STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634070	A. BUILDING _____ B. WING _____	11/30/2022

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WOODWARD HILLS HEALTH AND REHABILITATION CTR	39312 WOODWARD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS Woodward Hills Nursing Home was surveyed for a re-visit survey on 11/30/2022. Census=114	F0000		
F0554 SS= D	Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure five residents (R701, R702, R716, R722 and R723) of a total of six residents reviewed for self-administration of medication were assessed to safely self-administer their own medication. Findings include: According to the facility's policy titled, "Self-Administration of Drugs" dated 5/2018, "...If a resident desires to participate in self-administration, the interdisciplinary team shall assess the competence of the resident to participate, by completing a Self-Administration of Medication Assessment...Based on the interdisciplinary team's review, a decision is made as to whether or not the resident is a candidate for self-administration. This will be recorded on the Self-Administration of Medication Assessment form. *Please note: If the resident is currently taking any of the following medications, he/she will be deemed an inappropriate candidate to self-administer Tranquilizers, Narcotics, Antipsychotics & Pain medication...In addition, if the resident's BIMS - (mental exam) is less than 13 this will also deem the resident inappropriate	F0554	F554 D Element 1: It is the practice of this facility to ensure all residents who request to self-administering medications are assessed for clinical appropriateness. Resident 716 no longer resides at the facility. Residents 722,701, 723, and 702 were seen by physician team to assess for any harm from medications found at bedside. Nursing managers assessed the ability to self-administer the medications that residents have requested at bedside. Element 2: All residents have the potential to be affected by this cited practice. All rooms were inspected for unattended medications. Element 3: The IDT reviewed the Self-Administration of Drugs policy it was discussed with the corporate team and revisions were made to the policy. The assessment for self-administration of medication was reviewed and deemed appropriate. A facility wide sweep was done of all rooms for medications at bedside. The nurses were educated on the new version of the policy to include the process for residents requesting bedside medication, surveillance of authorized bedside medication, how to sign out patient administered medication in the MAR., and to never leave medications unattended that have not been authorized to be at bedside. Element 4: Nursing staff or designee will conduct inspection of 5 resident rooms at	10/25/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/15/2022

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

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	to self-administer medications..." R716 On 11/28/22 at approximately 12:15 PM, an interview was conducted with R716. During this time, a small bottle of Flonase (a nasal steroid spray) and a bottle of "Deep Sea Nasal Spray" was on the top of the overbed table. When asked about the nasal sprays, R716 reported they use the sprays on a daily basis. When asked if they facility was aware the self-administered both of the sprays, R716 reported that they were not sure, but noted she had the medication for a while. On 11/28/22 at approximately 1:36 PM Assigned Nurse "L" was interviewed regarding the facility's protocol for the self-administration of medication. Nurse "L" stated that residents should be assessed and have an order. When asked if they were aware that R716 had the nasal spray on their bedside table, Nurse "L" stated that she was aware and was certain the resident had been assessed to self-administer the medication. Review of the clinical record revealed R716 was recently admitted to the facility 10/27/22 with diagnoses that included: Type II diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic kidney disease and Heart Failure. A review of the resident Minimum Data Set (MDS) indicated the resident was cognitively intact. Continued review of the R716's clinical record, documented, in part: Baseline Admission Evaluation (date 10/27/22): " ...F. Medications: ...2. Self-administer medications ...NO." A Medication order created by Nurse "L" with a creation date of 11/28/22 at 1:45 PM		random to ensure no medications are left bedside for anyone who has not been assessed and approved to self-administer medications weekly x 4 then monthly x 3. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	documented: "Order date 10/28/22 - Resident to keep Flonase and sea spray for use at bedside". A Medication Self-Administration Safety Screen was noted to have a start date of 10/28/22, however the Lock/signed date was noted as 11/28/22 at 1:50 PM and was authored by Nurse "L" During an interivew on 11/29/22 at approximately 9:45 AM, the Director of Nursing (DON) stated that Nurse "L" should not have back-dated the assessment and the assessment and order had a start date of 11/28/22. R722 On 11/28/22 at approximately 11:51 AM, R 722 was observed lying in bed. On the bedside table was a prescribed tube of Augmented lotion .05% (corticosteroid medication used on the skin), a tube of Neosporin and a tube of Hydrocortisone. When asked about the medication, R722 reported that they put the medication lotion on their skin as needed. On 11/28/22 at approximately 1:20 PM, the same medication as noted above was still on R722's bedside table. On 11/28/22 at approximately 1:40 PM, Nurse "M" who was interviewed regarding R722's self-administration of medication. Nurse "M" reviewed the resident's chart and noted that she was not able to find an order or assessment for the self-administration. A review of R722 clinical record revealed the resident was initially admitted to the facility on 12/18/20 and readmitted on 1/13/21 with diagnoses that included, in part: unspecified dementia, bipolar disorder chronic and chronic			

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	kidney disease. The resident's MDS indicated the resident was cognitively intact. Further review of R722's record showed no indication the resident had been assessed to self-administer medications. On 11/29/22 at approximately 9:45 AM, an interview was conducted with the Director of Nursing (DON). When asked about the protocol for self-administration of medication, the DON reported that a resident must be assessed, an order is placed and the information should be placed in the resident's care plan. R701 On 11/28/22 at 11:15 AM, R701 was observed lying in bed on their right side, asleep. The room was very cluttered with many personal items stored on and around the bed and tables. Stored on top of the overbed tray table was a bottle of deep seas nasal spray with a pharmacy label dated 6/14/22. On 11/28/22 at 12:28 PM, R701's room was observed to have the nasal spray on the overbed tray table and now had a box of "Pepto Bismol" tablets visible from the top of their opened bedside dresser drawer. On 11/28/22 at 1:02 PM, an interview was conducted with R701's assigned nurse (Nurse 'M'). When asked to see R701's nasal spray in the medication cart, Nurse 'M' reported the resident normally self-administered that. Nurse 'M' then proceeded to look through the medication cart and reported there was none in the cart. When asked if R701 had been assessed for self-administration of			

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	medications, they reported they were not sure but there should be some sort of an assessment for that. Nurse 'M' reported there was no order for the Pepto-Bismol. Review of the clinical record revealed R701 was admitted into the facility on 2/22/18, readmitted on 7/29/22 with diagnoses that included: obsessive-compulsive personality disorder, unspecified dementia unspecified severity with other behavioral disturbance, and schizoaffective disorder. According to quarterly MDS dated 11/4/22, R701 had intact cognition and required supervision of one person for personal hygiene, supervision for set up with feeding, and had no impairment to their functional limitation in range of motion. Review of the physician orders included both non-narcotic and narcotic pain medication. According to current policy, R701 would not have qualified for self-administration since they received these medications. Further review of the clinical record revealed there was no self-administration assessment completed, or care plan to indicate R701 had been assessed and approved to self-administer their own medication/biologicals. According to current policy, R723 would not have qualified for self-administration. R723			

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	On 11/28/22 at 12:35 PM, a bottle of medicine was observed on R723's overbed table. When asked about the medication (Generic Acetaminophen 500 mg tablets), the resident reported that had been brought from home as they had phantom pains in their lower extremities and hands. When asked if they received any other pain medication, they reported they got "Oxy" at times. When asked if they could recall being assessed to be able to self-administer medication, R701 reported they didn't think so. On 11/28/22 at 12:49 PM, Nurse 'M' was asked about the medication at bedside and upon looking into the room from the hallway, Nurse 'M' reported they had not known that and would follow up as they were not aware the resident was able to self-administer medication. Review of the clinical record revealed R723 was admitted into the facility on 12/30/21 and readmitted on 7/29/22 with diagnoses that included: necrotizing fasciitis, acquired absence of right leg below knee, chronic atrial fibrillation, major depressive disorder single episode, type 2 diabetes mellitus with diabetic neuropathy, and phantom limb syndrome with pain. According to the MDS assessment dated 9/29/22, R723 had intact cognition. Review of R723's current physician's orders			

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included an order for as needed oxycodone/acetaminophen (narcotic pain medication). Review of the medication administration records revealed R723 had received this medication several times.

Further review of the clinical record revealed there was no self-administration assessment completed, or care plan to indicate R701 had been assessed and approved to self-administer their own medication/biologicals. According to current policy, R723 would not have qualified for self-administration since they received narcotic pain medication.

R702

Review of the medical record revealed R702 was admitted to the facility on 9/1/22 with diagnoses that included major depressive disorder.

On 11/28/22 at 4:03 PM, R702 was observed sitting on the side of their bed watching television. Observed on the resident side table was a clear plastic medication cup that contained a light blue pill with the letters and numbers of YH133 engraved on the pill. R702 was asked what the pill was and replied they didn't know that is why they have not taken the pill. R702 continued to say the nurses always leave their pills on their side table when they are sleeping instead of waking them up to administer the medication. R702 stated it has been there for a while and they refuse to take the medication not knowing what the pill is.

At approximately 4:42 PM, R702's nurse (identified as Nurse "A") was asked to accompany the surveyor to R702's room to verify the pill left at R702's bedside. Nurse "A" picked

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	up the medication cup and stated they were unable to verify the pill. At that time Nurse "A" was asked to accompany the surveyor to the medication cart to compare the unidentified pill to R702's medications. The blue pill was verified and confirmed by Nurse "A" as R702's Wellbutrin medication. Review of the physician orders documented Wellbutrin tablet Extended Release 100 MG (milligram), Give 1 tablet by mouth at bedtime for antidepressant. Review of the November 2022 Medication Administration Record (MAR) documented the administration time of the Wellbutrin as 9 PM and was signed off as administered for the whole month of November 2022 at the time of review. Review of the medical record revealed an assessment for self-administration for the Wellbutrin medication for R702 had not been completed. On 11/29/22 at 9:16 AM, the Director of Nursing (DON) was interviewed and asked about the Wellbutrin observed at the bedside of R702 and the DON stated they were informed of the pill by Nurse "A" and will follow up with the night nurse to provide education. The DON stated the nurses were already educated on this; however, they will reeducate the nurses again.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F0609	F609 D Element 1: It is the practice of this facility to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. Resident R705 still resides in the facility. She has been	12/15/2022

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	hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely report an allegation of abuse to the State Agency (SA) for one (R705) out of one resident reviewed for abuse. Findings include: The facility policy titled "Abuse Program..." (date approved 4.23.2022) documented, in part: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse...Reporting/Response...Reporting of alleged violations to the Administrator, state agency...within specified timeframes...a. Immediately, but not later than 2 hours after the allegation is made, if the allegations involve abuse...".		moved to LTC unit. Visits from SO remain in common areas. R705 states she feels safe in facility. Element 2: All residents have potential to be affected by stated deficiency; The referenced incident in this citation was reported to respective State Agency. An audit was done by social work team to assess any residents that have concerns of abuse. No similar findings and/or negative effects have been identified by this alleged deficient practice. Element 3: Interdisciplinary Team was educated on the requirements of F609, Reporting of Alleged Violations. Specifically, this education focused on the facility□s responsibility to ensure alleged violations involving misappropriation, neglect and/or abuse are immediately reported to the Administrator and respective State Agency as indicated. All allegations of abuse will be reported to the Administrator immediately and the respective state agency with in 2 hours. Element 4: Administrator will review all alleged allegations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property to ensure they are reported to the respective State Agency with in 2 hours weekly x 4 and monthly there after to ensure ongoing and sustained compliance with this alleged deficient practice. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is	

