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. This REQUIREMENT is not met as evidenced	F 684		12/1/22

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F 684	Continued From page 48 by: Based on interview and record review, it was determined that the facility failed to ensure that for three (R25, R45 and R21) out of five residents reviewed for unnecessary medications, the facility failed to assess the residents for signs or symptoms of constipation and administer medications as ordered for no bowel movement (BM) after three days. In addition, for one (R102) out of three residents reviewed for infection control, the facility failed to ensure the resident received prescribed medication to treat an infection. Findings include: 1. Review of R25's clinical record revealed: 6/11/22 - R25 was admitted to the facility. 6/11/22- Review of the physician's orders included medications for constipation: - Milk of Magnesia as needed for if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia within eight hours. - Fleet Enema as needed for constipation or no BM from Dulcolax in eight hours, call MD if no results in eight hours. 6/12/22 - The care plan for potential for constipation due to decreased mobility and history of constipation included a goal that R25 will have a BM every three days (9 shifts). Interventions included BM protocol (ordered laxatives) as needed, bowel medicine as ordered, inform MD if not effective or if loose stool occurs, encourage mobility as resident is able. 7/1/22 through 10/6/22 - The CNA documentation	F 684	Residents R 45 and R 21 remain in the facility. Residents R 25 and R 102 no longer resides in the facility. Resident R21 and R45 continue to have their BM records reviewed daily to ensure bowel protocol is followed. The facility had no opportunity to correct the deficient practice. All residents have the potential to be affected by the deficient practice. Daily audits of BM records are being completed by the DON/designee to identify that no others have been affected.. The root cause analysis identified that staff failed to follow the facility Bowel Protocol . Root cause analysis also identified that the facility failed to ensure that the resident R 102 received medication as prescribed by the physician. The Staff Development RN/designee is in servicing licensed nursing staff on the facility "Bowel Protocol, and Medication Administration". The Director of Nursing or designee will continue audits of the bowel records and medications administration records to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, . The QA committee will determine the need for further audits and/or action plans.	

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F 684	Continued From page 49 of R25's BM activity revealed that the facility failed to ensure that physician's orders were implemented when R25 failed to have bowel activity for nine (9) shifts on the following dates: - Ending on day shift on 7/13/22, total of 21 shifts - Ending on day shift on 7/26/22, total of 20 shifts - Ending on evening shift or 7/31/22, total of 13 shifts - Ending on day shift on 8/12/22, total of 18 shifts - Ending on night shift on 8/17/22, total of nine shifts - Ending on evening shift or 9/16/22, total of nine - Ending on night shift on 9/28/22, total of nine - Ending on day shift on 10/6/22, total of 25 shifts 10/18/22 8:30 AM - An interview with E3 (ADON) revealed that during the survey, the facility identified that the night shift licensed nurses were not accessing the EMR report for residents who had not had a BM in three days or nine shifts, thus, resulting in failure to assess the resident for constipation and implement the orders for the bowel protocol. 2. Review of R45's clinical records revealed: 7/31/20 - R45 was admitted to the facility. 7/31/20 - Review of the physician's order included the following medications for constipation: - Milk of Magnesia as needed for if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Milk of Magnesia within eight hours. - Fleet Enema as needed for constipation or no BM from Dulcolax in eight hours, call MD if no results in eight hours.	F 684		

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F 684	Continued From page 50 9/6/22 (Initial date of 8/2/20) - The care plan for potential for constipation due to decreased mobility and history of constipation included a goal that R45 will have a BM every three days. Interventions included BM protocol (ordered laxatives) as needed, encourage mobility as resident able, monitor and encourage fluids as per dietary needs and as ordered, and monitor consistency and frequency of bowel movements. 8/1/22 through night shift on 10/17/22 - The CNA documentation of R45's BM activity revealed that the facility failed to ensure that physician's orders were implemented when R25 failed to have bowel activity for total of 12 shifts on night shift on 8/6/22 and on night shift on 10/17/22. 3. Review of R21's clinical records revealed: 6/28/22 - R21 was readmitted to the facility from the hospital. 6/28/22- Review of the physician's order included medications for constipation: - Lactulose as needed for if no BM in three days. - Dulcolax Suppository as needed for constipation if no result from Lactulose within eight hours. - Fleet Enema as needed for constipation or no BM from Dulcolax in eight hours, call MD if no results in eight hours. 6/28/22- The care plan for potential for constipation due to decreased mobility and history of constipation included a goal that R21 will have a BM every three days. Interventions included BM protocol (ordered laxatives) as needed, encourage mobility as resident able, monitor and encourage fluids as per dietary needs and as ordered, and monitor consistency	F 684		

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F 684	Continued From page 51 and frequency of bowel movements. 8/1/22 through night shift on 10/17/22 - The CNA documentation of R21's BM activity revealed that the facility failed to ensure that physician's orders were implemented when R21 failed to have bowel activity for three days from 8/8/22 evening shift through night shifts on 8/12/22 for total of 11 shifts. 10/18/22 8:30 AM - An interview with E3 (ADON) confirmed that the facility failed to implement the physician's orders for Lactulose when R21 had no BM for three days. 4. Review of R102's clinical record revealed: 8/18/22 - R102 tested positive for COVID 19. 8/18/22- An order was written for R102 to receive Paxlovid tablet therapy for respiratory infection due to COVID 19 for five days. 8/18/22 9:52 PM - A note in R102's clinical record regarding administration of the Paxlovid documented, "Medication not available, waiting for delivery from pharmacy." 8/19/22 1:00 AM - A note in R102's clinical record documented, "Medication still have not arrived. Phoned pharmacy and they stated the form was missing patient information, they re-faxed the form to be filled out with patient information". 8/19/22 7:55 PM - A note in R102's clinical record regarding administration of the Paxlovid documented, "Medication not available, waiting for delivery from pharmacy." The clinical record lacked evidence that a physician was notified at	F 684		

