STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	9/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	8365 NEWBURGH RD WESTLAND, MI 48185

(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
F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center of Westland was surveyed for a recertification survey on 09/22/2022. Census=134.	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual	F0578	Element 1: Upon notification, resident R129□s advance directive form was found in the soft file. An order for full code was entered for the resident. Element 2 All current residents are at risk to be affected by the cited practice. The Director of Social Services had audited all of the residents in the facility to ensure that advance directives were completed, orders placed and uploaded in the electronic health record. Risk analysis: Social Service staff are to accurately coordinate the completion, uploading and ordering of advance directives. Any variances upon identification were corrected immediately. If there is no DPOA or legal representative and the resident is not capable of making appropriate decisions, resident will default to be full code. Element 3: The Policy on Advance Directives was reviewed and deemed appropriate. IDT, Nursing, Social Services and Medical Records clerk were re-educated on the reviewed policy with emphasis on timely completion, uploading and writing orders for advance directives. Element 4: The Social Service Director will randomly audit 10% of resident□s advance directives weekly for 4 weeks and then monthly for 2 months to ensure that an advance directive is entered in the resident□s clinical record. Any deficient practice will be immediately	10/17/2022

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

Electronically Signed | 10/17/2022

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	once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately record code status for one sampled resident (R129) out of two reviewed for Advance Directives, resulting in a lack of assessment and documentation of code status, and the potential for a resident not to receive life sustaining medical treatment as they wish. Findings Include: A review of the medical record revealed that R129 admitted into the facility on 8/26/2022 with the following diagnoses, Non-Traumatic Intracerebral Hemorrhage, Aphasia, and Muscle Weakness. A review of the Minimum Data Set (MDS) dated 8/29/2022 revealed a Brief Interview of Mental Status (BIMS) score of 0/15 indicating a severely impaired cognition. R129 also required one person limited to total dependence with bed mobility and transfers. Further review of the medical record failed to reveal a code status for R129. On 9/21/2022 at 1:28 PM, a copy of the advance directive for R129 was received via email. Review of the advance directive dated 8/29/2022 noted the following, "Full code by default. Son pursuing L.G (Legal		addressed by the social service staff. Results of the audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The Director of Social Services is responsible for continued monitoring. The Administrator is responsible for ongoing compliance with regulatory requirements. Element 5: Date of completion: 10/17/22	

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	Guardianship)." On 9/22/2022 at 9:03 AM, an interview was conducted with Accounts Payable (AP) "G" regarding the advance directive. AP "G" stated that they did email the advance directive for R129 but that they have no role in it. AP "G" stated that they were unaware that the advance directive was not uploaded in the R129's chart. On 9/22/2022 at 9:21 AM, an interview was conducted with Social Worker (SW) "H" regarding advance directives in the facility. SW "H" stated that upon admission the SW's obtain the advance directives and then they are given to the Director of Nursing (DON) to upload in the system and put the orders in. On 9/22/2022 at 2:19 PM, an interview was conducted with the Director of Nursing (DON) regarding R129's advance directive not being in R129's medical record. The DON stated that they usually put the Advance Directives in the residents' charts, but they have been looking for medical records staff. The DON stated that the nurses know that if there is no paperwork, the nurses do know to treat them as a full code. A review of a facility policy titled, "Advance Directive" and dated 6/29/2022 noted the following, " ...3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff."			

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F0656 SS= D	Develop/Implement Comprehensive Care Plan §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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F0656	Element 1: R81: Upon notification, resident was re-evaluated for current fall interventions and it was determined that she did not need bilateral floor mats and perimeter mattress. Both interventions were discontinued, care plan was updated. Resident did not suffer negative outcome from the cited practice R135: Upon notification, resident□s care plan was reviewed. Bilateral floor mats are in place, no negative outcome from the cited practice. R48: Upon notification, resident□s care plan was reviewed. Bilateral floor mats are in place, no negative outcome from the cited practice. Element 2 All current residents who are at risk for falls were identified and their care plans were reviewed. Fall interventions are implemented based on care plans. Risk analysis: Nursing staff are to follow fall interventions as care planned. Variances upon identification were corrected immediately. Element 3: The Policy on Care Plans and Fall Interventions were reviewed and deemed appropriate. IDT, Nursing and Housekeeping staff were re-educated on the reviewed policy. The Nurse Managers will conduct weekly audits to ensure that fall interventions are implemented according to the care plan. Element 4: The Nurse Managers or designee will randomly audit 10% of resident□s care plan with fall interventions weekly for 4 weeks and then monthly for 2 months to ensure that fall interventions are in place as identified in the care plan. Any deficient practice will be immediately addressed by the facility nursing staff according to plan of care. Results of the	10/17/2022

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement fall interventions for three of seven residents (R48, R81, and R135) reviewed for falls resulting in the potential for injury. Findings include: Resident 81 (R81) On 9/20/22 at 10:23 AM, R82 was observed asleep in bed, no bilateral floor mats were observed on the floor. In addition, there was no perimeter mattress observed in place. A review of R81's medical record revealed that they were admitted into the facility on 2/13/18 with diagnoses that included Dementia, Depression and Muscle Weakness. A review of their Minimum Data Set assessment dated 8/5/22 revealed a 3/15 Brief Interview for Mental Status score of 3/15 indicating a severe cognitively impairment, and required extensive assistance with Activities of Daily Living. A review of R81'a care plan revealed the following: Focus: [R81] is at Risk for Fall and Potential for Injury related to: dementia with poor decision making skills, impaired mobility unsteady gait and poor balance, uses wheelchair for locomotion as needed and requires limited staff assistance with all[their]		audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The Director of Nursing is responsible for continued monitoring. The Administrator is responsible for ongoing compliance with regulatory requirements. Element 5: Date of completion: 10/17/22	

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	transfers. Resident's safety is monitored by staff daily. Has history of recent exiting building with fall. Date Initiated: 04/30/2019. Interventions:.. Bilateral floor mats, while in bed. Date Initiated: 06/21/2021...Perimeter mattress on bed at all times. Date Initiated: 06/21/2021..." A review of R81's physician's orders also noted the following order dated for 6/21/21, "B/L (bilateral) floor mats while in bed & concave mattress." Resident 135 (R135) On 9/20/22 at 10:28 AM, R135 was observed asleep in bed lying on their right side. One fall mat was observed on the left side of the resident's bed. A review of R135's medical record revealed that the resident was admitted into the facility on 2/18/21 with diagnoses that included Dementia, Acute Kidney Failure, and Depression. Further review of the resident's medical record revealed a cognitive impairment and required extensive assistance with Activities of Daily Living. On 9/21/22 at 9:14 AM, R135 was observed in bed asleep. The same one fall mat was observed on the left side of the resident's bed. On 9/22/22 at 9:45 AM, R135 was observed in bed asleep. One fall mat was observed on the			

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right side of the resident's bed.

A review of R135's care plan revealed the following, "Focus: [R135] Is at risk for Fall(s) and Potential for Injury related to: cognitive impairment, dementia with impaired decision making skills and poor safety awareness, muscle weakness, potential side effect of medications used, psychotropic medication use. Resident's safety is monitored by staff daily. Date initiated: 02/26/2021. Interventions: B/L (bilateral) floor mats while in bed. Date initiated: 06/22/2022..."

A review of R135's physician orders dated for 6/22/22 revealed the following, "B/L floor mats while in bed. Every shift check for placement."

R48

On 9/20/22 at 10:28 AM, R48 was observed in their room lying in bed. R48's left side of the bed was observed with a fall mat and another fall mat against the wall under the tv. R48 was unable to be interviewed due to cognitive impairment.

On 9/20/22 at 12:33 PM, R48 was observed in bed with the fall mats in the same position as before.

On 9/21/22 at 8:25 AM and on 9/22/22 9:10 AM, R48 was observed in lying in bed, the bilateral fall mats were not on the floor next to bed.

