STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	814040A	A. BUILDING _____ B. WING _____	**2/6/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT BLUFFS PARK	**355 HURON VIEW BLVD ANN ARBOR, MI 48103**

(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 Regency at Bluffs Park was surveyed for a Recertification survey on 2/6/23. Intakes: MI00130319, MI00131920, MI00133039 and MI00134151 Census: 67	F0000		
F0578 SS= D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive	F0578	1. Resident #268 no longer resides in the facility. 2. Current residents that have Advanced Directives have the potential to be affected and have been reviewed. Variances corrected as identified. 3. Administrator/designee will provide re-education Social Workers and Licensed Nurses, by the alleged date of compliance, on the facility□s Policies/Procedures on Advanced Directives and Code Status, which includes completing with all signatures/dates as required. 4. Social Work/Designee will randomly audit 5 residents medical record 1x/weekly for 4 weeks and then 1x/Monthly for 3 months, to ensure that Advanced Directives/Code Status has been completed per state guidelines and facility Policy. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	3/2/2023

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

Electronically Signed | 02/24/2023

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

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	information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate completion of advance directive information for 1 (Resident #268) of 2 residents reviewed for advance directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time) resulting in the potential for a resident's preferences for medical care to not be followed by the facility. Findings include: Review of the MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT, Act 193 of 1996 (Revised 3-25-14), revealed that, "An order executed under this section shall be on a form described in section 4. The order shall be dated and executed voluntarily and signed by each of the following persons: (a) The declarant, the declarant's patient advocate, or another person who, at the time of the signing, is in the presence of the declarant and acting			

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	pursuant to the directions of the declarant. (b) The declarant's attending physician. (c) Two witnesses 18 years of age or older, at least 1 of whom is not the declarant's spouse, parent, child, grandchild, sibling, or presumptive heir. (3) The names of all signatories shall be printed or typed below the corresponding signatures. A witness shall not sign an order unless the declarant or the declarant's patient advocate appears to the witness to be of sound mind and under no duress, fraud, or undue influence. Further review of this Act revealed, "Sec. 4. A do-not-resuscitate order executed under section 3 or 3a shall include, but is not limited to, the following language, and shall be in substantially the following form: "DO-NOT-RESUSCITATE ORDER This do-not-resuscitate order is issued by _____, attending physician for _____. (Type or print declarant's or ward's name) Use the appropriate consent section below:			

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	A. DECLARANT CONSENT I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me. This order will remain in effect until it is revoked as provided by law. Being of sound mind, I voluntarily execute this order, and I understand its full import. _____ _____ (Declarant's signature) (Date) _____ _____ (Signature of person who signed for declarant, if applicable) (Date) _____ (Type or print full name) B. PATIENT ADVOCATE CONSENT I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. _____			

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	_____ (Patient advocate's signature) (Date) _____ (Type or print patient advocate's name) C. GUARDIAN CONSENT I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law. _____ _____ (Guardian's signature) (Date) _____ (Type or print guardian's name) _____ _____ (Physician's signature) (Date) _____ (Type or print physician's full name)			

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	ATTESTATION OF WITNESSES The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the declarant has (has not)received an identification bracelet. _____ _____ (Witness signature) (Date) (Witness signature) (Date) _____ _____ (Type or print witness's name) (Type or print witness's name) THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT." Resident # 268 (R268) was admitted to facility 1/19/23 with diagnoses including peritonitis, Crohn's disease, pneumonia, systemic lupus erythematosus, muscle weakness and anxiety disorder. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/25/23 reflected Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section G of MDS revealed that R268 required two-person limited assist with bed mobility, two-person extensive assist with			

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transfers and toilet use, one-person extensive assist with dressing, and set up assist with eating. Section H of same MDS reflected that R268 was receiving IV (intravenous) medications.

Review of the "Do-Not-Resuscitate Order" scanned in the electronic medical record complete with R268 noted to sign in the indicated spot for "Declarant's signature" but the indicated spot on the same line labeled "date" was left blank. In the area labeled Attestation of Witness, the form was noted to be signed and dated by witness one with no second witness noted to have signed or dated the form.

In an interview on 2/01/23 at 1:03 PM, Social Worker (SW) "X" stated that nursing staff typically completed the "Resident Code Status" form and, if warranted, the "Do-Not-Resuscitate Order" for each resident at admission. SW "X" stated that these forms were then audited by SW and that each resident's code status would be reviewed at the 72 hour admission care conference. Per SW "X", a "Resident Code Status" form was completed by every resident and if they have opted to be a "DNR" (Do-Not Resuscitate-No Cardiopulmonary Resuscitation), then the corresponding "Do-Not Resuscitate Order" was complete. Per SW "X", an accurate completion of the "Do-Not-Resuscitate Order" for a competent resident would include the declarant to both sign and date the form at the time of completion and be

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	witnessed by 2 people both of which needed to be present at the time the resident was signing the DNR at which time the witnesses would sign and date the form as well. SW "X" then stated that the Physician would sign and date the form which was typically done on the same day that the form was complete. During the same interview, SW "X" confirmed familiarity with R268, reviewed the "Do-Not-Resuscitate Order" form scanned into the electronic medical record, and confirmed that R268 signed but did not date the form and that the form only contained 1 witness as the second witness spot was blank. SW "X" stated that she reviewed R268's code status with her at the 72 hour conference and confirmed that the Physician order in the medical record matched the "Do-Not-Resuscitate Order" on the form but that the review of the "Do-Not-Resuscitate Order" form itself may have been missed in the review.			
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall	F0584	1. Resident #39 and #114 remain facility in stable condition. Heat was restored at the time of survey. Residents #1, #117, #118, #119 and #268 no longer reside in the facility. 2. Residents currently residing in the facility have potential to be affected. Residents queried with no room temperature concerns. 3. Administrator/Designee will provide re-education maintenance staff, by alleged compliance date, on CFR 483.10 (i)(6) on maintaining comfortable room temperatures. All staff will be provided re-education by the NHA/designee regarding reporting any	3/2/2023

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	exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain comfortable room temperatures for 8 residents (#'s1, 39, 114, 117, 118, 119, 256, 268) of 8 reviewed for ambient room temperatures and room 137-2, resulting in discomfort of feeling cold and anger. Findings include: Resident#114 According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/18/23, Resident 114 (R114) scored 15 of 15 (cognitively intact) on the Brief Interview for Mental Status. During the initial screening process on 1/30/23 that started at approximately 10:00 am, R114 reported his		temperature concerns in the TELS system and to maintenance staff to schedule repair if indicated. 4. Maintenance Director/Designee will randomly audit 5 residents□ rooms 3x/weekly for 4 weeks and then weekly for 3 months, to ensure that rooms are maintained at appropriate temperature. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	room had not had heat all weekend and he was told by staff that the heating system had been out for days. R114 stated he ate meals in his room and would like to sit near the window for the scenery (there was a fresh snow fall), but could not sit there due to the already frigid room temperature. Upon this surveyor leaving R114's room he requested to leave the door open in the hopes if there was any heat in the hall it would enter his room. Resident # 117 On 1/30/23 during the initial screen, at approximately 10:10 am, Resident 117 (R117) reported her room was very cold. This surveyor felt cold air blowing out of the ceiling vent. R117 stated she was admitted on Saturday 1/28/23 and had not had any heat in her room the entire time. R117 said someone from the maintenance was in her room twice over the weekend but it never warmed up. Resident #118 According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/18/23, Resident 118 (R118) scored 15 of 15 on the Brief Interview for Mental Status, during the initial screening process at 10:30 am, R118 was observed sitting on his bed, and wearing an outdoor type of knit winter hat, R118 reported the heat had been out for days and he was cold.			