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F 684	Continued From page 52 that time. 8/20/22 7:59 AM - A physician's note in R102's clinical record documented, "She is seen today for follow up after I saw her yesterday due to request of her daughter due to her cough, She tested positive [for COVID 19] yesterday and CXR was done which was positive for pneumonia. I started her on Paxlovid and Dexamethasone (steroid) yesterday...". 8/21/22 9:55 AM - A note in R102's clinical record regarding administration of the Paxlovid documented, "Continue to await delivery." 8/22/22 11:10 PM - A physician's note in R102's clinical record documented, "She tested positive [for COVID 19] last week...I started her on Paxlovid and Dexamethasone for COVID infection...but she never received Paxlovid as pharmacy never sent it. She is no longer eligible for Paxlovid as she is not in window period." During an interview on 10/14/22 at 2:57 PM, E1(NHA) and E2 (DON), E2 stated, the facility's process for obtaining medications for new orders was to, "Call the pharmacy then we have it processed. If it's not delivered we can call and see where it is and have it delivered from our back up pharmacy in town if the specific medication is there. Our pharmacy reaches out to other pharmacies as well but the medication [Paxlovid] was unavailable." At time of exit the facility was unable to provide evidence of correspondence with other pharmacy's and immediate notification of the physician regarding a lack of availability of the prescribed Paxlovid to treat R102 for COVID 19.	F 684		

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F 684	Continued From page 53 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R22) out of two residents sampled for hearing/vision, the facility failed to ensure that R22 received proper treatment to maintain hearing abilities. Findings include: Cross Refer F656 Ex. # 5 Review of R22's clinical record revealed: 1/18/22 - R22 was admitted to the facility. 8/7/22 - Review of R22's quarterly MDS revealed that R22 had minimal difficulty with hearing meaning difficulty in some environment when person speaks softly or sett ng is noisy.	F 685	Resident R#22 remains in the facility. She has been evaluated by the physician and appointment is being scheduled with Nemours for hearing follow up. The facility had no opportunity to correct the deficient practice All residents have to potential to be affected by the deficient practice. Current residents recent MDS Section B have been audited by the DON/designee to identify other any residents with hearing loss. These resident been seen by our NP and referrals have been made if necessary per physician orders. The Root Cause analysis identified the facility failed to follow facility protocol when identifying residents with hearing	12/1/22

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F 685	Continued From page 54 8/12/22 - Review of R22's Physician Order Summary Report revealed that R22 had a physician's order for an audiology consult and treatment as needed. The order status was marked "Discontinued". 10/10/22 9:55 AM - During observation when this Surveyor knocked on R22's room to greet "Good morning", R22 was looking at the Surveyor pointing at her right ear and waved her hand for surveyor to come closer. R22 stated that she can't hear very well especially with some noise and that she used to wear a hearing aid before. 10/12/22 2:27 PM - When interviewed, E7 (LPN) stated that she was not aware of R22's hearing difficulty and will check with Social Services. 10/13/22 8:45 AM - During interview, E5 (Social Services) stated that she was not aware of R22's hearing difficulty. There was a lack of evidence that the facility identifed that R22 was having difficulty with hearing. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 685	loss. The Staff Development RN/designee shall complete in-servicing on facility policy on Hearing Impaired Residents. The Director of Nursing or designee will continue audits of MDS Section B to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, . The QA committee will determine the need for further audits and/or action plans.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		12/1/22

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F 695	Continued From page 55 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, record review, and review of other facility documents, it was determined that for three (R100, R45 and R22) out of four residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice and the resident's comprehensive person-centered care plan. Findings include: 1. Cross refer F580, Cross refer F655, Example **#1** Review of R100's clinical records revealed the following: 6/24/22 - R100 was admitted to the facility from the hospital with diagnoses including pneumonia, chronic obstructive pulmonary disease, and pulmonary fibrosis. 6/24/22 - The admission Physician's Orders were written for the facility to assess R100 every shift for fever, shortness of breath, sore throat, cough, pulse oximetry and lung sounds and to write a progress note of any abnormal findings. In addition, to administer oxygen via nasal cannula, as needed to maintain oxygen saturation of 92% or above. Lastly, an oxygen order at 2 liters per minute via nasal cannula continuously every shift. 6/29/22 9:38 AM - The Weight and Vitals Summary documented by E26 (Agency LPN) stated that R100's oxygen saturation was 90% on	F 695	Resident R#100 no longer resides in the facility. Resident R# 45 physicians orders for oxygen are being followed. Resident R# 22 has a physicians order use her C-PAP. All residents have the potential to be affect by the deficient practice. Current residents have been audited by the DON/designee to identify other residents accurate respiratory orders and C-PAP administration. The Root Cause Analysis identified that staff failed to follow physician orders for oxygen administration and failed to obtain orders for C-PAP administration. The Staff Development RN/designee is providing in-services on Oxygen Administration and C-PAP/Bi-PAP support The Director of Nursing or designee will continue audits of oxygen and C-PAP orders to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. . The QA committee will determine the need for further audits and/or action plans.	

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F 695	Continued From page 56 room air. 6/29/22 7 AM to 3 PM - The Medication Administration Record (MAR) documented by E9 (LPN, UM) that the oxygen saturation was 90% and that oxygen at 2 liters per minute via nasal cannula was being administered. There was a lack of evidence that the facility implemented the order for PRN oxygen to maintain oxygen saturation 92% or above when R100's oxygen saturation was documented at 90% on 6/29/22 at 9:38 AM. 6/29/22 10:36 AM - An Alert Note by E25 (LPN, UM) documented, "Resident discharged from facility against medical advise, resident's daughters in facility to pack up belongings...LOA (Leave of absence) 1033 (10:33 AM)..." There was lack of evidence that the facility responded to the low oxygen saturation of 90%, to include comprehensive assessment of respiratory system, including auscultation of lung sounds and consultation with the physician. 10/13/22 beginning at 2:56 PM - An interview with E25 (LPN, UM) confirmed the lack of comprehensive respiratory assessment when R100 was documented as having decreased oxygen saturation of 90% on 6/29/22 at 9:38 AM. 10/13/22 beginning at 3:00 PM - An interview with E9 (LPN, UM) revealed that she does not recall if she was assigned to R100 on 6/29/22 during the 7:00 AM to 3:00 PM shift and does not recall when R100 was documented to have had an oxygen saturation of 90% on the MAR and what actions, if any were taken. E9 stated that an	F 695		

