STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	**12/8/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	**508 RANDOM LANE GAYLORD, MI 49735**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Medilodge of Gaylord was surveyed for a Recertification and abbreviated survey on 12/08/2022. Intakes: MI00127677, MI00128001, MI001231227, MI00131233, MI00131565 and MI00132197. Census = 72.	F0000		
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: **The citation pertains to intake MI00131233.** **Based on observation, interview and record review, the facility failed to ensure freedom from resident-to-resident abuse for two Residents (#17 and #322) of seven residents reviewed for abuse. This deficient practice resulted in the potential for physical and psychosocial injury. Findings include:** **Resident #17** **Resident #17 was admitted to the facility on**	F0600		

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

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	5/20/2021 and had diagnoses including dementia without behavioral disturbance and generalized weakness. A review of Resident #17's Minimum Data Set (MDS) assessment, dated 11/06/2022, revealed the Resident required supervision and oversight with walking in the corridors and in her room. Further review of the MDS assessment revealed Resident #17 scored four out of 15 (4/15) on the Brief Interview for Mental Status (BIMS), indicating she had severe cognitive impairment. An observation on 12/06/2022 revealed Resident #17 walking from the dining room on C-Hall to her room. Resident #17 entered her room and returned to the hallway to ask this Surveyor if her coat would be safe if she left it on the bed in her room. Resident #17 repeated this behavior twice before walking back toward the dining room. Resident #17 stopped to speak to this Surveyor in the hallway outside her room and expressed concern regarding if her belongings were safe before continuing down the hall to the dining room. A review of Resident #17's electronic medical record (EMR) revealed the following: "4/1/2022, 11:41 (a.m.), Pertinent Charting - Falls. Note Text: Date of Fall: 04/01/2022. Situation Details: resident was pushed to the ground by another resident. Resident fell backwards onto buttocks to the floor and then her head hit the floor as she fell backwards all the way ... pain upon palpation to left hip/side. EMS (emergency medical services) ... ordered to send to ER (emergency room) ... Mitigating Factors: was pushed by another resident..."			

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	A review of the facility's incident report regarding Resident #17's fall on 4/01/2022, provided by the Director of Nursing (DON), revealed the following: "Date of Incident: 4/1/22. Time of Incident: 10:50 (a.m.). Was the incident witnessed? Yes. Brief Description: Resident was observed being shoved by another resident causing her to fall backwards onto her bottom and then hitting her head floor." A review of the facility "Fall RCA (Root Cause Analysis) Investigation Tool," dated 4/1/2022, revealed the following: "Factors observed at time of fall: resident pushed her. What was resident doing during or just prior to fall? Standing in (her) room. What type of assistance was resident receiving at time of fall? Alone and unattended. What did the resident say they were trying to do just before they fell? Standing in room telling the other resident not to touch her and that she wasn't going with him ... description to re-create the life of the resident before the fall: Resident was in her room cleaning her room and herself up. Resident also ate breakfast in her room ... Another resident trying to get her to go with that resident. When she said, "no don't touch me" and was yelling, that resident shoved her. Conclusion: Resident yelling at another resident who was in her room and grabbing at her. The other resident shoved her causing her to fall backwards and hitting her head." A review of the facility investigation documents provided by the Nursing Home Administrator (NHA) identified the resident who pushed Resident #17 to the floor was			

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	Resident #322. Further review revealed a witness statement, dated 4/1/2022 and signed by Certified Nurse Aide (CNA) "V", revealed the following: **"Resident name: (Resident #17). Date and time of incident: 4/1/22, 10:45 (a.m.). Statement of witness: I was down (C-Hall) getting a bed (and) heard screaming (help). I ran to see who was screaming help (and) just as I got to the doorway (across the hall), I seen (Resident #322) shove (Resident #17) through the door. She (Resident #17) fell (and) landed on her butt first (and) then smacked her head on the floor."** **A review of a witness statement, dated 4/1/2022 and signed by CNA "X", revealed the following: "(Resident #17) was yelling for help. When I got there, (Resident #322) was pushing (Resident #17) in doorway. She fell on her butt and then fell back and hit her head."** **Resident #322** **Resident #322 was admitted to the facility on 12/07/2021 and had diagnoses including: Alzheimer's Disease, cognitive communication deficit, restlessness and agitation and mood disorder. A review of Resident #322's MDS assessment, dated 1/27/2022, revealed the Resident required supervision with setup help only for walking in the corridors and in his room. Further review of the MDS assessment revealed Resident #322 scored one out of 15 (1/15) on the BIMS, indicating he had severe cognitive impairment.** **A review of Resident #322's EMR from 3/14/2022 to the date of the incident on**			

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	4/01/2022, revealed the following behaviors were charted prior to the incident with Resident #17 on 4/01/2022: 3/14/2022 at 12:41 p.m. - "redirected from others pt. personal space and room..." 3/15/2022 at 6:41 a.m. - "continues to wander and sleep on other people's beds..." 3/16/2022 at 12:41 p.m. - "resident very anxious and pacing on unit, going into other resident's rooms, very difficult to redirect..." 3/18/2022 at 11:00 a.m. - "resident noted to be wandering ... attempted to redirect resident with no success, resident noted to be attempting to make negative statements to staff and residents..." 3/19/2022 at 22:15 (10:15 p.m.) - "resident slightly restless after dinner, pacing hallway and going into other resident's rooms, was observed in another residents bed..." 3/20/22 at 16:38 (4:38 p.m.) - "resident took another resident's walker, making the other resident upset, she asked for it back, resident walked toward her with the walker, the nurse attempted to remove walker as it seemed as through resident was going to run into other resident with it, he became aggressive and combative, grabbing the nurses hand and twisting it, would not let go, this nurse separated from resident and resident attempted to kick at this nurse ... prior to incident, attempts to redirection were no effective ... resident kept going into other resident's rooms..." 3/22/2022 at 7:15 a.m. - "wandering into			

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	other patient's rooms, not easily redirected, resident tried to hit staff member early ... continues to wander into other people's rooms and beds." 3/22/2022 at 3:15 p.m. - "resident attempted to kick another resident..." 3/24/2022 at 9:16 p.m. - "resident was wandering in and out of resident rooms earlier in shift, difficult to redirect at times..." 3/29/2022 at 6:00 a.m. - "resident hit CNA, knocked off her glasses, he continues to go into people's rooms and sit in wheelchairs, will not get out of them..." A review of Resident #322's care plan revealed the following, in part: "Focus: Resident can be physically/verbally aggressive ... resident has (history) of pacing up and down the hall, in and out of other resident's rooms, rummages through items in other resident's rooms. Resident is known to become loud and yell at staff, push staff away at times ... Date Initiated: 1/21/2021. Interventions: Intervene as necessary to protect the rights and safety of others ... Date Initiated: 1/21/2021. Focus: The resident exhibits inappropriate social behavior ... sexually inappropriate at times ... Date Initiated: 9/18/2021. Interventions: Try to identify triggers for behaviors and intervene to remove trigger ... Date Initiated: 9/18/2021." A review of Resident #322's facility incident report, dated 4/01/2022, revealed the following: "Date of incident: 4/1/222. Time of incident: 10:50 (a.m.). Brief Description: Resident was			

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	in another resident's room and was observed shoving that resident causing that resident to fall to the ground ..." A review of the "Fall RCA Investigation Tool," dated 4/01/2022, revealed the following: "Factors observed at time of fall? Other resident yelling ... Fall location? other resident's room ... What was resident doing during or just prior to fall? Ambulating ... What type of assistance was resident receiving at time of fall? Alone and unattended. What did the resident say they were trying to do just before they fell? Per other resident (#17) this resident (#322) was grabbing other resident and other resident was yelling at this resident and this resident shoved the other resident ... description to re-create the life of the resident before the fall? Resident was in and out of other resident rooms, when taking back to his room or into an activity, just gets up and starts roaming again ... resident (#322) was being yelled at by another resident (#17) ... Conclusion: Resident (#322) in another resident (#17) room grabbing at that resident who began yelling at him, he shoved her causing her to fall to the ground and hit her head." During an interview on 12/08/2022 at 1:45 p.m., the DON confirmed Resident #322 had a history of intruding on other resident's private spaces and exhibiting aggressive behaviors toward staff and residents prior to the incident with Resident #17 on 4/01/2022. The DON stated she believed the trigger causing Resident #322 to shove Resident #17 to the ground on 4/01/2022 was when Resident #17 began yelling for help. The DON stated Resident #17 exhibited behaviors of paranoia related to her			

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	belongings and personal space which could have caused her to yell out when Resident #322 entered her room. The DON was unsure if staff could have intervened prior to the incident. **A review of the facility policy titled "Abuse, Neglect and Exploitation," last reviewed on 10/24/2022, revealed the following, 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 ... Prevention of abuse, neglect and exploitation - The facility will implement policies and procedure to prevent and prohibit all types of abuse ... that achieves: Identifying, correcting and intervening in situations in which abuse ... is more likely to occur with the deployment of trained and qualified, registered, licensed and certified staff on each shift in sufficient numbers to mee the needs of the residents ... The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect."**			
F0623 SS= E	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance	F0623		

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	with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and			

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	developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written notification of the reason for transfer to residents and resident representatived for six Residents (#10, #56, #60, #64, #66, & #319) of eight			

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residents reviewed for notice before transfer. This deficient practice resulted in the potential for residents and/or representatives lack of understanding regarding course of treatment. Findings include:

Resident #10

Resident #10 had an admission to the hospital on 11/24/22 with the following progress note below:

"11/24/2022 (4:52 p.m.) Progress Note-Respiratory ... during a routine vital check it was brought to my attention (Resident #10's) sa02 (oxygen saturation) may be low ... albuterol (respiratory medication) tx (treatment) given, sao2 did increase from 86 (%) to 91(%) (Range 92-100%) with baging (use of a manual device to provide respirations) but decreased to 88(%) after. vt (fixed tidal volume [amount of air supplied to lungs]) increased to 600(ml) and 4 liter of 02 (oxygen) added. still only 89% o2 increased to 7 L (liters) and held at 90%. nurses called for transport and she was transported to hospital."

Resident #56

A review of the "Census" tab in the Electronic Medical Record on 12/5/22 at 1:27 p.m., indicated Resident #56 was at the hospital on 11/23/22 and assigned a Discharge Return Expected (DRE) status. There was no written notification located indicating the reason for

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transfer to Resident #56's representative.

Another hospitalization occurred on 10/19/22:

Progress Notes read, "10/19/2022 (12:30 a.m.) Progress Note-Respiratory ... (Resident #56) face flushed and swollen, temp (temperature) 103.6 HR(Heart Rate):132 RR (Respiratory Rate):22 (Resident #56) breathing quietly on vent(ventilator) Breath sounds bilat crackles bases. Sent to hospital to eval(evaluate) and treat in stable condition."