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Resident#119

According to the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/18/23- Resident 119 (R119) scored 15 of 15 on the Brief Interview for Mental Status (BIMS). R119 was admitted for short term rehab and resided in room 117. During the initial tour on 01/30/23 at 10:11 am, R119 reported the heat had been out for days and she was "freezing" R119 was observed sitting in a chair, she was fully dressed and wrapped in blanket, cold air was felt blowing out of the vent, a small oscillating portable heater was observed on at her bedside. When R119 was queried about the portable heater R#119 stated her daughter had to bring a portable heater.

On 01/30/23 10:48 AM , interview with Maintenance Director "E" he reported he was made aware of temperature problem on Friday stated "We have a technician on the way now, its one unit I think isn't working." Maintenance Director "E" stated the facility had 2 different heating units with 8 sub units, but none of the facility heating units were designated for the "Northwest climate." Maintenance Director "E" further stated he was not aware of heat out on the 100 hall, "I was informed issues on Hoover and McKinley" hall but not the 100 hall/Monroe unit. Maintenance Director "E" and surveyor entered rooms 117 and 123, Maintenance Director "E" agreed rooms felt cold, observed

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	portable heater in room 117 and felt cold air blowing out of vents. On 01/30/23 at 04:11 PM during an interview with Nursing Home Administrator (NHA) "A" He reported the facility had 2 heating systems and one of the systems went out last Friday (1/27/23) in which a heating and cooling company was called out and fixed Friday. NHA "A" stated he was not made aware of current issue on Monroe (100) hall until after this surveyor spoke with Maintenance Director "E" this morning. On 1/31/23 at 7:50 am, the beauty shop (located on the Monroe unit) was observed to have a large tube coming through the window to deliver heat. The tubing was observed to extend to the length of the beauty shop and the door to the beauty shop was observed closed. On 01/31/23 at 08:02 AM, room rounds with done with Maintenance Director "E", he acknowledge the 100 hall was still cold and there was an additional heating company that would be delivering additional tubing today to extend to hall on first floor/Monroe unit. Room temperatures were taken by Maintenance Director "E" during the rounds on 1/31, findings : Room 115 68 degrees Fahrenheit Room 117 69.8 degrees Fahrenheit			

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	Room 123 66.9 degrees Fahrenheit Room 125 64.5 degrees Fahrenheit Room 213 64 degrees Fahrenheit Room 218 65.4 degrees, Resident 1 (R1) was observed sitting on the edge of her bed eating breakfast, R1 was wrapped in blankets and wearing a winter hat. R1 was voiced how cold and angry she was about the situation, accused staff of giving false information about room temperatures "They always tell me its 68 degrees, I keep my house at 68 and I don't have to wear a hat and gloves at my house. This is unacceptable, I am leaving here today!" Of note, R1 was discharged home the following day. According to the National Weather services temperatures for Ann Arbor Michigan were a low of 20 degrees Fahrenheit on 1/27, 22 degrees Fahrenheit on 1/28, 1/29 27 degrees Fahrenheit, 1/30 19 degrees, and on 1/31 negative 3 degrees Fahrenheit. Resident #1 (R1) Review of the medical record revealed R1 was admitted to the facility 12/7/2022 with diagnoses that include hypothyroidism (low thyroid levels), type 2 diabetes, chronic obstructive pulmonary disease (COPD) and Gout (increased uric acid deposits in bone joints). The most recent Minimum Data Set (MDS), with an Assessment Reference Date			

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(ARD) of 12/23/2022, revealed R1 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognitive response) out of 15.

During observation and interview 01/20/2023 at 09:27 a.m. R1 , in their room was observed lying in bed. She was observed to be covered with a bath robe and two blankets. R1 explained that she was requesting to be discharged today because she was tired of being frozen while in her room. The thermostat in the room demonstrated a temperature in the room as 76 degrees Fahrenheit. R1 explained stated, "there is no way it is 76 degrees in this room". The room felt cold to this surveyor as well.

During observation and interview on 01/20/2021 at 10:26 a.m. Maintenance Director "E" was observed taking a temperature with a facility infrared thermometer, at which time demonstrated a temperature of 68.9 degrees Fahrenheit in R1's room. Maintenance Director "E" explained that someone was working on the heating system currently.

Resident #39 (R39)

Review of the medical record revealed R39 was admitted to the facility 5/7/2021 with diagnoses that include chronic kidney disease, rhabdomyolysis (breakdown of muscle tissue), spinal stenosis, osteoarthritis, congestive heart failure (CHF), dorsalgia (back pain), and iron deficient anemia (low

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iron in blood). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/12/2022, revealed R39 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognitive response) out of 15.

During observation and interview on 01/20/2023 at 09:55 a.m. R39, in their room, was observed lying in bed. R39 was observed to have gloves on both hands and was wrapped in several blankets. R39 stated, "I'm freezing". She explained that the room had been freezing all weekend. The room thermostat was observed to read 78 degrees Fahrenheit. The room felt cold to this surveyor as well.

During observation and interview on 01/20/2021 at 10:25 a.m. Maintenance Director "E" was observed taking a temperature with a facility infrared thermometer, at which time demonstrated a temperature of 67.8 degrees Fahrenheit in R39's room. Maintenance Director "E" explained that someone was working on the heating system currently.

Resident #268

Resident # 268 (R268) was admitted to facility 1/19/23 with diagnoses including peritonitis, Crohn's disease, pneumonia, systemic lupus erythematosus, muscle weakness and anxiety disorder. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

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	1/25/23 reflected Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section G of MDS revealed that R268 required two-person limited assist with bed mobility, two-person extensive assist with transfers and toilet use, one-person extensive assist with dressing, and set up assist with eating. Section H of same MDS reflected that R268 was receiving IV (intravenous) medications. In an observation and interview on 1/30/23 at 10:39 AM, R268 was observed laying in bed in facility gown with numerous blankets, including personal bed spread, noted to be covering her and tucked up to her neck. R268 stated that her room had been cold since her admission the prior week, staff including maintenance had been notified, and that maintenance tried covering the vent on the ceiling, stating that it may have helped some but nothing meaningful and that the covering that had been placed to the ceiling vent had since been removed. R268 Stated that she was always cold even with numerous blankets and that the staff tried to provide extra blankets but that they just became heavy and made it harder to move. R268's interview was conducted at bedside where cool air could be felt coming from the vent, on the ceiling, above the bed. Upon exiting room, R268 stated "please leave the door open so maybe I'll get a little heat from the hall". In an interview on 1/30/23 at 2:33 PM,			

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	Maintenance Director "E" stated that he had checked the room temperature in room 137-2 approximately one hour prior and stated that the room temperature was noted to range from 69 to 71 degrees Fahrenheit depending on where he stood in the room. Maintenance Director "E" further stated that "the end rooms on each hall are going to be our cooler rooms" which included room 137-2 located at the end of Madison Hall. Maintenance Director "E" offered no further explanation as to the ongoing cool room temperature in 137-2.			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the	F0609	Resident #8 continues to reside in the facility, feels safe in the facility, and participates in facility life. 2. Residents currently residing in the facility have potential to be affected, residents in the facility interviewed, no other issues noted. 3. RCC/Designee will provide re-education to Nursing Home Administrator on facilities Abuse Prohibition Policy, by alleged compliance date, on state reporting requirements. Administrator/Designee will re-educate all staff, by alleged date of compliance, on the facility policy on Abuse Prohibition Policy including reporting of injury of unknown origin to Nursing Home Administrator and DON immediately. 4. Don/Designee will randomly audit 5 residents charts 1x/weekly for 4 weeks and then 1x/Monthly for 3 months, to ensure that no potential injuries of unknown origin did not go unreported to the Administrator/DON and	3/2/2023