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(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 695	Continued From page 57 Agency Nurse (E26, LPN) had documented the 90% oxygen saturation in the EMR system, however, E26 no longer was employed by the facility. 2. Cross refer F656, Example #1. Review of R45's clinical records revealed the following: 7/31/20 - R45 was admitted to the facility. 9/23/22 - A Physician's Order was written for oxygen at 3 liters per minute via nasal cannula. 10/6/22 12:25 PM - During an observation of R45's oxygen concentrator with E3 (ADON), the oxygen was set at 2.5 liters/minute via nasal cannula (NC) and E3 confirmed that the order was for 3 liters/minute. 10/10/22 11:40 AM - During an observation of R45's oxygen concentrator with E9 (LPN, UM), the oxygen was set at 4 liters via NC and E9 confirmed that the order was for 3 liters via NC. The facility failed to ensure R45's order for oxygen was carried out as ordered. 4. Cross Refer F657, example #3 Review of R22's record revealed the following: A facility policy titled, CPAP/BIPAP (bi-level positive airway pressure) Support" revised March 2015, stated, "Review the physician's order to determine...the pressure (CPAP...) for the machine."	F 695		

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	085058	A. BUILDING _____ B. WING _____	C 10/18/2022

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F 695	Continued From page 58 1/18/22 - R22 was admitted to the facility with diagnoses including sleep apnea, a sleeping disorder in which breathing repeatedly stops and starts. 8/25/22 - R22 was careplanned for potential for respiratory distress with interventions including the use of a C-PAP machine. 10/10/22 9:47 AM - During observation, a C-PAP machine with face mask was observed laying on top of R22's bedside table. R22 stated she wears them every night "...So I can sleep better.". 10/12/22 2:20 PM - Joint observation with E7 (LPN), revealed R22's C-PAP machine and face mask sitting on R22's bedside table. 10/12/22 2:22 PM - During interview, E7 stated that R22 wears her C-PAP at night and takes it off in the morning. E7 further confirmed that R22 did not have a physician's order for C-PAP pressure setting. 10/13/22 1:09 PM - In an interview, E3 (ADON) confirmed that R22 did not have an active physician's order for the use of CPAP machine. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		12/1/22

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F 697	Continued From page 59 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R104) out of three residents reviewed for pain management, the facility failed to ensure that the prescribed pain medication was provided. Findings include: Review of R104's clinical record revealed the following: 6.16/22 - R104 was admitted to the facility with diagnoses including end stage lymphoma, which means that cancer has spread to an organ external to the lymphatic system (consists of lymph, lymph nodes, collecting ducts and spleen) and chronic back pain with sciatica (compressed nerve pain in the lower back). 6.16/22 - A care plan was developed for R104's potential alteration in comfort related to chronic pain and terminal illness with interventions including medicine as ordered and to call MD (physician) if not effective or side effects noted. 6.21/22 - R104's Admission MDS (Minimum Data Set) pain assessment interview revealed that R104 had pain and was hurting and had experienced frequent moderate pain that made it hard for him to sleep at night and limited his day to day activities. R104 had an order for scheduled and PRN (as needed) pain medications. 7.15/22 - R104 had a routine/scheduled physician's order for Dilaudid liquid 6 ml by mouth every 3 hours for chronic pain.	F 697	R 104 no longer resides in the facility. The facility had no opportunity to correct the deficient practice. All residents have the potential to be affect by this deficient practice. Current residents are being monitored by the DON/designee daily for medication availability to identify that no other residents have been affected. The root cause analysis identified that the physician and staff failed to ensure medications were available for the resident in a timely manor. The Physician failed to write C2□s for more than 2 days at a time causing a delay in obtaining medications for the resident. This physician no longer works in the facility. The Staff Development RN/designee shall in-service all licensed nursing staff on the facility policy Change in Resident Condition and Medication availability. The Director of Nursing or designee will continue audits on medication availability to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, . The QA committee will determine the need for further audits and/or action plans.	

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F 697	Continued From page 60 10/14/22 3:00 PM - Review of R104's July 2022 Medication Administration Record revealed that R104 did not receive five doses of routine Dilaudid liquid 6 ml every 3 hours on the following dates and times: July 15, 2022 - 6:00 PM & 9:00 PM July 16, 2022 - 12:00 AM, 3:00 AM & 6:00 PM 10/17/22 8:50 AM - Review of R104's nurse progress notes documented the following: 7/15/22 4:03 PM - "Per pharmacist Dilaudid liquid will be here tonight." 7/15/22 10:45 PM - "Waiting on pharm (pharmacy), none on back up." 7/16/22 12:14 AM - "Med (medicine) on ordered." 7/16/22 2:45 AM - "Med (Dilaudid) on order. Morphine (as needed) was given instead." 7/16/22 6:38 PM - "(Dilaudid) On order." 7/19/22 12:50 PM - Routine Dilaudid called in by MD to local back up pharmacy for stat (immediate) delivery. Med should arrive within 3-4 hours." Further review of R104's records revealed a lack of evidence that the physician was informed of five out of five of R104's missing Dilaudid doses. 10/17/22 8:30 AM - In an interview, E3 (ADON) confirmed that they had a shortage with R104's liquid Dilaudid. E3 stated that she had to check R104's clinical records if the physician was notified of the missing doses. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		12/1/22

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F 698	Continued From page 61 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R105) out of one resident reviewed for dialysis the facility failed to ensure dialysis services were received when R105 missed a scheduled dialysis appointment due to the facility's failure to arrange transportation. Findings include: Review of the facility Dialysis contract initiated 2.1/20 indicated, "The facility will have the responsibility for arranging and will bear all cost relating to transportation of any resident to and from dialysis center." 9.21/22 - R105 was admitted to the facility with multiple diagnoses including, end stage renal disease. R105 had admitting orders to receive dialysis on Mondays, Wednesdays and Fridays. 10/3/22 5:16 AM - A note in R105's clinical record documented, "transportation called and did not have patient scheduled for pickup this AM. [Dialysis Center] notified and will call this AM to reschedule transport today. Patient notified of delay for dialysis." R105's TAR revealed the resident did not receive dialysis until the next scheduled dialysis date of 10/5/22. During an interview on 10/6/22 at 12:30 PM FM4 reported that R105 "Missed dialysis because they	F 698	R105 remains in the facility and has transportation arrangements for dialysis .The facility had no opportunity to correct the deficient practice. All dialysis residents have the potential to be affected by this deficient practice. Current and new residents are audited by the DON/designee to identify that transportation is arranged for dialysis. The root cause analysis identified the facility failed to verify transportation arrangements for dialysis. The Staff Development RN/designee shall provide in-servicing on facility policy ESRD care and transportation verification The Director of Nursing or designee will continue audits on dialysis transportation to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting,. . The QA committee will determine the need for further audits and/or action plans.	