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	On 11/28/22 at approximately 11:45 AM, R705 was observed in their room. The resident was being assisted by a Certified Nursing Assistant (CNA) and stated that she was not able to be interviewed. A second attempt to interview R705 was made on 11/29/22 at approximately 3:52 AM. R705 was sleeping and was not interviewed. A review of R705's clinical record revealed the resident was admitted to the facility on 9/22/21 with diagnoses that included: Type II diabetes, Crohn's disease and dysphasia. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 11/15 (moderately impaired cognition) and required extensive one-to-two-person assistance for most Activities of Daily Living (ADLs). Further review of the resident's clinical record documented, in part, the follow: Progress note dated 11/9/22 and authored by Social Worker (SW) "N": "...SW met with resident r/t concerns reported by CNA today 11/9/22 over patient's Significant Other (herein after "SO") being noticeably "rough" when handling patient during visit and overhearing resident state to SO "don't hit me"...SW interviewed resident who stated to writer that lately SO has been "very tired and angry"...When asked if he had physically harmed her in any way she demonstrated that he sometimes will hit her in the knee or leg when he is mad...When SW asked if she was afraid of SO she hesitated for a few moments than responded "I don't think so"...Resident does acknowledge that this behavior is inappropriate and relays fears that if addressed he may stop visiting her...DON (Director of Nursing) and writer spoke with		responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	resident and staff and advised that SO will not be allowed to visit alone in room and that all visits will have to be supervised in common areas..". Psychiatry Note (11/11/22): "...R705 referred and seen for supportive therapy and to follow up after abuse allegations were reported to the state by facility.... discussed patient situation.... patient and SO were seen by facility staff exercising and SO "hit" patients' leg/knee and patient was heard to say, "don't hit me". Patient informed by staff that future visits with SO must be in the common area, and he can no longer visit alone in her room. LMSW informed of the reason patient was being seen today and asked patient to relay what happened with her SO and the abuse allegations. Patient stated "I was down in the room with puzzles, and SO started doing leg and arm exercised with me. He will give me a tiny "push in the leg" when I don't do the exercises correctly. It's enough to hurt me." Patient denied any bruising or injury...Patient stated that "staff must have heard me say something to him and reported it. "..."I have asked him not to, but it doesn't help."".... inquired if patient feels safe with SO and wants him to continue to visit her at the facility. Patient reported "yes I feel safe with him" and "it hurts very minimal".... educated patient about safety and that this is not an appropriate behavior for her SO to be doing...reinforced that the facility is obligated to report any type of abuse and that it was reported to the state...Patient appears to have some cognitive deficits and was observed to have trouble with comprehension at times during session...". A request was made for all Incident/Accident (I/A) reports for R705. The initial IAs provided did not address the incident as noted above. A second request for any I/As and/or State Agency reports pertaining to R705 was made.			

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	The facility provided a two-piece document titled, "Detailed Facility Investigation" that documented, "...Date/Time of Incident: BLANK...Reported to: Director of Nursing (DON)...Date/Time: 11/9/2022...Statement of incident: CNA "R" .... stated that he has noted behavior from significant other of R705 to include a report that he hit her in the legs. CNA "R" reports that he went to move her, and she said her legs were sore. He works with her frequently and states this is unusual for her. Upon inquiry she stated he hits her sometimes. She states he is not trying to hurt her he is usually telling her to work harder and try to move and walk to come home...Witness statements: enter who gave witness statements - statements to be attached: Person(s) witness to Incident: CNA "N" (*it should be noted that there were no statements attached to the document)....Patient/Resident Data: BLANK...Summation of Items ...MSW "N" and DON interviewed resident. Do you feel safe her? Yes. How long have you been with your boyfriend? Since 1983. Did he hit your legs? Yes, he has been more frustrated with me not walking. Are you afraid? No, he is not trying to hurt me he wants me to walk. Do you want the police called? No, he drives 2 hours a day to see me and is working on the house. He is not trying to be mean.... Detail of interventions...Discussed with team. Will institute supervised visits in common areas during normal hours of visiting. Discussed this with resident and she agrees. Left message with significant other to call to discuss a concern...". On 11/29/22 at approximately 3:41 PM, the Administrator/Abuse Coordinator was interviewed regarding the incident involving R705 and their SO and why the incident/allegation was not reported to the SA. The Administrator stated that after interviewing the resident we determined that SO was taping her leg and R705 denied the incident. When			

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	asked the date the alleged incident occurred and when the Administrator was informed, the Administrator was not certain and noted the DON and SW "N" completed the investigation. When asked the facility protocol for reporting allegation of abuse the Administrator reported within two hours for allegations of abuse. The Administrator was again asked for any additional documentation that included interviews. No additional documents were provided before the end of the survey.			
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 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:	F0657	F657 E Element 1: It is the practice of this facility to ensure implementation of care plans and updating of interventions to meet resident care needs. Resident R716 no longer resides in the facility. Resident R705 still resides in the facility and was evaluated by nursing. Nursing care plans were reviewed and updated. Appropriate interventions were added or resolved to meet residents care needs. Element 2: All residents have the potential to affected by this cited practice. A facility wide audit was conducted to ensure that any residents with safety concerns have psychosocial wellbeing items care planned to keep them safe. All residents who have orders for wound care were reviewed to ensure the treatments were care planned. Element 3: The IDT reviewed the Comprehensive Person-Centered Care Planning Process/Conference and deemed it appropriate. The Skin and Wound Documentation process was updated to detail the steps to ensure wounds are fully addressed upon recognition. This includes writing treatment orders and opening a wound care plan. The nurses, social workers and	10/25/2022

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	Based on interview, and record review, the facility failed to implement care plans and update interventions to reflect and address resident care needs for two of two residents (R705 and R716) reviewed for care plans, resulting in the potential for discrepancies in delivery of care, and unmet care needs. Findings include: According to the facility's policy titled, "Comprehensive Person-Centered Care Planning Process/Conference" dated 10/8/2020, "...All disciplines involved in the resident's plan of care must contribute to the development of the care plan...All disciplines are responsible for updating, adding or resolving their problems to the person-centered care plan...". R705: On 11/28/22 at approximately 11:45 AM, R705 was observed in their room. The resident was being assisted by a Certified Nursing Assistant (CNA) and stated that she was not able to be interviewed. A review of R705's clinical record revealed the resident was admitted to the facility on 9/22/2021 with diagnoses that included: Type II diabetes, Crohn's disease and dysphasia. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 11/15 (moderately impaired cognition) and required extensive one-to-two-person assistance for most Activities of Daily Living (ADLs). Further review of the resident's clinical record documented, in part, the follow: Progress note dated 11/9/22 and authored by		MDS staff were re-educated on the process for updating resident Care Plans to reflect current interventions. A new process was started to add psychosocial concerns in care plan and on Kardex for resident□s safety. Education was done on new processes. Element 4: The MDS Director or designee will audit for a random sampling of 5 residents with an order for wound care to evaluate that treatment plans were written and reflected in the wound care plan weekly x 4 then monthly x 3. The MDS director or designee will audit 5 random charts to ensure any new intervention implemented for psychosocial safety were care planned weekly x 4 then monthly x 3. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of MDS in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	Social Worker (SW) "N": "...SW met with resident r/t concerns reported by CNA today 11/9/22 over patient's Significant Other (herein after "SO") being noticeably "rough" when handling patient during visit and overhearing resident state to SO "don't hit me"...SW interviewed resident who stated to writer that lately SO has been "very tired and angry"...When asked if he had physically harmed her in any way she demonstrated that he sometimes will hit her in the knee or leg when he is mad...When SW asked if she was afraid of SO she hesitated for a few moments than responded "I don't think so"...Resident does acknowledge that this behavior is inappropriate and relays fears that if addressed he may stop visiting her...DON (Director of Nursing) and writer spoke with resident and staff and advised that SO will not be allowed to visit alone in room and that all visits will have to be supervised in common areas..". A facility document titled, "Detailed Facility Investigation" documented, in part, "...Date/Time of Incident: BLANK...Reported to: Director of Nursing (DON)...Date/Time: 11/9/2022...Statement of incident: CNA "R" .... stated that he has noted behavior from significant other of R705 to include a report that he hit her in the legs. CNA "R" reports that he went to move her, and she said her legs were sore. He works with her frequently and states this is unusual for her. Upon inquiry she stated he hits her sometimes. She states he is not trying to hurt her he is usually telling her to work harder and try to move and walk to come home... Will institute supervised visits in common areas during normal hours of visiting. Discussed this with resident and she agrees. Left message with significant other to call to discuss a concern...". There was no documentation, including a care plan, that addressed the resident was to have only supervised visits with the SO.			

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Certified Nursing Assistant (CNA) "V" and "W"" were interviewed on 11/29/22 at approximately 2:19 PM. When asked if they were aware of any type of restrictions regarding R705's SO visitation with her, both noted that they were not aware of any and that SO visits with the resident in her room.

On 11/29/22 at approximately 2:30 PM an interview and record review were conducted with the Director of Nursing (DON). When asked if the resident's care plan was updated regarding visitation restrictions, the DON initially stated that she personally had placed interventions into the resident's care plan. The DON reviewed R705's record and stated that it must not have been uploaded. When asked how staff would know that visits with the SO should be in a common area, the DON responded that information, including a care plan should be in the resident's record.

R716

On 11/28/22 at approximately 12:15 PM, R716 was observed in their room. When asked if they had any pressure sores or wounds, the resident replied there was something on her bottom.

Review of the clinical record revealed R716 was recently admitted to the facility 10/27/22 with diagnoses that included: Type II diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic kidney disease and Heart Failure. A review of the resident Minimum Data Set (MDS) indicated the resident was cognitively intact.

Continued review of R716's clinical record documented, in part, the following:

Baseline Admission Evaluation (10/27/22): "...M.

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	Skin...Site...23) Coccyx...healed stage 2, discoloration noted...". Total Body Eval (11/3/22), "... Does the resident have any skin abnormalities: ...2. No...". Skin and Wound Evaluation (11/13/22/Lock Date: 11/18/22): "A. describe...Type: Pressure...Stage 2...Location: Right Buttock...Acquired: In-House...How long has the sound been present...Unknown... Wound Measurements: Area: 2.0 cm...Length 1.8 cm...Width...1.4...". The resident's care plan was reviewed and did not contain any documentation that focused on wound/pressure sore care that would have included interventions for pressure sores either prior to the determination of the wound on or about 11/13/22 or after the wound was observed. On 11/30/22 at approximately 2:55 PM, an interview and record review were conducted with the Regional DON (Nurse 'H') to ask if there should have been a care plan to address R716's Skin and Wound, Nurse "H" confirmed there should have been a care plan.for R716.			
F0686 SS= H	Treatment/Svcs to Prevent/Heal Pressure 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	F0686	F686 Element 1: It is the practice of this facility accurately assess, identify, and implement timely treatments and interventions for residents with wounds. Resident 704, 716 no longer resides in the facility. Resident 709 was reviewed for wound orders to ensure there were no duplicate orders or competing orders for the same area with pharmacy items for wound care separate from treatment orders. Element 2: All residents have the potential to affected by this cited practice. A facility wide	10/27/2022

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	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 accurately assess, identify, and implement timely treatments and interventions for three (R704, R709 and R716) of five residents reviewed for pressure ulcers, resulting in the developing and/or worsening of pressure ulcers. Findings include: According to the facility's policy titled, "Skin & Wound Policy" dated April 2022, "...A full body, or head to toes, skin and oral cavity assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter...All wounds will have treatment orders from the physician team. The wound care physicians will be consulted to evaluate and treat unless resident is being followed by an outside wound clinic...Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change...Treatment decisions will be based on...Etiology of the wound...Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage...Characteristics of the		audit of all wound care orders was completed to ensure all orders were current and there were no duplicates orders or competing orders for the same area with pharmacy items for wound care separate from treatment orders. Element 3: The IDT reviewed the wound care policy and deemed it appropriate. The nursing team was re-educated on accurately assessing, identifying, and implementing timely treatments and interventions for residents with wounds. The admission nurse will be the first line of assessment of the resident skin, The floor nurses are the second line for weekly monitoring of resident skin. The wound care nurse will be assessing the resident the day after admission and all ongoing wounds. All wounds will have timely treatments ordered. Element 4: The nurse manager or designee will audit 5 residents with wounds to see that timely orders were entered for wounds without duplication weekly x 4 then monthly x 3. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	wound...Treatments will be documented on the Treatment Administration Record..." R704: On 11/28/22 from 11:28 AM until 2:55 PM, R704 was observed lying in bed on their back with the head of the bed elevated. The resident was observed positioned in bed leaning slightly onto their right side. There were no positioning devices observed, no specialty mattress such as a low air loss mattress and no feet/heel protectors on. The feet/heel boots were observed on a chair opposite the bed. A urinary catheter drainage bag and tubing were also observed in use for R704 and observed lying directly on the floor next to the bed. (It should be noted that R704 was one of several residents identified during the recertification survey for the same concerns related to development/worsening of pressure ulcer/injury and lack of timely interventions.) On 11/28/22 at 2:55 PM, an interview was conducted with R704. The resident reported they had pressure ulcers and they were having pain specifically more on the right side (same side resident was observed positioned on throughout the day). When asked about what interventions they were to have in place such as a wedge/pillow or specialty mattress, R704 reported they were supposed to have a wedge or pillow to help with positioning as they were unable to move themselves in the bed and they thought they			