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	State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake M100134151 Based on observation, interview, and record review, the facility failed to timely identify, investigate, and report an injury of unknown origin to the Nursing Home Administrator, and failed to report the injury of unknown origin to the State Agency for 1 (resident # 8) of 2 residents reviewed for abuse resulting in delayed investigation, identification, and treatment of a fracture and the potential for further injuries of unknown origin to go unreported. Findings include: Resident # 8 (R8) initially admitted to facility 8/4/2021 with most recent facility readmission 1/11/23 with diagnoses including COVID-19, unspecified fracture of left femur, muscle weakness, unspecified atrial fibrillation, embolism and thrombosis of arteries of the upper extremities, and cognitive communication deficit. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/23 revealed that R8 had unclear speech, was usually understood and understands, and that a Brief Interview for Mental Status was		investigated/ reported to state agency timely. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	not conducted. Staff assessment for mental status revealed short and long-term memory impairment and severely impaired cognitive skills for daily decision making. Section G of MDS revealed that R8 required two-person extensive assistance with bed mobility, personal hygiene, and toilet use; two-person total dependence with transfers; one-person extensive assistance with dressing; and set up assistance with eating. Review of the Discharge MDS dated 1/4/23, revealed that R8 had an unplanned discharge to an acute care hospital and that her return to the facility was anticipated. On 1/31/23 at 1:21 PM, R8 was observed sitting in wheelchair with meal tray positioned in front of her on over the bed table. R8 was dressed in personal clothing, well-groomed, and was noted to have consumed lunch meal with exception of rice. R8 denied pain "right now" but stated "I have pain in my legs" at which time resident was noted to point at left leg and began to rub left thigh with left hand. Irregular shaped fading purple bruise noted to dorsal left hand with R8 acknowledging stating "they took my blood there". R8 recalled recent hospitalization for "my left leg pain" but denied injury or surgery to extremity. Review of R8's medical record complete with the following findings noted: Nurses Note dated 12/27/2022 at 1:47 PM, stated "Writer informed Dr. (Doctor) of			

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	bruising and warmth to left upper thigh area. Patient denies pain/discomfort at this time. Dr. ordered venous ultrasound to LLE (left lower extremity) STAT (immediately) ..." No further assessment information noted within chart regarding size and color of bruise or range of motion of left lower extremity at time of identification with no additional entries on 12/27/2022 reflecting resident status or presentation of left lower extremity. Nurses Note dated 12/28/2022 at 8:33 AM, stated "Pt (patient) tested positive for covid 12/28/22. MD (Medical Doctor) notified and family member notified. Upon assessing pt and obtaining vital signs pt had a non productive cough and temp (temperature) ..." No documentation contained within note regarding assessment of left lower extremity. Venous Doppler with 12/28/22 1:05 PM examination date and 12/28/22 5:27 PM reported date, indicated "CONCLUSION: No evidence of deep venous thrombosis in the left lower extremity." No Nurses Note entry noted to be placed on 12/29/22. Nurses Note dated 12/30/2022 4:33 PM, stated "Message left for (name of family) to call facility. Call was placed to inform of patient's refusal to get out of bed today. Patient stated she would get out of bed			

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	"tomorrow." No documentation contained within note regarding assessment of left lower extremity. Nurses Note dated 12/30/2022 at 11:03 PM, stated "writer spoke to Dr. about hematoma/bruise left posterior leg and pain 1st reported on 12/27 continues to bother patient. He ordered to discontinue Eliquis." No additional documentation contained within note regarding characteristics (size and color) of the hematoma/bruise to left leg, range of motion assessment to extremity, or pain assessment. Skin/Wound Progress Note dated 1/2/2023 at 4:17 PM, stated "Cena (Certified Nurse Aide) (name of staff) raised concern over swelling and diffuse stages of bruising noted to lle (left lower extremity), vascular studies done and results negative for DVT (Deep Vein Thrombosis). Reassurance given to res. (resident) test results are negative." No additional documentation contained within note regarding characteristics (size and color) of the hematoma/bruise to left leg, range of motion assessment to extremity, or pain assessment. Physician Note dated 1/4/2023 at 8:55 AM, stated " ...History of present illness: Currently lying in bed and complains of left leg/thigh pain. Left thigh is swollen and also painful to move ...ASSESSMENT AND PLAN Left thigh pain and swelling. No reported trauma. Could be spontaneous hematoma. Eliquis is on			

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	hold. Considering worsening pain, will send her to hospital for further evaluation ..." Nurses Note dated 1/4/2023 at 9:45 AM, stated "MD (Medical Doctor) notified of increased discoloration to LLE. Pt (patient) not currently on Eliquis. MD examined pt. Per MD: send pt to hospital for evaluation and tx (treatment) of spontaneous hematoma without trauma." Review of notes titled "Skilled Care Note - COVID - 19" dated 12/29/22, 12/30/22, 12/31/22, 1/2/23, 1/3/23, and 1/4/23 reflected no documentation which pertained to the assessment or monitoring of left lower extremity, range of motion, pain, or size and shape of the bruising. Hospital History and Physical dated 1/4/2023 indicated "Pt (patient) has bruising (yellowish-purple) to left lateral calf with knee swelling ...Pt complaining of pain to area, unknown if injury occurred as pt cannot give detailed description." CT (computerized tomography) scan results contained within same document reflected "MUSCULOSKELETAL FINDINGS: There is a spiral fracture of the mid left femoral diaphysis. There is approximately three cm (centimeters) of medial displacement of the distal fracture fragment ..." Review of Medication Administration Record (MAR) dated 12/1/2022-12/31/2022 and 1/2/2023-1/31/2023 complete with an as			

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	needed dose of oxycodone (a strong opioid used medically for treatment of moderate to severe pain) noted to be administered x 1 on 12/1, 12/2, 12/5, 12/6, 12/7, 12/9, 12/11, 12/12, 12/16, 12/19, 12/21, 12/22, 12/24, 12/25, 12/27 with an increase frequency of administration noted to start on 12/30/22 as an as needed dose of oxycodone noted to be administered x 3 on 12/30, x 1 on 12/31, x 2 on 1/1/23, x 2 on 1/2/23, x 3 on 1/3/23 and x 1 on 1/4/23 prior to R8's hospital transfer. Comprehensive review of R8's medical record reflected that left thigh alteration identified on 12/27/2022 with physician notification on same date with no follow up assessment, documentation, or physician notification of left lower extremity status until 12/30/22, despite completion of negative left lower extremity venous doppler on 1/28/22, at which time physician order received for discontinuation of Eliquis. Further review reflected no documented assessment of left lower extremity status on 12/31/22, 1/1/23, and 1/3/23 with documentation contained within 1/2/23 Skin/Wound Progress Note indicating "swelling and diffuse stages of bruising noted to lle (left lower extremity)" with no follow-up physician notification despite reported ongoing pain with increased frequency of as needed oxycodone usage. Furthermore, no physician assessment complete from the time the alteration was initially identified on 12/27/22 until 1/4/23 at which time R8 was transferred to the Emergency Room with CT indicative of "spiral			

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fracture of the mid left femoral diaphysis".

In a telephone interview on 2/06/23 at 9:33 AM, Licensed Practical Nurse (LPN) "T" stated that from what she could recall, R8 was transferred to the second floor on 12/27/22 as prior roommate had tested positive for COVID. LPN "T" stated that upon R8's arrival to unit, was notified by assigned CNA that R8's left thigh was swollen. Per LPN "T", upon completion of assessment, noted swelling to left thigh and a bruise to middle aspect of left inner thigh which presented yellowish/blue to purple in color, irregular shaped and that area was inflamed and warm to touch. LPN "T" stated that R8 denied pain, known injury or fall and upon physician notification of leg presentation received orders for doppler of left lower extremity and labs. LPN "T" stated that her assessment led her to believe alteration was vascular in nature, denied that assessment included movement or range of motion of the left lower extremity, and did not even consider the need for an x ray. LPN "T" stated that she had not received report regarding any concerns to R8's left lower extremity and that to her knowledge, was the first to identify this change in status. LPN "T" confirmed that she was not aware of how the bruise to left thigh happened and stated that she did not report this injury of unknown origin to the Nursing Home Administrator.