A review of R48's care plan noted, "Focus: Risk for Fall(s) and Potential for Injury related to: [R48] has history fall, dementia with impaired decision making skills and psychotropic

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	medication use Date Initiated: 04/21/2022. Goal: Will have minimized risk factors for falls daily x 90 days Date Initiated: 04/21/2022. Intervention: Bilateral floor mats Date Initiated: 05/05/2022. Bilateral mobility bars to aid with transfers and bed mobility. Date Initiated: 04/21/2022. Fall assessment per facility protocol Date Initiated: 04/21/2022. frequent check and change res as tolerated Date Initiated: 08/29/2022." A review of R48's medical record noted, R48 was admitted to the facility on 4/7/22 with diagnosis of multiple rib fractures of the right side. A review of R498's MDS assessment noted, an impaired cognition and required extensive to total assistance with activities of daily living. On 9/22/22 at 1:36 PM, the DON was asked about fall mats not being in place of the floor and stated, "They should be down. We even in-serviced housekeeping to make sure they put them back in place." A review of the facility's "Care Plan" policy was reviewed and did not address implementing care planned interventions.			
F0657 SS= D	Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical	F0657	Element 1: Upon notification, R96's care plans were reviewed. A behavior care plan was initiated for resident's pulling out his tracheostomy tube. Interventions are in place. Element 2 All current residents due for comprehensive care plans were identified and are considered like residents. Risk analysis: IDT, nursing and Social Services are to initiate a care plan in a timely manner for residents within 7 days upon the completion of the comprehensive assessment. Variances upon identification will be corrected immediately.	10/17/2022

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	record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to address a behavior in a care plan for one sampled resident (R96) out of one reviewed for behaviors, resulting in the lack of interventions and respiratory distress. Findings Include: A review of the medical record revealed that R96 admitted into the facility on 7/27/2022 with the following diagnoses, Respiratory Failure with Hypoxia, Encephalopathy, and Encounter for Attention to Tracheostomy (trach). Further review of the Minimum Data Set (MDS) dated 8/2/2022 revealed a Brief Interview for Mental Status score of 99, indicating R96 was unable to complete the assessment. R96 also required extensive to total two persons assist with transfers and bed mobility. A review of the progress notes revealed the following,		Element 3: The Policy on “Care Plans” was reviewed and deemed appropriate. IDT, Nursing and Social Service staff were educated on the reviewed policy. All identified concerns by the IDT from the comprehensive assessment or care conferences will be care planned within the 7 day time frame. The MDS staff will conduct weekly audits to ensure that care plans are completed timely. Element 4: The MDS Coordinator or designee will randomly audit 10% of residents’ care plan weekly for 4 weeks and then monthly for 2 months to ensure that care plans are completed within 7 days based on comprehensive assessment completion date. Any deficient practice will be immediately addressed by the IDT. Results of the audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The Director of Nursing is responsible for continued monitoring. The Administrator is responsible for ongoing compliance. Element 5: Date of completion: 10/17/22	

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	"Date:5/13/2022. Resident self decannulated while out on patio ..." "Date:7/30/2022 ...Writer observed residents trach pulled out and sitting on [their] chest ..." "Date:7/31/2022 ...Observed resident with both hands wrapped around [their] trach tie on either side of the trach, resident pulling tie and trach forcefully forward away from [their] neck, trach halfway out from the force of him pulling but the trach tie prevented dislodgement ..." "Date:8/12/2022 ...While CNA (Certified Nursing Assistant) was doing rounds, [they] observed that residents trach was out and notified the nurse." "Date:8/16/2022 ...Resident agitated pulling at trach causing small amount of bleeding ..." "Date:9/19/2022 ...When we went to remove trach mask to suction it was discovered that the resident had pulled out [their] trach." "Date:9/21/2022 ...Resident pulled out trach ..." A review of R96's behavior care plan did not address R96 pulling out their tracheostomy. On 9/22/2022 at 9:21 AM, an interview was conducted with Social Service Director (SSD) "J" and Social Worker (SW) "H" regarding R96			

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	not having a behavior care plan to address them pulling out their tracheostomy. SW "H" stated that the first time they heard about R96 pulling out their trach was on 9/21/2022 and when they heard about it, they updated the care plans and got psychiatric services involved. SW "J" stated that behaviors are usually brought to them in morning meetings. A review of a facility policy titled, "Care Plans" and dated 11/1/2020 noted the following, "Revisions to the care plan should be based on changing goals, preferences, and needs of the resident and in response to current interventions."			
F0677 SS= E	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provided showers and timely activities of daily (ADLs) care for six of 13 residents (R103, 109, 127, 129, 387, and 389) reviewed for ADLs, resulting in being left soiled for an extended time resident's feeling of poor hygiene, and the potential for embarrassment. Findings include: R103	F0677	Element 1 Resident 127 no longer resides in facility. Residents R103, 109, 129, 387 and 389 were provided ADL care and showers upon notification. These tasks were documented in the clinical record. Element 2 Current residents residing in the facility who require assistance with Showers and ADL□s are considered like residents. All shower schedules and ADL tasks were reviewed by the Licensed Nurse and deemed appropriate. Risk analysis: Nursing staff are to provide showers as scheduled as well as timely ADL care for residents. Said tasks will be documented in the clinical record. Variances upon identification were corrected immediately. Element 3 The facility Policy on Assisting with Activity of Daily Living including but not limited to	10/17/2022

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	On 9/20/22 at 1:30 PM R103 was asked about the care at the facility and stated, "We have to wait a long time for help." R103 was asked on what shift did this occur and explained, on all the shifts, and that the longest they have waited has been about an hour. R103 stated, "They don't have enough people to do what they need to do." R103 continued and explained, that last week the staff did not give them a shower and only received a bed bath. R103 stated, "I need my hair washed." R103 explained that they were scheduled to get a shower today and asked the CNA (Certified Nursing Assistant) and the CNA said they would be right back and never came back. A review of R103's medical record noted R103 was admitted to the facility on 2/10/22 with diagnosis of Multiple sclerosis. A review of R103's Minimum Data Set (MDS) assessment noted, R103 with an intact cognition and required total assistance with two staff members for ADLs. A review of R103's care plan noted, "Focus SELF-CARE DEFICIT (ADLs): Resident needs assistance with ADLs r/t (related to) ADL abilities will fluctuate between therapy staff and nursing staff, impaired physical mobility, weakness. Date Initiated: 02/11/2022. Goal: Resident will reach highest practicable physical, mental, and psychosocial well-being, and will continue to participate in ADLs daily x 90 days. Date Initiated: 02/11/2022. Intervention: Resident's needs will be anticipated and met daily x 90 days Date Initiated: 02/11/2022. Assist with ADLS: eating, toileting, personal hygiene, bathing, bed mobility and wheelchair mobility Q (every) shift and PRN (as needed) Date Initiated: 02/11/2022. R109		showers and grooming was reviewed and deemed appropriate. All Licensed Nurses and CNA□s were reeducated on policy by Director of Nursing/designee with special emphasis on shower□s and timely ADL care that is established for each resident to avoid residents potential feeling of poor hygiene and embarrassment. The nurse managers will conduct rounds and resident interviews weekly and as needed to ensure staff compliance for assisting resident with ADLs. Element 4 The Director of Nursing or designee will randomly audit 10% of the facility□s population weekly for 4 weeks and then monthly times 2 months to ensure showering and assistance with ADLs are carried out according to their plan of care to meet the residents needs and the potential for poor hygiene. Any deficient practice will be immediately addressed by the facility nursing staff according to the plan of care. Results of the audits will be forwarded to the facility Quality Assurance Committee for ongoing monitoring and follow up. The Director of Nursing is responsible for ongoing monitoring. The administrator is responsible for continued compliance. Completion Date: 10/17/22	

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	On 9/20/22 at 1:35 PM, R109 was asked about the stay at the facility and stated, "Waiting a long time and not getting two showers per week due to staffing." R109 explained, that the showers average once per week, not two per week, or nothing. A review of R109's medical record noted R103 was admitted to the facility on 5/14/2021 with diagnosis of Heart Failure. A review of R109's MDS noted, R103 with an intact cognition and required extensive assistance from one staff with ADLs. On 9/21/22 at 1:00 PM, both R103 and R109 reported that they had not had any AM care and last check and change was at 5:00 AM. On 9/21/22 at 1:14 PM, CNA "A" was asked about the AM care for R103 and R109 and stated, "I didn't have them, I just got them at 11:00 AM." CNA "A" was asked if the residents had been check or changed and stated, "I am not sure. I haven't been in their room." On 1/22 at 1:19 PM, the Unit manager was asked if there was another CNA assigned to R103 and R109 and stated, "There was an orientee that we moved to another unit." The Unit Manager was asked the time the change in the assignment happened and report around 8:00 AM. The Unit Manager was told about the needed ADL care for R103 and R109 and was observed to go in and talk to the residents along with a CNA "A". Resident 127 (R127) On 9/20/2022 at 12:24 PM, an interview was conducted with R127 regarding their care in the facility. R127 stated that the care was fine, but they would not mind a shower.			