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F 698	Continued From page 62 [the facility] didn't schedule it." During an interview on 10/13/22 at 10:08 AM E37 (transportation coordinator) confirmed R105's missed dialysis appointment and showed the surveyor a transportation form for R105 to receive transportation to dialysis that was dated 10/3/22. R105 was admitted to the facility 9/21/22. During an interview on 10/13/22 at 11:18 AM E25 (RN unit manager) confirmed the facility does not arrange transportation to dialysis for new residents. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		11/30/22

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F 732	Continued From page 63 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for three out of three units the facility failed to ensure the nurse staff data posting requirement was accurate and complete. Findings include: 1. 10/7/22 8:37 AM - During a random observation of the facility's ventilator unit, the staff posting displayed was dated for the day prior, 10/6/22, the finding was immediately confirmed by E29 (ICP). 10/12/22 12:26 PM - During a random observation of the facility's ventilator unit, the staff posting displayed was dated for the day prior, 10/11/22, the finding was immediately confirmed by E7 (LPN). 2. 10/11/22 - Observations of the two units, The	F 732	1. A] Facilities must post the nurse staffing data on a daily basis at the beginning of each shift. Policy was not followed as the previous shift schedule was posted. B] All residents have the potential to be affected. Director of Nursing, ADON, and scheduler were notified that the prior day□s staffing posting information was not changed to the current days posting. Scheduler posted the current days□ schedule. Administrator and scheduler posted same at each of the 3 units. DON, ADON and Scheduler were educated on proper posting requirements by Administrator on 10/18/22. C] Root cause analysis determine that scheduler is aware of the requirements. The documentation provided to the units	

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F 732	Continued From page 64 Reserve and The Riverwalk from 9:42 AM - 9:55 AM revealed the total number of hours worked for nurses was not broken down into Registered Nurses and Licensed Practical Nurses, but was combined for both categories. 10/14/22 10:02 AM - In an interview, E6 (Scheduler) confirmed that the nurses hours were documented in the staff posting collectively and not broken down into Registered Nurses and Licensed Practical Nurses. 10/18/22 9:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 732	was not changed by scheduler or nursing staff to reflect current information. Scheduler will provide each unit a current posting daily. The DON or designee will educate the nursing supervisors, nurse managers and scheduler on the requirements of posting current date schedule on or by November 30, 2022. D] The ADON/designee will monitor the daily postings and ensure all three units are current. A nursing designee will ensure daily posting are current on the weekend. DON/designee will monitor for compliance until facility consistently reach 100% success over 3 consecutive evaluations. Audits will be completed 5x/week for 3 weeks, then 3s/week for3weeks, then weekly for 3 weeks. DNS or designee will report any negative finding of audits to QAPI. Data will be collected on a tracking tool. 2. A. Current posting format listed □nurse 1, nurse 2&□ and did not differentiate between LPN and RN and posting combined LPN/RN hours. Posting format was edited to separate the LPN and RN hours by scheduler and posted. B] All residents have the potential to be affected. Director of Nursing, ADON, and scheduler were notified that the daily staffing posting information did not contain the appropriate breakdown of staffing by shift/licensure. Scheduler edited schedule with the corrected days□s breakdown of staff. Administrator and scheduler posted same at each of the 3 units. DON, ADON and Scheduler were educated on proper posting requirements by Administrator on 10/18/22.	

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F 732	Continued From page 65	F 732	C] Root cause analysis determine that scheduler was unaware of the requirements of the separation of LPN/RN hours posting. The DON or designee will educate the nursing supervisors, nurse managers and scheduler on posting s schedule by licensure hours. The ADON will monitor the daily postings and ensure all three units are current. A nursing designee will ensure daily posting are current on the weekend. Review of the policy for posting nurse staffing information- no edits needed. The DON or designee will educate the nursing supervisors, nurse managers and scheduler on the requirements of the posting on or by November 30, 2022. D] The ADON/designee will monitor the daily postings and ensure all three units are current. A nursing designee will ensure daily posting are current on the weekend. DON/designee will monitor for compliance until facility consistently reach 100% success over 3 consecutive evaluations. Audits will be completed 5x/week for 3 weeks, then 3s/week for3weeks, then weekly for 3 weeks. DNS or designee will report any negative finding of audits to QAPI. Data will be collected on a tracking tool.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		12/1/22

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F 755	Continued From page 66 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two out of three sampled medication carts the facility failed to ensure that an account of all controlled drugs were maintained. Findings include: 10/17/22 beginning at 11:30 AM - The following Narcotic Count Sheets were reviewed, which lacked evidence that the facility maintained account of all controlled drugs and following findings were confirmed with E9 (LPN, UM):	F 755	Medication carts #4 and #5 narcotic count sheets are current with signatures The facility had no opportunity to correct the deficient practice. Narcotic count sheets are reviewed daily by the DON/Unit Manager for compliance of signatures. Nurses who fail to sign shall be asked to return to complete their signatures. The root cause analysis identified the staff failed to follow protocol on signing the	

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F 755	Continued From page 67 - Medication Cart #4 lacked signatures of either the outgoing or on coming nurses on 10/5/22, 10/8/22, and from 10/15/22 through day shift on 10/17/22. - Medication Cart #5 lacked signature of either the outgoing or on coming nurse on 10/7/22 and 10/10/22. 10/18/22 beginning at approximately 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 755	controlled substance count sheet at change of shift. The Staff Development RN/designee shall in-service all licensed nursing staff on facility Controlled Substance policy. The Director of Nursing or designee will continue to review the controlled substance count sheets determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, . The QA committee will determine the need for further audits and/or action plans.	
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	F 756		12/1/22

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F 756	Continued From page 68 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R9, R22, R104, R21, R25, and R45) out of six residents sampled for medication review, the facility failed to consistently act on irregularities identified during medication regimen reviews (MRRs) by the pharmacist . In addition, for R21, the facility failed to have evidence that a MRR was conducted between the the MRR dated 11/28/21 and 1/25/22. Lastly, the facility failed to develop policies and procedures for the monthly MRR that included, but not limited to, time frames for different steps in the MRR process and steps the facility must take when the pharmacist identifies an irregularity that requires urgent action to protect the resident. Findings include:	F 756	Resident□s R# 25 and 104 no longer reside in the facility. Resident□s R# 9, 21, 22 and 45 have had their medications reviewed by the physician and changes made as the physician deemed necessary. The facility had no opportunity to correct the deficient practice. All residents have the potential to be affect by the deficient practice. Current and new residents pharmacist recommendation are reviewed by the DON/designee to identify other residents that have been affected. Staff Development RN/designee shall in-service licensed nursing staff on facility policy Medication Therapy.	