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	had a low air loss mattress currently but realized it was not. The resident further reported they were very frustrated as no one had been in to reposition them at all today. When asked about the soft boots observed placed on the chair across from the bed, they reported they were supposed to be on but staff did not do that today. On 11/28/22 at 3:00 PM, an interview was conducted with R704's assigned Certified Nursing Assistant (CNA 'D'). When asked about their assignment, they reported they had been assigned to a split hall which included R704. When asked about the observations of lack of repositioning, use of positioning devices and feet/heel protectors, CNA 'D' reported they should've done that every two hours and didn't because they were busy. On 11/28/22 at 3:15 PM, an interview was conducted with R704's assigned nurse (Nurse 'E'). When asked about R704's wounds and whether wound care had already been completed for the day shift, Nurse 'E' reported they had not done that yet and thought maybe the wound care team would be doing it since they were here today. When asked about the lack of repositioning, or use of preventative interventions for the wounds such as pillows/wedges/boots/specialty mattress, Nurse 'E' reported they were not sure as they were with an agency but the resident should've been repositioned by the CNA.			

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On 11/29/22 at 8:00 AM and 11/30/22 at 9:17 AM, R704's bed remained without a specialty mattress such as a low air loss mattress.

Review of the clinical record revealed R704 was admitted into the facility on 8/22/22, hospitalized on 11/16/22 and readmitted on 11/22/22. Diagnoses according to the diagnosis tab of the electronic medical record (EMR) included: pressure ulcer of right buttock stage 4 (as of 9/15/22), urinary tract infection (UTI), klebsiella pneumoniae (a gram-negative bacteria that had a high degree of antibiotic resistance), infection and inflammatory reaction due to indwelling urethral catheter, multiple cranial nerve palsies in sarcoidosis, other disorders of peripheral nervous system, type 2 diabetes mellitus with diabetic chronic kidney disease, paraplegia, chronic pain syndrome, sickle-cell trait, and myoneural disorder.

According to the Minimum Data Set (MDS) assessment dated 10/24/22, R704 had intact cognition, had no behavioral concerns, required extensive assistance of two or more people for physical assist with bed mobility and transfers, had functional limitation in range of motion to both lower extremities, had an indwelling catheter and was always incontinent of bowel, had two stage three pressure ulcers that were present on admission/entry or reentry, and had pressure reducing device for chair and bed.

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	Review of R704's current care plans included: "The resident has actual impairment to skin integrity of the sacrum, left buttocks, left and right inner buttocks, perineum, and posterior thighs r/t (related to) fragile skin". This care plan had been initiated 10/18/22 and revised on 10/22/22. Interventions included: "The resident needs low air loss mattress to protect the skin while up in Bed." Date initiated 10/22/22. Review of R704's Braden scale scores revealed R704 was at moderate risk for pressure ulcer development. According to R704's hospital discharge documentation on 11/22/22: "...Why you were hospitalized...Your primary diagnosis was...Complicated UTI...UTI due to Klebsiella species...Decubitus ulcer of right buttock, stage 4...Decubitus ulcer of left buttock, stage 3...Pressure ulcer of sacral region, stage 3...Pressure injury of left buttock, stage 3...Pressure injury of left ischium, unstageable...Pressure ulcer of right ischium, stage 3...Pressure injury of right buttock, stage 4...Chronic indwelling Foley catheter...Urinary tract infection associated with indwelling urethral catheter..." Review of the physician orders included:			

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Order date 11/25/22: "Wound Care Order Site: left/right buttock / left post. (posterior) Thigh 1) Cleanse wound with NS (Normal Saline) 2) Pat Dry with Gauze 3) Apply calmoseptine with anti-fungal mix every shift (Day/Evening/Midnight) for wound care".

Order date 11/23/22: "Please reposition with pillows/wedge every two hours for wound care/comfort".

Order date 11/23/22: "Foam heel suspension boots to be worn while in bed every shift".

There was no wound care order which addressed the sacral area until 11/29/22 which read, "Dakins (1/4 strength) Solution (Sodium Hypochlorite) Apply to sacrum topically every day shift for wound care after cleansing with wound cleanser, pat dry, place dakins soaked gauze in wound and cover with border gauze daily and prn (as needed)".

The physician order for a low air-loss mattress was initiated on 11/23/22 for three days.

On 11/29/22 at 9:00 AM, review of R704's Treatment Administration Records (TARs) revealed a blank/missing entry for the wound care treatment from 11/28/22 day shift. The evening shift identified Nurse 'E' had signed off for the wound care for that shift.

Although there were additional pressure

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ulcer/injury areas, this review of the wound care evaluations since R704's readmission on 11/22/22 focused on the sacral and right buttock which included:

An entry on 11/29/22 at 3:35 PM from Wound Care Nurse Practitioner (NP 'J') included, "...Her sacrum wound is now appearing as unstageable. She has pain in left leg today and she is tearful...The examination focused on the sacral and the buttock region. She does have 3 areas, 1 on the left and the right buttock, along with the sacral area; there is full skin loss with irregular borders with central darkening area..."

Further review of the wound documentation including wound descriptions included:

R704's Sacral Area:

Documentation from Nurse 'F' on 11/29/22 at 3:44 PM identified wound deterioration since 11/23/22 which included, "Pressure Stage 3: Full-thickness skin loss...Sacrum...Present on Admission...Exact Date: 11/22/2022...Wound Measurements...Area 2.4 cm2 (square centimeters)...Length 2.1 cm...Width 1.3 cm...Depth Not applicable...Wound Bed Eschar...% Eschar 80% of wound filled...Evidence of Infection...Increased drainage...Bleeding...Exudate...Amount Heavy...Type Serosanguineous...Odor noted after cleansing...Faint...Periwound...Rolled Edge (Epibole): Edge appears curled

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	under...Surrounding Tissue...Denuded - loss of epidermis caused by exposure to urine, feces, body fluids, wound exudate or friction...Induration <2cm around wound...Periwound Temperature...Warm...Pain Frequency...Intermittent...Treatment...Dressing appearance...Saturated...Cleansing Solution...Normal Saline...Additional Care...Cushion...Heel Suspension/Protection device...Mattress with Pump...Progress...Deteriorating..." Documentation from Nurse 'G' dated 11/23/22 at 1:38 PM (assessment was not locked/completed until 11/28/22 at 7:20 AM) included, "...Pressure...Stage 3. Full-thickness skin loss...Sacrum...Present on Admission...How long has the wound been present? (portion was left blank)...Wound Measurements...Area 17.2 cm2...Length 3.9 cm...Width 6.9 cm...Depth 0.3 cm...Wound Bed...% Granulation 100% of wound filled...Evidence of Infection...None...Other...Bleeding...Exudate...Amount...Light...Type...Sanguineous/Bloody...Odor noted after cleansing...None...Periwound...Edges...Attached: Edge appears flush with wound bed or as a sloping edge...Surrounding Tissue...Fragile: Skin that is at risk for breakdown...Scarring...Periwound Temperature...Normal...Wound Pain...Pain Frequency...None...Treatment (left blank)..." R704's Right Buttock:			

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	Documentation from Nurse 'F' dated 11/29/22 at 3:43 PM included, "...Pressure...Stage 3: Full-thickness skin loss...Right Buttock...Present on Admission...How long has the wound been present? (non-identified - left blank)...Exact Date (left blank)...Wound Measurements...Area 15.9 cm2...Length...6.7 cm...Width 3.5 cm...Depth Not Applicable...Wound Bed (section left blank)...Exudate (section left blank)...Periwound (section left blank)...Wound Pain (section left blank)...Treatment (section left blank)...Progress (section left blank)..." Documentation of R704's skin & wound evaluation for the right buttock since 11/29/22 was dated 10/19/22 which read, "...Pressure...Stage 3: Full-thickness skin loss...Right Buttock...Present on Admission...How long has the wound been present? (section left blank)...Exact Date (left blank)...Wound Measurements...Area 0 cm2...Length 0 cm...Width 0 cm...Wound Bed...% Epithelial 100% of wound covered, surface intact...Evidence of Infection...None...Exudate...None...Odor noted after cleansing None...Periwound...Attached: Edge appears flush with wound bed or as a sloping edge...Surrounding Tissue...Fragile: Skin that is at risk for breakdown...Periwound Temperature...Normal...Wound Pain...None...Treatment (section left blank)...Progress...7. Resolved..."			

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	On 11/29/22 at 9:10 AM, an interview was conducted with Nurse 'E' who was assigned to R704. When asked about whether the resident had received wound care yesterday, Nurse 'E' reported the wound care team had done that. When asked if they had not provided the wound care, why were their initials on the TAR that it had been provided by them, Nurse 'E' reported they were not sure, and confirmed there was no wound care treatment provided to R704 for the day shift on 11/28/22. On 11/29/22 at 9:30 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for wound care, the DON reported they were actively changing the wound care team as the previous wound care nurse (Nurse 'G') had stepped down from that role about a week ago. The DON reported Nurse 'F' had come over from a sister facility to help and their Regional DON (Nurse 'H') stepped into the wound care nurse role about two weeks ago. The DON further reported the wound consultants (Physician 'I') and (Nurse Practitioner/NP 'J') rounded at the facility once a week on Tuesdays. The DON was asked about whether there were any additional wound care audits since 11/15/22 (most recent available in POC binder) as R704 had not been included in any of the previous audits and they reported they would see what other documentation they had. There was no further documentation provided that identified R704 had been identified on any			

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	other audits. When asked about the lack of wound care orders for the resident's sacral pressure ulcer/injury, the DON reported they would have to follow up. There was no additional information provided by the end of the survey. When asked about the order for the low air-loss mattress upon R704's readmission for only three days, and lack of provision of this since readmission, the DON reported that must've been an error would follow up. When informed of the concern R704 received no treatment for the day shift on 11/28/22, and the conflicting documentation of wound care provided by Nurse 'E' that reported they did not provide wound care, despite their initials being documented, the DON reported the nurses that provide the treatments should be the person signing off on the TAR and was not sure if possibly the nurse coming from their sister facility was given logon access and would follow up. There was no further follow up by the end of the survey. On 11/30/22 at 12:13 PM, an interview was conducted with the DON. When asked to clarify what their process was for residents that were admitted with or readmitted with pressure ulcers/injuries, the DON reported the nurse does the baseline admission evaluation which this just has the nurse state where the wounds are located, then the nurse			

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	should call the physician and get treatment orders until someone can come and see the wound, then the next day it should be reviewed by myself and Nurse Manager to make sure there were no concerns. When asked when the care plans should be implemented/reviewed, the DON reported as soon as the treatment order was written, the nurses should care plan, consult wound care and a photo (of the wound) should be taken. The DON reported if it was a new area identified during regular hours, or if off hours and someone notices something, the nurses were to immediately call the physician, implement treatments, and the picture and care plan may not happen until the next morning. The DON further reported they never saw R704's pressure ulcers/injuries since readmission. On 11/30/22 at 2:43 PM, the DON reported they were able to provide R704 with a low air loss mattress today. When asked why this had not been identified during the facility's monitoring as their plan of correction in which R704 was included with the same concerns identified during the recertification survey, the DON was unable to offer any further explanation. There was no further explanation as to the lack of/delay in wound care treatment for the sacral area. When asked to when the wound nurse would evaluate residents with pressure ulcers/injuries, the DON reported in a normal situation the wound nurse sees all new			

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residents for skin and check the orders. The DON acknowledged the concerns identified during this survey and reported they were working on correcting their processes.