A review of the Situation Backround Assessment Recommendation (SBAR) assessment, dated 11/23/22, revealed Resident #56 was sent out to the hospital for increased seizures, HR, RR, fever, pale, increased O2 (oxygen) need, change in secretions. Resident #56 was admitted to the hospital for "PNA(pneumonia) HR(Heart Rate) 124, Temp(Temperature) 102.2, RR (Respiratory Rate) 28, B/P(Blood Pressure) 125/70, Sat (Oxygen Saturation) 84% following seizure. " An order was given to send Resident #56 to the emergency room for suspected pneumonia.

A review of SBAR dated 10/19/22 revealed Resident #56 had an elevated temp at 103 degrees, a rapid pulse at 132, and was flushed and lethargic. Resident #56's oxygen saturation was 92%. He was set to the emergency room and was treated for

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	bilateral pneumonia. Resident #60 A review of the "Progress Notes" section of the EMR revealed the following: "10/20/2022 (4:40 a.m.) Progress Note-Respiratory ... (Resident #60) woke up out of a sound sleep acutely short of breath, SPO2 (oxygen saturation): 82% to 86% on vent support w(with)/6L 02 bled in. Increased liter flow to 10, changed inner cannula and HME (Heat Moisture Exchanger), sxed(suctioned) for a moderate amount yellow secretions. In line neb(breathing treatment) given, breath sounds very diminished on R(right) with wheezes L(left). Shortness of breath not resolving, began ventilating (Resident #60) with AMBU(manual emergency ventilation equipment) @(at) 15L to maintain sats greater than 90%. BP and HR elevated, EMS (Emergency Medical Services) here to transfer for eval and treatment." "10/14/2022 (9:95 a.m.) Progress Note-Respiratory ... Called to resident's (#60) room by nurse. Resident (#60) lying in bed in semi fowlers position and appeared in distress. Resident (#60) stated he was having difficulty breathing. RR 28 on arrival with increased Tidal Volumes (Vt) and Minute Ventilation (MV). Pallor(Pale looking) somewhat ashen, Lung sounds diminished to absent throughout. Suction non-productive. SpO2 84% on 9 Lpm(Liter per minute)			

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supplemental O2. O2 increased to 15 Lpm and SpO2 rose to >90%. Resident appeared to be more relaxed and Pallor improved to pink. resident (#60) shipped to hospital via EMS. Facility unable to continually maintain current resident requirement of 15 Lpm supplemental O2."

10/4/2022 (4:20 p.m.) Nurses' Notes "... Resident (#60) being sent to ER for right pneumothorax (abnormal air pocket in between lung sac and lung), identified on CXR(chest x-ray) today..."

12/24/2021 (9:27 a.m.) Nurses' Notes "... At (7:00 a.m.), resident had SOB (shortness of breath), bluish color and could not get his SPO2 to increase. RT(Respiratory Therapy) in room, assessed resident, started to ambu-bag to increase SPO2 which was successful. His SPO2 at 92% on vent at that time. After RT bagged resident and reconnected to vent, resident was back at normal baseline for him. At approximately (7:30 a.m.), call light came on, RT answered call light and resident was on his commode next to his bed and noted to be turning blue with decreased LOC(level of conciousness) and SOB. Large BM(bowel movement) noted in commode. RT summoned assistance while he ambu bagged resident. Code blue (emergency life sustaining measures) was initiated, EMS was summoned. Staff assisted resident to the floor to start CPR(Cardiopulmonary Resuscitation). CPR and AED(Automated External Defibrillator) started, At this time

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resident did not have a pulse and was grey/blue. Several rounds of chest compressions performed and AED did not advise a shock. After approximately 10 minutes of CPR, resident noted to have a bounding pulse and was starting to retain his color and shallow breathing. EMS arrived and transferred resident to (local hospital emergency room)..."

Resident #319

A review of the EMR for Resident #319 per the EMR had a recent diagnosis of pneumonia on 9/22/21 with acute kidney failure. Resident #319 was was discharged to the hospital on 11/9/22 for this issue and readmitted to the faciility on 11/14/22. Resident #319 was also discharged to the hospital on 10/30/22, 10/25/22, 9/10/22, and 5/10/22. There were no written notifications of the need for transfer to the hospital provided to Resident #319 or the resident representative.

During an interview on 12/7/22 at 11:52 a.m., Registered Nurse (RN) "O" stated there was no ombudsman log being completed for notifications regarding facility initiated discharges.

During an interview on 12/7/22 at 3:10 p.m., the Nursing Home Administrator (NHA) acknowledged the facility was deficient in written notification of the reason for transfer to the resident or responsible party, bed hold

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	notifications and notifications to the ombudsman. A review of the facility policy titled "Involuntary Transfer and Discharge" with a revised date of 1/1/2022, read in part: "The purpose of this policy is to establish uniform guidelines relating to the involuntary transfer/discharge process, to ensure the resident's rights are properly observed and proper notifications to all intrested parties occurs... 1. Facility initiated transfers and discharges are permitted when: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility... 2. Before an involuntary discharge or transfer notice may be issued, the facility will verify that the reason for the discharge or transfer is one of those listed above, and that there is appropriate and adequate documentation in the resident file supporting the transfer or discharge... 3. Notice concerning the transfer or discharge shall be provided to the resident, resident representative, long term care ombudsman, state survey agency, and the physician. A copy shall also be placed in the resident's file...			

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	5. The notice shall be in writing that the resident/representative can understand, and shall include: a. An explanation of the reason for the transfer or discharge b. Whether the resident is expected to return to the facility c. The transfer or discharge location..." Resident #66 A review of Resident #66's EMR revealed an admission date of 12/26/19 and medical diagnoses which included dementia, and anxiety. Residenet #66's progress notes revealed he developed complications from covid-19 and was transferrred out to the hospital. On 12/08/22 at 2:16 p.m., the Nursing Home Administrator (NHA) verified there is no process in place for ombudsman notification or notice of transfer, when residents are transferred out. Resident #64 Review of Resident #64's Electronic Medical Record (EMR) revealed Resident #64 was admitted to the facility on 10/05/22, and hospitalized on 11/23/22 for wound management. Review of Resident #64's Census report revealed Resident #64 was hospitalized from 11/23/22 through 11/29/22.			

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Review of Resident #64's EMR revealed there was no written transfer notification to Resident #64, or his guardian. Additionally, there was no Ombudsman notification of the acute transfer.

Review of a blank form titled, "Transfer Notice [Resident Expected to Return]", received from the Director of Nursing (DON), revealed, "Resident Name:...Transfer date:...Please take notice that due to circumstances noted below, the Resident listed above will be transferred from our facility IMMEDIATELY or a soon as appropriate arrangements for the transfer can be made. (In bold) It is anticipated the Resident will return to the facility after the circumstances requiring transfer are resolved. Transfer location:....Reason for Transfer: (Check one and include resident symptoms):....(Box) The Transfer is necessary for the Resident's welfare and the Resident's needs cannot be met in the Facility. (Box) The safety of individuals in the Facility is endangered. (Box) The health of individuals in the Facility would otherwise be endangered....Appeal Rights...(described the right to appeal the decision, contacts)...Resident/Representative Signature:..."

Review of the Monthly Ombudsman Notification Form (blank), received from the DON, revealed, "Facility:...City...Month...Resident Last Name...First Name...Transfer Date...Resident Return: [Choose either] Expected...Not Expected...Primary Reason for Emergency Transfer: [Choose either] Acute Care...Psychiatric or Mental Health..."

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	During an interview on 12/07/22 at 05:00 p.m., the NHA confirmed there was no written notification of hospital (acute) transfer or Ombudsman notification of the hospital transfer for Resident #64, and no process being completed for hospital transfers or Ombudsman notifications.			
F0625 SS= E	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written notification of the facility bed hold policy for six	F0625		

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	Residents/Resident Representatives (#10, #56, #60, #64, #66, and #319) of eight residents reviewed for written notification of bed hold policy. This deficient practice resulted in the potential for unexpected incurrment of charges and the potential for financial hardship. Findings include: Resident #10 Resident #10 had an admission to the hospital on 11/24/22 with the following progress note below: "11/24/2022 (4:52 p.m.) Progress Note-Respiratory ... during a routine vital check it was brought to my attention (Resident #10's) sa02 (oxygen saturation) may be low ... albuterol (respiratory medication) tx (treatment) given, sao2 did increase from 86 (%) to 91(%) (Range 92-100%) with baging (use of a manual device to provide respirations) but decreased to 88(%) after. vt (fixed tidal volume [amount of air supplied to lungs]) increased to 600(ml) and 4 liter of 02 (oxygen) added. still only 89% o2 increased to 7 L (liters) and held at 90%. nurses called for transport and she was transported to hospital. During an interview on 12/7/22 at 11:52 a.m., Registered Nurse (RN) "O" stated there was no ombudsman log being completed ombudsman log being completed for notifications regarding facility initiated discharges.			

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During an interview on 12/7/22 at 3:10 p.m., the Nursing Home Administrator (NHA) acknowledged the facility was deficient in written notification of the reason for transfer to the resident or responsible party, bed hold notifications and notifications to the ombudsman.

Resident #56

A review of the "Census" tab in the Electronic Medical Record on 12/5/22 at 1:27 p.m., indicated Resident #56 was at the hospital on 11/23/22 and assigned a Discharge Return Expected (DRE) status. No written notification of the reason for transfer to Resident #56's representative.

Another hospitalization occurred on 10/19/22:

Progress Notes

"10/19/2022 (12:30 a.m.) Progress Note-Respiratory ... (Resident #56) face flushed and swollen, temp(temperature) 103.6 HR(Heart Rate):132 RR(Respiratory Rate):22 (Resident #56) breathing quietly on vent(ventilator) Breath sounds bilat crackles bases. Sent to hospital to eval(evaluate) and treat in stable condition."

12/07/22 11:32 AM

A review of the Situation Backround

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Assessment Recommendation (SBAR) assessment, dated 11/23/22, revealed Resident #56 was sent out to the hospital for increased seizures, HR, RR, fever, pale, increased O2 (oxygen) need, change in secretions. Resident #56 was admitted to the hospital for "PNA(pneumonia) HR(Heart Rate) 124, Temp(Temperature) 102.2, RR (Respiratory Rate) 28, B/P(Blood Pressure) 125/70, Sat (Oxygen Saturation) 84% following seizure. " An order was given to send Resident #56 to the emergency room for suspected pneumonia.

A review of SBAR dated 10/19/22 revealed Resident #56 had an elevated temp at 103 degrees, a rapid pulse at 132, and was flushed and lethargic. Resident #56's oxygen saturation was 92%. He was set to the emergency room and was treated for bilateral pneumonia.