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F 756	Continued From page 69 1. Cross Refer F842, example #4 Review of R22's clinical record revealed: 10/10/22 - R22's MRR's from September 2021 - September 2022 were reviewed. The pharmacist identified irregularities on the following dates: 11/28/21, 1/24/22, 2/23/22, 3/21/22, 4/30/22, 5/28/22, 7/31/22, and 8/28/22. There was no response by E32 (Medical Director) found in the clinical record. 2. Cross Refer F842, example #3 Review of R9's clinical record revealed: 10/12/22 - R9's MRR's from September 2021 - September 2022 were reviewed. The pharmacist identified irregularities on the following dates: 3/21/22, 4/30/22, and 9/21/22. There was no response by E32 (Medical Director) found in the clinical record. 3. Cross Refer F758 Review of R104's clinical record revealed: 10/12/22 - R104's MRR's for June 2022 and July 2022 were reviewed. The pharmacist identified irregularities on the following dates: 6/24/22 and 7/31/22. There was no response by E32 (Medical Director) found in the clinical record. 10/12/22 11:20 AM - During an interview, E2	F 756	The root cause analysis identified that staff failed to address Pharmacist recommendations with the physician in a timely manor. The Staff Development RN/designee shall in-service licensed nursing staff on facility policy Medication Therapy. The Director of Nursing or designee will continue audits pharmacist recommendations to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QA committee will determine the need for further audits and/or action plans.	

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F 756	Continued From page 70 (DON) stated that prior to this surveyor's inquiry, in order for her to review incomplete EHR (electronic health records) evaluations/assessments including the monthly Pharmacy Consultant Resident Recommendations, she would look at all the pending tasks. The tasks under the monthly pharmacy review showed "completed" for her when accessed. E2 further stated that it must have something to do with how the pharmacy documentation was saved and typed in the EHR that automatically populated a completed task for her when she reviewed. 10/12/22 11:25 AM - E2 confirmed that there was no physician response to several months of R9, R22 and R104's pharmacy recommendations and they were not in the clinical record. 10/14/22 10:30 AM - In an interview, RPh1 (Pharmacy Consultant) stated that at the beginning of this year, he was advised by the facility corporate to save and lock his documentation everytime he conducts the monthly pharmacy medication review and transcribes it in the Pharmacy Consultant Resident Recommendations tab of the facility's EHR. 4. Review of R21's clinical record revealed the following: 9/21 through 9/22 - The review of the facility's monthly regimen review (MRR) report, the monthly Pharmacist Consultant Resident Recommendations Report revealed the following: - The facility failed to ensure for the following seven (7) MRR reports with irregularities	F 756		

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F 756	Continued From page 71 identified by RPh1(Pharmac st) were reported to the attending physician, the facility's medical director, and director of nursing, and these reports were acted upon: 9/26/21, 10/31/21, 11/28/21, 1/25/22, 2/23/22, 3/21/22, 4/30/22, 5/28/22, 6/24/22, 6/30/22, 7/31/22, 8/28/22, and 9/22/22. - The facility failed to have evidence that a MRR was conducted between the the MRR dated 11/28/21 and 1/25/22. 5. Cross Refer F842, Example #2. Review of R45's clinical record revealed the following: 9/2021 through 9/2022 - The review of the facility's monthly regimen review (MRR) report, the monthly Pharmacist Consultant Resident Recommendations Report revealed the following: The facility failed to ensure for R45, eight monthly irregularities identified by RPh1 (Pharmacist) were reported to the attending physician, the facility's medical director, and director of nursing, and these reports must be acted upon. The monthly reports were dated - The facility failed to ensure for the following eight (8) MRR reports with irregularities identified by RPh1 were reported to the attending physician, the facility's medical director, and director of nursing, and these reports were acted upon: 12/24/21, 1/24/22, 2/23/22, 3/31/22, 5/27/22, 6/24/22, 7/31/22, and 8/28/22. 6. Review of R25's clinical record revealed the following:	F 756		

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F 756	Continued From page 72 6/11/22 - R25 was admitted to the facility. 6/2022 through 9/2022 - The review of the facility's monthly regimen review (MRR) report, the monthly Pharmacist Consultant Resident Recommendations Report revealed, the facility failed to ensure four (4) monthly irregularities identified by RPh1 (Pharmacist) were reported to the attending physician, the facility's medical director, and director of nursing, and these reports must be acted upon. The monthly reports were dated 6/24/22, 7/31/22, 8/28/22, 9/22/22. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	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; (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;	F 758		12/1/22

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F 758	Continued From page 73 §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. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R104) out of five residents sampled for unnecessary medications the facility failed to limit a PRN (as needed) psychotropic medication orders to 14 days . Findings include: Cross Refer F756 example #3 Review of R104's clinical record revealed:	F 758	Resident R# 104 no longer resides in the facility. The facility had no opportunity to correct the deficient practice. All residents have the potential to be affected by the deficient practice. The DON/designee have reviewed current residents to identify any others affect by this deficient practice. The root cause analysis identified that staff failed for follow protocal for review of	