On 11/30/22 at 2:50 PM, an interview was conducted with the Regional DON (Nurse 'H'). When asked to review the wound care and assessments for R704, Nurse 'H' reported the facility had recently began using a new skin assessment and when the pictures were taken of the wound, the measurements were done automatically, electronically and pulled into the documentation in the EMR. When asked about the discrepancies for the dates of when the wounds were identified, Nurse 'H' reported that was a system glitch and those areas once initiated were grayed out and automatically pulled forward to the next opened assessment. Nurse 'H' further reported there were several changes with the wound care nurses and they had started using this new assessment since 11/21/22 and had been overseeing the wounds since the recertification survey. Nurse 'H' acknowledged the concerns and was unable to offer any further explanation.

R709

Review of the medical record revealed R709 was admitted to the facility on 11/12/21 with a readmission date of 5/2/22 and diagnoses that included: dysphagia and aphasia following cerebral infarctions, aneurysm of carotid artery and seizures. A MDS assessment dated 10/14/22 documented a BIMS score of 00 which indicated

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severely impaired cognition and required staff assistance for all ADLs.

Review of the October and November 2022 MAR and TAR revealed the following orders:

October 2022

Calcium Alginate-Silver Pad 4.25 x 4.25, Apply to Right heel topically every day shift for wound care (Start Date of 8/11/22 and a discontinued date of 11/3/22).

Wound Care Order ... right heel ... Cleanse wound with wound cleaner ... Pat dry with gauze ... Apply oil emulsion gauze then Betadine to area ... Cover with 4x4 gauze and Abd (Abdominal) pad ... Wrap in kerlix ... Tape - date and time the tape every day shift every Tue (Tuesday), Fri (Friday) for wound care (Start Date of 10/7/22 and a discontinued date of 11/18/22).

From 10/7/22 until 11/3/22, more than a month the facility nurses had applied two different treatments to the same area without clarifying the two orders. The facility was out of compliance for pressure wounds until 10/27/22 therefore the review from 10/27/22 until 11/3/22 is the concern.

Review of a "Wound Rounds" note dated 11/1/22 at 4:38 PM, documented in part, " ... Right heel, stage 3 healing well, measuring 2.0 cm (centimeters) x 3.2 cm ... Will clean with normal saline, use NS (normal saline) to wash, use Adaptec to the wound, cover with, Betadine iodine dressing keep heel protectors ..."

Further review of the medical record revealed no clarification regarding the wound practitioner orders and no clarification of the two implemented wound treatment orders to the right

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	heel. On 11/29/22 at 5:20 PM, the DON (with the Administrator present) in attendance was interviewed and asked about the two different orders for R709's right heel. The DON stated they would look into it and follow back up. On 11/30/22 at 11:02 AM, the DON was recalled for a follow-up interview and asked about the clarification of the two wound orders for R709's right heel and the DON replied they did not see two orders in place for R709's heel. At this time the DON and the Infection Control Director (ICD) "C" was shown the Medication Administration Record and Treatment Administration Record (MARs and TARs) for the months of October and November 2022 and both confirmed they saw the signatures of the facility nurses signing for both treatments to R709's heel. The DON then stated they would look further into it and follow back up. On 11/30/22 at 12:37 PM, the DON provided a typed overview of their research into R709's orders, however, did not type an explanation on why the staff was applying two different treatments to the resident's right heel without clarification of which order should be applied. On 11/30/22 at 1:42 PM, the DON (with the Administrator, ICD "C" and the Infection Control Consultant (ICC) "C" present) stated the physician (who is not the wound practitioner) wanted the Calcium Alginate on hand if needed and that is how the facility was able to keep it in stock by placing a treatment order for it. When asked if the physician wanted the Calcium Alginate on hand if needed then why was the facility nurses applying it every day with the ordered wound cleanser, oil emulsion gauze, betadine, ABD wrap with kerlix treatment? The			

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	DON did not provide an explanation that explained why the resident had two different orders for the same wound site (right heel) and why the facility staff failed to clarify the orders. R716 On 11/28/22 at approximately 12:15 PM, R716 was observed in their room. The resident was alert and able to answer questions asked. The resident reported that she needed the assistance of two people for bed mobility and transfers and noted that her family member was assisting with providing most showers. When asked if they had any pressure sores or wounds, the resident replied there was something on her bottom. Review of the clinical record revealed R716 was recently admitted to the facility 10/27/22 with diagnoses that included: Type II diabetes, Chronic Obstructive Pulmonary Disease (COPD), chronic kidney disease and Heart Failure. A review of the resident Minimum Data Set (MDS) indicated the resident was cognitively intact. Continued review of R716's clinical record documented, in part, the following: Baseline Admission Evaluation (10/27/22) : "...M. Skin...Site...23) Coccyx...healed stage 2, discoloration noted...". Braden Scale for Predicting Pressure Sore Risk dated (10/28/22) documented the resident with a score of 14 (moderate risk). Total Body Eval (11/3/22) , "... Does the resident have any skin abnormalities: ...2. No...". Total Body Eval (11/11/22): "...Does the resident have any skin abnormalities...1. Yes...Describe abnormalities...right buttock shearing...".			

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Skin and Wound Evaluation (11/13/22/Lock Date: 11/18/22): "A. describe...Type...Pressure...Stage 2...Location: Right Buttock...Acquired: In-House...How long has the sound been present...Unknown... Wound Measurements: Area: 2.0 cm...Length 1.8 cm...Width...1.4...".

A Wound Rounds Note (11/15/22): "...Assessment and plan...1. Stage 2 on the right buttocks cleanse with normal saline, Apply Adaptec (A Non-Adhering Dressing designed to protect fragile tissue in Wounds) and dry dressing...".

A review of R716's Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the resident received the following treatments: "Apply to peri-area buttock topically every shift for Health & Wellness; Incontinence Clean area with soap and water, dry, apply ointment to area after each incontinence episode (start date 10/28/22)...a second order with a start date of 11/13/2022 documented: "Peri Guard Ointment (skin Protectants misc.) Apply to right/left buttock topically every shift for wound care...". *There was no indication that noted the application of Adaptec dressing.

The resident's care plan was reviewed and did not contain any documentation including interventions for pressure sores either prior to the determination of the wound on or about 11/13/22 or after the wound was observed.

On 11/30/22 at approximately 2:55 PM, an interview and record review were conducted with the Regional DON (Nurse 'H'). Nurse "H" queried as to what interventions were put into place to prevent R716's facility acquired pressure sore given the fact the facility was aware the resident

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	had a past history of pressure ulcers. Nurse "H" reported that she was aware that R716 initial assessment documented a prior pressure ulcer and indicated that the standard of practice would be, at a minimum, to ensure the resident was frequently turned and re-positioned. Nurse "H" also noted interventions should have been placed in the resident's care plan. When asked about the lack of documentation regarding an Adaptive dressing, Nurse "H" noted that starting 11/13/22 Peri Guard ointment was used as a treatment.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and	F0690	F690 Element 1: It is the practice of this facility to provide care and maintenance of an indwelling urinary catheter according to professional standards. Element 2: All residents with a foley catheter have the potential to be affected. An audit was conducted on all residents with a foley catheter to ensure the bag was less than half full and maintained below the level of the bladder and off the floor. Element 3: The IDT reviewed the "Indwelling Catheter-Insertion, Care Removal" Policy and deemed it appropriate. All direct patient care staff was educated on the proper positioning of a foley catheter (below bladder and off the ground) and the need to empty at least once every 8 hours and anytime half full. Housekeeping was educated to notify the nurse if the bag is noted to be on the ground or greater than half full. Element 4: The nurse manager or designee will audit 5 residents with catheters to ensure that their bags are less than half full and off the ground below the level of the bladder x 4 then monthly x 3.	12/15/2022

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	services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and maintenance of an indwelling urinary catheter for two (R704 and R707) of two residents reviewed for urinary catheters, resulting in the increased likelihood for re-occurring urinary tract infection (UTI) and complications in the resident's health conditions. Findings include: According to the facility's policy titled, "Indwelling Catheter-Insertion, Care Removal" dated 6/1/22, "...Catheter care will be performed every shift and as needed by nursing personnel...Empty drainage bags when bag is half-full, as requested by resident or every shift...Ensure drainage bag is located below the level of the bladder to discourage backflow of urine..." R704 On 11/28/22 from 11:28 AM until 2:55 PM, R704 was observed lying in bed on their back with the head of the bed elevated. The resident was observed positioned in bed leaning slightly onto their right side. A urinary catheter drainage bag and tubing were also observed in use for R704 and		Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	observed lying directly on the floor next to the bed during this time. On 11/28/22 at 2:55 PM, an interview was conducted with R704. The resident reported they had an indwelling urinary catheter and were receiving intravenous antibiotics for a urinary tract infection. The urinary drainage bag and tubing remained directly on the floor (carpeted) and was full of urine backing up the urinary tubing. At that time, the resident's assigned Certified Nursing Assistant (CNA 'D') entered the room, turned off the call light and then exited the room without attending to R704's Catheter bag or tubing. On 11/28/22 at 3:00 PM, an interview was conducted with R704's assigned Certified Nursing Assistant (CNA 'D'). When asked about the observations of the full urinary catheter and placement on the floor, CNA 'D' acknowledged them being on the floor and reported they would correct that. When asked why it had been like that all day, and whether they had monitored any urine output throughout their shift, or provided any catheter care, CNA 'D' reported they had not done that since earlier around 7:00 AM when they first started. When asked how often that should be done, CNA 'D' reported should be every two hours and they had not because they were busy, they knew it wasn't an excuse but it was the truth and they should've been in there.			

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	On 11/28/22 at 3:15 PM, an interview was conducted with R704's assigned nurse (Nurse 'E'). Nurse 'E' was asked to observe the catheter and entered the room. When asked about the catheter drainage bag being stored on the floor, Nurse 'E' picked up the bag from the floor and raised it up above the bed (and above the bladder) approximately three feet. The urine was observed to flow backward up the urinary tubing. The nurse was asked about when the drainage bag should be emptied and reported when it got at least half full. The nurse confirmed the bag was full and attempted to hang on the side of the resident's bed but reported there was no hook and then placed the entire full bag on the mattress next to the resident's right hip. Review of the clinical record revealed R704 was admitted into the facility on 8/22/22, hospitalized on 11/16/22 and readmitted on 11/22/22. Diagnoses according to the electronic medical record (EMR) included: urinary tract infection (as of 11/22/22), klebsiella pneumoniae (as of 11/22/22), infection and inflammatory reaction due to indwelling urethral catheter (as of 10/18/22), multiple cranial nerve palsies in sarcoidosis, pressure ulcer of right buttock stage 4 (as of 9/15/22), type 2 diabetes mellitus with diabetic chronic kidney disease, neuromuscular dysfunction of bladder, chronic kidney disease stage 3, paraplegia, chronic pain syndrome, sickle-cell trait, and myoneural disorder.			