Resident #60

A review of the "Progress Notes" section of the EMR revealed the following:

"10/20/2022 (4:40 a.m.) Progress Note-Respiratory ... (Resident #60) woke up out of a sound sleep acutely short of breath, SPO2 (oxygen saturation): 82% to 86% on vent support w(with)/6L 02 bled in. Increased liter flow to 10, changed inner cannula and HME (Heat Moisture Exchanger), sxed(suctioned) for a moderate amount yellow secretions. In line neb(breathing treatment) given, breath

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sounds very diminished on R(right) with wheezes L(left). Shortness of breath not resolving, began ventilating (Resident #60) with AMBU(manual emergency ventilation equipment) @(at) 15L to maintain sats greater than 90%. BP and HR elevated, EMS (Emergency Medical Services) here to transfer for eval and treatment.

"10/14/2022 (9:95 a.m.) Progress Note-Respiratory ... Called to resident's (#60) room by nurse. Resident (#60) lying in bed in semi fowlers position and appeared in distress. Resident (#60) stated he was having difficulty breathing. RR 28 on arrival with increased Tidal Volumes (Vt) and Minute Ventilation (MV). Pallor(Pale looking) somewhat ashen, Lung sounds diminished to absent throughout. Suction non-productive. SpO2 84% on 9 Lpm(Liter per minute) supplemental O2. O2 increased to 15 Lpm and SpO2 rose to >90%. Resident appeared to be more relaxed and Pallor improved to pink. resident (#60) shipped to hospital via EMS. Facility unable to continually maintain current resident requirement of 15 Lpm supplemental O2.

10/4/2022 (4:20 p.m.) Nurses' Notes ... Resident (#60) being sent to ER for right pneumothorax (abnormal air pocket in between lung sac and lung), identified on CXR(chest x-ray) today...

12/24/2021 (9:27 a.m.) Nurses' Notes ... At (7:00 a.m.), resident had SOB (shortness of

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	breath), bluish color and could not get his SPO2 to increase. RT(Respiratory Therapy) in room, assessed resident, started to ambu-bag to increase SPO2 which was successful. His SPO2 at 92% on vent at that time. After RT bagged resident and reconnected to vent, resident was back at normal baseline for him. At approximately (7:30 a.m.), call light came on, RT answered call light and resident was on his commode next to his bed and noted to be turning blue with decreased LOC(level of conciousness) and SOB. Large BM(bowel movement) noted in commode. RT summoned assistance while he ambu bagged resident. Code blue (emergency life sustaining measures) was initiated, EMS was summoned. Staff assisted resident to the floor to start CPR(Cardiopulmonary Resuscitation). CPR and AED(Automated External Defibrillator) started, At this time resident did not have a pulse and was grey/blue. Several rounds of chest compressions performed and AED did not advise a shock. After approximately 10 minutes of CPR, resident noted to have a bounding pulse and was starting to retain his color and shallow breathing. EMS arrived and transferred resident to (local hospital emergency room)... Resident #319 A review of the EMR for Resident #319 per the EMR had a recent diagnosis of pneumonia on 9/22/21 with acute kidney failure. Resident #319 was was discharged to			

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the hospital on 11/9/22 for this issue and readmitted to the faciility on 11/14/22. Resident #319 was also discharged to the hospital on 10/30/22, 10/25/22, 9/10/22, and 5/10/22. There were no written notifications of the need for transfer to the hospital provided to Resident #319 or the resident representative.

During an interview on 12/7/22 at 11:52 a.m., Registered Nurse (RN) "O" stated there was no ombudsman log being completed ombudsman log being completed for notifications regarding facility initiated discharges.

During an interview on 12/7/22 at 3:10 p.m., the Nursing Home Administrator (NHA) acknowledged the facility was deficient in written notification of the reason for transfer to the resident or responsible party, bed hold notifications and notifications to the ombudsman.

A review of the facility policy titled "Holding Bed Space", with a revised date of 1/1/2022, read in part:

"Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy."

1. ... when a resident is transferred for hospitalization ... a representative of the business office will provide information

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	concerning our bed-hold policy to the resident , the resident representative and the state Ombudsman. 2. When emergency transfers are necessary, the facility will provide the resident, resident representative and the representative of the office of the State Ombudsman with information concerning our bed-hold policy. 3. The bed-hold information will include any time limits established by the State Medicaid Plan for which the facility will reserve a Medicaid resident's bed-space... 4. The maximum number of days that our State Medicaid Plan will pay for holding a Medicaid resident's bed varies by State and is fully explained in each respective Notice of Bed Hold Policy. 5. Bed-hold days in excess of our State Medicaid Plan are considered non-covered services. A Medicaid resident will be required to pay for any additional days that he/she wishes the facility to hold the bed. 6. Medicaid residents whose bed-hold days have expired will be required to provide the facility with written authorization to either reserve or release the bed space within 24 hours of the expiration of such bed-hold days, subject to the terms of the Notice of Bed Hold Policy. 7. Non-Medicaid residents will be required to			

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provide the facility with written authorization to either reserve or release the bed space within 24 hours of the resident's tranafer from the facility.

8. The reason for dischare will be documented in the medical record and a copy of the resident's bed-hold or release record will be filed in the resident's medical record..."

Resident #66

A review of Resident #66's EMR revealed an admission date of 12/26/19 and medical diagnoses which included dementia, and anxiety. Residenet #66's progress notes revealed he developed complications from covid-19 and was transferrred out to the hospital.

On 12/08/22 at 2:16 p.m., the Nursing Home Administrator (NHA) verified there is no process in place for bed hold notification when residents are transferred out.

Resident #64

Review of Resident #64's Electronic Medical Record (EMR) revealed Resident #64 was admitted to the facility on 10/05/22, and hospitalized 11/23/22 for wound management.

Review of Resident #64's Census report revealed Resident #64 was hospitalized from 11/23/22 through 11/29/22. The census showed Resident #64 returned to his former room post hospitalization.

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	Review of Resident #64's EMR revealed there was no bed hold form for Resident #64. Review of a blank form titled, "Center Room Change/Bed Change Policy", received from the DON, revealed, "I [fillable line] acknowledge and understand that at the time of admission to [Facility Name], I was informed that I may be required to relocate to another room should the source of funds used to pay my expenses [payor source] change ...Acknowledgement of Room Change/Bed Change Policy. By signing below, I acknowledged being informed of this at the time of admission, and consent to a future room change should it become necessary based on changes to my payor source. [fillable line]. Resident/responsible party signature and [fillable line] date signed. Attached was a form titled, "Notice of Bed Hold...", which showed a Resident's bed would be held for hospital (acute) transfers for a specified period, given the facility census and other circumstances, including payor source and resident/representative wishes. During an interview on 12/07/22 at 05:00 p.m., the NHA confirmed there was no bed hold form for Resident #64, and no process being completed related to resident/representative notification of bed holds during acute transfers.			
F0656 SS= D	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F0656		

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:			

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	Based on observation, interview and record review, the facility failed to develop a comprehensive, person-centered care plan for one Resident (#17) of two residents reviewed for care planning. This deficient practice resulted in the potential for unmet care needs, fear and anxiety. Findings include: Resident #17 was admitted to the facility on 5/20/2021 and had diagnoses including dementia without behavioral disturbance and generalized weakness. A review of Resident #17's Minimum Data Set (MDS) assessment, dated 11/06/2022, revealed the Resident required supervision and oversight with walking in the corridors and in her room. Further review of the MDS assessment revealed Resident #17 scored four out of 15 (4/15) on the Brief Interview for Mental Status (BIMS), indicating she had severe cognitive impairment. An observation on 12/06/2022 revealed Resident #17 walking from the dining room on C-Hall to her room. Resident #17 entered her room and returned to the hallway to ask this Surveyor if her coat would be safe if she left it on the bed in her room. Resident #17 repeated this behavior twice before walking back toward the dining room. Resident #17 stopped to speak to this Surveyor in the hallway outside her room and expressed concern regarding if her belongings were safe before continuing down the hall to the dining room. A review of the facility's incident report regarding Resident #17 falling on 4/01/2022, provided by the Director of Nursing (DON), revealed the following:			

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	"Date of Incident: 4/1/22. Time of Incident: 10:50 (a.m.). Was the incident witnessed? Yes. Brief Description: Resident was observed being shoved by another resident causing her to fall backwards onto her bottom and then hitting her head floor." A review of the facility "Fall RCA (Root Cause Analysis) Investigation Tool," dated 4/1/2022, revealed the following: "Factors observed at time of fall: resident pushed her. What was resident doing during or just prior to fall? Standing in (her) room. What type of assistance was resident receiving at time of fall? Alone and unattended. What did the resident say they were trying to do just before they fell? Standing in room telling the other resident not to touch her and that she wasn't going with him ... description to re-create the life of the resident before the fall: Resident was in her room cleaning her room and herself up. Resident also ate breakfast in her room ... Another resident trying to get her to go with that resident. When she said, "no don't touch me" and was yelling, that resident shoved her. Conclusion: Resident yelling at another resident who was in her room and grabbing at her. The other resident shoved her causing her to fall backwards and hitting her head." A review of Resident #17's electronic medical record (EMR) revealed the following behavior documented prior to the incident on 4/01/2022: 1/12/2022 at 4:49 p.m. - "Resident is very paranoid today, states "everyone is stealing all my stuff ... people are stealing all my money!" Attempts to reassure are not			

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	successful..." Further review of Resident #17's EMR for 11/01/2022 to 12/08/2022 revealed the following: 11/01/2022 at 12:00 p.m. - "Resident tends to start arguing with female resident walking by her door. Afternoons she feels residents are trying to take her walker and items in her room ..." 11/03/2022 at 11:00 a.m. - "Talks out lout to self about others taking her belongings including her clothing ..." 11/09/2022 at 10:21 a.m. - "Resident has been in her room most of the morning ... States that "people are taking my stuff." 11/10/2022 at 12:10 p.m. - "Still believes others are taking her items ..." 11/13/2022 at 4:18 p.m. - "Resident continues to state other resident are stealing her belongings. Hard to redirect ..." 11/14/2022 at 10:30 p.m. - "Somewhat argumentative, accusing another resident of stealing he things and threatening to call the cops ..." 11/16/2022 at 11:30 a.m. - "Resident continues to state that people are taking her clothing. Voices concern that "everyone is against me." Further review of Resident #17's EMR revealed documentation of the Resident exhibiting behaviors or paranoia as follows:			

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	11/17/2022 at 11:30 a.m. 11/23/2022 at 11:35 p.m. 11/24/2022 at 12:35 p.m. 11/26/2022 at 6:32 a.m. 11/29/2022 at 11:19 a.m. 11/29/2022 at 2:28 p.m. A review of Resident #17's care plan revealed no focus area goals or interventions related to Resident #17's expressions of fear related to her preoccupation regarding the safety of her belongings. During an interview on 12/08/2022 at 1:45 a.m., the DON confirmed Resident #17 often exhibited fear and paranoid behavior related to the safety of her belongings. The DON stated all behaviors should be documented in the EMR and noted on the Resident's care plan to allow staff to anticipate the Resident's needs and provide for appropriate care. A review of the facility policy titled "Comprehensive Care Plans," last reviewed 6/30/2022, revealed the following, in part: "It is the policy of this facility to develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs ... Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives..."			