In a telephone interview on 2/6/23 at 9:35 AM, nurses note dated 12/28/22 8:33 AM reviewed with LPN "W" with LPN

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acknowledging completion. LPN "W" stated that she worked part time at the facility and floated throughout the building but from what she could recall, did not receive anything in shift report regarding acute changes in R8's status involving her left lower extremity. LPN "W" further stated that, from what she could recall, a respiratory assessment was complete based on R8's symptoms and that she tested positive for COVID. Per LPN "W", a skin assessment or a head-to-toe assessment was not completed and she did not recall the CNA reporting that R8 had any pain or skin alterations. LPN "W" stated, "whatever assessment I did, was what was documented".

In an interview on 2/02/23 at 2:30 PM, LPN "G" stated that she was a Unit Manager and therefore assisted in the oversight of all residents in the building. LPN "G" confirmed that on 12/30/22 she had worked as a nurse on the floor and was the nurse assigned to R8 from 7:00 AM to 7:30 PM. LPN "G" reviewed the 12/30/22 4:33 PM nurses note entry that she had completed regarding R8's refusal to get out of bed but stated that she did not complete a resident assessment or assess left lower extremity on the 12/30/22 shift. LPN "G" stated that she was unaware that R8 had concerns with her left leg or that a doppler had been completed previously as did not receive this information in shift report. LPN "G" stated that assigned CNA did not report any concerns regarding pain or alterations in skin status on 12/30/22 but

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	noted that at 1:17 PM she had administered an as needed dose of oxycodone for indication of "leg pain" but did not recall specific location of reported pain. LPN "G" further stated that R8 may have had tearful episodes during the shift and that these were indications of pain for her. In a telephone interview on 2/02/23 at 12:09 PM, LPN "I" confirmed familiarity with R8 and that she was the assigned nurse on 1/2/23 and 1/3/23 from 7:00 AM to 7:30 PM. LPN "I" stated that she was informed in shift report from prior nurse on both dates that R8 was experiencing ongoing pain despite negative doppler results. LPN "I" also stated that assigned CNA, on both dates, had informed her of R8's ongoing pain, most notably with movement of left leg. LPN "I" stated that she witnessed R8 to be "crying out in pain" and that as needed oxycodone had been administered on both dates for a pain level as high as "9". LPN "U" stated that as R8 was in an even numbered room (132), routine COVID assessment/documentation was assigned to night shift and therefore she did not complete. Although LPN "U" acknowledged resident to be in distress, denied completion of any resident assessment including that of the left lower extremity. LPN "U" stated that she tried to contact physician via phone once on 1/3/23 without success and that no follow up attempt was complete. In an interview on 2/02/23 at 3:12 PM,			

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	Certified Nurse Aide (CNA) "Q" confirmed familiarity with R8 and stated that had frequently been assigned to her for the approximate 4-5 months that had been employed at facility. CNA "Q" stated that sometime after Christmas (was unable to provide a more specific time frame), R8 was noted to require more assist with incontinency care and bed mobility as would cry out in pain with movement of the left leg. CNA "Q" also stated that he noted a small purple bruise (which he estimated to be about the size of a quarter) at the middle of the inner thigh region and that he reported both the increase in pain and the bruise to Licensed Practical Nurse (LPN) "U". CNA "Q" further stated that upon the start of shift on 1/2/23, as R8 was still painful and crying out when care was provided, was concerned and informed Registered Nurse (RN) "S". CNA "Q" stated that RN "S" assisted with incontinency care and repositioning of R8 and that he noted ongoing bruising to left thigh region now, from what he could recall, presented as a small area of yellow/purple fading discoloration about the same quarter size. In an interview on 2/02/23 at 2:12 PM, Registered Nurse (RN) "S" stated that she was not assigned to R8 or following resident for wound management but assisted CNA "Q" with resident care on 1/2/23 and assessed left leg. RN "S" stated that R8 was in bed and upon assisting CNA "Q" with incontinency care, noted irregular shaped fading purple discoloration at left inner mid-thigh no			

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	bigger than 5cm (centimeters) and greenish discoloration just below knee which presented as a fading bruise. Per RN "S", R8 was smiling and interacting with CNA "Q" during care, was not sensitive to touch and that no swelling was noted to left thigh or knee. RN "S" stated that as resident had recently been diagnosed with COVID, thought that the discoloration was circulation related, reviewed chart, confirmed that dopplers had been complete and were negative. RN "S" that she had not seen bruising at R8's left leg prior and that she did not report bruising to the Nursing Home Administrator. In a telephone interview on 2/06/23 at 8:45 AM, LPN "U" confirmed familiarity with R8 and that she was the assigned nurse on 12/29/22, 12/30/23, 1/2/23, and 1/3/23 from 7:00 PM to 7:30 AM. LPN "U" stated that on 12/29/22 she did not receive information in shift report regarding concerns with R8's left lower extremity or that a doppler had recently been complete. Per LPN "U", a focused COVID assessment was complete that included a respiratory assessment but that an assessment of R8's left lower extremity was not completed as stated that she did not assist the assigned CNA with resident care that night and received no concerns from the CNA regarding pain or skin presentation. During same interview, LPN "U" stated that 12/30/22 shift report did not include any			

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	concerns with R8's left lower extremity, but that CNA "Q" notified her of discoloration and pain to left upper leg. Nurses Note dated 12/30/22 at 11:03 PM reviewed with LPN "U" which included "writer spoke to Dr. about hematoma/bruise left posterior leg and pain 1st reported on 12/27 continues to bother patient ..." with LPN confirming to have completed. Per LPN "U", upon notification of alteration by CNA, assessment complete with approximate half dollar size red and purple hematoma noted at posterior left upper thigh region. LPN "U" denied inflammation at site and to surrounding area stating that surrounding skin was within normal limits. Per LPN "U", range of motion was not attempted as was using caution as R8 was not able to move extremity without being in pain. Per LPN "U", R8 was noted to have "moderate to severe" pain in left lower extremity and as R8 had an existing order for as needed oxycodone, administered a dose, which LPN "U" stated was unusual as R8 had not been previously noted to require oxycodone for pain management on the night shifts that she had worked. LPN "U" stated that she proceeded to review R8's medical record, noted that the alteration was first identified 12/27/22 and that the dopplers were negative. LPN "U" stated that upon physician notification of the hematoma presentation and ongoing pain, order received to discontinue Eliquis. Per LPN "U", physician was questioned if additional order changes were desired or if Emergency Room evaluation was warranted but that physician			

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	declined need as did not believe anything additional would be done. LPN "U" stated that she did not request additional testing, including a X Ray, from physician as had seen the negative doppler and did not make the connection that a fracture may be present. LPN "U" stated that 12/30/22 was the first date that she had assessed R8's left lower extremity and saw the bruising and confirmed that she was unaware of how the injury was obtained but that she did not report the bruise of unknown origin to the Nursing Home Administrator. During the same interview, LPN "U" confirmed that she was the nurse assigned to R8 on 1/2/23 and 1/3/23 from 7:00 PM to 7:30 AM. LPN "U" confirmed that she completed and documented COVID assessments for these dates. Per LPN "U", on both 1/2/23 and 1/3/23, R8's left thigh presented much the same as on 12/30/22 as was noted to have same hematoma with no additional discoloration or inflammation. LPN "U" stated that R8 was noted to have "severe pain" on both days and that movement of R8's left leg was minimized as "movement of lower extremity was so painful for her". LPN "U" stated that assessment of left lower extremity was not documented on 1/2/23 or 1/3/23 and that physician was not contacted as stated that it would have been her preference to send R8 to the Emergency Room on 12/30/22 but as physician declined, did not follow up again. LPN "U" stated that although assessment was not documented,			