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F 758	Continued From page 74 6/16/22 - R104 was admitted to the facility. 6/20/22 - R104 had a physician's order for Lorazepam) concentrate 2 mg/ml give 0.25 ml by mouth every 6 hours PRN (as needed) for anxiety/SOB (shortness of breath). 6/24/22 - A Pharmacy Consultant recommended the physician's order be limited to 14 days. 7/31/22 - A Pharmacy Consultant Resident Recommendation suggested physician's order include a length of therapy up to 90 days. 10/17/22 - Review of R104's Medication Administration Records from June 2022 through August 2022 revealed the following: -June 2022 - R104 received 1 dose of PRN Lorazepam -July 2022 - R104 received 12 doses of PRN Lorazepam -August 2022 - R104 received 4 doses of PRN Lorazepam The facility failed to provide evidence that R104 was reassessed by the physician for the need to extend the use of Lorazepam for more than 14 days. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 758	psychotropic medication orders. The Staff Development RN/designee are in servicing licensed nursing staff on facility policy Psychotropic Medication Use. The Director of Nursing or designee will continue audits on psychotropic medication orders to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for further audits and/or action plans.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		12/1/22

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F 761	Continued From page 75 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs l sted in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation it was determined that the facility failed to store and maintain drugs in accordance with acceptable professional standards by having expired or discontinued medications or biologicals in two out of three medication carts and one out of two medication storage rooms. Additionally, the facility failed to ensure for one out of three medication rooms and two out of three medication carts inspected, that the drugs and biologicals were kept in locked compartments with only authorized personnel having keys to access. Findings include:	F 761	Medications are being stored properly when medication are not in use by the nurse. Expired medications are removed from the medication carts and medication rooms. The facility has no opportunity to correct the deficient practice. Rounds are being completed by the DON/designee on medication storage and expired medications to identify that there are no other issues identified related to the deficient practice. The root cause analysis identified the staff failed to follow protocol for locking on med carts, storage of medications and	

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F 761	Continued From page 76 The facility's policy titled, Storage of Medication , with a revision date of 4/2007, indicated "...The facility shall not use discontinued, outdated...drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed...7. Compartments (including, but not limited to, drawers, cabinets, rooms, ...carts...) containing drugs and biologicals shall be locked when not in use...10. Only persons authorized to prepare and administer medications shall have access to the medication room, including keys." 1. 10/17/22 10:20 AM - During random observation of the Reserve Unit's medication storage room with E25 (LPN, UM), the following expired biologicals were observed: - Juven (nutritional supplement) packets, 20 packets with expiration date of 8/2022 - Povidone iodine (a skin disinfectant) solution 16 oz, two bottles with expiration date of 9/2022 2. 10/17/22 10:45 AM - During random observation of medication cart #4 with E7 (LPN) revealed the following expired and/or discontinued medications or biologicals: - unopened bottle of Advil containing 10 tablets with expiration date of 3/2022 - Juven supplement packets, four (4) packets with an expiration date of 8/2022 - opened tube of Santyl ointment with an expiration date of 9/8/22 - discontinued Lispro insulin pen for R23 - discontinued Lantus insulin for R22 3. 10/12/22 beginning at 4:22 PM - E24 (RN) left the medication cart #4 unlocked, unsecured and unattended in the hallway and entered R22's room to administer her medications. On top of the medication cart, there were two medications	F 761	destruction of expired medications. The Staff Development RN/designee are providing in-servicing on facility policies Security of Medications and Storage of Medications. The Director of Nursing or designee will continue audits on locking of medication carts, destruction of expired medications and storage of medications. to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, . The QA committee will determine the need for further audits and/or action plans.	

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F 761	Continued From page 77 unsecured inside the medication cart. At 4:44 PM, E24 confirmed that the medication cart and the two medications were not locked in the medication cart for approximately 22 minutes. E24 immediately placed the medications in the medication cart and locked the cart. 4. 10/17/22 beginning at 10:15 AM - During random observation of medication cart #2 revealed the cart was unlocked and unattended. At 10:18 AM, E25 (LPN, UM) walked by the cart and proceeded to lock the cart and interview immediately after this observation with E25 confirmed that the cart was unlocked and unattended until 10:18 AM and should have been locked. 5. 10/7/22 8:26 AM - The medication room on the unit was observed with the entry door opened and medications visible on the counter. During an interview on 10/7/22 8:31 AM E27 (RT) accompanied the surveyor to the medication room and confirmed the open door and visible medications. E27 then closed the door and demonstrated that the door locked upon closing and a badge must then be swiped for entry. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		12/1/22

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F 791	Continued From page 78 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 791		

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F 791	Continued From page 79 Based on observation, interview, record review and review of the facility's policy, it was determined that for two (R45 and R21) out of four residents reviewed for dental services, the facility failed to assist in obtaining routine dental services. Findings include: Review of the facility's policy and procedure titled Dental Services with a revision date of December 2016 stated, "...Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care..." 1. Review of R21's clinical record revealed: 10/30/20 - R21 was admitted to the facility. 11/6/21 - The Annual MDS Assessment indicated that R21 was moderately impaired for daily decision making, required extensive assistance of one staff for personal hygiene, and had no oral health issues. 10/7/22 8:34 AM - A random observation revealed R21 with missing upper and lower teeth and R21 denied pain or discomfort of her teeth, gums, and/or mouth. R21 states she was uncertain if she had received any dental services, including routine dental. There was lack of evidence that R21 was offered and/or received routine dental services. 10/12/22 1:00 PM - An interview with E2 (DON) confirmed that the facility was unable to provide evidence that R21 was offered and/or received routine dental services.	F 791	Residents R# 21 and 45, remain in the facility have been assessed for any dental concerns at present. The facility had no opportunity to correct the deficient practice All residents have the potential to be affected by the deficient practice. Audits are being completed by the DON/designee on residents with natural dentation to identify other residents that have been affected. The facility has signed a contract with Senior Dent for dental services in the facility. The root cause analysis identified that the facility failed to provide routine dental care to 2 of our residents. The Staff Development RN/designee are inservicing all licensed nursing staff on facility police Dental Care. The Director of Nursing or designee will continue audits on residents dental needs to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for further audits and/or action plans.	