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F0677 SS= E	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00132197 and MI00131127 Based on observation, interview, and record review, the facility failed to provide adequate Activities of Daily Living (ADLs) services pertaining to bathing and nail care for seven (Resident #1, #4, #8, #13, #34, #45 and #54) of eight residents reviewed for ADL care. This deficient practice resulted in the potential for an increased risk of infection, embarrassment, and impaired self esteem due to poor hygiene. Findings include: Resident #1 Resident #1's face sheet revealed a most recent admission date of 5/19/22 and medical diagnoses which included multiple sclerosis, cerebral palsy, depression, and anxiety. Resident #1's Minimum Data Set (MDS) assessment dated 10/7/22 revealed Resident #1 had a Brief Interview Status for Mental Status (BIMS) score of 14/15 which indicated Resident #1 was cognitively intact. The MDS Functional Status assessment revealed Resident #1 required the assistance of two staff members to perform showering/bathing activities. During an observation of Resident #1 on	F0677		

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	12/05/22 at 2:25 p.m., Resident #1's hair was greasy and uncombed. Resident #1 said there was a period of time where showers were not being provided consistently and being unclean had made her feel bad about herself. Further review of Resident #1's Electronic Medical Record (EMR) included a 30 day shower/bathing look back for 11/6/22 through 12/6/22. The look back revealed Resident #1 had received a shower on 11/14/22 and 12/1/22. Resident #1's care plan included the following information pertaining to ADLs, in part, "The resident needs activities of daily living related to ms [multiple sclerosis] the resident requires the following amount of assistance [two person] for bathing Monday and Thursdays..." **Resident #8** **Resident #8's face sheet revealed a most recent admission date of 6/16/22 and medical diagnoses which included profound intellectual disabilities, developmental disorders of speech and language, and multiple muscle contractures, Resident #8's MDS assessment dated 9/21/22 included a Functional Status assessment, which indicated Resident #8 required the assistance of two staff members to perform showering/bathing activities.** On 12/05/22 at 2:38 p.m., Resident #8 was observed to have hair uncombed and greasy, disheveled and unkempt. Resident #8 was non verbal and was unable provide information pertaining to bathing.			

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A 30 day shower/bathing task look back for the period of 11/1/22 through 11/30/22 revealed Resident #8 received one shower on 11/5/22. There were no further showers documented for this time period.

Resident #13

Resident #13's face sheet revealed a most recent admission date of 8/19/21 and medical diagnoses which included depression, osteomyelitis (infection of the bone) diabetes with diabetic foot ulcer and charcot's joint. Resident #8's MDS assessment dated 11/24/22 included a BIMS score of 15/15, indicating Resident #13 was cognitively intact. Functional Status assessment, indicated Resident #13 required the assistance of two staff members to perform showering/bathing activities.

During an interview with Resident #13 on 12/05/22 at 11:39 a.m., Resident #13 said she had received a shower the previous night, but it had been a couple of weeks between showers. When asked how not receiving her showers made her feel, Resident #13 said it made her feel gross and not good about herself.

A 30 day shower/bathing task look back for the period of 11/4/22 through 12/4/22 revealed Resident #13 received one shower on 11/20/22 and 12/4/22, and had refused a shower on 11/17/22. There were no further showers documented for this time period. Resident #13's care plan dated 8/20/21 included the following information, in part, "The resident needs activities of daily living

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	assistance related to: Osteomyelitis of right foot, DM [diabetes mellitus], HTN [hypertension], decreased mobility and generalized weakness... BATHING/SHOWERING: 2x/week and prn [as needed] via 1 staff..." **Resident #45** **Resident #45's face sheet revealed a most recent admission date of 1/31/20 and medical diagnoses which included schizoaffective disorder of the bipolar type, depression, PTSD (post traumatic stress disorder), intellectual disability,and obesity. Resident #45's MDS assessment dated 10/24/22 included a BIMS score of 8/15, indicating Resident #45 was moderately cognitively impaired. The Functional Status assessment, indicated Resident #45 was totally staff dependent for showering/bathing activities.** **A 30 day shower/bathing task look back for the period of 11/7/22 through 12/7/22 revealed Resident #45 received one shower on 11/17/22 and 12/5/22. There were no further showers documented for this time period.** **During an interview on 12/06/22 at 3:06 p.m., Certified Nurse Aide (CNA) "H" reported showers were not being provided to residents on a timely basis. CNA "H" said there was a shower tech who came in on Sunday 12/4/22 and gave some of the residents showers and then again yesterday to finish them because the State was here. Resident #1, #13, and #45's shower schedules were reviewed in the EMR. CNA "H" confirmed this was where**			

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	showers were documented and the expectation was to document the showers in the EMR and not on shower logs. When asked what 'Not-appliable" meant, CNA "H" replied it meant the residents had not received showers. When the residents care plans were reviewed, CNA "H" said she was not aware residents were on a schedule to receive showers. CNA "H" said, "I can tell you, they {the reviewed residents} were not receiving showers twice a week." During an interview on 12/07/22 at 10:29 a.m., the Director of Nursing (DON) reported the expectation would be for residents to receive showers as scheduled and whenever they requested them. The DON said there had been a problem with residents receiving showers because the facility had only one shower room and they were not able to accommodate the residents because of this. The facility's "Activity of Daily Living (ADLs)" Policy with the most recent revision date of 1/1/22 included the following information, in part, "The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable....3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..." Resident #4 A review of Resident #4's most recent MDS assessment, dated 8/25/2022, revealed the Resident required extensive, two-person			

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physical assistance with toileting, personal hygiene and bathing.

An observation on 12/05/2022 at 12:18 p.m., revealed resident #4 being transferred to the bathroom by CNA "E" and CNA "F" using a sit-to-stand lift. Resident #4's hair was disheveled and knotty at the crown of her head. Upon rising from the bed, it was noted Resident #4's incontinence brief was skewed to the left side of her buttocks, leaving her right buttock exposed. Resident #4 began urinating while being assisted to standing position and was observed to have urine running down her right leg to the floor. After toileting Resident #4, CNA "F" provided peri-care to the Resident and proceeded to pull up her sweatpants. Resident #17's sweatpants were observed to have a large wet stain down the back of the right leg of her pants. CNA "E" changed Resident #17's pants with the assistance of CNA "F". It was noted that Resident #17 was not provided with care to cleanse her right leg after the Resident was observed to have urine running down her right leg upon standing.

A review of Resident #4's point of care documentation for bathing/showers from 09/01/2022 through 12/08/2022, revealed a task for "ADL - Bathing: 2x/week and prn (two times per week and as needed)." A review of the task documentation from 09/01/2022 through 12/06/2022 revealed the following:

Resident #4 received two bed baths during the month of September: 9/01/22 at 8:45 p.m. and 9/06/2022 at 10:06 p.m., and one shower documented on 9/06/2022 at 2:20 p.m. Resident #4 had no documented refusals for bathing and showers for

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	September 2022. Resident #4 had no documented baths or showers during the month of October 2022. Resident #4 had one documented refusal on 10/4/2022 at 10:20 p.m. Resident #4 had documented bed baths on 11/15/2022 at 9:50 p.m. and 11/25/2022 at 9:09 p.m. and two documented showers on 11/11/2022 at 8:08 a.m. and 4:00 p.m. It was noted the Resident's showers in November 2022 were both on the same day. Resident #4 had no documented refusals of bathing or showers for November 2022. Resident #4 had no documented baths or showers, or refusals of such, from 12/01/2022 through 12/06/2022 at 3:10 p.m. Resident #34 A review of Resident #34's most recent MDS assessment, dated 8/31/2022, revealed the Resident was totally dependent on staff for personal hygiene and bathing. An observation on 12/07/2022 at approximately 11:30 a.m., revealed Resident #34 being repositioned in bed by CNA "E" and Licensed Practical Nurse (LPN) "B". Further observation revealed the toenails on both Resident #34's feet were overgrown past the end of all 10 of the Resident's toes. When asked how often nail care was provided to Resident #34, CNA "E" reported nail care was provided with every shower. Resident #34 did not know when they had last received a shower or bed bath. A review of Resident #34's point of care			

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	documentation for bathing/showers from 09/01/2022 through 12/08/2022, revealed a task for "ADL - Bathing/Shower: 2x/week and prn (two times per week and as needed)." A review of the task documentation for 9/01/2022 through 12/06/2022 revealed the following: Resident #34 had one documented bed bath on 9/17/2022 at 6:12 p.m. and no documented showers. The Resident had no documented refusals during September 2022. Resident #34 had no documented bed baths or showers during October 2022 and one documented refusal of such on 10/4/2022 at 6:03 a.m. Resident #34 had showers documented on 11/2/2022 at 1:21 p.m., 11/10/2022 at 12:49 p.m., 11/11/2022 at 8:11 a.m. and 11/24/2022 at 7:53 a.m. Resident #34 had no documented refusals for November 2022. Resident #34 had no documented bed baths or showers or refusals of such from 12/01/2022 through 12/06/2022 at 2:25 p.m. It was noted during the review of Resident #34's point of care documentation there was no task assigned for Resident #34's nail care from 9/01/2022 through 12/06/2022. Resident #54 A review of Resident #54's MDS assessment, dated 11/06/2022, revealed the Resident required extensive, one-person physical assistance for toileting and personal hygiene and was totally dependent on staff			

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for bathing.

An observation on 12/05/2022 at 12:55 p.m., revealed resident #54 in her bed lying in a fetal position on her left side. Resident #54 was not covered with a blanket and further observation revealed the bed underneath the Resident's hips, buttocks and thighs to be saturated and yellow. The saturated area was spread out toward the Resident's upper thigh with a dark dried area of demarcation surrounding the stain. It was noted during the observation, Resident #54 smelled strongly of urine.

On 12/05/2022 at 1:04 p.m., CNA "E" was observed walking into Resident #54's room, turning to check on the Resident and promptly exited the Resident's room and was then observed assisting other residents in the dining room. Resident #54 continued sleeping in the urine-soaked bed.

A review of Resident #54's point of care documentation for bathing/showers from 09/01/2022 through 12/06/2022, revealed a task for "ADL - Bathing/Shower: 2x/week and prn (two times per week and as needed)." A review of the task documentation revealed the following:

Resident #54 had one documented shower on 9/17/2022 at 6:04 p.m. and no documented bed baths or refusals for September 2022.

Resident #54 had no documented showers, bed baths and two refusals of such on 9/3/2022 at 11:15 p.m. and 9/4/2022 at 10:06 p.m.