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	According to the Minimum Data Set (MDS) assessment dated 10/24/22, R704 had intact cognition, required extensive assistance of two or more people for physical assist for toilet use, had an indwelling urinary catheter, and was always incontinent of bowel. Review of the physician orders included: Order Date 11/23/22, "Contact Precautions for: ESBL (Extended Spectrum Beta-Lactamase - a bacteria resistant to some antibiotics which require isolation precautions to prevent spread of transmission) in urine". Order Date 11/23/22, "Foley Catheter Care every shift". Order Date 11/23/22, "Suprapubic, Foley or condom Catheter output amount every shift". Order Date 11/23/22, "Ertapenem Sodium Solution Reconstituted 1 GM (Gram) Use 1 gram intravenously every 24 hours for Infection for 11 days". (An intravenous antibiotic medication.) On 11/29/22 at 9:30 AM, an interview was conducted with the DON. When asked what should be done to monitor a resident's indwelling urinary catheter, the DON reported they did education with staff today. The DON reported technically the physician order for indwelling urinary catheter is to check every eight hours, but reported it was a			

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	standard of practice to empty when half full. R707 On 11/28/22 at approximately 12:02 PM, R707 was observed lying in bed. The resident's had a urinary catheter foley that was overflowing, and urine could be seen extending up the tubing. The catheter bag was touching the floor and was not covered. On 11/28/22 at approximately 1:25 PM, the bag was still touching in the floor. The urine had not been emptied, again urine was observed extending up through the tubing and the bag was uncovered. On 11/28/22 at approximately 1:30 PM, Nurse "CC" entered into the resident's room and was asked as to the facility protocol pertaining to catheter care and noted that the catheter bag should have been emptied, covered and properly hung off the floor. A review of R707's clinical record documented the resident was initially admitted to the facility on 12/21/17 and readmitted on 11/14/22 with diagnoses that included: Multiple Sclerosis, Type II diabetes and Alzheimer's disease. A review of the resident's MDS indicated the resident was severely cognitively impaired. An order dated 11/14/22 documented, "Foley Catheter Care every shift ...Every shift Monitor urinary meatus and rotate anchor site when needed ..."			
F0761 SS= E	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	F0761	F761 Element 1: It is the practice of this facility to ensure appropriate medication storage and labeling of medication and treatment carts.	10/25/2022

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	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 evidenced by: Based on observation, interview, and record review the facility failed to ensure appropriate medication storage and labeling in two of three medication carts and one of two treatment carts reviewed, resulting in the potential for misuse, contamination, reduced strength/effectiveness, and medication administration errors. Findings include: According to the facility's policy titled, "Medication & Treatment Cart Storage" dated 5/4/22, "...It is the policy of this facility to ensure all supplies for treatments and		Element 2: All residents have the potential to be affected. An audit was conducted on all medication and treatment carts to ensure all items dated and labelled. Element 3: The IDT reviewed the Medication Storage and labelling Policy and deemed it appropriate. A process for routine audits by midnight staff was put into place. A new MN supervisor was hired and trained on proper cart audits. The audits will be given to DON. All nurses were trained on how to do a cart audit and re-educated on labelling all items when opened. The nursing staff were re-educated on the need to have the medication cart always locked while unattended and to ensure all items in cart are labelled and in proper packaging. Element 4: The nurse manager or designee will audit 1 random time to ensure all unattended carts are locked weekly x 4 then monthly x 3. The nurse manager or designee will audit 1 random cart/ unit to ensure items are properly labelled and packaged weekly x 4 then monthly x 3. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security...All drugs and biologicals will be stored in locked compartments (i.e., medication carts...All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room...Unused 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..." On 11/28/22 at 9:59 AM, observation of the 500-hall medication cart was conducted with Nurse 'O'. Nurse 'O' reported they had just arrived to work and been assigned to the medication cart. Upon observation, the following concerns were identified: Five multi-dose insulin pens (Humalog, Basaglar and Novolog Flex Pen) for multiple residents were opened and undated of when they had been opened. The labels on these items prompted nursing staff to discard within 28 days of opening. Two multi-dose insulin pens (Lantus and Humalog) contained no label to identify resident name, when medication had arrived from the pharmacy, or when they had been			

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	opened. When asked about whether the facility's process for labeling/dating medication/biologicals, Nurse 'O' reported they should be labeled and dated when opened. On 11/28/22 at 10:10 AM, observation of the 300-hall medication cart was conducted with Nurse Manager (Nurse 'K') who reported they currently had the medication cart keys as they were covering for an agency nurse that needed to take a phone call. Upon observation, the following concerns were identified: Two multi-dose insulin pens (Lispro) were opened and undated of when they had been opened. One multi-dose insulin pens (Lantus Solostar) contained no label to identify resident name, when medication had arrived from the pharmacy, or when it had been opened. One unopened multi-dose Insulin Lispro Humalog Pen. The label from pharmacy was dated 11/26/22, with a small blue sticker that read "Refrigerate Until Opened". One unopened multi-dose Insulin Glargine pen. The label from pharmacy was dated 11/24/22, with a small blue sticker that read, "Refrigerate Until Opened".			

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	Two opened, undated inhalers (Incruse Ellipta and Budesonide/Formoterol). When asked about what the facility's process was for labeling/dating and storing medication, Nurse 'K' reported the above items should be labeled and dated when opened, and the unopened insulin should be refrigerated. Nurse 'K' was asked why there were so many concerns with the labeling and dating of medications/biologicals since that had been identified on the recent recertification survey and reported they were the only nurse manager for the entire facility and was difficult to monitor but would take care of that now. On 11/29/22 at 9:30 AM, an interview was conducted with the Director of Nursing (DON) to review the above concerns. When asked what their process was with auditing medication carts as this was part of their plan of correction, the DON reported an audit had been last done on 11/18/22 and that those items should've been dated when opened. On 11/29/22 at 12:18 PM, the medication cart for the 300 hall was observed unattended and unlocked. A short time later, Nurse 'P' was observed to pass by the cart and when asked about the cart being unlocked, Nurse 'P' pushed in the lock to secure the cart and reported that should've been locked when they left the cart, but they were working double duty passing lunch trays and answering call lights.			

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	On 11/30/22 at 9:08 AM, the treatment cart located just outside room 203 was observed to have a drawer pulled open slightly. All other drawers were able to be opened and contained various treatment supplies and biologicals. There were no nursing staff observed in the hallway. On 11/30/22 at 9:15 AM, Nurse 'Q' exited a room about four doors down and began to walk past the unlocked treatment cart. When asked about the cart, Nurse 'Q' stated it was locked as the button to press it was all the way in. Nurse 'Q' was then asked about the middle drawer sticking out (open) and if they were able to open any of the drawers. Upon checking the cart, Nurse 'Q' was able to open the drawers. Nurse 'Q' reported they were not sure how long it had been like that but they hadn't done anything with the treatment cart today.			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement an effective plan of correction (POC) to correct identified quality deficiencies related to pressure	F0867	F867 Element 1: It is the practice of this facility to develop and implement appropriate plans of action to correct identified quality deficiencies. Element 2: All residents have the potential to be affected. The IDT reviewed all tags to ensure progress to gain compliance. All findings and audits were reviewed in QAPI meeting on 12/13/2022. Element 3: The Administrator and DON have hired and are ensuring the proper support to train 2-unit managers, Infection Preventionist, Wound care nurse, Evening Supervisor, & MN	12/15/2022

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	sores, infection control, medication administration and storage, care plans and professional standards, resulting in the continuation of deficient practices. This had the potential to affect all residents who resided in the facility. Findings include: On 11/28/22 through 11/30/22, a revisit survey was conducted to determine compliance with deficiencies identified during the facility's recertification survey completed on 9/28/22. According to a CMS (Center for Medicare and Medicaid) 2567 form dated 9/28/22, the facility was found to be noncompliant with regulatory requirements, including but not limited to, the following: pressure ulcers/wound care, infection control, medication administration, medication storage, care plans and professional standards of nursing practice. Review of the facility's Plan of Correction (POC) noted a compliance date of 10/25/22 for all citations with the exception of pressure sores and wounds that indicated a compliance date of 10/27/22. The POC revealed the facility would address concerns to residents who were noted in the citations and/or potentially affected by the deficiencies, educate staff, based on facility policy(s) and audit residents weekly and then monthly to ensure compliance. Interviews with the Director of Nursing (DON) were conducted during the survey on 11/28/22, 11/29/22 and 11/30/22 regarding concerns as to whether the facility was addressing the POC. The DON noted that prior to the facility compliance date the facility was in the process of hiring clinical managers, including but not limited to a wound nurse and an infection preventionist. The DON reported that they were responsible for most of the audits and education of staff making it		supervisor. The team has reviewed the 2567 and all the items for compliance. The audits were delegated to appropriate staff. Additional oversight from DON for wound care and Infectious disease continues until ongoing compliance is ensured. Element 4: Results of the audits will be reviewed weekly by IDT team in morning meeting. Results will also be presented in QAPI for ongoing compliance and monitoring. The Administrator and Director of Nursing in collaboration is responsible for on-going monitoring and compliance.	

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	difficult to ensure compliance. On 11/30/22 at approximately 3:45 PM, the Administrator/QAPI coordinator regarding the several concerns identified during the revisit. They were asked about the facility's method to secure compliance including the method of auditing and alleged staff education. The Administrator noted that following the Recertification Survey (9/28/22) several key personnel had ceased employment making it difficult to ensure compliance.			
F0880 SS= F	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 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)	F0880	F880- Element 1: It is the practice of this facility to ensure a comprehensive infection control program that documents infections, applies designated criteria for infection definition, defines whether infections were community or healthcare acquired, calculates monthly infection rates, analyzes infections for clusters or trends, performs infection surveillance, and consistently provides education for infection control. R704 no longer resides at this facility. R709 was reviewed by new infection preventionist and found to be appropriately prescribed Azithromycin for URI. Element 2: All residents have the potential to be affected. All resident charts were reviewed for recent infections, they were noted as community or healthcare acquired and analyzed for cluster or trends in the WH 2022 Infection-Antibiotic Log on the server. Element 3: The IDT reviewed the Infection Control Program Policy and deemed it appropriate. The infection preventionist nurse was replaced with an Infection Preventionist with over 2 years experience in LTC facility	10/25/2022

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	Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to consistently maintain an ongoing Infection surveillance system and ensure infection control standards and practices were consistently followed by the facility staff. Findings include: R704 Review of a "Physician Team" note dated 11/15/22 at 6:30 PM, documented in part " ... patient's urine cultures came positive for ESBL (extended spectrum beta-lactamase) bacteria for		that has the appropriate certification from the CDC and the Certification Board of Infection Control (CBIC) with a Bachelor of Science in Medical Technology. He will be running an order listing report daily when at work to screen for new antibiotics. He will attend morning meeting when working and review admissions as well as change in condition for concerns of infections. He will bring all Infection surveillance items to QA monthly. He will meet regularly with Medical Director and DON on infection control items. All staff will be educated on types of isolation and PPE required for each. New isolation signs will be introduced and used going forward that indicate level of isolation and PPE necessary. Element 4: The DON or designee will review the infection control logs weekly until competency noted by comprehensiveness of logs and monthly thereafter in QA. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance. DPOC Woodward Hills F880 Directed Plan of Correction Infection Prevention Plan: 1.As a result, from the RCA, the facility determined and addressed the reason for	