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F 791	Continued From page 80 2. Review of R45's clinical record revealed: 7/31/20 - R45 was admitted to the facility. 8/23/22- The Annual MDS Assessment indicated that R45 was independent with daily decision making and had no oral health issues. 10/7/22 11:24 AM - A random observation revealed R45 with upper and lower teeth and R45 denied pain or discomfort of her teeth, gums, and/or mouth. R45 stated she has not had any dental services, including routine since admission to the facility on 7/31/20. There was lack of evidence that R45 was offered and/or received routine dental services. 10/12/22 1:00 PM - An interview with E2 (DON) confirmed that the facility was unable to provide evidence that R45 was offered and/or received routine dental services. 10/18/22 beginning at approximately 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 791		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of	F 825		12/1/22

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F 825	Continued From page 81 care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R105) out of two residents reviewed for rehabilitation services the facility failed to ensure speech services were provided in accordance with the residents plan of care. R105 was ordered to receive eight visits over four weeks and received three visits total over three weeks. Findings include: Review of R105's clinical record revealed: 9/21/22 - R105 was admitted to the facility. 9/21/22 - The following order was written for R105, "Speech therapy evaluate and treat as indicated". 9/22/22 - A speech therapy evaluation and plan of treatment for R105 documented a frequency of eight visits in four weeks, from 9/22/22 - 10/21/22. Review of R105's speech therapy encounter notes revealed R105 was visited by the speech therapist a total of three times, 9/22, 9/27, and 10/13 over three weeks.	F 825	A] R105 did not receive correct frequency of speech visits as per evaluation and plan. B] All residents have the potential to be effected. C] ¿ Issue brought forth by state surveyor regarding lack of Speech services was reviewed with corporate team and Administrator to arrange to have sufficient speech coverage for necessary treatments. Director of Rehabilitation and Administrator will be responsible for existing casual employee to provide consistent schedule and this commitment will be secured through facility administration. D] Administrator /designee will confirm number of speech staff levels on a daily weekly basis for 4 weeks, and then weekly basis for 4 weeks and then monthly until 100% compliance is achieved for two consecutive months.	

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F 825	Continued From page 82 During an interview on 10/6/22 at 12:47 PM, FM4 reported to the surveyor, "There's no full time speech therapist on staff so he's not getting amount of visits prescribed." During an interview on 10/14/22 at 11:42 AM, E35 (DOR) confirmed the facility did not have a full time speech therapist on staff. E35 stated speech therapist visit, "2-3 times a week if they can". During an interview on 10/14/22 at 12:37 PM, E35 (DOR) confirmed that at present R105 had received three our of eight scheduled visits. E35 also stated that R105 had "none scheduled at present" and that "two to three per week typically" would have been needed to meet R105's ordered eight visits in four weeks. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 825		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		12/1/22

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F 842	Continued From page 83 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 84 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation as necessary, it was determined that for four (R9, R22, R25, and R45) out of 38 sampled residents, the facility failed to ensure that medical records were accurate. Findings include: Review of The National Pressure Ulcer (PU) Advisory Panel staging, revised in April 2014 revealed the following staging a PU: - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. 1. Review of R25's clinical records revealed the following: 6/11/22 - R25 was admitted to the facility. 6/11/22 11:28 AM - The Admission Nursing Assessment and the Skin Only Progress Note lacked evidence of a PU of the heel.	F 842	Resident R#25 no longer resides in the facility. Residents # 9, 22, and 45 have been reviewed for their Pharmacist recommendation to ensure signatures are in place. The facility had no opportunity to correct the deficient practice.. All residents have the potential to be affected. Audits were completed by the DON/designee to identify that no others have been affected by the deficient practice. The root cause analysis identified that the facility failed to follow protocol related to skin assessment and pharmacist monthly reviews. The Staff Development RN/designee are in servicing staff on "Admission Assessments and Medication Management", and in-servicing for the Pharmacy Consultant on the monthly medication regimen reviews. The Director of Nursing or designee will continue random interviews audit for all residents to determine compliance. The audit will be conducted at the rate of 10% weekly until 100% compliance is achieved	

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F 842	Continued From page 85 There was lack of documentaion of additional PU on admission. 6/13/22 1:00 AM (electronically dated and signed 6/14/22 and 10:27 AM respectively) - The Encounter Progress Note by E31 (NP) documented, "...History of Present Illness:...on 6/2/22...Physical Exam...Skin ...right heel blister..." There was lack of evidence of identifying the right heel blister as a PU and comprehensively assessing and documenting the characteristics of the PU, including the stage of the PU. 10/7/22 11:55 AM - An interview with E2 (DON) revealed R25 was admitted with PU of sacrum and on the right heel. 10/17/22 8:40 AM - An interview with E31 (NP) revealed that her first assessment of R25 was during day shift on 6/13/22 and it was her understanding that the blister on R25's right heel was present on admission to the facility on 6/11/22. E31 stated the the blister was intact and not open without maroon or purple color. The interventions initiated upon admission were to float the heels and to apply sure prep (skin protectant). 10/17/22 approximately 10:30 AM - E2 (DON) provided hospital records dated 5/27/22 which provided evidence that R25 had a right heel intact fluid filled blister prior to R25 being admitted to the facility on 6/11/22 and verbalized that the facility did not document the presence of the PU on admission. 2. Cross refer F756, Example #5.	F 842	for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QAI committee will determine the need for further audits and/or action plans.	

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F 842	Continued From page 86 Review of R45's clinical record revealed the following: 9/30/21 and 10/31/21 - The facility's two, monthly regimen review (MRR) reports lacked evidence of the signature of RPh1 (Pharmacist), however, E34 (Former ADON) electronically signed the report. 3. Cross Refer F756, Example #2. Review of R9's clinical record revealed the following: 9/26/21 - The facility's monthly regimen review (MRR) lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON). 10/31/21 - The MRR lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON). 4. Cross Refer F756, Example #1. Review of 22's clinical record revealed the following: 9/1/21 - The facility's MRR Report lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON). 9/26/21 - The MRR lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON).	F 842		

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F 842	Continued From page 87 10/31/21 - The MRR lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON). 11/28/21 - The MRR lacked evidence of the signature of the Pharmacy Consultant and included the electronic signature of E34 (Former ADON). 10/18/22 beginning at approximately 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		11/16/22

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F 880	Continued From page 88 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.	F 880		