Resident #54 had documented showers on

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	11/07/2022 at 10:37 a.m. and 11/24/2022 at 1:58 p.m. Resident #54 had no bed baths or refusals of baths/showers for November 2022. Resident #54 had no documented showers, bed baths or refusals for 12/01/2022 through 12/06/2022 at 3:15 p.m. During an interview on 12/08/2022 at 1:45 p.m., the DON reported all showers and bed baths are documented in point of care task documentation. The DON stated if residents refused care, the refusal should be documented in the point of care task documentation and the resident should be reapproached to complete the task at a later time.			
F0679 SS= D	Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meanigful activities for one Resident (#60) of one residents reviewed for meaningful activities.	F0679		

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	This deficient practice resulted in the potential for boredom and decreased quality of life. Findings include: Resident #60 During an interview and observation on 12/6/22 at 11:22 a.m., Resident #60 appeared frustrated and down. When asked if the facility provided Resident #60 with any meaningful activities, stated "No." and relayed he had nothing to pass the time. When asked if anyone had come in from activities to talk with him about his interests, Resident #60 confirmed no one had come in to talk with him that he could remember. An interview was conducted on 12/08/22 at approximately 9:15 a.m., with Activities Director (AD) "P" and Activities Aide (AA) "Q". AA "Q" stated Resident #60 used to get one-to-one visits, but he was not getting them recently. AA "Q" could not state why Resident #60 was no longer getting one-to-one visits now. When asked to see how she documented on one-to-one activities for Resident #60, AA "Q" stated, "I am not sure why (Resident #60) hasn't been getting them (one-to-one visiting activity)." AD "P" confirmed Resident #60 did not have one-to-one visits and stated AA "Q" was accurate in stating he had one-to-one visits in place at one time. AD "P" stated this intervention must have fallen off when Resident #60 went back to the hospital. AD "P" was asked to verify when Resident #60 was last in the			

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	hospital and when he returned. AD "P" confirmed Resident's last admission to the hospital was on 10/20/22 and he returned on 10/21/22. AD "P" and AA "Q" confirmed one-to-one activities visits have not been completed since that time. During an interview on 12/8/22 at approximately 9:20 a.m., the DON was informed of the issue of missing interventions since Resident #60's last readmission. The DON confirmed they facility has been having an issue with certain interventions for residents dropping off when they go out to the hospital and then return.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility provided to provide necessary services according to professional standards of care pertaining to neurological assessments for two (Resident #8 and #45) of two residents reviewed. This deficient practice resulted in the potential for undetected neurological changes along with a delay or lack of treatment pertaining to	F0684		

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	these changes. Findings include: Resident #8 Resident #8's face sheet revealed a most recent admission date of 6/16/22 and medical diagnoses which included profound intellectual disabilities, developmental disorders of speech and language, and multiple muscle contractures. On 12/05/22 at 2:38 p.m., Resident #8 was observed to be in her bed, excessively grinding her teeth and demonstrating involuntary lip smacking. Further review of Resident # 8's Electronic Medical Record (EMR) included an an order dated 6/16/22 for olanazapine 5 mg (milligrams) daily. An Abnormal Involuntary Movement Scale (AIMS) test which was performed on 6/19/22 in which Resident #8 received a score of three (moderate) for the following question, "Jaw, e.g. biting, clenching, chewing, mouth opening, lateral movement." The instruction for the AIMS test for a score of three included the following information, in part, " A score of 3 or 4 in only one of the 7 body areas (items 1 to 7) - resident should be referred for a complete neurological exam..." Neither a History and Physical nor a neurological assessment performed by a physician was present in Resident # 8's EMR to indicate provider awareness of Resident # 8's involuntary muscle movements. The following information pertaining to olanzapine side effects was obtained from Drugs. com, in part, "High doses or long-term use of olanzapine can cause a serious movement disorder that may not be			

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reversible. The longer you use olanzapine, the more likely you are to develop this disorder, especially if you are a woman or an older adult." retrieved on 12/15/22 from https://www.drugs.com/mtm/olanzapine.html

On 12/06/22 at 3:28 p.m., the Director of Nursing (DON) was asked to provide additional information pertaining to neurological assessment and history and physical was requested. The DON acknowledged the potential for the olanzapine to cause involuntary muscle movements.

On 12/07/22 at 9:46 a.m., the DON confirmed there was no history and physical or neurological exam performed by the provider.

The facility's "Use of Psychotropic Drugs and Gradual Dose Reductions" policy did not include information pertaining to AIMS testing and physician follow up.

Resident #45

Resident #45's face sheet revealed a most recent admission date of 1/31/20 and medical diagnoses which included schizoaffective disorder of the bipolar type, depression, PTSD (post traumatic stress disorder), intellectual disability,and obesity. Resident #45's MDS assessment dated 10/24/22 included a BIMS score of 8/15, indicating Resident #45 was moderately cognitively impaired.

On 12/06/22 at 10:07 a.m., Resident #45 was

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	observed in bed, with a faint bruise to her upper right forehead. Resident #45 said she had fallen from her wheelchair. Resident #45 was unable to provide any additional details regarding her fall. Further review of Resident #45's EMR included a nurse's note dated 8/12/22 1527 (3:27 p.m.) which contained the following information, "Note Text: Therapist was walking by and noticed resident on the floor face down in front of her wheelchair in her room." An additional nurse's note written 8/12/22 at 1530 (3:30 p.m.) included the following information, "CNAs {Certified Nurse Aide] and nurse used a hoyer to get her off the floor...Asked if she had pain she shook her head yes. PRN [as needed] [brand name for acetaminophen]given po [by mouth] and ice bag was placed on her head. Able to move all extremities. Notified Dr on call and family." The initial fall assessment documentation performed on 8/12/22 at 1445 (2:45 p.m.) contained the following information in part, "New orders related to this fall? no,...Decreased level of consciousness or suspected head injury? yes...new complaint of headache? yes...Does resident have a new complaint of pain? yes..., describe pain including location. states headaches, ice applied...Any injury or suspected injury? yes describe injury, suspected injury. has a hematoma on her forehead, bruise to her left knee. " There were no additional documentation of neurology assessments until a "Fall Follow Up" note which had been written on 8/12/22 at 2245 (10:45 p.m.). The note contained the following information, in part, "Describe injury/suspected injury, large bruise to rt [right] forehead and swelling..."			

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	On 12/07/22 at 9:19 a.m., the DON confirmed neurological checks were not performed every 15 minutes. The facility's policy was for neurological checks to be performed every shift (12 hours) unless the physician ordered more frequent neurological checks. The DON confirmed Resident #45 had a hematoma and complained of a headache but did not feel as though it placed Resident at a higher risk and did not believe closer neurological monitoring was necessary. The facility's "Falls-Clinical Protocol" policy with the most recent revision date of 1/1/22 included the following information, in part, " Residents who have fallen and have been witnessed to hit their head, suspected to have hit their head, and all un-witnessed falls regardless of the resident's cognitive status should have neurochecks per MD orders or protocol." The following information was retrieved from the RN Journal website, in part, ":The post-fall algorithm begins with a decision diamond that requires the nurse to determine if loss of consciousness has occurred and, if so, the nurse must immediately check circulation, airway, and breathing and call rapid response as needed. baseline information, including neurologic, cardiac, musculoskeletal, and integument assessment. Neurologic assessment includes blood sugar and assessment of Glasgow coma scale (pupils, speech, sensation, and level of consciousness). If there is no head trauma then vital signs should be taken every eight hours for the next 24 hours and then reassessed; if minor			

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	head trauma or head injury has occurred then neurologic vitals should occur every hour for at least four hours, then every eight hours for the first 24 hours prior to reassessment, or as indicated by the doctor or nurse practitioner. It is during the 24 hour reassessment period that the doctor or the nurse practitioner determines if further assessment should occur, thus termination of the protocol..." Retrieved from https://rn-journal.com/journal-of-nursing/post-fall-care-nursing-algorithm#:~:text=The%20general%20scheme%20of%20the%20algorithm%20is%20as,and%20breathing%20and%20call%20rapid%20response%20as%20needed on 12/7/22. Additional information pertaining to post fall neurological monitoring of residents was reviewed on the Medleague Post Fall Assessment for a Head Injury website and contained the following information in part, "Here's what should be done by a nurse in the assessment of a patient who has fallen, hit her head or had an unwitnessed fall. The first priority is to make sure the patient has a pulse and is breathing...The patient's Glasgow Coma Scale should be checked - the ability to open her eyes, respond verbally and use her muscles is rated on a scale from 3 at the lowest point to 15 (normal)...The nurse should watch for signs of deterioration: a headache, change in the level of consciousness, amnesia, vomiting, or weakness...Vital signs and neurological observations should be performed hourly for 4 hours and then every 4 hours for 24 hours, then as required...The attorney reviewing a fall case may see this series of steps break down in a couple of common areas: Failure			

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	to recognize signs of deterioration. For example, the staff may fail to make periodic assessments of the patient's level of consciousness. I've seen cases in which the staff did not differentiate between a person who is sleeping versus one who is in a coma..." Retrieved from med league Post Fall Assessment for a Head Injury https://www.medleague.com/patient-falls-the-critical-role-of-post-fall-assessment-in-a-head-injury-slip/ on 12/8/22.			
F0686 SS= D	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 practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00132197 and MI00131127. Based on observation, interview and record review, the facility failed to implement appropriate positioning interventions to prevent worsening and promote healing of pressure injuries for one Resident (#4) of three resident reviewed for pressure injuries.	F0686		

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	This deficient practice resulted in the potential worsening of pressure injuries and delayed healing. Findings include: Resident #4 was admitted to the facility on 12/12/2018 and had diagnoses including dementia and diabetes. A review of Resident #4's Minimum Data Set (MDS) assessment, dated 8/25/2022, revealed the Resident required extensive, two-person assistance with bed mobility and transfers. Further review of the MDS assessment revealed Resident #4 scored five out of 15 (5/15) on the Brief Interview for Mental Status (BIMS), indicating Resident #4 had severe cognitive impairment. An observation on 12/05/2022 at 11:42 a.m. revealed Resident #4 lying in bed, with the head of the bed elevated to approximately 80 degrees. Resident #4 was observed to be resting fully on her buttocks and yelling out for help. Resident #4 reported her "butt hurt so bad." An observation on 12/05/2022 at 12:18 p.m. revealed Certified Nurse Aide (CNA) "F" enter Resident #4's room to offer assistance. CNA "F" called out to CNA "E" for help to transfer Resident #4 to her wheelchair per the Resident's request. CNA "F" assisted Resident #4 to sit up in the bed, facing the left side, with her left leg dangling off the bed toward the floor and her right leg positioned with her right knee bent and fully on the bed with her right foot hanging over the edge of the bed. CNA "E" placed a sling around Resident #4's upper torso for use with a sit-to-stand lift. Resident #4 called out stating her right knee was hurting. CNA "E" positioned her hand on the sling that was secured around the Resident's torso and			