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A review of the medical record revealed that R127 was admitted into the facility on 8/25/2022 with the following diagnoses, Muscle Wasting and Atrophy, Disease of Spinal Cord, and Paraplegia. A review of the Minimum Data Set (MDS) Assessment revealed a Brief Interview for Mental Status score of 11/15 indicating an impaired cognition. R127 also required total to extensive two person assist with bed mobility and transfers.

Review of the bathing task for the last thirty days revealed the following documentation, "9/5/2022-N/A (Not Applicable) and 9/21/2022-Shower."

Resident 129 (R129)

On 9/20/2022 at 12:26 PM, R129 was observed in the bed. R129 did not respond to interview questions. R129 was in bed with a gown on, facial hair, and long matted hair.

A review of the medical record revealed that R129 admitted into the facility on 8/26/2022 with the following diagnoses, Non-Traumatic Intracerebral Hemorrhage, Aphasia, and Muscle Weakness. A review of the Minimum Data Set (MDS) dated 8/29/2022 revealed a Brief Interview of Mental Status (BIMS) score of 0/15 indicating a severely impaired cognition. R129 also required one person limited to total dependence with bed mobility and transfers.

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	Further review of the bathing task for the last thirty days revealed the following documentation, "8/30/2022-N/A,9/5/2022-Shower,9/6/2022-N/A,9/15/2022-Bed Bath." Resident 387 (R387) On 9/20/2022 at 12:30 PM, R387 was interviewed regarding their care in the facility. R387 stated that they admitted the beginning of September and they have never received a shower. R387 stated, "How can I get better when I don't feel good and clean." A review of the medical record revealed that R387 admitted into the facility on 9/10/2022 with the following diagnoses, Muscle Weakness, Difficulty in Walking, and Cellulitis. A review of the Minimum Data Set (MDS) dated 9/12/2022 revealed a Brief Interview for Mental Status score of 13/15 indicating intact cognition. R387 also required extensive to total two persons assist with bed mobility and transfers. Further review of the bathing task for the last thirty days revealed the following documentation, "9/15/2022-Bed Bath." Resident 389 (R389) On 9/20/2022 at 12:35 PM, R389 was observed in bed. R389 was saying that they had to go to the restroom. R389 hair was matted and with facial hair.			

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	A review of the medical record revealed that R389 admitted into the facility on 9/7/2022 with the following diagnoses, Urinary Tract Infection, Aphasia, and Muscle Weakness. Further review of the Minimum Data Set (MDS) dated 9/8/2022 revealed a Brief Interview for Mental Status score of 8/15 indicating an impaired cognition. R389 also required extensive one person assistance with bed mobility and transfers. Further review of the bathing task for the last thirty days revealed the following documentation, "9/14/2022-N/A." On 9/22/2022 at 2:56 PM, an interview was conducted with the Director of Nursing (DON) regarding showers in the facility. The DON stated that they have identified showers as a problem and looking to get a shower team and move more showers to the day shift. The DON stated that they believe the shower team will resolve a lot of issues they are having with showers in the facility. A review of a facility policy titled, "Activities of Daily Living (ADLs, Supporting) noted the following, "Residents will (be) provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs)."			
F0684 SS= D	Quality of Care § 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	F0684	Element 1: Resident R127 no longer resides in the facility. Resident R129, upon notification was drawn PT/INR on scheduled days. No	10/17/2022

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain appropriate labratory test for two of two residents (R127 and R129) reviewed for anticoagulant medications (Blood Thinner) resulting in the potential for increased bleeding. Findings Include: Resident 127 (R127) A review of the medical record revealed that R127 was admitted into the facility on 8/25/2022 with the following diagnoses, Muscle Wasting and Atrophy, Disease of Spinal Cord, and Paraplegia. A review of the Minimum Data Set (MDS) Assessment revealed a Brief Interview for Mental Status score of 11/15 indicating an impaired cognition. R127 also required total to extensive two person assist with bed mobility and transfers. A review of the physician orders revealed the following order, "Coumadin (a medication used to prevent blood clots) 2.5 MG. Give one tablet by mouth one time a day for blood thinner. Start Date: 8/26/2022.Status: Active."		negative outcome was observed. Element 2: All residents who are on anticoagulant therapy requiring PT/INR monitoring were identified. These identified residents have the potential to be affected by the cited practice. Risk Analysis: Nursing staff are to ensure that PT/INR are completed for residents on anticoagulant therapy as ordered. Results will be documented in the clinical record. Variances upon identification were corrected immediately. Element 3: The policy on Anticoagulation with Warfarin or Low Molecular Weight Heparin was reviewed and deemed appropriate. Nursing staff will be educated on the reviewed policy with focus on PT/INR monitoring. They will also be educated on the importance of documenting results in the Electronic Health Record Coumadin Flow Sheet when PT/INR is done in the facility using the portable PT/INR machine or by the lab. The nurse managers will review documentation weekly. Element 4: The Nurse Managers or designee will review 10% of residents who require PT/INR monitoring weekly. Nurse Managers will also review the residents Coumadin Flow Sheet in EHR to ensure that documentation of PT/INR is completed weekly. This audit will be completed for 4 weeks, then monthly for 2 months or until substantial compliance is achieved. Any concerns will be addressed immediately. Results of the audits will be presented to the Quality Assurance Committee. The Director of Nursing is responsible for continued	

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	Further review of the physician orders revealed the following, "PT/INR (Prothrombin Time/international normalized ratio, a labratory test that measures how long it takes for a clot to form in a blood sample) q (every) Monday and Thursday." Further review of the PT/INR results on 9/21/22 only revealed two results dated 9/2/2022 and 9/19/2022. No additional results were provided prior to end of survey. Resident 129 (R129) A review of the medical record revealed that R129 admitted into the facility on 8/26/2022 with the following diagnoses, Non-Traumatic Intracerebral Hemorrhage, Aphasia, and Muscle Weakness. A review of the Minimum Data Set (MDS) dated 8/29/2022 revealed a Brief Interview of Mental Status (BIMS) score of 0/15 indicating a severely impaired cognition. R129 also required one person limited to total dependence with bed mobility and transfers. A review of the physician orders revealed the following, "Warfarin (Coumadin) 7.5 MG. Give one tablet by mouth one time a day for blood thinner. Start Date: 8/27/2022. Status: Active." Further review of the physician orders revealed the following, "PT/INR q Monday		monitoring. The Administrator is responsible for sustaining compliance. Compliance Date: 10/17/22	

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	and Thursday." Further review of lab results revealed three results dated 8/31/2022, 9/1/2022, and 9/21/2022. No additional results were provided prior to end of survey. On 9/21/2022 at 12:18 PM, an interview was conducted with Unit Manager (UM) "M" regarding obtaining PT/INR's. UM "M" stated that they document the PT/INR results in an assessment tab in the medical record or upload the results if the lab completes them. On 9/22/2022 at 2:56 PM, an interview was conducted with the Director of Nursing (DON) regarding PT/INR's. The DON stated that they have a machine and are ordering another one. The DON stated that they do not know why the results were not obtained for R127 and R129 and it was an oversight. A review of a facility policy titled, "Anticoagulation with Warfarin or Low Molecular Weight Heparin" noted the following, " ...The physician should stop, taper, or change medications that interact with warfarin, or monitor the PT/INR very closely while the individual is receiving warfarin, to ensure that the PT/INR stabilizes within a therapeutic range."			
F0686	Treatment/Svcs to Prevent/Heal Pressure	F0686	Element #1	10/17/2022