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	left lower extremity assessment information was passed onto day shift nurse through report in the morning of 1/4/23. LPN "U" confirmed that she did not report R8's bruising and associated pain to the Nursing Home Administrator on either her 1/2/23 or 1/3/23 shifts. In an interview on 2/02/23 at 3:07 PM, LPN "O" confirmed that on the morning of 1/4/23 she had received in shift report that the bruising at R8's left posterior thigh was extending anteriorly and that severe pain in the same extremity was ongoing. LPN "O" stated that she did not complete resident assessment on 1/4/23 and had never seen left lower extremity alteration as floated to various units and was not the assigned nurse when a skin assessment was due. LPN "O" stated that as the physician was at the facility in the morning of 1/4/23, she provided him with the assessment information that she had been provided in shift report and that the physician proceeded to assess resident and provided orders for R8's Emergency Room transfer. LPN "O" confirmed that although she notified R8's physician, she did not provide Nursing Home Administrator with a report of R8's worsening left leg bruising and pain. In an interview on 2/06/23 at 10:30 AM, Nursing Home Administrator (NHA) "A" initially stated that he was notified of R8's bruise on 12/27/22 but upon review of his records, stated that he had been notified on			

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	1/5/23 by DON "B" after she was notified by the Hospital regarding the identified left femur fracture. NHA "A" stated that he would have been expected to be notified of R8's bruise on 12/27/22 when it was initially identified so that an investigation could have been initiated, further assessment could be completed, and R8's status could have been discussed at daily interdisciplinary team meeting. Per NHA, it is the expectation that any bruise of unknown origin be reported to the NHA immediately upon identification. During the same interview, NHA "A" confirmed that the State Agency was not notified on 1/5/23 when NHA "A" and DON "B" were notified by the Hospital of R8's bruising and fracture of unknown origin as stated that through follow-up investigations that the bruising and fracture correlated with the 12/24/22 and 12/25/22 1-person mechanical lift transfer although no injury was reported to have occurred with these transfers. NHA "A" further stated that when he contacted the Hospital on 1/5/23, was informed by hospital staff that R8 reported that left leg injury occurred during a transfer, but that facility staff did not speak directly with resident at that time. NHA "A" offered no response when questioned as to why a resident injury resulting from the facilities failure to follow the plan of care was not immediately reported to the State Agency. In an interview on 2/06/23 at 11:42 AM, Director of Nursing (DON) "B" stated that she			

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	would have expected that a comprehensive assessment be completed with any change in resident condition and that follow up assessment and documentation of resident status be completed thereafter. Per DON "B", would have expected to see descriptive documentation of any skin alteration including color, size, and shape of alteration as well as a corresponding assessment of surrounding tissue, extremity range of motion, and signs and symptoms of pain as well as physician follow-up for any ongoing symptoms. DON "B" stated that it would have been the expectation that R8's bruise was reported upon initial identification on 12/27/22 and that facility staff will report to herself or another manager, if not directly to abuse coordinator/Nursing Home Administrator and that the management team would then immediately report to the Nursing Home Administrator. Review of the facility policy titled "Abuse Prohibition Policy" with 9/9/2022 revision date, indicated " ...Definitions: Injuries of unknown source - An injury should be classified as an "injury of unknown source" when ALL of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the guest/resident; and the injury is suspicious because of the extent of the injury or the location ...Reporting abuse and facility response to the allegation ...1) The staff will report any allegation suspicion of mistreatment ...injuries			

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	of unknown source to the Administrator and DON immediately 2) The Administrator or designee will notify the guest's/resident representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours.). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action ..."			
F0636 SS= D	Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F0636	1. Resident #5 remains in facility in stable condition, no adverse effects noted. 2. Current residents who have annual MDS Assessments scheduled have the potential to be affected and have been reviewed for timely completion. 3. RCRS (Regional Clinical Resource Specialist)/designee to provide education to MDS staff by the alleged date of compliance related to the regulation and completing annual MDS assessment within 14 days of the assessment reference date. 4. DON/designee will audit 5 annual MDS assessments 1x/weekly times 4 weeks and then 1x monthly x 3 months to ensure annual assessments are completed timely within the requirements Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained	3/2/2023

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	regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the timely completion of an annual Minimum Data Set (MDS) assessment for one (Resident #5) of 17 reviewed for MDS, resulting in a late MDS assessment and the potential for further late assessments. Findings include:		compliance	

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	Review of the medical record reflected Resident #5 (R5) admitted to the facility on 8/3/17, with diagnoses that included delusional disorder and insomnia. On 02/01/23 at 02:20 PM, review of R5's MDS history reflected the annual MDS, with an Assessment Reference Date (ARD) of 8/10/22, was completed on 9/3/22. During an interview on 02/06/23 at 01:10 PM, MDS Licensed Practical Nurse (LPN) "FF" reported an annual MDS was to be completed within 14 days after the ARD. LPN "FF" acknowledged R5's annual MDS with an ARD of 8/10/22 was late and was completed on 9/3/22. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October, 2019, "...Annual Assessment...The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days)..."			
F0637 SS= D	Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F0637	1. Resident #13 significant change MDS assessment has been scheduled and completed. No adverse effects noted. 2. Current residents that sustain a decline/improvement in condition have the potential to be affected, have been reviewed and assessments scheduled as indicated. 3. RCRS (Regional Clinical Resource Specialist)/designee to provide education to	3/2/2023

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	interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA) for one (Resident #13) of 17 reviewed for Minimum Data Set (MDS), resulting in the potential for inaccurate Care Plans and unmet needs. Findings include: Review of the medical record reflected Resident #13 (R13) admitted to the facility on 6/20/22, with diagnoses that included urinary tract infection, unspecified hearing loss (bilateral/both sides), unspecified dementia and major depressive disorder. On 01/30/23 at 12:28 PM, R13 was observed seated in a recliner, in her room, with her head down and eyes closed. A meal tray was in front of her with the plate cover still on. The plastic wrapper was still covering her plate with cheesecake. Lids were observed on her beverage cups. The Admission/Medicare 5 day MDS, with an Assessment Reference Date (ARD) of 6/26/22, reflected R13 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview		MDS staff by the alleged date of compliance related to the regulation and completing a significant change MDS assessment when indicated. 4. DON/designee will audit MDS assessments weekly times 4 weeks and then monthly x 3 months to ensure significant change assessments are completed as indicated. Variances will be corrected as indicated. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R13 performed bed mobility, transfers, walking in the room and in the corridor, locomotion on and off the unit, dressing, toilet use and personal hygiene with limited assistance of one person. R13 was independent for eating and required extensive assistance of one person for bathing. There was no coded weight loss or weight gain on the MDS.

The Quarterly MDS, with an ARD of 9/25/22, reflected R13 performed bed mobility, transfers, dressing, toilet use, personal hygiene and bathing with extensive assistance of one person. There was no coded weight loss or weight gain on the MDS.

The Quarterly MDS, with an ARD of 12/22/22, reflected R13 performed bed mobility with extensive assistance of two or more people. Transfers, dressing, toilet use, personal hygiene and bathing were performed with extensive assistance of one person. The same MDS reflected R13 was coded for a weight loss of five percent or more in the last month or loss of ten percent or more in the last six months and was not on a prescribed weight-loss regimen.