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	which sensitivity have showed sensitive to nitrofurantoin. Patient has been started on nitrofurantoin 100 mg by mouth twice daily on 11/14/2022 ... Denies any fever or chills. Denies any nausea vomiting ..." Review of a "Physician Team" note dated 11/22/22 at 8:09 PM, documented in part " ... sent out on 11/16/2022 to (hospital name) ... suffering from recurrent UTI's (Urinary Tract Infection) due to indwelling Foley catheter which has been in place due to neurogenic bladder and inability to urinate ... Patient found to have severe UTI for which patient has been placed on ertapenem ..." Review of a November 2022 MAR documented Macrobid 100 MG, give 1 capsule by mouth two times a day for 7 days (Start date 11/15/22). Further review documented Ertapenem Sodium Solution reconstituted 1 GM (gram), use 1 gram intravenously every 24 hours for Infection for 11 days (Start Date 11/23/22). Review of the Infection Control Surveillance log for November 2022 revealed no documentation of R704's infection. R709 Review of a "Nursing" note dated 11/25/22 at 5:13 PM, documented in part " ... Received resident in bed resting with eyes closed, no distress noted and easily arousable ... Resident is in stable condition without changes to baseline. Vitals obtained: 113/54 (blood pressure)-80 (heart rate)-95% (oxygen saturation) ra (room air)-16 (respirations)-bs (blood sugar) 162-98.0 (temperature) (temporal) ... (doctor name) gave verbal order for azithromycin ... Albuterol 0.083% q6 (every six) hours ... robitussin ... Medrol ... Resident had chest x ray performed on 11/23/22 d/t (due to) wheezing with conclusion		non- compliance with ensuring to maintain an ongoing Infection surveillance system and ensure infection control standards and practices are followed by the staff. The facility implemented an antibiotic stewardship program with protocols for appropriate antibiotic use, The facility□s Infection Preventionist consistently performs the duties of the position, physically works onsite, and can properly assess, develop, implement, monitor, and manage the Infection control program. The Infection Preventionist educates and offers the pneumococcal vaccine to residents. He tracks and maintains accurate documentation of any facility outbreak investigation/testing to include documentation of COVID positive staff. He monitors all staff COVID 19 vaccination status as identified in the CMS 2567 and implemented a contingency plan for the facility□s unvaccinated staff to include weekly covid testing. Several policies covered the content of deficiencies. They were reviewed to include Infection Control Program Policy #1002, Covid-9 vaccination policy- #1016, Pneumococcal Vaccine Policy #1020 All staff were re-trained on the policies, with focus on a comprehensive infection control program. The program documents infections utilizing designated criteria for defining infections. The program defined whether infections were community or facility acquired, calculated monthly infection rates, analyzed infections for clusters or trends, performed infection surveillance, and consistently provided education for infection control. 2.Results of the RCA was reported by the QAA committee to the Governing Body. 3.Staff retraining was immediately implemented, no negative outcome was	

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	being negative- no acute cardio pulmonary process. Writer has been with resident often during shift for close monitoring no s/s (signs/symptoms) of lethargy or cough observed. Lung sounds clear upon auscultation in all 6 anterior fields, no wheezing heard upon exhale ..." Review of the November 2022 Medication Administration Record (MAR) documented Azithromycin (antibiotic) 250 MG (milligram), give 2 tablets via PEG (percutaneous endoscopic gastrostomy)- tube one time only for infection for 1 day (Start date 11/25/22) and an Azithromycin 250 mg, one tablet one time a day for 4 days "for infection". Review of the Infection Control Surveillance log for November 2022 revealed no documentation of R709's infection. On 11/30/22 at 11:02 AM, an interview was conducted with the Director of Nursing (DON), the Infection Control Director (ICD) "C" (who also serves as the facility Infection Control Preventionist) and the Infection Control Consultant "B". All three was asked how the infection data is reported to the responsible personnel to be logged onto the log and mapped to readily be able to identify any outbreaks, clusters or potential breaches in infection control so that the facility is able to identify, intervene, contain (if necessary), implement precautions and provide education if needed. The ICD "C" explained they have been at the facility periodically but will start full time in the building on December 5th, 2022. The ICD "C" stated they have not taken over the responsibility of the Infection control program yet, but will be doing so once their full time at the facility. The Infection Control Consultant (ICC) "B" stated they are an independent contracted Infection Control consultant that is helping the facility to		observed for residents in the facility. 4.Outline of the trainings provided to staff including you tube video presentation: The Director of Nursing, In-Service Director, and Infection Preventionist provided additional training to all staff providing direct care to residents and all staff entering residents rooms on the following topics: " Nursing Home Infection Preventionist Training Course https://www.train.org/cdctrain/training_plan/3814 " Targeted COVID-19 Training for Nursing Homes https://qsep.cms.gov/ProvidersAndOthers/home.aspx " Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA " Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw " Standard Infection Control Practices /Transmission-Based Precautions https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html " Hand Hygiene https://www.youtube.com/watch?v=d914EnpU4Fo " Appropriate use of PPE https://youtu.be/YYTATw9yav4 5.Names and positions of all staff to be trained: All staff providing direct care to residents and all staff entering residents rooms, whether for residents dietary needs or cleaning and maintenance services are included in education. 6.Staff training sign-in sheets: The sign in sheets is included in the attachments.	

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	get their infection control program back up and running. ICC "B" stated they have been tracking the infections and antibiotics prescribed in the facility by obtaining the data from staff, the morning facility meeting, the DON and the facility's electronic medical system. The DON then stated they also keep track of the day-to-day infection control in the building. All parties were again asked who maintained the infection control data daily to be able to identify outbreaks, clusters and all infections throughout the facility and ICC "B" stated they maintain the logs and if they notice any outbreaks or clusters, they would let the DON know. The DON then stated in return they would address it and contact the physician. All parties were then informed of a few sampled residents diagnosed with an infection that was not identified and documented on the November 2022 infection control surveillance log. The DON and ICC "B" reviewed the log provided by the DON and Administrator to the surveyor and stated they didn't understand why the provided log didn't have all of the data but they had a current log that could be provided with the current data. The DON, ICC "B" and ICD "C" was asked to provide the current log for review and a follow-up interview will be conducted after review of the current log. The DON and ICC "B" provided a binder with all of the current data for the infection control surveillance for the facility. Review of the provided Infection Control binder was completed and the sampled residents diagnosed with an infection (R's 704 and 709) was not identified on the current surveillance log nor in the current infection control data provided. On 11/30/22 at 1:42 PM, a recall meeting was conducted with the DON, ICC "B" ICD "C" and the Administrator was present. The names of R's 704 and 709 was provided to the DON, ICC "B", ICD "C" and Administrator, and the ICC "B" was asked to look through the data to see if they had		7.Summary of staff training: the employees responded very well to the education. A post training test was completed to validate staff competency. Those who did not answer questions correctly on the first try were re-educated and permitted to change answers. The Director of Nursing. In-service Director, Infection Control and nursing management team will conduct audits to ensure comprehensive infection control program to consistently maintain an ongoing Infection surveillance system and ensure infection control standards and practices were consistently followed by the staff. Ongoing education/audits for infection control along with utilize appropriate infection control standards and practices throughout the facility including implementing transmission-based precautions, following proper protocols for residents on transmission-based precautions, hand hygiene and glove use during wound care, and equipment cleaning. Results will be brought to Quality Assurance (QAPI) meeting. 8.Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of policies and procedures. The DON or Designee will review the infection control infection logs weekly to ensure compliance with a comprehensive infection control program. The infection preventionist, unit managers, and off shift supervisors will be monitoring staff for correct practice of handwashing and standard precautions. The Infection Preventionist reports on current isolations in the morning meeting with leadership.	

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	identified the infections that R's 704 and 709 was diagnosed with. ICC "B" reviewed their data and stated they were unable to find any documentation of an infection logged for R's 704 and 709. All parties were then asked how they are able to identify, investigate, prevent the spread of infections and educate if the facility is not identifying and tracking infections accurately and there was no response provided that answered the questioned asked. Review of a facility policy titled "Infection Prevention and control program" dated "09.2022", documented in part " ... This facility has established and maintains 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 as per accepted national standards and guidelines ... The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases ... A system of surveillance is utilized for prevention, 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 a facility assessment and accepted national standards ... The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made ..." R704 On 11/28/22 from 11:28 AM until 2:55 PM,		The following are attachments: 1.Completed Root Cause Analysis (RCA) as well as the intervention or corrective action plan developed from the RCA with signatures of the QAA Committee members and members of the Governing Body. 2.Documentation that the intervention and corrective action plan that resulted from the RCA were fully implemented. 3.Content of training provided to staff, including a syllabus, outline or agenda, as well as the qualifications of the individual leading the training and any other materials used or provided to staff for the training. 4.Names and positions of all staff that attended the trainings, including signed and dated staff training sign-in sheets. 5.Summary of staff training post-test results, to include the facility actions in response to any failed post tests 6.Documentation of efforts to monitor and track progress of the interventions and corrective action plan.	

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	R704 was observed lying in bed on their back with the head of the bed elevated. The resident was observed positioned in bed leaning slightly onto their right side. A urinary catheter drainage bag and tubing were also observed in use for R704 and observed lying directly on the floor next to the bed during this time. A small sign was magnetically attached to the doorframe that indicated R704 was on contact precautions and read "Stop CONTACT See nurse for Instructions", and a personal protective equipment (PPE) caddy with disposable gowns and gloves was secured to the door. Throughout these observations of R704, staff were observed going in/out of the room without donning/doffing any PPE. The only waist receptacle was a small, regular bin with clear bag that had no PPE discarded. There was no PPE hung inside the room. On 11/28/22 at 2:50 PM, R704's call light was observed activated. On 11/28/22 at 2:55 PM, an interview was conducted with R704. The resident reported they had an indwelling urinary catheter and were receiving intravenous antibiotics for a urinary tract infection. The urinary drainage bag and tubing remained directly on the floor (carpeted) and was full of urine backing up the urinary tubing. At that time, the resident's assigned Certified Nursing Assistant (CNA 'D') entered the room without donning any PPE, washing hands, and turned off the call light. CNA 'D' then was observed exiting the room without washing hands and proceeded to go into other resident rooms. On 11/28/22 at 3:00 PM, an interview was conducted with R704's assigned Certified Nursing Assistant (CNA 'D'). When asked about what they knew about the reason for R704 being on contact isolation precautions, CNA 'D' reported they			

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weren't aware of any for the resident and the signage and PPE were probably still up since the unit had been used as the facility's covid area a few weeks ago. When asked about the observations of the full urinary catheter and placement on the floor, CNA 'D' acknowledged them being on the floor and reported they would correct that.

On 11/28/22 at 3:15 PM, an interview was conducted with R704's assigned nurse (Nurse 'E'). When asked about why R704 was on contact isolation precautions, Nurse 'E' reported they weren't sure. Nurse 'E' was asked to observe the catheter and began to enter the room, then upon observing this surveyor donning PPE, Nurse 'E' proceeded to don as well. When asked about the disposal of the PPE, Nurse 'E' reported there was none in the room. When asked what had been used throughout the day, Nurse 'E' offered no further response.

On 11/28/22 at 3:28 PM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's protocol for donning/doffing PPE, the DON reported there were signs on the door and disposable gowns were hung on the door and to be used for the day, then disposed in bin near the door. The DON was informed of the concerns with lack of infection control practices and discussion with staff and reported they would have to follow up.