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SS= D	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete/document wound care treatments for two residents (Resident #47 and #59) of six residents reviewed for pressure ulcers (a wound caused by prolonged pressure over a bony prominence) care, resulting in the potential for a delay in treatment, pain, infection, and the worsening of wounds. Findings include: Resident #47 On 09/20/2022 at 10:47 AM, Resident #47 was observed lying in bed on their left side. The Resident appeared restless as they were shifting in the bed and crying out hysterically. When approached, the Resident was not able to answer questions appropriately.		Resident #47 and #59, upon notification were provided with wound care treatment and documentation in the treatment administration record. Element #2 All residents with pressure ulcer and other skin conditions were reviewed and identified. Their Treatment Administration Record were reviewed and completed. identified. Any variances were corrected immediately. Risk analysis: Nursing staff are to complete and document wound care treatments as ordered. The treatment nurse and unit managers will ensure staff compliance. Element #3 The facility's policy and protocol for Pressure Ulcer Prevention Guideline was reviewed and deemed appropriate. The Nursing staff were re-educated on the reviewed policy with focus on completion and documentation of wound care treatments. The nurse managers will do weekly audits to verify staff compliance. Element #4 The Nurse Managers/Designee will review 5 residents with actual pressure ulcer or other skin condition requiring wound treatments to ensure staff compliance with completion and documentation of wound care treatments. This audit will be completed weekly for 4 weeks, then monthly for 2 months or until substantial compliance is achieved. Any concerns will be addressed immediately. Results of the audits will be presented to the monthly Quality Assurance meeting. The Director of Nursing is responsible for ongoing monitoring. The Administrator is responsible for compliance. Date of completion: 10/17/22	

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	A review of the Minimum Data Set (MDS) assessment dated 07/13/2022 revealed that Resident #47 was readmitted to the facility on 01/04/2022 with the diagnoses of Dementia and Cerebrovascular Accident (stroke). Resident #47 had a Brief Interview for Mental Status (BIMS) score of 05, indicating a severely impaired cognition, and needed extensive assistance with most activities of daily living (ADL), including bed mobility and transfers. According to the MDS, Resident #47 had a stage three pressure ulcer wound (a wound extending into the fat and muscle tissue), a stage four pressure ulcer (a wound extending beyond the fat and extending to the muscle and bone) and a deep tissue injury (DTI/a wound underneath the skin that has not presented yet). A record review of the Progress Notes for Resident #47 revealed the following: "9/21/2022 09:55 (AM)...Wound rounds...Seen on wound rounds re multiple areas. In bed. Comfortable. Positioning wedge in place with slight lateral tilt. LAL (low air loss) mattress in place. Heels afloat on a pillow. Needs assistance with repositioning...No edema (swelling). Contractures at knees/hips. Stage IV ulcer to left buttock covered mostly with dark necrotic tissue. Moderate serosanguineous (clear, blood-tinged) drainage. Margin irregular/slightly macerated. Continue Rx (prescription) with Santyl on 4 x 4 to wound base, apply triad			

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	paste to the surrounding area, and cover with dry dressing daily. Stage 3 ulcer to the right hip open. With slight scattered dark slough (dead, nonviable tissue). Continu (sic) Rx with Triad paste and cover with foam dressing. Change q (every) other day and prn (as needed). Stage 4 ulcer to the middle of lateral border of the right foot with scant necrotic slough. Mild serosanguineous drainage. Margin irregular. Continue Rx with Santyl on 4 x 4 daily and wrap with ABD + Kerlix. Stage 4 ulcer to the distal right lateral foot border with scant dark slough. Mild serosanguineous drainage. Margin irregular. Continue Rx with Santyl on 4 x 4 daily and wrap with ABD...Dementia with poor ability to follow or comprehend directions. Bedbound status...Multiple medical issues. Skin breakdown and worsening unavoidable...Hospice consulted...". On 09/22/2022 at 11:18 AM, a request was made to observe wound care for Resident #47 with Wound Care Nurse "C", however, Resident #47's treatment had been done earlier and the Resident was uncomfortable (in pain). Wound Care Nurse "C" was interviewed in regard to the wound progression for Resident #47. Wound Care Nurse "C" explained that Resident #47 was admitted with a "huge" left hip wound (a stage 4), it had healed, but then it re-opened			

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	in a "couple of months". Wound Care Nurse "C" stated, "We did everything we could (to prevent skin breakdown). Wound Care Nurse "C" also explained that the Resident has had a change in condition and is declining and was put on hospice on (09/21/2022). A record review of the admission note for Resident #47, dated 9/27/2021 revealed the following: "...Skin and wound assessment (Re-admit)...Right hip and right ischium (area near lower buttocks)- dark discolorations r/t (related to) DTI, skin still intact measuring 16x14 cm (centimeters) with skin bridge. Coccyx- dark discolorations r/t DTI, skin still intact measuring 2.5x3.0 cm. Right iliac crest (upper hip bone)- unstageable pressure ulcer, measuring 4.7x2.0 cm covered with yellow slough with scant serosanguinous drainage. Left buttock- stage 4 pressure ulcer measuring 9x7x3cm, undermining 5.0 at 9 o'clock. Muscle and bone exposed with clean base and margins, moderate serosanguinous drainage noted. Pain r/t Wound: Is the resident experiencing pain related to the wound? Yes. Pain medication order in place? Yes. New order implemented? Yes. Non-verbal			

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demonstrated: Guarding, Irritability...".

A record review of Resident #47's Treatment Administration Record (TAR) revealed the following:

July 2022

"Apply foam dressing to the left hip and change 2x a week and prn. every day shift every Mon, Fri for Skin care." The treatment was not documented as being completed on 07/27/2022.

"Cleanse left buttock with NS (normal saline), Pat dry. Apply Triad paste daily and prn cover with

dry dressing. every day shift for wound care". The treatment was not documented as being completed on 07/03/2022, 07/15/2022, 07/17/2022 and 07/19/2022.

"Cleanse Right foot with NS, Part (sic) dry. Wrap ABD + Kerlix and change q other day and prn.

every day shift every other day for wound care." The treatment was not documented as being completed on 07/03/2022, 07/15/2022, 07/17/2022, 07/19/2022, 07/25/2022 and 07/27/2022.

"Cleanse Right hip with NS, Part dry. Apply foam dressing and change q other day and prn. every day shift every other day for

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wound care." The treatment was not documented as being completed on 07/03/2022, 07/15/2022, 07/17/2022, 07/19/2022, 07/25/2022 and 07/27/2022.

September 2022

"Cleanse Right hip with NS, Part dry. Apply foam dressing and change q other day and prn. every day shift every other day for wound care." The treatment was not documented as being completed on 09/05/2022. The right hip treatment was changed to the following on 09/09/2022: "Cleanse Right hip with NS, Part dry. Apply Triad paste and cover with foam dressing. Change q other day and prn. every day shift every other day for wound care." The treatment was not documented as being completed on 09/11/2022.

"Santyl Ointment...Apply to Left hip, Right foot topically every day shift for wound care." The treatment was not documented as being completed on 09/02/2022, 09/04/2022, 09/05/2022, 09/10/2022, 09/11/2022 and 09/18/2022."

A record review of the care plan for Resident #47 revealed the following:

"Focus- [Resident #47] is at Risk for Pressure Ulcer Formation related to: generalized debility and weakness as evidenced by: decreased mobility in bed and wheelchair, incontinence of bowel and bladder. Resident

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	need staff assistance with incontinence care, turning and repositioning, Braden score <17. Date Initiated: 07/10/2020". "Goals- Skin will remain intact without reddened or open areas x 90 days Date Initiated: 07/10/2020". "Focus-Actual Pressure Ulcer Formation Related to: Resident was Re-admitted with Left buttock stage 4 and Right iliac crest unstageable pressure ulcer, DTPI to Right hip, right ischium and coccyx, with risk for delayed wound healing secondary to progressing comorbidities, Debility and generalized weakness with decreased physical mobility and bowel/ bladder incontinence daily..." "Goals-Will have pressure ulcer decrease in size or show signs of healing through next 90 day". "Interventions-...Provide wound care as ordered by physician and wound consult recommendations. Date Initiated: 07/07/2022". Resident #59 On 09/20/2022 at 10:23 AM, Resident #59 was observed lying in bed watching			

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	television. Resident #59 had clear speech and was alert and oriented. The Resident had explained that they had a left heal wound and a wound on their buttocks. When asked if the wounds were improving, Resident #59 stated, "Yes, I believe they are." A review of the MDS dated 07/22/2022 revealed that Resident #59 was readmitted to the facility on 07/16/2022 with the diagnoses of Hypertension and Peripheral Vascular Disease (PVD). Resident #59 had a BIMS score of 14, indicating intact cognition, and needed extensive assistance with bed mobility and transfers. According to the MDS, Resident #59 had one stage four pressure ulcer. A review of the physician orders for Resident #59 revealed the following order initiated on 08/25/2022: "Cleanse coccyx with NS, Pat dry. Apply Triad paste and cover with dry dressing daily." On 09/22/2022 at 11:05 AM, Wound Care Nurse "C" was observed completing wound care on Resident #59's coccyx wound. The wound was irregular shaped with a clean, slightly moist, pink triangular wound bed. There was no odor or drainage. There was scar tissue around the actual wound, indicating it had decreased in size. Wound Care Nurse "C" stated, "(Resident #59) was admitted (to the facility) with it (the wound) and that it had greatly improved.			