In an interview on 02/06/23 at 01:10 PM, MDS Licensed Practical Nurse (LPN) "FF" reported that to her knowledge, a SCSA may have been warranted by dialysis, hospice and being deemed incompetent. LPN "FF"

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	reported that it usually had to be two things to do a significant change or if there was a significant decline. When asked if weight loss was included as a change, LPN "FF" acknowledged that it was but stated it usually went with two things. She reported there had to be weight loss and dehydration or something else to go along with it. When asked if weight loss and a decline in activities of daily living (ADL) abilities could be a significant change, LPN "FF" reported she would have to ask Corporate. On 02/06/23 at 03:24 PM, LPN "FF" reported R13's only change in December (2022) was her weight because they charted her as extensive assistance in September (2022). LPN "FF" stated it would have to be two changes within that period. If someone had a significant change, they had 14 days to watch them, then set the ARD within that 14 days. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October, 2019, "...The SCSA is a comprehensive assessment for a resident that must be completed when the IDT [Interdisciplinary Team] has determined that a resident meets the significant change guidelines for either major improvement or decline...An SCSA is appropriate when...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the			

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	resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and...The resident's condition is not expected to return to baseline within two weeks...Some Guidelines to Assist in Deciding If a Change Is Significant or Not...Decline in two or more of the following...Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning...Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days)..." The same User's Manual reflected, "...The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days)...The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met..."			
F0641 SS= D	Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	F0641	1. Resident #5: The MDS dated 8/10/22 was modified to state that the resident currently considered by state level II PASRR process to have serious mental illness and/or intellectual disability. No adverse effects noted for the resident. 2. Current residents with Level II PASARR that would indicated serious mental	3/2/2023

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	facility failed to ensure the Minimum Data Set (MDS) assessment was coded to accurately reflected the resident's status for one (Resident #5) of 17 reviewed for MDS, resulting for the potential for inaccurate Care Plans and unmet needs. Findings include: Review of the medical record reflected Resident #5 (R5) admitted to the facility on 8/3/17, with diagnoses that included delusional disorder and insomnia. R5's medical record revealed a "PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)" Level I Screening (form DCH-3877), dated 3/14/22, which reflected R5 was marked as having a current diagnosis of mental illness and had received treatment for mental illness. A Comprehensive Level II Evaluation, with a submission date of 3/21/22, was noted in R5's medical record. An attached letter reflected a Level II Evaluation was needed by 3/27/23 if R5 remained in the nursing facility. R5's annual MDS, with an ARD of 8/10/22, revealed question A1500 for, "Preadmission Screening and Resident Review (PASRR)" reflected, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" was marked "No".		illness/intellectual disability have the potential to be affected and most recent MDS assessment reviewed for accuracy. Variances corrected as identified. 3. RCRS (Regional Clinical Resource Specialist)/designee to provide education to MDS staff by the alleged date of compliance on accurate coding of the MDS assessment. 4. The Director of Nursing/designee will randomly audit three 3 MDS assessments 1x/week for 4 weeks and then monthly x 3 months to ensure accurate coding related to residents states level II PASARR status. Variances will be corrected as identified. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance.	

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	814040A	A. BUILDING _____ B. WING _____	**2/6/2023**

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	During an interview on 02/01/23 at 11:17 AM, MDS Licensed Practical Nurse (LPN) "FF" reported she completed the PASARR section of the annual MDS, and there was a coding error. LPN "FF" reported the PASARR question (A1500) should have been answered as "Yes".			
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 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	F0656	1. Resident #36 no longer resides in facility. 2. Current residents at risk for skin breakdown have the potential to be affected. Care plans reviewed updated as indicated. 3. The IDT members who participate in care planning will be re in-serviced by the RCRS/designee by the alleged date of compliance on implementing person centered-comprehensive care plans. Director of Nursing/designee will re-educate licensed nurses, by the alleged date of compliance on implementing person centered-comprehensive care plans. 4. Director of Nursing/Designee will randomly audit 5 residents care plan 1x weekly for 4 weeks and then 1x monthly x 3 months, to assure accuracy and that they are person centered. Variances will be corrected as identified. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	3/2/2023

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	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: Based on observation, interview and record review, the facility failed to develop and implement comprehensive care plans for one (Resident #36) of 17 residents reviewed, resulting in the potential for additional skin breakdown as well as unmet care needs and services. Findings include: Resident # 36 (R36) was initially admitted to facility 12/20/22 with diagnoses including osteomyelitis of vertebra, dysphagia, COVID 19, muscle weakness, age related osteoporosis, type 2 diabetes mellitus, unspecified severe protein-calorie malnutrition, malignant neoplasm of female breast, and malignant neoplasm of esophagus. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/22 revealed that resident was			

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	understood and understands with a Brief Interview for Mental Status (BIMS) score of 14. Section G of MDS revealed that R36 required 2-person extensive assist with bed mobility and toilet use, 2-person limited assist with transfers, 1-person extensive assist with dressing, eating, and personal hygiene. Section H of MDS reflected that R36 was frequently incontinent of bowel and bladder. Section M of MDS indicated that R36 had 1 unstageable pressure injury and was at risk of developing pressure injuries. On 1/30/23 at 11:23 AM, R36 was observed laying in bed positioned toward left side watching television with head of bed at an approximate 45-degree angle. R36 was noted to gripper socks on both feet with heels resting directly on mattress. R36 stated, "I do have a sore on my butt, but it's fine" and did not elaborate further. On 1/31/23 at 9:35 AM, R36 was observed laying in bed, on back, with head of bed at an approximate 45-degree angle. R36's left leg was noted to be extended straight out, right leg was bent at knee, and gripper socks were noted on feet with both heels in direct contact with mattress. On 2/01/23 at 1:00 PM, R36 was observed laying in bed positioned toward left side with head of bead at an approximate 30-degree angle. R36 observed to have bilateral lower extremities extended straight out with both heels in direct contact with mattress.			

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ON 2/01/23 at 1:15 PM, Registered Nurse (RN) "S" was observed to complete R36's wound care in presence of Physician "AA", Nurse Practitioner (NP) "BB ", and Certified Nurse Aide (CNA) "R". Upon completion of wound care, RN "S" and CNA "R" were observed to position R36 toward right side with stuffed bear placed at back as CNA "R" looked in closet verifying no additional pillows in room with RN "S" confirming use of bear for positioning as the only pillow noted in room was beneath R36's head. R36's legs were noted to remain extended straight out with gripper socks on feet and both heels in direct contact with mattress. RN "S" and CNA "R" were then observed to pull blankets up around resident and moved the over the bed table back within R36's reach.

In an interview on 2/1/23 at 1:48 PM, CNA "R" confirmed that she was assigned to R36 since 11:30 AM that date. When questioned regarding R36's care needs, CNA "R" stated that she had completed morning care including incontinency care at approximately 11:45 AM and stated that R36 required one-person extensive assist for incontinency care and dressing with two-person assist for repositioning. CNA "R" stated that she repositioned R36 every 2 hours and generally used pillows to position her off back but denied knowledge of special positioning for legs, feet, or heels as stated, "I personally don't know because this is only the second time, I've worked this hallway."

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On 02/02/23 at 8:26 AM, R36 was observed sleeping in bed positioned toward right side with bilateral legs extended straight out. R36 was noted to have gripper socks in place at bilateral feet with both heels in direct contact with mattress.

In in interview on 2/02/23 at 8:31 AM, Licensed Practical Nurse (LPN) "O" confirmed familiarity with R36 and that she had been R36's nurse from 7:00 AM to 7:30 PM on 2/1/22. LPN "O" confirmed that R36 had a pressure injury at her coccyx stating that she had a specialty mattress and that pillows were used at her back for positioning on side but stated that she couldn't think of any other positioning devices used for R36. When questioned regarding order for "medix boots" and order to "float heels at all times", LPN "O" proceeded to R36's room, looked through two dressers and closet without finding boots stating, "sometimes they are soiled and are sent to laundry". LPN "O" confirmed that although she had signed on the Medication Administration Record that boots were in place on 2/1/23, that she did not recall seeing the boots in R36's room on that date nor did she place the boots on 2/1/23.