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F 880	Continued From page 89 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other documentation as indicated, it was determined that the facility failed to maintain an effective infection prevention and control program by failing to clean and disinfect the blood glucose meter between resident uses. In addition, failed to ensure adherence to infection control practices when staff picked up a resident's oral medication using her bare hand, thus, contaminating the medication and failed to discard the medication. Findings include: Review of the manufacturer's instructions for Assure Prism Multi Blood Glucose Monitoring System (a glucometer) revealed the following: - ...The meter should be cleaned and disinfected after use on each patient...(meter) may only be used for testing multiple patients when...the manufacturer's disinfection procedure is followed...A variety of the most commonly use EPA registered wipes have been tested and approved for cleaning and disinfecting the (meter)...". 1. During random medication pass observation on 10/12/22 beginning at 3:53 PM, E36 (RN) performed FSBS on R40 by using the Assure Prism meter and after the use, E36 cleansed the glucometer with alcohol pad. An interview immediately after the observation confirmed that E36 used an alcohol pad to clean the meter and failed to use an approved EPA approved cleaning and disinfectant wipe.	F 880	Resident R#40 no longer resides in the facility. Resident R#22 continues to receive FSBS with proper cleaning of the Assure Prism meter and oral medication administration. DON/designee are doing observation rounds to determine proper cleaning, and medication administration. The facility had no Opportunity to correct the deficient practice. All residents have the potential to be affected by the deficient practice. The DON/designee have completed audits to identify no other residents have been affected by the deficient practice. The root cause analysis identified that No PDI Sani-Wipes on the medication carts when nurses looked for them. Nurses looked in the wrong storage cabinets for the PDI Sani-Wipe s. Nurses unaware that alcohol wipes are not among the approved disinfectants for cleaning the glucometer per the manufacturer□s instructions. Nurses failed to follow policy and manufacturer□s instructions for disinfection . The nurse failed to follow facility policy and standard regarding not handling medication with their hands and if so disposing of the medication. The staff development RN/designee have inserviced licensed nursing staff on Need to check their medication carts at start of shift to ensure PDI Sani-Wipe supplies. Where the PDI Sani-Wipes are stored on	

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F 880	Continued From page 90 2a. During random medication administration observation on 10/12/22 beginning at 4:22 PM, E24 (RN) after performing FSBS on R22 by using the Assure Prism meter, E24 stated that she uses alcohol pad to clean the meter after resident use but if she had time, she would use a disinfectant wipe. E24 proceeded to the nurses station where she was met by E3 (ADON) who stated that the facility used an EPA approved disinfectant wipe to clean and disinfect the meter in between resident use. 2b. During random medication observation beginning 10/12/22 at approximately 4:30 PM, E24 poured an oral medication (one tablet) into a medication cup and proceeded to administer to R22, however, the pill dropped out of the medication cup onto R22's clothing. E24 subsequently picked up the pill with her bare right hand, placed it back into the medication cup, gave the cup to R22 who proceeded to swallow the medication. An interview immediately after the above observation with E24 confirmed that she picked up the pill with her bare hand and she should have discarded the medication as it was contaminated. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 880	the unit. Facility policy and manufacturer□s instructions for glucometer disinfection with the approved disinfectant. Nurses will be educated on facility policy and standard to not handle oral medication with bare (ungloved) hands and if so to discard per policy and obtain another dose. The DON/designee shall complete audits on Audits of medication administration will be performed to ensure aseptic medication administration technique. The audit will be conducted at the rate of 10% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QAI committee will determine the need for further audits and/or action plans.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the	F 887		12/1/22

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F 880	Continued From page 90 2a. During random medication administration observation on 10/12/22 beginning at 4:22 PM, E24 (RN) after performing FSBS on R22 by using the Assure Prism meter, E24 stated that she uses alcohol pad to clean the meter after resident use but if she had time, she would use a disinfectant wipe. E24 proceeded to the nurses station where she was met by E3 (ADON) who stated that the facility used an EPA approved disinfectant wipe to clean and disinfect the meter in between resident use. 2b. During random medication observation beginning 10/12/22 at approximately 4:30 PM, E24 poured an oral medication (one tablet) into a medication cup and proceeded to administer to R22, however, the pill dropped out of the medication cup onto R22's clothing. E24 subsequently picked up the pill with her bare right hand, placed it back into the medication cup, gave the cup to R22 who proceeded to swallow the medication. An interview immediately after the above observation with E24 confirmed that she picked up the pill with her bare hand and she should have discarded the medication as it was contaminated. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 880	the unit. Facility policy and manufacturer□s instructions for glucometer disinfection with the approved disinfectant. Nurses will be educated on facility policy and standard to not handle oral medication with bare (ungloved) hands and if so to discard per policy and obtain another dose. The DON/designee shall complete audits on Audits of medication administration will be performed to ensure aseptic medication administration technique. The audit will be conducted at the rate of 10% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. The QAI committee will determine the need for further audits and/or action plans.	
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(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 887	Continued From page 91 facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085058	A. BUILDING _____ B. WING _____	C 10/18/2022

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F 887	Continued From page 92 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R28) out of five residents reviewed for COVID -19 vaccination the facility failed to provide evidence that COVID-19 vaccination was offered to the resident. Findings include: The facility policy for COVID-19 vaccination of residents and staff created May 2021, indicated, "The facility will offer all unvaccinated residents (or the resident representative) vaccination against COVID-19." Review of R28's clinical record revealed: 6/4/22 - R28 was admitted to the facility. R28's immunization record documented the resident as having refused COVID 19 vaccination.	F 887	Resident R# 28 remains in the facility. She has been offered the COVID vaccine and refused as of 10/14/2022. Current resident have been offered COVID vaccine. And documentation is in their clinical record. The Staff Development RN/designee has in-serviced licensed nursing staff on facility policyCOVID-19 vaccinations. The Director of Nursing or designee will continue audits to determine compliance. The audit will be conducted weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting, The QA committee will determine the need for	

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F 887	Continued From page 93 10/14/22 1:28 PM - The surveyor requested R28's documentation of refusal and education regarding COVID-19 vaccination. E29 (ICP) presented the surveyor with a refusal of COVID 19 vaccination dated 10/14/22. E29 stated she believed R29 refused previously but did not have the documentation and obtained the refusal presented to the surveyor that day after surveyor request the documentation. 10/18/22 9:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 887	further audits and/or action plans.	