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	A review of the care plan (initiated 07/16/2020) for Resident #59 revealed the following: "Focus-Risk for Pressure Ulcer Formation related to: [Resident #59] has dx (diagnoses) of DM (Diabetes Mellitus) and PVD, generalized debility and weakness as evidenced by: decreased mobility in bed and wheelchair, incontinence of bowels. Resident need staff assistance with incontinence care, turning and repositioning, Braden score <17." "Goals- Will have no new pressure ulcer formation through next 90 day review period". "Focus- Actual Pressure Ulcer Formation Related to: [Resident #59] was admitted to facility with pressure ulcers; stage 4 to coccyx area and unstageable to Right heel." "Goals- Will have pressure ulcer decrease in size or show signs of healing through next 90 day review period by:". "Interventions-Provide wound care as ordered by physician and wound consult recommendations Date Initiated: 01/06/2022".			

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A record review of the TAR for Resident #59 revealed the following:

June 2022

"Cleanse coccyx wound with NS, Pat dry. Apply quarter strength Dakin's solution moistened gauze and cover with dry dressing daily. every day shift for wound care." The wound care was not documented as being completed on 06/03/2022, 06/17/2022, 06/19/2022 and 06/25/2022.

July 2022

The treatment was not documented as being completed on 07/02/2022, 07/03/2022, 07/10/2022, 07/12/2022, 07/13/2022, 07/14/2022, 07/15/2022, 07/17/2022, 07/25/2022 and 07/30/2022.

September 2022

"Cleanse coccyx with NS, Pat dry. Apply Triad paste and cover with dry dressing daily." Initiated 08/25/2022. The treatment was not documented as completed on 09/02/2022, 09/04/2022,09/05/2022, 09/10/2022, 09/11/2022 and 09/18/2022.

On 09/22/2022 at 02:58 PM, the Director of Nursing (DON) was interviewed in regard to the multiple missing treatment documentation for Resident #47 and #59. The DON reviewed the TARS and stated, "I know they (the wound care treatments) were

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	done because the wounds improved. We have a wound care nurse here every day." The DON further explained that the weekend nurse that did the treatments had a child and was on a leave. The DON stated, "But the nurses know they are supposed to do it (the treatment) if they (wound care nurse) are not here." A review of the facility policy titled "Skin & Wound Policy" dated 04/22, revealed the following: "...6. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change...11. Treatments will be documented on the Treatment Administration Record."			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain safety during a bed bath, for one of seven residents (R44) reviewed for falls, resulting in a fall from bed and a fracture femur. Findings include: On 9/20/22 at 1:40 PM, R44 was observed lying in bed with their right leg observed with a healing	F0689	Element #1 Resident R44 upon notification was reassessed for safety in bed mobility and bathing. Her care plan for fall and ADL care was reviewed and updated. Staff were educated regarding 2 person physical assist for bed mobility and bathing. Element #2 All residents at risk for falls were identified, their fall care plans were reviewed and updated. The Tasks in PCC were also reviewed and updated to alert nursing staff of required physical assist with ADLs. Risk analysis: Nursing staff are to maintain safety during bed bath or ADL care by checking assistance required for tasks. Element #3 The policy for Falls Prevention was reviewed and deemed appropriate. The policy for	10/17/2022

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	surgical cut. R44 was asked what had happen to their leg and stated, "I fell from the bed to the floor about seven weeks ago." R44 was asked how it happened and stated, "A CNA was giving me a bed bath." R44 continued and explained that they broke their femur and had surgery to repair the break. On 9/22/22 at 12:04 PM, CNA "E" was called for a phone interview, a voice message was left, CNA "E" did not return the call by the end of this survey. A review of the facility's written statement from CNA "E", noted, "On Friday July 1, 2022, I [CNA "E] where assign to the summer hall. I gave resident a bed bath 219-2 as I pull the pad towards me to turn [R44] onto [their]] left side, to complete washing [R44] I turn pivot to retrieve the lotion that I placed on the other bed. Never once leaving the resident side. turning back around I notice [R44] sliding off the bed holding on to the rail of the bed. I then hurried around over to her to see if [R44] was ok. I then notice [R44's] legs was on the legs of the side table. toes was press against the vent. I ran to get the nurse they look [R44] over , ask [R44] questions what hurt and then we proceed to pick [R44] up put resident back in bed. [CNA "E"]." On 9/22/22 at 12:36 PM, R44 was asked more about the fall out of bed and stated, "It was bath day and I asked her (CNA "E") are you going to take me to get my bath. She told me 'No. I am going to give you a bed bath.'" R44 explained, that CNA "E" prepared them to get a bed bath, during the bed bath it was time to roll over on their side. R44 stated, "Once I got on my side, I guess I wasn't far enough, so she pushed me. I knew I was about to fall and said I'm falling." "R44 was asked if CNA was putting lotion on their back when they were asked to roll to the side		Assisting with ADL Care was also reviewed and updated to include measures to prevent falls during care with focus on checking PCC tasks for required number of physical assist and to turn resident toward the care giver while providing care. Nursing staff were re-educated on the reviewed policy. The nurse managers will do weekly review to ensure staff compliance. Element #4 The nurse managers will conduct weekly observations of 10% of facility population while CNAs are giving care to ensure that safety is maintained by providing the necessary number of staff assist and to observe for safety measures during care. Any variances will be corrected immediately. Result of said audits will be presented to Quality Assurance Committee meeting monthly for 3 months or until substantial compliance is achieved. The Director of Nursing is responsible for on-going monitoring. The Administrator is responsible for maintaining compliance. Completion Date: 10/17/22	

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	and stated, "She was washing my back. There wasn't anything about any lotion." R44 explained that they came to the facility after a stroke and couldn't move lower legs and that the fall out of bed was the worse. R44 stated, "I did nothing but scream at the hospital. It still hurts." On 9/22/22 at 12:52 PM, Nurse "F" was asked about the incident with R44 and CNA "E" and stated "I was the nurse that day, [R44] was my resident, [R44] needed a bath that day and I thought [R44] was a two person assist, so I told the CNA to let me know when she was going to give the bath." Nurse "F" explained that CNA "E" did not come to them for assistance before starting the bed bath. Nurse "F" was asked the condition of R44 when they walked into the resident's room and explained, R44 was in a lot of pain, a full body assessment was completed and R44 had a discolored area on their leg and was unable to move. Review of R44's Self Care Deficit (ADLs) careplan initiated 9/26/19 revealed an intervention that was initiated on 10/27/20 which stated, "BED MOBILITY: 2 Person Assist". A review of R44's medical record revealed the following progress notes, "7/1/2022 10:29 Nursing - Progress Note Text: At 1030 am, other summer unit nurse told writer to come into room 219 because the pt (patient) fell. Upon entry of room writer saw pt sitting on floor. Writer (Nurse "F) asked what happened and CNA (Certified Nursing Assistant, CNA "E") explained that she was giving the pt a bed bath and she turned her back to grab lotion and she heard pt slide out of the bed. CNA (CNA "E") asked if [R44] was okay and went to get the nearest nurse. Nurse completed a full body assessment. Nurse asked pt if [they] hit [their] head [R44] stated "no". Writer noted pt's left toes were purple. Writer asked if			