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	pulled the Resident's buttocks across the bed, so the Resident's legs were both dangling over the side toward the floor. Upon transferring the Resident to a standing position, the Resident's incontinence brief was observed to be skewed fully to the left side of the Resident's body, leaving her right, outer buttock fully exposed. Resident #4 was then transferred to the bathroom for toileting. An observation immediately following Resident #4 being lifted from the toilet revealed two open wounds on Resident #4's left medial buttock and one open wound on her right medical buttock. All three wounds were actively bleeding, with bright red blood observed covering the wound beds. CNA "F" confirmed the wounds were bleeding while she cleansed the Resident's buttock with a peri-wipe. The Resident's brief was refastened without any barrier or dressing applied to the wounds. A review of Resident #4's "Skin & Wound Evaluation(s)," revealed the following: 11/29/2022 at 7:57 a.m. - "Type: Pressure. Stage 3: Full thickness skin loss. Location: Right buttock. How long has the wound been present? New. Wound Measurements: Length 0.7 cm (centimeters), Width 1.0 cm, Depth 0.2 cm. 100% of wound bed covered, surface intact. Other (including bleeding): None. " During an interview on 12/07/2022 at 11:48 a.m., the facility Wound Care Nurse, Registered Nurse (RN) "A" confirmed Resident #4 had a Stage 3 pressure injury on her right buttock. RN "A" stated the pressure injury was observed to be closed on her last observation (11/29/2022) but appeared to be			

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	open again as of 12/06/2022. RN "A" was queried if pulling a resident across the bed while the resident was resting fully on their buttocks could cause shearing (pressure injury caused by friction) to which she answered yes. RN "A" reported areas of healed pressure injuries such as Resident #4's right buttock wound, were more susceptible to future injury. RN "A" stated staff should be careful not to cause friction while repositioning and transferring residents to eliminate the risk of re-injuring the skin. A review of the facility policy titled "Pressure Injury Prevention and Management," last reviewed 1/01/2022, revealed the following, in part: "This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate ... Interventions for Prevention and to Promote Healing: Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment ..."			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives	F0688		

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appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure the use of an orthotic splint device for one Resident (#10) of one resident reviewed for range of motion maintenance. This deficient practice resulted in the potential for decline in hand function, contractures and skin impairment. Findings include:

On 12/5/22 at 12:04 p.m., Resident #10 had observable contractures to bilateral hands. There was no splint observed in place for Resident #10. A right hand orthotic splint was observed located in the closet along with a picture of how it was to be applied which was affixed to the inside of the closed door.

On 12/05/22 at 12:12 p.m., Certified Nurse Aide (CNA) "R" proceeded to provide incontinence care and turning/repositioning care for Resident #10. Once completed with cares, CNA "R" did not apply any orthotic splint to Resident #10. Registered Nurse (RN) "T" came in to assist with the care being provided and did not recognize Resident #10

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did not have her right hand orthotic splint applied.

A review of the orders section of the EMR revealed no order for the orthotic splint and when it was to be applied for Resident #10. The orthotic splint was also not care planned and not active as a task to be completed in the Electronic Medical Record (EMR).

On 12/5/22 at 2:15 p.m., no orthotic splint was observed applied to Resident #10.

On 12/6/22 at 11:15 a.m., no orthotic splint was observed applied to Resident #10.

On 12/6/22 at 2:15 p.m., no orthotic splint was observed applied to Resident #10.

On 12/6/22 at 5:00 p.m., no orthotic splint was observed applied to Resident #10.

On 12/7/22 at 11:26 a.m., Resident # 10 had the right hand orthotic splint in place.

During an interview on 12/7/22 at 3:15 p.m., Physical Therapy Assistant (PTA) "S" stated the therapy department had recommended Resident #10's orthotic hand splint, and that it should be applied every two hours and then taken off for two hours. PTA "S" stated he was not sure why the splint would not have been applied over the last couple of days.

During an interview on 12/7/22 at 3:30 p.m.,

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	CNA "R" was asked if she knew about Resident #10 requiring the use of a right orthotic hand splint. CNA "R" stated she did not remember and had not put it on over the last couple of days. CNA "R" stated she had forgotten about it because it was not on the care plan tasks. CNA "R" stated the reason it was applied today was because she was working with a CNA who does restorative services for the residents and she had remembered to apply the orthotic splint. CNA "R" acknowledged the lack of it being in the care plan contributed to her not remembering to apply the splint. This would have presented a problem with other staff who are not familiar with Resident #10 caring for her. During an interview on 12/7/22 at 3:52 p.m., RN "O" and Regional Director of Clinical Operations (RDCO) "U" stated the problem was the task directing CNA's to apply the orthotic hand splint and the parameters for use was turned off due to a recent hospitalization. RN "O" and RDCO "U" stated the task was still in the Electronic Medical Record (EMR) system, but that it had just been turned back on. RN "O" and RDCO "U" explained that was why there was only charting for this day in the EMR since Resident #10 went out to the hospital. RN "O" and RDCO "U" acknowledged this as a root cause for interventions not being completed for resident needs related to restorative therapy. RN "O" and RDCO "U" stated when a resident gets transferred out			

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	to the hospital some of the tasks ended up getting turned off and they needed to be turned back on.			
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 services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: **Based on observation, interview, and record**	F0690		

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	review, the facility failed to provide appropriate services pertaining to infection control and resident safety for indwelling urinary catheters (a tube inserted into the bladder to accommodate bladder emptying) for two (Resident #1 and # 60) of five residents reviewed for indwelling catheters. This deficient practice resulted in the increased risk of infection and complications pertaining to dislodgement of the indwelling catheter. Findings include: **Resident #1** **A review of Resident #1's Electronic Medical Record revealed a most recent admission date of 5/19/22 and medical diagnoses which included multiple sclerosis, cerebral palsy, depression, and anxiety. Resident #1's Minimum Data Set (MDS) assessment dated 10/7/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #1 was cognitively intact. The MDS Bowel and Bladder assessment revealed Resident #1 had an indwelling suprapubic catheter.** On 12/05/22 at 2:25 p.m., Resident #1 was observed in her bed, Resident #1's urinary collection bag was observed on the floor. On 12/07/22 at 2:55 p.m., Resident #1's urinary collection bag inside a privacy bag was observed on the floor. Certified Nurse Aide (CNA) "I" was asked to observe the urinary collection bag and said it should not be on the floor, even if it was inside a privacy bag. CNA "I" proceeded to wash her hands, don gloves, and pick up the collection bag from the floor. CNA "I" the proceeded to			

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empty the urinary collection bag without removing her gloves and rewashing her hands. Resident #1's legs were observed with permission. A catheter secure strap (a device used to keep catheters in place to prevent the tubing from moving and dislodgement) was not present on either of Resident's #1's legs. Resident #1 said sometimes staff placed one on her legs and sometimes they did not. CNA "I" was unable to clarify why a catheter secure device was not present.

On 12/07/22 at 3:05 p.m., Registered Nurse (RN) "M" said urinary collection bags should not be on the floor, even if they were in privacy bags and catheter secure devices should be in place.

During an interview with the Director of Nursing (DON) on 12/07/22 at 3:21 p.m., the DON said urinary collection bags should not be on the floor and catheter secures should be in place. The DON said if a collection bag was inside a privacy bag, they could be on the floor because sometimes it was impossible to get them off the floor when they were in bed and the bed was in low position. This surveyor notified the DON that CNA "I" was able to position the collection bag off the floor when the bed was in the low position. The DON did not express any concerns regarding the collection bag getting stepped on or tripped over and becoming dislodged.

The facility's "Catheterization" policy with the

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	most recent revision date of 1/1/22 contained the following information, "Urinary catheterizations will be performed in accordance with current standards of practice to minimize risk for bacterial contamination or urethral trauma...6. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include, but are not limited to :urinary tract infection, blockage of the catheter, expulsion of the catheter, pain, discomfort, and bleeding." The following information was obtained from the Center for Disease Control (CDC) website, in part, "GUIDELINE FOR PREVENTION OF CATHETERASSOCIATED URINARY TRACT INFECTIONS 2009...Proper Techniques for Urinary Catheter Maintenance....Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor..." Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines-H.pdf on 12/13/22.			
F0693 SS= D	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral	F0693		

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	methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: **Based on observation, interview and record review, the facility failed to implement interventions to reduce complications of tube feeding according to professional standards of practice for three Residents (#34, #10 and #56) of three residents reviewed for tube feeding. This deficient practice resulted in the potential for aspiration of tube feeding contents and pneumonia. Findings include:** **Resident #34** **Resident #34 was admitted to the facility on 10/17/2020 and had diagnoses including stroke, dementia and chronic respiratory failure. A review of Resident #34's Minimum Data Set (MDS) assessment, dated 8/31/2022, revealed the Resident was fully dependent on staff for bed mobility and transfers.** **An observation on 12/06/2022 at 5:18 p.m., revealed Certified Nurse Aide (CNA) "D" and Licensed Practical Nurse (LPN) "Y" preparing Resident #34 to be repositioned in bed. CNA "D" was observed to be positioned on the**			

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	right side of the Resident's bed, near a tube feeding pump that was observed to be delivering tube feeding formula to the Resident at 49 milliliters per hour (49 ml/hr). CNA "D" proceeded to lower the head of Resident #34's bed so the Resident was lying flat in the bed without pausing or turning off the tube feeding. LPN "Y" was observed standing on the left side of the Resident's bed and did not intervene or instruct CNA "D" to pause or turn off the Resident's tube feeding. This surveyor immediately queried CNA "D" and LPN "Y" as to why the Resident's tube feeding was not paused or turned off when the Resident was lying flat in the bed. CNA "D" reported she was instructed not to touch the tube feeding pump. CNA "D" added she was instructed by nursing the pump did not have to be paused or turned off when lying the Resident flat "if we hurry." Upon this Surveyor's query, LPN "Y" walked to the right side of the Resident's bed and turned off the tube feeding. LPN "Y" confirmed the tube feeding should be paused or turned off when the Resident was lying flat to eliminate the risk of the Resident aspirating the tube feeding formula. Resident #10 A review of the Electronic Medical Record (EMR) face sheet for Resident #10, revealed admission to the facility on 12/18/2006 with diagnoses including chronic respiratory failure, anoxic (lack of oxygen) brain damage, persistent vegetative state, tracheostomy (artificial airway exiting throat), ventilator dependence, dysphagia (difficulty swallowing), gastro-esophageal reflux disease, and a gastrostomy (skin surface			

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opening to stomach).

On 12/5/22 at 12:12 p.m., CNA "R" entered the room to perform cares and turn/reposition Resident #10. Registered Nurse (RN) "T" also came into the room to assist CNA "R" with the care being provided. CNA "R" lowered the head of the bed without turning off the tube feeding and/or asking the nurse to turn the tube feeding off. RN "T" also failed to recognize the tube feeding was not turned off prior to lowering the head of Resident #10 flat for care.