Review of the clinical record revealed R704 was admitted into the facility on 8/22/22, hospitalized on 11/16/22 and readmitted on 11/22/22. Diagnoses according to the electronic medical record (EMR) included: urinary tract infection (as of 11/22/22), klebsiella pneumoniae (as of 11/22/22), infection and inflammatory reaction due to indwelling urethral catheter (as of 10/18/22), multiple cranial nerve palsies in

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	sarcoidosis, pressure ulcer of right buttock stage 4 (as of 9/15/22), type 2 diabetes mellitus with diabetic chronic kidney disease, neuromuscular dysfunction of bladder, chronic kidney disease stage 3, paraplegia, chronic pain syndrome, sickle-cell trait, and myoneural disorder. According to the Minimum Data Set (MDS) assessment dated 10/24/22, R704 had intact cognition, required extensive assistance of two or more people for physical assist for toilet use, had an indwelling urinary catheter, and was always incontinent of bowel. Review of the physician orders included: Order Date 11/23/22, "Contact Precautions for: ESBL (Extended Spectrum Beta-Lactamase - a bacteria resistant to some antibiotics which require isolation precautions to prevent spread of transmission) in urine". Order Date 11/23/22, "Foley Catheter Care every shift". Order Date 11/23/22, "Suprapubic, Foley or condom Catheter output amount every shift". Order Date 11/23/22, "Ertapenem Sodium Solution Reconstituted 1 GM (Gram) Use 1 gram intravenously every 24 hours for Infection for 11 days". (An intravenous antibiotic medication.)			
F0881 SS= C	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor	F0881	F881 Element 1: It is the practice of this facility to ensure a comprehensive infection control program that included monitoring for appropriate use of antibiotics, resulting in the potential for unnecessary antibiotic usage and the development of multiple drug resistant organisms. R704 no longer resides at this	10/25/2022

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	antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to continuously implement an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for three of three sampled residents. Findings include: According to the Center for Disease Control's (CDC) "The Core Elements of Antibiotic Stewardship for Nursing Homes," dated 2015: "...Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to "optimize the treatment of infections while reducing the adverse events associated with antibiotic use...Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year...studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms...Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections...Identify clinical situations which may be driving inappropriate courses of antibiotics		facility. R709 was reviewed by new infection preventionist and found to be appropriately prescribed Azithromycin for URI. R725 was reviewed for appropriateness of the prophylactic antibiotic. It was deemed appropriate. Element 2: All residents have the potential to be affected. All resident charts were reviewed for recent infections, they were noted as community or healthcare acquired and analyzed for cluster or trends. Documentation can be found in the WH 2022 Infection-Antibiotic Log on the server. Element 3: The IDT reviewed the Infection Control Program Policy and deemed it appropriate. New infection preventionist at WWH will monitor completion and accuracy of antibiotic stewardship by pulling an order listing report on business days to capture all new antibiotics. That list will be compared to the laboratories reports on culture results. Those cases will be evaluated for use of Mcgeers criteria and antibiotic stewardship. New antibiotics will be discussed at morning meeting daily for appropriate diagnosis. Element 4: The Director of Nursing or designee will audit 5 random residents on antibiotics for proper evaluation of appropriate use of antibiotics weekly x 4 then monthly x3. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance.	

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	such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use..." R704 Review of a "Physician Team" note dated 11/15/22 at 6:30 PM, documented in part " ... patient's urine cultures came positive for ESBL (extended spectrum beta-lactamase) bacteria for which sensitivity have showed sensitive to nitrofurantoin. Patient has been started on nitrofurantoin 100 mg by mouth twice daily on 11/14/2022 ... Denies any fever or chills. Denies any nausea vomiting ..." Review of the Infection Control Surveillance log for November 2022 revealed no documentation of R704's infection. Further review of the Infection Control Surveillance and Antibiotic Stewardship program revealed no documentation of the infection to have met criteria for an antibiotic, documentation of signs and symptoms identified or the review of the appropriateness of the antibiotic. Review of the medical record revealed no documentation of R704's urinalysis culture results. Review of a "Physician Team" note dated 11/22/22 at 8:09 PM, documented in part " ... sent out on 11/16/2022 to (hospital name) ... suffering from recurrent UTI's (Urinary Tract Infection) due to indwelling Foley catheter which has been in place due to neurogenic bladder and inability to urinate ... Patient found to have severe UTI for which patient has been placed on ertapenem ..." Review of the hospital documentation revealed no urinalysis or culture reports obtained from R704's hospitalization to be reviewed by the facility's		The Administrator is responsible for continued compliance.	

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infection control staff.

Review of a November 2022 MAR documented Macrobid 100 MG, give 1 capsule by mouth two times a day for 7 days (Start date 11/15/22). Further review documented Ertapenem Sodium Solution reconstituted 1 GM (gram), use 1 gram intravenously every 24 hours for Infection for 11 days (Start Date 11/23/22).

Review of the Infection Control Surveillance log and antibiotic stewardship data for November 2022 revealed no identification or documentation of the facility's infection control staff to have identified the prescribed antibiotic for R704.

R709

Review of a "Nursing" note dated 11/25/22 at 5:13 PM, documented in part " ... Received resident in bed resting with eyes closed, no distress noted and easily arousable ... Resident is in stable condition without changes to baseline. Vitals obtained: 113/54 (blood pressure)-80 (heart rate)-95% (oxygen saturation) ra (room air)-16 (respirations)-bs (blood sugar) 162-98.0 (temperature) (temporal) ... (doctor name) gave verbal order for azithromycin ... Albuterol 0.083% q6 (every six) hours ... robitussin ... Medrol ... Resident had chest x ray performed on 11/23/22 d/t (due to) wheezing with conclusion being negative- no acute cardio pulmonary process. Writer has been with resident often during shift for close monitoring no s/s (signs/symptoms) of lethargy or cough observed. Lung sounds clear upon auscultation in all 6 anterior fields, no wheezing heard upon exhale ..."

Review of the November 2022 Medication Administration Record (MAR) documented Azithromycin (antibiotic) 250 MG (milligram), give 2 tablets via PEG (percutaneous endoscopic

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	gastrostomy)- tube one time only for infection for 1 day (Start date 11/25/22) and an Azithromycin 250 mg, one tablet one time a day for 4 days "for infection". Review of the Infection Control Surveillance log for November 2022 revealed no documentation of R709's infection. Review of the Infection Control Surveillance log for November 2022 revealed no documentation of R709's infection. Further review of the Infection Control Surveillance and Antibiotic Stewardship program revealed no documentation of the infection to have met criteria for an antibiotic, documentation of signs and symptoms identified or the review of the appropriateness of the antibiotic. R725 Review of R725's November 2022 MAR documented in part Fosfomycin Tromethamine Packet 3 GM, Give 1 packet by mouth one time a day every Wed (Wednesday) for prophylaxis for recurrent UTI (Urinary Tract Infection). This medication was administered on 11/9, 11/17 & 11/23/22. Review of the Infection Surveillance log and Antibiotic Stewardship data for November 2022 revealed no documentation or identification of the prophylactic antibiotic prescribed to R725. Review of the medical record revealed no documentation of the Fosfomycin Tromethamine to have been reviewed for appropriateness. On 11/30/22 at 1:42 PM, an interview was conducted with the DON, ICC "B" ICD "C" and the Administrator was present. The names of R's 704 and 709 was provided to the DON, ICC "B",			

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	ICD "C" and Administrator, and the ICC "B" was asked and confirmed McGeer's criteria is utilized in the facility. ICC "B" was asked to look through the data to see if they had identified the infections and the antibiotic prescribed to R's 704 and 709. ICC "B" reviewed their data and stated they were unable to find any documentation of an infection or antibiotic to have been prescribed to R's 704 and 709. The DON and ICC "B" was asked why R725 was on a prophylactic antibiotic and if the antibiotic had been reviewed for appropriateness and the ICC "B" stated they do not track or review the prophylactic antibiotics prescribed in the facility. Review of a facility policy titled "Infection Surveillance Program and Antibiotic Stewardship" dated "09.2022" documented in part " ... It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use ... Infection Preventionist-coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff ... The program includes antibiotic use protocols and a system to monitor antibiotic use ... Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made ... Antibiotic orders obtained upon admission , whether new admission or readmission, to the facility shall be reviewed for appropriateness ... Monitor during each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic or any antibiotic regimen review ..."			
F0882	Infection Preventionist Qualifications/Role	F0882	F882	10/25/2022

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SS= C	§483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the facility's Infection Preventionist was consistently performing the duties of the position, physically worked onsite and was able to properly assess, develop, implement, monitor and manage the Infection Control Program. Findings include: The Administrator and Director of Nursing (DON) identified Infection Control Director (ICD) "C" as the facility's Infection Preventionist (IP). ICD "C" certification was reviewed and verified. During the survey multiple Infection Control concerns with the facility's Infection Surveillance program, Antibiotic Stewardship and Infection		Element 1: It is the practice of this facility to ensure their infection control preventionist had completed specialized training in infection prevention and control Element 2: All residents have the potential to be affected. The infection preventionist was replaced by an experienced infection preventionist who hold the CDC certification Element 3: The IDT reviewed the Infection Control Program Policy and deemed it appropriate. The facility held a QAPI meeting 12/13/2022 with team members for a full introduction of the new infection preventionist for him to explain how he runs a comprehensive program and what is needed from team members and what is expected. Element 4: The DON or designee will attend the QAPI meeting and ensure comprehensive minutes are taken. The infection preventionist or designee will turn in monthly reports in QAPI meeting to show evidence of the infection program being completed. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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control practices throughout the facility were identified. The hours for ICD "C" see were requested from the DON and Administrator for review.

Review of ICD "C" time sheet revealed a timesheet provided with a header of another facility name (a sister facility). Documented was eight hours for 11/8/22 and 11/11/22. Seven hours for 11/18/22 and four hours for 11/25/22.

Review of the facility's entry screening documentation revealed ICD "C" name to have only been documented on 11/11/22 and 11/25/22 as having to been screened for entering the building.

Review of the facility's COVID 19 outbreak tracing revealed the facility experienced a COVID 19 outbreak on 10/31/22, 11/1/22, 11/3/22, 11/4/22, 11/6/22, 11/7/22, 11/9/22, 11/10/22 and 11/13/22 that documented more than 20 confirmed positive COVID 19 residents identified.

On 11/30/22 at 11:02 AM, ICD "C" was interviewed and asked what their hours were in the facility. ICD "C" replied they currently work at a sister facility and will start at the current facility full time on 12/5/22. ICD "C" stated they try to come every Friday to the current facility. ICD "C" was asked about the dates of 11/8/22 and 11/18/22 on their timesheet compared to the facility's screening documentation which showed no documentation of ICD "C" to have been screen in on the days of 11/8/22 and 11/18/22. ICD "C" stated one of the days no one was in the front to screen them in so they entered the facility through a different entrance and ICD "C" stated they remember being screened by the receptionist for the 18th and could not provide an explanation of why their name was not documented on the

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	screening sheet. ICD "C" was then asked what their current responsibilities are as the facility's Infection Preventionist, and ICD "C" replied they will take over the Infection Control Program once they start full time, but currently the Infection Control Consultant and DON will inform and consult with them when needed. ICD "C" was then asked if they came to the facility while the facility had experience a COVID 19 outbreak and if so, what were their findings and what did they implement? ICD "C" replied they came to the facility on 11/8/22 and reviewed the list of the COVID 19 positive residents, but the DON was running the program at the time. ICD "C" stated they did not investigate or implement anything during the COVID 19 outbreak, however, did advise the clinical staff when needed. Review of a facility policy titled "Infection Prevention and control Program" dated "09.2022" documented in part " ... The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases ... The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee ... The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program ..."			
F0883 SS= D	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the	F0883	F883 Element 1: It is the practice of this facility to ensure accurate tracking and administration of the pneumococcal vaccinations for residents residing in the facility. Residents 717, 718,	10/25/2022

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	influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal		721, 720 were offered the vaccine on 11/28/2022 all declined the vaccination. Resident 719 was offered the vaccine and indicated wanting the vaccine if she was due, however, she was not due. Element 2: All residents have the potential to be affected. All residents were screened for pneumococcal vaccine. Those who were eligible were offered the vaccine. All residents were mailed information regarding all vaccinations and eligibility. Resident representatives are being called for those that did not return the mailed consent forms. The Infection preventionist is giving Pneumococcal, Flu and covid vaccinations ongoing. Element 3: The IDT reviewed the Pneumococcal Vaccine (Series) Policy and deemed it appropriate. The process for identifying vaccine requests was changed and all responsible staff were educated. The admission team will send the admission paperwork which includes consent for vaccines electronically to the resident or representative. They will print consents that are returned on admission and give to the infection preventionist or designee. The infection preventionist or designee will follow up on any new admissions. Requested vaccines will be given if appropriate and consents/ declinations not received will be followed up on. Nursing Staff was reeducated on how to communicate request for vaccines to the infection preventionist. Element 4: The infection preventionist or designee will audit 5 admit chart for consent for vaccination and appropriate follow up weekly x 4 weeks and monthly thereafter in QAPI.	