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	[R44] toes hurt and [R44] stated [R44] never really had feeling in [their] toes. Nurse asked CNA [if] [R44's] toes were purple prior to fall and she stated no. Pt was also crying and said [their] Right knee hurts. Nurse obtained a full set of vitals... When asked the pain out of 10. Pt stated 10. Nurse gave pt a PRN (as needed) norco and is icing knee 15 minutes on 15 minutes off. Writer notified director of Nursing (DON) of fall. Writer notified NP (Nurse Practitioner) of fall and ordered two STAT x-rays of the L (left). foot and R (right) knee. NP stated if pt feels [they] needs to go to the hospital [R44] can but pt denied wanting to go to the hospital. Currently waiting on x-ray results. (Nurse "F")." "7/1/2022 10:40 Nursing - Progress Note Text: Writer also noticed raised purple contusion on leg. Measures 3 1/4 in. Pt had brown discolorations on LE (lower extremities) bilaterally. Pt has a history of PVD (Peripheral vascular disease). Pt has no redness swelling or warmth. Asked CNA if it was there while she was giving a bed bath she stated "yes". Writer assessed capillary refill and was present in both feet < 3 seconds. Notified wound care. (Nurse "F")." "7/1/2022 16:15 (4:15 PM) Nursing - Progress Note Text: Writer went to check on pt status and assess [R44's] knee, shin and toes. Writer noticed the pt had redness and warmth around the contusion on [R44's] left leg. Writer sent a picture to the doctor. Doctor... said [R44] needed to go to the hospital because [R44] is prone to blood clots and [R44] could have an infection. Writer spoke with pt regarding contusion and [R44] agreed to go to the hospital. Notified DON. Notified son. Writer called 911. EMS (Emergency Medical Services) arrived with a stretcher. Gave report to EMS and gave them appropriate paper work regarding pt. (Nurse "F")."			

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"7/9/2022 19:48 (7:48 PM) Nursing - Progress Note Text: Resident into building at 530pm. Waiting for report NP notified and will see resident and write/clarify orders. Splint/brace in place RLE (Right Lower Extremities) toes warm and moveable. "

"7/12/2022 18:43 (6:43 PM) Nursing - Progress Note Text: cna attempted to given resident shower via (by way of) shower bed. resident stated "I changed my mind, I want a bed bath instead cause scared of hurting leg. bed bath given. no complaints or other concerns noted at this time."

Further review of R44's medical record noted, R44 was admitted to the facility on 9/26/2019 and readmitted on 7/9/2021 with diagnoses of Fracture of Right Femur, Chronic Respiratory Failure with Hypercapnia, Muscle Weakness, and Peripheral Vascular Disease. A review of R44's Minimum Data Set (MDS) assessment dated, 7/1/22, noted, R44's cognition intact and bed mobility as extensive assistance with one-person physical assist."

On 9/22/22 at 1:50 PM, the DON was asked about the incident with CNA "E" and stated, "The only thing she (CNA "E") did and was in-serviced on, was to turn [R44] towards her and not away from her."

A review of the facility's policy titled, "Fall Risk / Injury Prevention" dated, 06.20.2022, did not address the above concern. A review of the facility's policy titled, "Activities of Daily Living (ADLs), Supporting" dated, 10/21, noted, "Policy Interpretation and Implementation 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that

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	diminishing ADLs are unavoidable..." The policies did not address the positioning of the aide and resident during a bed bath.			
F0692 SS= E	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete nutritional assessments and/or food acceptance records (FARS) for three of nine residents (Residents #33, #93, and #116) reviewed for nutrition, resulting in a lack of nutritional evaluation, monitoring and assessment, and the potential for continued weight loss. Findings include:	F0692	Element 1: Upon notification, Resident # 33, 93, and 116, were assessed for nutritional status, by completing a full nutritional assessment. Element 2 All current residents due for quarterly, and annuals will have appropriate documentation in the nutritional assessment and/or progress note per policy. The CENA□s will complete FAR□s for any resident identified at risk. Risk analysis: Nursing staff are to accurately coordinate the completion of the FAR. Element 3: The Policies on Nutrition Management and Tray Pass and FAR were reviewed and deemed appropriate. IDT, RD, nursing staff were educated on the reviewed policy with emphasis on timely completion of nutritional documentation and accurate recording of FAR. Element 4: The Corporate RD or designee will audit 100% of resident□s quarterly reviews weekly for 4 weeks and then monthly for 2 months. Any deficient practice will be immediately addressed by the RD staff. The DON will audit the completion of the FAR. Results of the audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The RD is responsible for continued monitoring. The Administrator is responsible for ongoing compliance with regulatory requirements. Element 5: Date of completion: 10/17/22	10/17/2022

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Resident #93

On 09/20/2022 at 01:02 PM, Resident #93 was lying with their bed flat on their left side eating lunch. The Resident's food was at eye level as they were eating. Their head was on their pillow looking at their food, using their hand in a scooping motion to pick up the food and place it into their mouth. There were particles of food on the sheets, clothes, and blanket.

A record review of the Minimum Data Set (MDS) assessment dated 08/12/2022 revealed that Resident #93 was admitted to the facility on 08/05/2022 with the diagnosis of an unstable burst fracture of T11-T12 (thoracic spine). Resident #93 had a Brief Interview for Mental Status (BIMS) of 15 and needed extensive assistance with bed mobility and transfers.

A record review of the weights for Resident #93 revealed the following:

09/09/2022 328.0 pounds (Lbs).

08/23/2022 332.0 Lbs

08/16/2022 333.2 Lbs

08/08/2022 332.0 Lbs

A record review of the FARS for Resident #93 revealed the following documentation of the amount of food the Resident ate in the last

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30 days:

Breakfast and lunch: 08/25/2022, 09/01/2022, 09/07/2022, 09/21/2022 and 09/22/2022.

Dinner: 09/01/2022, 09/03/2022 and 09/05/2022.

There was no other documentation of the food intake noted in the electronic medical record (EMR)

A record review of the care plan for Resident #93 revealed the following:

"Focus-Resident is at nutrition risk r.t (related to) signs and symptoms of protein calorie malnutrition.

Evidence of Skin Breakdown, Fluid accumulation...DM (Diabetes Mellitus), wound...to Coccyx w/ (with) increased nutritional needs. Date Initiated: 08/11/2022."

"Goals- No significant weight loss."

"Interventions/tasks- Provide, serve diet as ordered. Monitor intake and record q meal.

Date Initiated: 08/11/2022."

Resident #116

On 09/20/2022 at 01:34 PM, Resident #116 was observed lying in bed with their significant other. Resident #116 was alert and

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	oriented and had clear speech. When asked about how the meals were in the facility, the Resident stated, "It is okay, somedays better than others." A record review of the weights of Resident #116 revealed the following: 09/05/2022 11:43 289.4 Lbs 08/30/2022 08:16 289.4 Lbs 08/23/2022 13:24 289.0 Lbs 08/22/2022 13:50 289.0 Lbs 08/02/2022 14:05 298.6 Lbs 07/26/2022 10:20 299.5 Lbs 07/08/2022 07:11 314.0 Lbs 06/27/2022 07:31 315.4 Lbs 06/22/2022 12:13 312.0 Lbs 06/13/2022 11:23 314.0 Lbs 06/13/2022 10:44 314.0 Lbs A record review of the FARs (from the last 30 days) for Resident #93 revealed the following: Breakfast and lunch-09/02/2022, 09/03/2022, 09/07/2022, 09/15/2022, 09/21/2022 and 09/22/2022.			

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Dinner-09/03/2022, 09/05/2022 and 09/06/2022.

There was no other food intake documentation in the EMR.

A record review of the care plan for Resident #116 revealed the following:

"Focus-Resident is at nutrition risk r/t signs and symptoms of protein calorie malnutrition AEB (as evidenced by) Weight loss per UBW (usual body weight), surgery...poor intake..." (initiated 06/13/2022).

"Goals- No significant weight loss."

"Interventions-Provide, serve diet as ordered. Monitor intake and record q (every) meal."

On 12:48 PM, the Nursing Home Administrator (NHA) was interviewed in regard to FAR completion. The NHA explained that the nurse aides fill out the FARs after every meal for every resident. The NHA was asked what purpose do the FARs serve and she stated, "To ensure that oral intake is met and to monitor if there was any decline in their (residents) appetite and getting the proper nutrition that they need.