On 12/5/22 at 12:19 p.m., CNA "R" completed the care of Resident #10 and placed the head of the bed back up to 35 degrees, and stated she needed to get a new bottom sheet for Resident #10. RN "T" was then asked if they forgot to do anything with the tube feeding while Resident #10 was laid flat in the bed. RN "T" acknowledged the tube feeding should have been shut off prior to lowering the head of the bed, but stated it didn't take that long to provide care so Resident #10 should be alright. The total time of care provided while the tube feeding was running was approximately 7 minutes.

During a follow-up interview on 12/5/22 at 12:24 p.m., CNA "R" confirmed Resident #10 had been sent out to the hospital recently and thought it was related to pneumonia. When asked why the tube feeding was not turned off prior to lowering the head of Resident #10 flat, CNA "R" stated she wished

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	there was a better way of doing things to prevent pneumonia for these residents. When asked to elaborate, CNA "R" stated she wished there was a better process for turning and repositioning residents with tube feeding because she cannot turn off the tube feeding. CNA "R" stated it was out of her scope of practice to turn the tube feeding off for care. When asked about having a nurse come in and turn the tube feeding off for care, CNA "R" stated she usually does that, but then stated this care didn't take that long. CNA "R" stated if the care was going to be longer, then she would have gotten a nurse to turn the tube feeding off. Of noted importance, RN "T" came into the room during the care being provided and was not asked to turn off the tube feeding for Resident #10. On 12/5/22 at 1:00 p.m., this Surveyor entered the room of Resident #10 to observe a bed sheet being changed. Upon entry, CNA "R" and Unit Manager, RN "Z" were observed in the midst of performing the bed sheet change. The tube feeding was observed on and running upon entry to the room. Resident #10 was already lying flat and turned to one side with sheet partially changed. RN "Z" made eye contact with this Surveyor and then reached for the feeding pump to turn the feeding off. On 12/5/22 at 1:17 p.m., a follow-up interview with RN "Z" was conducted. When asked if the tube feeding pump should have been shut off prior to lowering the head of			

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the bed for Resident #10, RN "Z" confirmed the tube feeding should have been shut off prior to lying her flat. RN "Z" offered that CNA "R" was just too quick for her, which was why she failed to have the tube feeding turned off.

A review of the "...tube feeding via g-tube..." care plan for Resident #10 with a revised date of 12/5/19, read in part:

"The resident needs the HOB (Head of Bed) elevated 30-45 degrees during and 30 minutes after tube feed." (Revision on: 4/26/22)

Resident #56

A review of the EMR face sheet for Resident #56, revealed admission to the facility on 1/29/21 with diagnoses including chronic respiratory failure, persistent vegetative state, tracheostomy, ventilator dependence, functional quadriplegia, traumatic brain injury, shaken infant syndrome, pneumonia, and dysphagia.

On 12/5/22 at 1:40 p.m., CNA "W" was observed performing care for Resident #56. Upon entry to the room CNA "W" had the head of the bed laid flat for Resident #56. The tube feeding was observed still running. CNA "W" finished the care she was providing including turning Resident #56 from side-to-side to remove soiled linens and then raised the head of the bed back to greater than 30

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	degrees approximately two minutes later. CNA "W" stated she needed to get help to lift and reposition Resident #56 from the nurse and left the room. CNA "W" returned with LPN "Y" at approximately 1:45 p.m. CNA "W" again laid Resident #56 flat without asking a LPN "Y" to place the feeding pump on hold. CNA "W" and LPN "Y" took approximately 5 minutes to reposition Resident #56 prior to elevated the head of bed back to greater than 30 degrees. The tube feeding was never placed on hold. A review of the "...requires tube feeding as ordered r/t(related to) dysphagia" care plan for Resident #56, revised on 2/10/21, read in part: "The resident needs the HOB elevated 30-45 degrees during and thirty minutes after tube feed." (Revised 2/1/22) A review of the facility policy titled "Feeding Tubes," last reviewed 6/30/2022, revealed the following, in part: "Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible." It was noted the facility policy did not include procedures for staff to follow regarding status of tube feeding during Resident care and positioning of the Resident while the tube feeding was running.			
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care,	F0695		

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	including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure emergency equipment was readily available at the bedside for two Residents (#10 & #56) of two residents reviewed for tracheostomy/mechanical ventilator care. This deficient practice resulted in the potential for emergency equipment not being readily available during respiratory related emergencies with the potential for worsening respiratory complications. Findings include: Resident #10 A review of the Electronic Medical Record (EMR) face sheet for Resident #10, revealed admission to the facility on 12/18/2006 with diagnoses including chronic respiratory failure, anoxic (lack of oxygen) brain damage, persistent vegetative state, tracheostomy (artificial airway exiting throat), ventilator dependence, dysphagia (difficulty swallowing), gastro-esophageal reflux disease, and a gastrostomy (skin surface			

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opening to stomach).

On 12/5/22 at 12:06 p.m., a review of the room for Resident #10 revealed no observation of an ambu-bag or replacement trach at the bedside in case of a respiratory emergency. There was a yankauer-tip suction catheter attached to the suction machine tubing which was left uncovered and touching the environmental surface of a basket type structure connected to the respiratory equipment. The closet, bedside dresser and walls were checked for any emergency respiratory equipment and none were located.

During a follow-up interview on 12/5/22 at 12:24 p.m., CNA "R" confirmed Resident #10 had been sent out to the hospital recently and thought it was related to pneumonia.

A review of the EMR progress notes revealed Resident #10 was sent to the hospital on 11/24/22 for sepsis.

A review of the progress note section for Resident #10, read in part:

"11/24/2022 (4:52 p.m.) Progress Note-Respiratory ... during a routine vital check it was brought to my attention (Resident #10's) sa02 (oxygen saturation) may be low ... albuterol (respiratory medication) tx (treatment) given, sao2 did increase from 86 (%) to 91(%) (Range 92-100%) with baging (use of a manual device to provide

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respirations) but decreased to 88(%) after. vt (fixed tidal volume [amount of air supplied to lungs]) increased to 600(ml) and 4 liter of 02 (oxygen) added. still only 89% o2 increased to 7 L (liters) and held at 90%. nurses called for transport and she was transported to hospital.

Resident #56

A review of the EMR face sheet for Resident #56, revealed admission to the facility on 1/29/21 with diagnoses including chronic respiratory failure, persistent vegetative state, tracheostomy, ventilator dependence, functional quadriplegia, traumatic brain injury, shaken infant syndrome, pneumonia, and dysphagia.

On 12/5/22 at 1:25 p.m., during an observation of the room for Resident #56, there was no ambu-bag or replacement tracheostomy tube kit able to be located readily available in the event of a respiratory emergency.

A review of the EMR progress notes revealed Resident #56 was sent to the hospital on five occasions in the last 9 months for respiratory complications and most recently pneumonia related issues on 11/23/22.

A review of the progress note section for Resident #56, read in part:

"10/19/2022 (12:30 a.m.) Progress Note-

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Respiratory ... (Resident #56) face flushed and swollen, temp(temperature) 103.6 HR(Heart Rate):132 RR(Respiratory Rate):22 (Resident #56) breathing quietly on vent(ventilator) Breath sounds bilat crackles bases. Sent to hospital to eval(evaluate) and treat in stable condition."

A review of the Situation Backround Assessment Recommendation (SBAR) assessment, dated 11/23/22, revealed Resident #56 was sent out to the hospital for increased seizures, HR, RR, fever, pale, increased O2 (oxygen) need, change in secretions. Resident #56 was admitted to the hospital for "PNA(pneumonia) HR(Heart Rate) 124, Temp(Temperature) 102.2, RR (Respiratory Rate) 28, B/P(Blood Pressure) 125/70, Sat (Oxygen Saturation) 84% following seizure. " An order was given to send Resident #56 to the emergency room for suspected pneumonia.

A review of SBAR dated 10/19/22 revealed Resident #56 had an elevated temp at 103 degrees, a rapid pulse at 132, and was flushed and lethargic. Resident #56's oxygen saturation was 92%. He was set to the emergency room and was treated for bilateral pneumonia.

During an interview on 12/6/22 at 3:45 p.m., the Director of Nursing (DON) stated the expectation of the facility was emegency equipment for ventilator residents should be readily accessible at the bedside. When asked

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	what type of emergency equipment should be available, the DON stated a back-up appropriate size tracheostomy kit, a suction machine, and ambu-bag. When asked to clarify readily accessible, the DON stated the items should be at the bedside, on a tray table, a bedside stand, or hanging from the mechanical ventilator stand, essentially within arm's reach. On 12/6/22 at 4:30 p.m., the DON confirmed Resident #10 did not have an ambu-bag present in her room, but was able to locate a replacement tracheostomy tube kit in her closet, within a drawer supply storage unit. The DON confirmed Resident #56 did not have an ambu-bag present in his room, but was able to locate a replacement tracheostomy tube kit in his closet, on the floor of the closet out of eyesight. The DON confirmed the lack of an ambu-bag for emergency airway maintenance and in the event of mechanical ventilator failure was not correct and that one should be at the bedside. A review of the facility policy, "Ventilator Unit - Accidental Tracheal Decannulation", with a revised date of 1/1/21, read in part: "1. A replacement tracheostomy tube of same size or one size smaller must be readily available. 2. Resuscitation bag, mas, oxygen source, and suction must be available..."			

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	A review of the facility policy, "Tracheostomy Care", with a revised date of 1/1/22, read in part: "The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences... 2. The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning..."			
F0713 SS= D	Physician for Emergency Care Available 24 hrs §483.30(d) Availability of physicians for emergency care The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency. This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to ensure physician availability for prompt response to resident needs for one (Resident # 45) of one resident reviewed for physician services. This deficient practice resulted in the potential for lack of physician guidance and orders in potentially life threatening situations. Findings include:** **Resident # 45**	F0713		

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	Resident #45's Electronic Medical Record revealed a most recent admission date of 1/31/20 and medical diagnoses which included schizoaffective disorder of the bipolar type, depression, PTSD (post traumatic stress disorder), intellectual disability,and obesity. Resident #45's Minimum Data Set (MDS) assessment dated 10/24/22 included a Brief Interview for Mental Status (BIMS) score of 8/15, indicating Resident #45 was moderately cognitively impaired. A nurses' note written on 8/16/2022 at 17:48 (5:48 p.m.) contained the following information, Resident returned from [Name of Hospital] ED [Emergency Department] at approximately 1600 [4:00 p.m.]with a dx [diagnoses] of UTI [urinary tract infection]. A CT [cat scan] of head was performed at [Name of Hospital] ED and was negative... Called [Physician "K"] to review new order for Keflex and no answer. Will at call[Physician "K"] back." An additional nurse's note was written on 8/16/2022 18:41 (6:41 p.m.), and included the following information, in part, "Off going nurse reported unable to reach MD on call, [Physician "K" and unable to leave message as has no voice mail set-up regarding new orders received from {name of hospital] Writer, RN attempted to contact [Physician "K"] on his cell phone with no answer and no voice mail setup and attempted to contact him on his home number;however, there was no answer and RN did not leave message on home voice mail. Will attempt to contact later in shift."			