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	immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews the facility failed to provide education and offer the pneumococcal vaccine to five (R's 717, 718, 719, 720 and 721) of five residents reveiwed for immunization. Findings include: R717 Review of the medical record revealed R717 was admitted to the facility on 10/21/22 and readmitted back to the facility on 11/23/22. Review of the medical record revealed no documentation of an administration of a pneumococcal vaccine and no documentation of education or a consent to have been provided to the resident and/or representative. Review of a "Baseline Admission Evaluation" dated 10/21/22, which has a section (General Information and Initial Goals - Nursing) which instructs the staff to ask residents that are admitting or readmitting to the facility if they would like the pneumococcal vaccine was not completed for R717. R718 Review of the medical record revealed R718 was admitted to the facility on 11/26/22. Review of the medical record revealed no documentation of an administration of a		Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	pneumococcal vaccine and no documentation of education or a consent to have been provided to the resident and/or representative. Review of a "Baseline Admission Evaluation" dated 10/26/22 at 5:13 PM, for the section (General Information and Initial Goals - Nursing) which instructs the staff to ask the admitting resident if they would like the pneumococcal vaccine was not completed for R718 R719 Review of the medical record revealed R719 was admitted to the facility on 11/23/22. Review of the medical record revealed no documentation of an administration of a pneumococcal vaccine and no documentation of education or a consent to have been provided to the resident and/or representative. Review of a "Baseline Admission Evaluation" dated 11/23/22 at 11:53 PM, documented in part, " ... Name of resident's representation ... Granddaughter ... Would you like to receive the Pneumonia Vaccine? Unable to Answer or Undecided ..." Further review of the medical record revealed no follow up documentation with the resident representative regarding the pneumococcal vaccine. R720 Review of the medical record revealed R720 was admitted to the facility on 11/22/22. Review of the medical record revealed no documentation of an administration of a pneumococcal vaccine and no documentation of education or a consent to have been provided to the resident and/or representative.			

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Review of a "Baseline Admission Evaluation" dated 11/23/22, checked the option of "Unable to Answer or Undecided" for the question "Would you like to receive the Pneumonia Vaccine?" Further review of the medical record revealed no documentation on if the resident was unable to answer or was undecided when asked. The record contained no further follow up regarding the pneumococcal vaccine.

R721

Review of the medical record revealed R720 was admitted to the facility on 11/22/22.

Review of the medical record revealed no documentation of an administration of a pneumococcal vaccine and no documentation of education or a consent to have been provided to the resident and/or representative.

Review of a "Baseline Admission Evaluation" dated 11/23/22 at 1:52 AM, revealed a blank section for the question "Would you like to receive the Pneumonia Vaccine?" Further review of the medical record revealed no follow-up documentation regarding the vaccine.

Review of a facility policy titled "Pneumococcal Vaccine (Series) Policy" dated "09.2022" documented in part " ... It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations ... Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type

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	of vaccine received ... Each resident will be offered a pneumococcal immunization unless it is medically contraindicated ... Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization ..." On 11/29/22 at 9:16 AM, the Director of Nursing (DON) was interviewed and asked about the process and who's responsibility it is to educate and offer the pneumococcal vaccine to residents and/or resident representatives when residents are being admitted to the facility. The DON stated they were not certain but will find out and follow back up. The DON was asked to provide all provided education and consents for the pneumococcal vaccine for R's 717, 718, 719, 720 and 721. The DON stated they would look into it and follow back up. On 11/29/22 at 12:03 PM, the Administrator provided the following pneumococcal consents: R719 signed "Yes ... If Needed" on 11/28/22. Documentation of was written on the consent "Not needed" due to the resident already receiving the PCV13 and PSSV23 vaccines. R720 signed "NO" on 11/28/22. R721 consent had a signature that was not the residents on the consent form dated 11/29/22 as "NO". R721 is listed as their own responsible party in their medical record. R718 consent had a signature that was not the residents on the consent form dated 11/28/22 as "NO". R718 is listed as their own responsible party in their medical record. R717 signed "NO" on 11/28/22.			

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	On 11/29/22 at 2:17 PM, the DON was interviewed and asked where they obtained the pneumococcal consents and why the consents were all dated for the 11/28/22 and one for 11/29/22 when all five residents had already resided in the facility for days before the survey team entered the facility. The DON stated the consents was obtained by a facility staff today (11/29/22) because there was no consents on file for any of the residents requested by the surveyor.			
F0886 SS= E	COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h) ((3) For each instance of testing: (i) Document that testing was completed and	F0886	F886 Element 1: It is the practice of this facility to ensure CDC guidelines for covid testing are followed for the protection against the virus. Resident R724 no longer resides in the facility. Element 2: All residents have the potential to be affected. The new infection preventionist reviewed the timeframes for contact tracing with the IDT team in morning meeting. Element 3: The new infection preventionist will be overseeing all COVID testing going forward. He will keep contact tracing separate from routine testing of unvaccinated staff. He will inform the IDT team of any positive tests in morning meeting. Element 4: The DON or designee will review any onsite COVID testing for positive tests and appropriate contact tracing weekly x 4 then monthly x1. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing in collaboration is	10/25/2022

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	the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to track and maintain accurate documentation of the facility's outbreak investigation/testing and accurately track and maintain consistent documentation of COVID positive staff. Findings include: Review of a facility document titled "Outbreak Oct 25 thru Nov 13 2022" testing and investigation revealed the following: -20 COVID positive residents for this time period. -Three COVID positive Staff members for this time period (Dietary "X"- positive 11/6/22, Housekeeper "Y"- positive 11/9/22 and Certified Nursing Assistant (CNA) "Z"- positive 11/3/22.		responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	

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	Further review of the Outbreak tracing and testing for the time period of Oct 25th thru Nov 13th revealed documentation of outbreak test results for the facility residents which stopped on November 13th, 2022. On 11/29/22 at 9:16 AM, the Director of Nursing (DON) was interviewed and asked why the Covid testing for the facility's outbreak stopped on 11/13/22 and the DON stated because everyone came back negative on 11/13/22 so testing was stopped. The DON was then asked about a resident that was documented with only a last name on the facility "Outbreak Oct 25 thru Nov 13 2022" document that documented the resident as Covid positive on 11/13/22. The DON stated the resident was admitted that day and tested and was identified as Covid positive upon admission so the facility does not count that as an outbreak because the resident was not "in house". The DON was then asked about R724 who was an "in house" resident and was also identified as Covid positive on 11/13/22 and the DON stated it did not ring a bell for them and they would look into it and follow back up. At approximately 4:30 PM, the DON confirmed R724 was Covid positive on 11/13/22 and the DON at that time provided additional outbreak testing for the facility residents. The DON was asked where the documentation was found considering they had previously stated Covid testing for the residents stopped on 11/13/22 and no additional Covid testing for the facility residents was documented on the logs provided to the survey team and the DON apologized and stated the tests were found on a desk in the office and they were unaware that they were in the office. Review of the additional outbreak testing for the facility residents was reviewed and revealed Covid test results for the date of 11/16/22 of all facility residents with the exception of the residents that resided in rooms 309A, 310A and			

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	634070	A. BUILDING _____ B. WING _____	11/30/2022

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	311A who were documented as negative on the log provided, but when compared to their Covid test results dated 11/16/22 revealed blank test results for each resident. Further review of the additional outbreak Covid testing provided revealed a facility roster with check marks next to the resident names as documentation that Covid tests had been completed on the residents for the date of 11/18/22, when asked the DON stated the facility had no other documentation to provide to show these tests were actually completed on the residents on 11/18/22. Review of a facility document titled " ... Employee Covid Testing" with the dates of "10/23-10/29, 10/30-11/15, 11/6-11/12, 11/13-11/19" was provided and revealed two additional staff members documented as COVID positive for Dietary "AA" on 11/6/22 and Laundry Aide "BB" on 11/12/22. These two staff members were not identified on the facility's "Outbreak Oct 25 thru Nov 13 2022" tracking, tracing and investigation documents. The Initial staff members who were identified as Covid positive on the facility's document titled "Outbreak Oct 25 thru Nov 13 2022" (Dietary "X", Housekeeper "Y" and CNA "Z") were not identified on the " ... Employee Covid Testing" list as Covid positive. On 11/30/22 at 5:30 PM, the DON and Administrator was interviewed and the DON was asked to confirm the number of positive staff members in the last four weeks and the DON stated to the best of their knowledge there was only three Covid positive staff members. The DON and Administrator was then informed that after review of the multiple logs provided to the survey team, two additional staff members were identified as Covid positive during the last four weeks which were not accurately documented consistently on the logs, traced and investigated during the facility's Covid outbreak.			

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F0888 SS= E	COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who	F0888	F888 Element 1: It is the practice of the facility to implement a policy to ensure staff are vaccinated against Covid 19 or exempt from this vaccine. Element 2: All residents have the potential to be affected. All staff members employee files have been reviewed for vaccination status or exemption status. All are up to date with current CDC regulations. Element 3: The IDT has reviewed the Covid 19 vaccination policy and update to reflect the current CDC guidelines. HR, staff development and scheduling office personnel were re-educated on staff requiring COVID vaccination or an exemption prior to working in facility. A contingency plan for all exempted staff was put into effect to include weekly testing for the weeks at work. The infection preventionist has built a separate spreadsheet for these employees and will personally track them against their schedule. Element 4: The DON /designee will review the vaccine exempted staff for weekly testing x4 weeks then monthly there after in QAPI until substantial compliance is obtained. Results will be brought and discussed during morning leadership meeting for corrective measures. Results will also be presented in QAPI for ongoing compliance and monitoring. The Director of Nursing is responsible for on-going monitoring and compliance. The Administrator is responsible for continued compliance.	10/25/2022

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	have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by,			

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	and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facilitys COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and			

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	implement a contingency plan for the facility's unvaccinated staff and failed to accurately track and monitor all staff COVID 19 vaccination status. Findings include: Review of the first policy provided by the Administrator on 11/29/22 at 8:20 AM, titled "COVID-19 Vaccination of Facility Staff" (an affiliated facility name was documented on the policy) which documented in part, " ... This policy and procedure applies to facility staff who provide any care, treatment or other services for the facility and/or its residents, regardless of clinical responsibility or resident contact ... Requiring staff members who have not completed their primary vaccination series to follow additional precautions. These precautions could include universal source control and physical distancing in areas restricted from patient access, such as an employee break room, regardless of the county transmission level. Requiring testing at least weekly for exempted staff ... Requiring staff who have not completed their primary vaccination series to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are patient-facing or not ..." On 11/28/22 Licensed Practical Nurse (LPN) "L" was observed throughout the shift in patient care areas and caring for residents with a surgical mask on. On 11/29/22 at 12:20 PM, LPN "L" was again observed at the nurses' station with several other employees and residents within feet with a surgical mask on. Review of the facility's staff vaccination matrix documented LPN "L" as granted an exemption for the COVID 19 vaccine and did not complete a COVID 19 vaccine primary series. On 11/29/22 at 12:28 PM, Wound Nurse (WN)			

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	"F" was observed in the resident care areas with a surgical mask on. Review of the requested vaccination documents for WN "F" revealed they were granted an exemption for the COVID 19 vaccine. On 11/29/22 at 5:20 PM, the Administrator and Director of Nursing (DON) was interviewed and asked about the implementation of the facility's contingency plan for unvaccinated staff and the DON stated the facility did not have a contingency plan and the facility was no longer required to have a contingency plan for their unvaccinated staff. The DON and Administrator were both read the policy that was provided and stated they made an error in providing the affiliated facility policy to the surveyor team and both restated the facility is no longer required to have a contingency plan in place for their unvaccinated staff. The concern was then verbalized to both the Administrator and DON regarding the concern of the facility to not have developed and implemented a contingency plan for the facility's unvaccinated staff. Review of a Centers For Medicare & Medicaid Services memo (Ref: QSO-23-02-ALL) dated 10/26/22, titled "Revised Guidance for Staff Vaccination Requirements" documented in part " ... Facilities are required to have contingency plans for staff who are not fully vaccinated ..."			