09/22/22 01:44 PM, the DON was interviewed in regard to the FAR documentation. The DON stated that the nurses' aides are supposed to chart after every meal under the task section in [EMR]. The DON stated, "I will

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have to follow up on that."

On 09/22/2022 at 02:05 PM, the Director of Nursing (DON) and Nurse "I" were interviewed in regard to the FARs not being completed. During the interview, the DON and Nurse "I" reviewed the FARs for Resident #93 and #116. Nurse "I" stated, "The documentation should be in there, the aides are supposed to chart every meal."

A review of the facility policy titled "Weight Policy" dated 05/03/2022, did not discuss FAR.

On 9/20/22 at 1:27 PM, R33 was observed in the dining room being assisted with eating their lunch. Resident appeared anxious and appeared to cry in between eating their food.

A review of R33's medical record revealed that they were admitted into the facility on 6/29/18 with diagnoses that included Dementia, Anxiety and Anemia. A review of R33's Minimum Data Set assessment revealed that the resident was severely cognitively impaired and required extensive assistance with Activities of Daily Living.

Further review of R33's medical record revealed the following care plan, "Focus: [R33] has an Alteration in Nutrition and Risk PCM (protein-calorie malnutrition) and dehydration AED (as evidenced by): underweight BMI (body mass index) 19.5, weight loss, consuming < (less than) 75%

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	nutrition needs, Dx (diagnoses) Dementia, MDD (Major Depressive Disorder), Anxiety, and s/p (status post) acute illness: UTI (urinary tract infection) on IV (intravenous) fluids in hospital. On mechanically altered diet. Date initiated: 07/06/2018..." On 9/22/22 at 10:01 AM, nutritional assessments for R33 were requested from the facility and were provided with two assessments titled "Medical Nutritional Therapy Assessment" dated for 1/6/2021 and 7/12/2021. In addition, R33's dietary progress notes were provided which included a quarterly progress note entered on 12/31/2021, five months after the 7/12/2021 assessment. A review of another quarterly review progress was dated for 4/3/2022, and another quarterly review progress note was not entered until 9/22/2022 during the survey. On 9/22/22 at 2:20 PM, the Director of Nursing (DON) was asked how often nutritional assessments should be completed, and explained that assessments should be completed upon admission, quarterly and as needed. The DON was asked about R33's missing assessments, and indicated that she would look into it. On 9/22/22 at 2:37 PM, the DON explained that she spoke to the dietician about the missing assessments, and she explained that it was an "oversight." A review of the facility's "Weight Policy" did not address quarterly			

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	nutritional assessments.			
F0732 SS= C	Posted Nurse Staffing Information §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 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 interview and record review, the facility failed to display current nurse staffing information on a daily basis, affecting all residents and visitors in the facility, resulting	F0732	Element 1: No specific resident was identified in the cited practice Element 2 All current residents have the potential to be affected by the cited practice. Risk analysis: Staffing Coordinator and/or designee are to follow guidelines for displaying current nurse staffing information on a daily basis and maintaining posted daily staffing data for a minimum of 18 months. Element 3: The Staffing coordinator was re-educated on the regulatory guideline for posting and maintaining nurse staffing data. A filing system will be initiated to ensure easy access for the Nurse staffing information. Element 4: The Director of Nursing or designee will do audit of daily posting weekly for 4 weeks and then monthly for 2 months to ensure that Any deficient practice will be immediately addressed and the facility meets the daily posting and data maintenance requirement. Results of the audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The Director of Nursing is responsible for continued monitoring. The Administrator is responsible for ongoing compliance with regulatory requirements. Element 5: Date of completion: 10/17/22	10/17/2022

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	in the likelihood of necessary staffing information not being readily available to residents and visitors. Findings include: A review of the facility's 18 months of daily staffing sheets were reviewed, and revealed that they were missing daily staff postings for the following dates in 2021: 3/1, 3/6, 3/7, 3/19, 3/20, 3/21, 3/27, 3/28, 4/2, 4/3, 4/4, 4/10, 4/11, 4/12, 4/16, 4/17, 4/18, 4/23, 4/24, 4/25, 5/1, 5/2, 5/3, 5/4, 5/8, 5/9, 5/15, 5/16, 5/22, 5/23, 5/29, 5/30, 5/31, 6/5, 6/6, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/19, 6/20, 6/21, 6/26, 6/27, 7/5, 7/10, 7/11, 7/15, 7/18, 7/31, 9/2, 9/4, 9/5, 9/6, 9/11, 9/12, 9/18, 9/19, 9/20, 9/21, 9/25, 9/26, 10/10, 10/16, 10/17, 10/23, 10/24, 10/25, 10/29, 10/30, 10/31, 11/6, 11/7, 11/11, 11/13, 11/14, 11/17, 11/20, 11/21, 11/25, 11/26, 11/27, 11/28, 11/29, 12/1-12/9, 12/11, 12/12, 12/18, 12/19, 12/25, 12/26 and 12/27. On 9/22/22 at 2:46 PM, the Director of Nursing (DON) was asked about the missing dates, and explained that they looked for them last night, but were unable to locate them.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §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)	F0758	Element 1 Upon notification, resident R29□s PRN anti-anxiety medication was reviewed, a 14 day stop date was provided by the psychiatrist. No negative outcome was observed related to the cited practice. Element 2 All residents in facility who are receiving PRN	10/17/2022

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	Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a stop date for a PRN (as needed) anti-anxiety medication for one sampled Resident (R29) of five residents reviewed for psychotropic medications, resulting in the potential for		psychotropic medication were identified and are at risk for this cited practice. All residents receiving PRN psychotropic medications were reviewed to ensure that stop dates are in place. Risk analysis: Physicians and Psych. team are to provide a stop date for PRN psychotropic medication order. Variances upon identification were corrected immediately. Social Services will do weekly audit to ensure compliance. Element 3 The facility policy titled Psychoactive Medication Monitoring/Reduction Program was reviewed and deemed appropriate by Interdisciplinary Team. Psych team, physicians, nurses and Social Services were educated on the policy with focus on Stop Date upon initiation of PRN psychotropic medication. New orders for PRN psychotropic medication are discussed at morning meeting to ensure that stop dates are provided. Element 4 The Social Service Director/Designee will audit 10% of the facility□s resident population who are receiving psychotropic medications weekly x4 then monthly x3 for compliance with providing stop date for PRN psychotropic medication. Results of the audits will be submitted to the facility Quarterly Quality Assurance Committee for review and on-going compliance The Director of Social Services/Designee will be responsible for continued monitoring. The Administrator is responsible for sustaining compliance. Completion Date: 10/17/22	

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	adverse reactions in the use of an unnecessary medication. Findings include: On 09/20/22 at 10:40 AM, R29 was observed sitting, and then spontaneously standing up out of their wheelchair in the dining room. R29 was unable to be interviewed due to their cognitive impairment. A review of R29's medical record revealed that they were admitted into the facility on 3/8/22 with diagnoses that included, Dementia, End Stage Renal Disease and Muscle Weakness. Further review of the resident's Minimum Data Set assessment revealed that the resident was severely cognitively impaired, and required extensive to total dependence for Activities of Daily Living. Further review of R29's medical record revealed that the resident was prescribed the following, dated for 9/19/22, "Ativan Tablet 0.5 MG (milligrams) Controlled Drug. Give 1 tablet via PEG-Tube every 12 hours as needed for agitation." On 9/22/22 at 2:37 PM, the Director of Nursing (DON) was asked about R29 having an order for a PRN anti-anxiety medication with no stop date, and indicated that she was surprised as PRN medications are discussed every day in morning meeting. A review of the facility's "Psychoactive Medication Monitoring/ Reduction Program"			

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	revealed the following, "...9.In addition to nursing review, Social Work will also assist in the responsibility to assess all PRN psychotropic medications to determine if their use is warranted with an appropriate condition documented in the clinical record. This includes having a stop date to review the need to continue treatment after 14 days. If an issue is noted, Nursing or Social Work will notify the physician or prescribing practitioner of the concern. PRN medications will also be monitored by the pharmacist monthly..."			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as	F0761	Element 1 No specific resident was identified in the cited practice. Upon notification, the unlabeled open vials of As part Insulin and Novolin R were removed from the medication cart. Element All residents receiving Insulin injections have the potential to affected by the cited practice. All medication carts were inspected, no unlabeled insulin vials were observed. Risk analysis: Nurses are to label insulin vials taken from the back-up box for specific residents. The nurse managers will do weekly audits to ensure staff compliance Element 3 The Policy on Storage of Medication/Biologicals was reviewed and updated to include labeling of opened medications. Nursing staff were in-serviced on the updated policy with focus on the importance of appropriate labeling of medications. The nurse managers will conduct rounds weekly to ensure that there are no unlabeled open vials of medications. Any deficient practice will be addressed	10/17/2022