In an interview on 2/02/23 at 8:37 AM, RN "S" confirmed that she was the facilities wound nurse and generally completed treatments Monday through Friday with assigned nurse completing on the weekends. RN "S"

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	confirmed that R36's heels were not offloaded upon entering room for wound care on 2/1/23 and confirmed that there were no pillows in room for offloading or positioning of resident. RN "S" confirmed that R36 was at risk for further skin breakdown, had a braden scale that indicated risk, and agreed that the order to offload the heels should be followed. RN "S" stated that she tried to make sure the care plan matched the orders so that there was flow to the Kardex. Upon review of R36's care plan, RN "S" stated that her goal was to update the care plan to reflect the current orders to "elevate both heels in heel medix boots while in bed" and to "Float heels at all times" so that these interventions could be seen by the Certified Nurses Aides on the Kardex for more routine implementation of the interventions. On 2/02/23 at 8:49 AM, LPN "O" was observed to return to unit with boots and enter R36's room. LPN "O" then confirmed that she had placed boots on R36 with R36 noted to have soft black boots in place at bilateral lower extremities with boots observed to position heels off mattress. Review of R36's medical record complete with the following findings noted: Review of "Braden Scale for Predicting Pressure Sore Risk" assessments complete since admission as follows: 12/22/22 Braden score = 16 (At risk for skin breakdown),			

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	12/29/22 Braden score = 12 (High risk for skin breakdown), 1/26/23 Braden score = 16 (At risk for skin breakdown). Order dated 1/17/20/23 stated, "elevate both heels in heel medix boots while in bed" with review of both January and February Medication Administration Record (MAR) complete reflecting same order with each corresponding "12 hr (hour)" box on MAR noted to be signed out as administered for 1/30/23, 1/31/23, and 2/1/23 although R36 was observed multiple times on these dates to be in bed without boots in place. Order dated 1/18/2023 stated, "Float heels at all times" with review of both January and February MAR complete reflecting same order with each corresponding "Day, Evening, and Night" box on MAR noted to be signed out as administered for 1/30/23, 1/31/23, and 2/1/23 although R36 was observed multiple times on these dates to be in bed without heels floated. Review of Care Plan Focus created 12/20/2022 and revised 12/23/22 stated, "(Resident name) is at risk for impaired skin integrity/pressure injury R/T (related to) ..." with Care Plan Intervention to "Encourage to float heels while in bed and assist as needed" with 12/20/22 created date. No Care Plan Intervention noted to correspond to orders to "elevate both heels in heel medix boots while in bed" or "float heels at all times".			

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	Review of Care Plan Focus created 12/21/23 and revised 2/1/23 stated, "(Resident name) has actual impairments to skin integrity r/t (related to) Stage 4 PU (pressure ulcer) to coccyx ..." with no Care Plan Intervention noted to correspond to orders to "elevate both heels in heel medix boots while in bed" or "float heels at all times". Review of the Kardex reflected Care Plan Intervention to "Encourage to float heels while in bed and assist as needed" with no further interventions listed which would guide Certified Nursing Aides to assist in the implementation of the orders to "elevate both heels in heel medix boots while in bed" and "float heels at all times". Review of the facility policy titled "Care Planning" with 6/24/2021 revision dated, stated "Purpose ...Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment ...Procedure ...7) The care plan must be specific, resident centered, individualized and unique to each resident ...It should be oriented toward preventing avoidable declines ...utilize an interdisciplinary approach to include certified nurse aide ...Involve and communicate the needs of the resident with the direct care staff (i.e. (such as)) CNA Kardex ...9) The care plan and resident Kardex will be updated on Admission, Quarterly, Annually and with significant changes. This includes adding new			

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	focuses, goals, and interventions and resolving ones that are no longer applicable ..."			
F0678 SS= G	Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) was performed timely by competent staff and according to standards of practice for one (Resident #60) of one reviewed for death, resulting in delayed CPR and the potential for ineffective CPR efforts and death. Findings include: Review of the medical record reflected Resident #60 (R60) was admitted to the facility on 1/13/23, with diagnoses that included unspecified severe protein-calorie malnutrition, atherosclerosis of coronary artery bypass graft(s) without angina pectoris, hypertension (high blood pressure), kidney transplant status, malignant neoplasm of kidney (except renal pelvis) and acute kidney failure. The Minimum Data Set (MDS) history reflected R60 died in the facility on 1/14/23.	F0678	2. Current residents that are designated a Full code have the potential to be affected. Facility policy on Medical Emergency Management revised on 10/01/2019 has been reviewed and deemed appropriate. Licensed nurses CPR cards reviewed to assure each are current. Variances corrected as identified. 3. DON/Designee will provide re-education to all staff, by alleged date of compliance, on Medical Emergency Management Policy. DON/Designee will re-educate License nursing, by alleged date of compliance, on maintaining current CPR card. 4. DON/Designee will randomly audit resident records 1x/week x 4 weeks and then 1x/month x 3 months to ensure staff call Medical Emergency timely, that qualified staff evaluates situation, initiate□s the appropriate emergency procedure(s) and calls Emergency Services 911. The staff continues to provide care and monitor until the emergency personnel arrive. Don/Designee will audit Licensed Nurses CPR Cards expiration dates 1x/weekly for 4 weeks, then 1x/monthly x 3 months. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	3/2/2023

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	Review of the medical record reflected R60 was a full code (full resuscitation and life sustaining treatment). The Miscellaneous tab of the Electronic Medical Record (EMR) reflected the code status document was effective 1/13/23 and was uploaded to the medical record on 1/17/23. A Progress Note for 1/14/23 at 11:16 AM reflected, "...CNA [Certified Nurse Aide] Trainee was changing resident, resident told trainee that she had difficulty breathing and as resident was on her side she rolled out of bed on to [sic] the floor. trainee [sic] aid came and notified nurse that resident fell to the floor and was non responsive, code blue was called at 10:56a [AM], paramedics was [sic] called at was called [sic] at 10:56a, compressions started at 11:00a, paramedics arrived @ [at] 11:05a took over cpr..." A Progress Note for 1/14/23 at 11:55 AM reflected, "...Paramedics called time of death at 11:40..." A Post Fall Evaluation for a fall date of 1/14/23 at 10:56 AM reflected R60 had a witnessed fall to the floor, while Certified Nurse Aide (CNA) "Z" was present, providing incontinence care. "...What did the guest/resident say they were trying to do just before they fell?" reflected, "Breathe". According to the Evaluation, R60 lost consciousness and became non-responsive. She was lying parallel to the bed, on her right			

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side, with her face towards the wall. The section for re-enactment of the fall reflected that during incontinence care, the CNA rolled R60 onto her side to tuck her brief. R60 stated, "I can't breathe", lost consciousness and rolled out of the bed, onto the floor. Code blue (cardiac/respiratory arrest) was called, and Emergency Medical Services (EMS) were called.

An Incident Report for a fall on 1/14/23 at 11:16 AM reflected R60 was lying on her right side, on the floor, next to the bed. Bloody saliva was noted, and R60 was having difficulty breathing. The immediate action taken reflected, "Attempted to clear airway, 911 called, CPR started."