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A nurse's note written on 8/16/22 2350 (11:50 p.m.) contained the following information, in part, "Writer, RN, attempted to contact MD on call to report resident's lab results, CT Head findings and prescription [hospital name] would like the resident to begin. No response, unable to leave voice mail; RN faxed esults to MD. Waiting for further instructions/orders from MD."

On 12/7/22 at 9:20 a.m., Resident #45's nurse and physician/physician assistant progress notes were reviewed with the Director of Nursing (DON). The DON confirmed there was no response from Physician "K" regarding her readmission orders from the Emergency Department. The DON verified Resident #45's antibiotic orders did not get entered until Physician Assistant "N" entered them on 8/17/22 at 15:50 {3:50 p.m.). The DON confirmed there was approximately a 22 hour delay in Resident #45 starting her antibiotics for her urinary tract infection and said there was potential for Resident #45 to go septic, as well as other residents who possibly needed emergent treatment to not get physician response. The DON was unable to provide explanation as to why Physician "K" had not responded to his phone calls. The expectation was that physician was on call should respond to requests promptly, Physician on call schedule and on call policy requested.

On 12/07/22 at 10:29 a.m., the DON provided this surveyor with the August 2022 physician on call schedule and confirmed Physician "K" would have been the provider on call during the evening and overnight hours on 8/16/22-8/17/22. The DON reported there was no provider on call policy available

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	at this time. Additional information pertaining to provider on call such as contracts and agreements had not been provided during the survey.			
F0755 SS= D	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure controlled medications were reconciled for one Resident (#272) of eight residents reviewed for	F0755		

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medication administration and one medication cart of two medication carts reviewed for medication storage. This deficient practice resulted in the potential for medication errors, untoward side effects of medication errors, and the potential for drug diversion. Findings include:

Resident #272

Medication administration was observed for Resident #272 on 12/6/22 at 3:52 p.m., performed by Licensed Practical Nurse (LPN) "AA". During this observation, LPN "AA" was observed pulling Ritalin 20 milligram (mg) tablet from the controlled medication locked cabinet. After LPN "AA" had removed the pill from the medication card, 15 tablets remained. The controlled medication log for this medication read 18 remaining. LPN "AA" explained she had forgotten to sign out two prior doses of this medication for Resident #272. LPN "AA" then proceeded to look back in the Electronic Medical Record (EMR) to determine what time the two other pills were removed from the controlled medication locked cabinet. An immediate interview with LPN "AA" was conducted. When asked when medications were supposed to be signed out during the administration process, LPN "AA" stated they were supposed to be signed out immediately.

Medication Storage and Labeling

A review of the D hall medication cart was

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conducted on 12/7/22 at 9:10 a.m. with LPN "AA". A random audit of the medication card for Resident #64 containing Klonopin 0.5 mg tablets revealed three tablets were remaining per the controlled medication log, and upon inspection, only two tablets remained in the medication card. LPN "AA" stated she had forgotten to sign the medication out and offered that she was distracted because she had to propel Resident #64 to the dining room. LPN "AA" had just finished medication administration for another unidentified resident at the time of the medication cart review.

During a follow-up interview on 12/7/22 at 9:15 a.m., LPN "AA" again confirmed medications should be signed out when removed for administration from the controlled medication locked cabinet.

On 12/7/22 at 9:46 a.m., a request was made for the facility to provide a policy regarding procedure to sign out controlled substance medications for medication administration.

A review of the facility policy titled "Medication Administration", with a revised date of 1/1/22, read in part:

"... 15. Observe resident consumption of medication ...

17. Sign MAR after administered ...

18. If medication is a controlled substance,

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	sign narcotic book (controlled medication log)..."			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that	F0758		

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	medication. This REQUIREMENT is not met as evidenced by: **Based on interview and record review, the facility failed to ensure appropriate indications for the use of as-needed, anxiolytic medication through documentation of target behavior and the use of non-pharmacological interventions for one Resident (#29) of five Residents reviewed for unnecessary medication. This deficient practice resulted in the potential for the unnecessary use of mind-altering medications, negative side-effects of medications and decreased quality of life. Findings include:** **Resident #29 was admitted to the facility on 7/19/2022 and had diagnoses including chronic obstructive pulmonary disease (COPD), heart failure and anxiety disorder. A review of Resident #29's Minimum Data Set (MDS) assessment, dated 9/15/2022, revealed the Resident scored three out of 15 (3/15) on the Brief Interview for Mental Status, indicating she had severe cognitive impairment.** **A review of Resident #29's October 2022 Medication Administration Record (MAR) revealed the following orders:** **"Lorazepam (controlled, anxiolytic medication) Tablet 0.5 MG (milligram). Give 1 tablet by mouth every 4 hours as needed for restlessness, anxiety and agitation. Start Date: 9/25/2022 ... D/C Date: 10/17/2022 ..."** **"Lorazepam Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for**			

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	restlessness, anxiety and agitation for 14 days. Start Date: 10/17/2022 ... D/C Date: 10/26/2022 ..." Further review of Resident #29's October 2022 MAR, progress notes, assessments and behavior notes, revealed the as needed lorazepam 0.5 mg tablets were administered on the following dates and times, without nursing documentation of targeted behaviors or the use of non-pharmacological interventions prior to the administration: 10/01/2022 at 7:13 a.m. and 4:42 p.m. 10/02/2022 at 12:15 p.m. and 5:11 p.m. 10/03/2022 at 4:00 p.m. 10/04/2022 at 12:01 p.m. 10/06/2022 at 19:42 p.m. 10/08/2022 at 3:10 p.m. 10/09/2022 at 2:45 p.m. 10/10/2022 at 7:15 a.m. 10/12/2022 at 2:16 p.m. 10/13/2022 at 8:46 a.m. and 7:07 p.m. 10/14/2022 at 9:29 a.m. and 6:30 p.m. 10/15/2022 at 9:17 a.m. and 7:27 p.m. 10/16/2022 at 6:28 p.m. 10/17/2022 at 7:44 p.m.			

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	10/18/2022 at 8:51 a.m. and 4:08 p.m. 10/19/2022 at 7:09 p.m. 10/20/2022 at 11:54 a.m. 10/22/2022 at 8:15 p.m. 10/23/2022 at 3:22 p.m. 10/25/2022 at 8:58 a.m. and 4:02 p.m. A review of Resident #29's November 2022 Medication Administration Record (MAR) revealed the following orders: "Lorazepam tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for anxiety. Start Date: 11/22/2022." Further review of Resident #29's November 2022 MAR, progress notes, assessments and behavior notes, revealed the as needed lorazepam 0.5 mg tablets were administered on the following dates and times, without nursing documentation of targeted behaviors or the use of non-pharmacological interventions prior to the administration: 11/22/2022 at 8:33 p.m. During an interview on 12/08/2022 at 1:15 p.m., the Director of Nursing stated all doses of as needed anxiolytic medications administered should have corresponding behavior documented to justify administration of the medication. The DON reported without appropriate documentation of the need for the medication, the Resident's treatment plan could not be appropriately evaluated for efficacy and needed changes to the plan of			

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	694020	A. BUILDING _____ B. WING _____	12/8/2022

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	care may be overlooked. The DON reported all behavior charting was completed in the electronic medical record and no paper charting occurred. **A review of the facility policy titled "Unnecessary Drugs - Without Adequate Indications for Use," last reviewed 10/24/2022, revealed the following, in part: "Documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed ... The Interdisciplinary team will evaluate the resident to identify his/her needs, goals, comorbid conditions, and prognosis to determine factors that are affecting signs. Symptoms, test results, selections of initial medications, non-pharmacological approaches when deciding on modification or discontinuation of a current medication ... A medication initiated as a result of a time-limited condition will be discontinued when the conditions has resolved, or there is documentation indicating why continued use is relevant."**			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent medication errors for three Residents (#224, #274, & #319) of eight residents reviewed for	F0759		

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	medication administration. This deficient practice resulted in 4 medication errors in 26 opportunities for error and a medication error rate of 11.54%. Findings include: Error 1 Medication administration was observed for Resident #224 on 12/7/22 at 8:15 a.m., performed by Registered Nurse (RN) "CC". Olopatadine 0.2% eye drops were administered to the left eye as ordered. RN "CC" held the tip of the eye drop applicator too close to the eye of Resident #224 and his eye lashes came into contact with applicator tip. RN "CC" stated she did not realize she had held the eye drop applicator tip that close to the eye of Resident #224. Error 2 and 3 Medication administration was observed for Resident #274 on 12/6/22 at 4:10 p.m., performed by Licensed Practical Nurse (LPN) "AA". Brimonidine 0.2% and Dorzolamide 2% eye drops were administered to Resident #274 in the right eye as ordered. LPN "AA" held the tip of the eye drop applicator too close to the eye of Resident #274 and his eye lashes came into contact with applicator tip. LPN "AA" stated she did not realize she had held the eye drop applicator tip that close to the eye of Resident #274. LPN "AA" also failed to hold the inner canthus following administration of each eye medication.			

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	Error 4 Medication administration was observed for Resident #319 on 12/6/22 at 2:20 p.m., performed by LPN "BB". An Ativan 0.5 mg tablet was removed from the locked controlled medication storage, crushed, and placed in water for administration via enteral tube. LPN "BB" entered the room of Resident #319 and proceeded to administer the medication without first flushing the enteral tube with water. LPN "BB" was immediately interviewed following the observation. When asked if she recognized she forgot to flush the enteral tube with water prior to administration of the medication, LPN "BB" acknowledged the error. LPN "BB" also failed to check for tube placement prior to administration. A review of the facility policy, "Medication Administration via Enteral Tube", with a revised date of 1/1/22, read in part: "... 9. Procedure: ... h. Enteral tube placement must be verified prior to administering any fluids or medication. (See Flushing a feeding tube policy) i. Flush enteral tube with at least 15 mL (milliliters) of water prior to administering medications unless otherwise ordered by prescriber ..."			

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	A review of the facility policy, "Medication - Eye Drops or Ointments", with a revised date of 1/1/22, read in part: "5. Administration: ... f. Avoid touching the tip of the bottle to the resident, lid, lashes, or surface of the eye. g. Instruct resident to close eyes slowly to allow for even distribution over the surface of the eye and apply gentle pressure to the tear duct (inner canthus) for one minute ..." The facility policy lacked any guidance on what to do with the eye drop medication if it becomes contaminated.			