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	evidenced by: Based on observation, interview and record review, the facility failed to label opened insulin vials in one medication cart (Winter cart) of four medication carts reviewed for medication storage, resulting in the potential for medications to be administered to the wrong resident. Findings include: On 09/22/2022 at 01:10 PM, the Winter medication cart was observed for medication storage with Registered Nurse (RN) "D". In the top drawer of the medication cart, there was an open bottle of Aspart insulin and Novolin R insulin. There was no name or label on the medication bottles. RN "D" was interviewed about who's insulin the bottles belonged to. RN "D" stated, I think this one (Novolin R) is for [stated a resident's name] and this one (the insulin Aspart), I am not sure, I think it is for someone in that room (pointing to a particular room number)." RN "D" was asked if the bottles should be labeled and explained that they usually are but the label must have fallen off. On 09/22/2022 at 01:42 PM, the DON was interviewed in regard to the unlabeled insulin bottles. The DON stated, "The insulin should be labeled if they are for a specific resident." A review of the facility policy titled, "Medication Storage" dated 05/04/2022 revealed the following: "...Unused		immediately. Element IV The Director of Nursing or designee will audit 8 medication carts per week for 4 weeks, then monthly for 2 months to ensure that no unlabeled open medication vials/bottles are in the medication carts. Results of the audits will be forwarded to the facility Quality Assurance committee for ongoing monitoring and review. The Director of Nursing is responsible for ongoing monitoring. The administrator is responsible for sustaining compliance. Completion Date: 10/17/22	

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	Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels...". The policy did not address the labeling of opened medications.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the kitchen and equipment in a sanitary manner, resulting in the increased potential for cross contamination. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 9/20/22 between 9:45-10:15 AM, during	F0812	Element 1: No specific resident was identified in the cited practice Element 2 All current residents have the potential to be affected by the cited practice. Risk analysis: Dietary Manager and/or designee are to follow guidelines for storage, preparation, distribution and serving food in accordance with professional standards for food service safety. Element 3: The policies on food storage and sanitization were reviewed and deemed appropriate. Dietary staff were educated on the reviewed policies. They were also educated on the importance of cleaning, frequency, and restrictions. Element 4: The Dietary Manager or designee will do audits of cleaning, ice scoops, spices, dented cans, and food labeling for 4 weeks and then monthly for 2 months to ensure that any deficient practice will be immediately addressed and the facility meets the requirement. Results of the audits will be submitted to the facility Quality Assurance Committee for review and on-going compliance The Dietary Manager is responsible for continued monitoring. The Administrator is responsible for ongoing compliance with	10/17/2022

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	an initial tour of the kitchen with Dietary Staff "O", the following items were observed: The ice scoop holder located in the main kitchen next to the ice machine, was observed with black debris at the bottom. The tip of the ice scoop was resting in the black debris. Dietary Staff "O" confirmed the ice scoop holder needed to be cleaned. The ice scoop holder located next to the ice machine in the hall by the employee break room, was observed with dead insects collected at the bottom of the holder. According to the Food & Drug administration (FDA) 2013 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..." In the dry storage room, there was a heavily dented can of peaches on the rack with the active stock. Dietary Staff "O" confirmed the can should not be there. There was a buildup of food debris and crumbs under the 3-compartment sink, and there were ants observed under the sink. There was a heavy buildup of crumbs along the baseboard under the sink and clean		regulatory requirements. Element 5: Date of completion: 10/17/22	

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	824350	A. BUILDING _____ B. WING _____	9/22/2022

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	dishware rack. According to the 2013 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, "(A) Physical facilities shall be cleaned as often as necessary to keep them clean." There were gnats observed throughout the kitchen, by the pop machine, the 3-compartment sink, and in the mop room. On the seasoning rack, there was an unlabeled pitcher with a dry seasoning mixture. Dietary Staff "O" confirmed the seasoning should be labeled. In addition, the outside lids and containers of the spices had a buildup of crumbs and food debris. According to the 2013 FDA Food Code section 3-302.12 Food Storage Containers, Identified with Common Name of Food, "Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD." In the Argus reach-in cooler, there were 2 large cambro containers with "turkey ham" dated 9/19-10/5. Dietary Staff "O" confirmed that the lunch meat should have a 7-day use			

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	by date. According to the 2013 FDA Food Code section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety."			
F0880 SS= E	Infection Prevention & Control §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	F0880	Element 1: There were no specific residents identified in the cited practice. Upon notification, dietary staff were provided with re-education on the appropriate use of mask. Any variances were corrected immediately. There were no negative outcomes observed for any residents in the facility Element 2: All current residents in the facility	10/17/2022

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	establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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		have the potential to be affected by the cited practice. Risk analysis: Non-compliance with use of proper PPE for unvaccinated as well as vaccinated staff based on current Infection Control guidance. Element 3: The policy for Use of PPE for unvaccinated and vaccinated staff was reviewed by the IDT and deemed appropriate. Staff K and L were provided with 1:1 education and successfully did return demonstration on appropriate use of PPE (facial covering). In-service training to all staff providing direct care to residents and all staff entering residents□ rooms, whether for residents□ dietary needs or cleaning and maintenance services on the following topics: o Nursing Home Infection Preventionist Training o Targeted Covid-19 Training for Nursing Homes o Keep Covid-19 Out! o Lessons o Standard Infection Control Practices o Appropriate Use of PPE Staff re-training and Management oversight will be provided to ensure that the cited practice will not recur. Element 4: The Nurse Management Team and Dietary Managers or designee will conduct audits of 5 employees to ensure proper PPE use in the kitchen is done. A tool was developed to document staff compliance. This audit will be conducted three times a week for four weeks, then once a week for 2 months or until substantial compliance is achieved. Any concerns will be addressed immediately. Results of the audits will be presented to the quarterly Quality Assurance meeting. The Department managers and Infection Preventionist will be responsible for	

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	so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain infection control practices, including, but not limited to the following: COVID-19 PPE guidelines for unvaccinated staff and wear masks in an appropriate manner. Findings include: On 9/20/22 at 2:35 PM, the assigned Fire Marshall for the survey reported, during the tour of the kitchen, there were four kitchen staff without their mask on. On 9/22/22 at 10:30 AM, while in the kitchen, Staff "K" was observed in the kitchen with a blue surgical mask under their chin. Staff "K" asked about the Covid-19 procedure for face covering and explained it should be over the nose and mouth. On 9/22/22 at 10:33 AM, Staff "L" was observed in the kitchen with a blue surgical mask on, that was not covering their nose. Staff "L" was listed as exempt from the Covid-19 vaccination on the staff matrix. Staff "L" was asked the required PPE for them and stated, N95. was interviewed and asked their vaccination status and explained they were unvaccinated with and exemption. On 9/22/22 at 10:04 AM, during the infection control task, the ICP Nurse was asked, facility's expectation regarding proper mask use. The ICP explained that the mask is to cover the nose and mouth of the staff. The ICP Nurse was asked required PPE for staff that are not vaccinated and		continued compliance. Element 5: Compliance date: October 17, 2022	

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	or not up to date with vaccination for Covid-19 and stated, "Unvaccinated and not up to date should wear a N95 at all times." An observation of N95 mask were observed in the facility's kitchen and in the office of the ICP. A review of the facility's policy titled, "COVID-19 Vaccination" dated, 4/1/2022, noted, "POLICY: The CDC has mandated that all facility employees, licensed practitioners, students, trainees, and volunteers, and individuals who provide care, treatment, or other services for the facility and/or its patients, under contract or other arrangement, must be fully vaccinated against Covid 19. The mandate applies to contractors or other providers who routinely enter onto the facility and provide care, such as therapy, hospice, pharmacy... 4. Staff and contractors granted a medical or religious exemption shall be required to wear N95 masks and undergo testing in accordance with DHHS guidelines..."			