During a phone interview on 02/02/23 at 08:55 AM, CNA "Z" reported she only cared for R60 that day (1/14/23). CNA "Z" described that as she was changing R60 and doing a complete bed change, it seemed to her like R60 went into cardiac arrest. CNA "Z" then reported she did not know for sure, as she was not a nurse. CNA "Z" described that R60 "launched" onto the floor. CNA "Z" stated she wanted to say R60 landed on her side or maybe even on her face. She looked at R60, then ran to get the nurse immediately.

CNA "Z" reported the incident to Licensed Practical Nurse (LPN) "O". According to CNA "Z", all the nurses in the facility responded, and 911 was called. After that, R60's vital signs were being checked, she was being

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assessed, and CNA "Z" went to call 911. The crash cart and suction were brought to the room, and maybe even the defibrillator, according to CNA "Z".

During an interview on 02/02/23 at 10:50 AM, LPN "O" reported nurses had to have their CPR up to date. Regarding R60, LPN "O" stated it was reported to her that between 10:00 AM and 11:00 AM, the CNA was providing pericare, cleaning R60, turned R60 on her side and was putting on her brief. R60 told the CNA she could not breathe, then went limp and "went out of the bed". When LPN "O" responded to the room, R60 was non-responsive, lying on her side and still had a pulse and was still breathing. LPN "O" could see that it was difficult for R60, as she was using accessory muscles when breathing. LPN "O" called for another nurse and called a code. LPN "O" reported that she turned R60 over, and there was bloody saliva in her mouth, which she had tried to clear. 911 was called, and they were doing compressions when EMS arrived. LPN "O" reported it was difficult to bag R60 (provide breaths via an ambu bag), and stated, "it was fighting".

When LPN "O" responded to R60's room, she had to change R60's position, check her head and check for a pulse. R60 did not have any muscle tone. Except for bloody saliva, LPN "O" did not see any visible injuries to R60. She then stated it could have been bloody mucus that she saw. R60 was "kind of" rolled back on her side in attempt to clear her until

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	they rolled R60 to her back to begin chest compressions. When asked how much time had passed until they had to perform chest compressions, LPN "O" stated maybe two minutes. (According to the Progress Note for 1/14/23 at 11:16 AM, code blue (cardiac/respiratory arrest) was called at 10:56 AM, and chest compressions began at 11:00 AM) LPN "O" reported R60 was still breathing and still had a pulse for that time (two minutes). She stated it looked like R60 wasn't "getting anything". LPN "O" described that R60 was placed on her back, and after about 30 to 40 chest compressions, they tried to use the ambu bag (to deliver breaths). LPN "O" reported they "kind of" kept that pattern until they were tired and switched (with another nurse). She stated Registered Nurse (RN) "DD" took over, then LPN "H" was performing CPR when EMS arrived. LPN "O" reported the automated external defibrillator (AED) was also placed on R60, which had a beeping mechanism to keep pace (for CPR). LPN "O" reported a shock was not advised by the AED. LPN "O" was unable to report a ratio for chest compressions and breaths, reporting the number was escaping her. When asked if they were doing CPR according to a ratio (of compressions to breaths), LPN "O" reported they were doing it with an AED. During a phone interview on 02/06/23 at 11:55 AM, LPN "O" reported that in the			

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	moment (of R60's code), she relied on the AED for timing and count (for CPR). She stated she would not say there were exactly 30 compressions. According to American Heart Association CPR & First Aid Emergency Cardiovascular Care, "...How is CPR Performed? There are two commonly known versions of CPR: 1. For healthcare providers and those trained: conventional CPR using chest compressions and mouth-to-mouth breathing at a ratio of 30:2 compressions-to-breaths..." (https://cpr.heart.org/en/resources/what-is-cpr) During a phone interview on 02/02/23 at 02:03 PM, RN "DD" stated a new CNA reported they were needed in a patient room. When she responded to the room, R60 was on the floor. The crash cart was already there. RN "DD" reported R60 was taking her last breaths when she walked in the room, and she had "pinkish stuff" coming out of her mouth. RN "DD" reported there were a "bunch" of people in the room. RN "DD" denied that she assisted in the code (CPR) for R60. She was going to but was hit in the head, so she ran to the phone to call 911. RN "DD" reported she placed the backboard beneath R60, and LPN "H" and LPN "O" started CPR. She denied being present for CPR but reported CPR was to be administered with 30 chest compressions and two breaths. She reported the AED had been applied, and chest compressions were being			

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delivered. There was no shock advised by the AED. RN "DD" reported they were required to have CPR certification.

During an interview on 02/02/23 at 02:49 PM, LPN "H" reported there was an in-service on CPR a month or two prior, as well as the crash cart and everything in it. She reported CPR certification was required for her job and was to be renewed every two years. LPN "H" described the process for CPR was to tilt the chin and give three breaths. She then stated first, the AED pads were to be applied. She stated they were to listen for when to do breaths, and when it (AED) said to do chest compressions, they used the "beat for 30 seconds", then they repeat. LPN "H" reported each round of CPR was to be delivered by 30 chest compressions and three breaths. LPN "H" reported she recently assisted in a code for a resident. The resident (R60) was on the floor, and the crash cart was in the room. She reported she just got down and started doing compressions. She stated LPN "O" gave three breaths with the ambu bag, and she started doing compressions until they got the AED on. Once the AED was on, they followed the prompts. She reported alternating CPR with LPN "O" until EMS arrived. LPN "H" reported R60 was not breathing and did not have a pulse when she arrived to the room.

LPN "H" reported they could tell the breaths were not going in, "like the air was splattering out" when trying to get air in (give breaths). LPN "H" stated they did not see

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	R60's chest expand (when breaths were delivered). She stated you could tell R60's airway was closed. LPN "H" reported the mask for the ambu bag was on properly and had a good fit. When asked if R60 was on oxygen, LPN "H" could not recall. On 02/02/2023 at 5:23 PM, an email was sent to Nursing Home Administrator (NHA) "A", requesting the most recent CPR certifications for all licensed nurses that were on duty on 1/14/23. An email was received from NHA "A" on 2/3/22 at 6:12 PM, with CPR cards for licensed nurses, in response to the survey request. LPN "H"'s Basic Life Support (BLS) Provider (CPR and AED) certificate was issued 9/2/2020 and was to be renewed by 9/2022 (certificate was expired). An email was received from NHA "A" on 2/4/23 at 8:47 AM with an updated BLS card for LPN "H", with an issue date of 2/2/23. During a phone interview on 02/06/23 at 12:10 PM, LPN "H" reported having CPR training the prior Thursday (2/2/23). She stated her CPR certification had been expired. LPN "H" described CPR administration and reported they would watch for the chest to rise to see if the patient was receiving the breaths. If it appeared the breaths were not being delivered, LPN "H" reported she did not know what she would do and stated she would just continue with CPR until EMS			

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	arrived. According to the American Red Cross CPR Steps, "...Giving CPR...Give 30 chest compressions...Give 2 breaths...Open the airway to a past-neutral position using the head-tilt/chin-lift technique...Ensure each breath lasts about 1 second and makes the chest rise; allow air to exit before giving the next breath Note: If the 1st breath does not cause the chest to rise, retilt the head and ensure a proper seal before giving the 2nd breath If the 2nd breath does not make the chest rise, an object may be blocking the airway...Continue giving sets of 30 chest compressions and 2 breaths. Use an AED as soon as one is available!..." (https://www.redcross.org/take-a-class/cpr/performing-cpr/cpr-steps) During an interview on 02/06/23 at 01:32 PM, Director of Nursing (DON) "B" reported that other than speaking to LPN "O" on the phone the day of R60's code, there had been no discussion with the CPR process (for R60). When they met the prior Thursday (2/2/23), it was identified that some of their practices were incorrect (nurses involved in R60's code). DON "B" conveyed that the answers the nurses provided to the State Agency were incorrect, but they could not necessarily say they were wrong for the code. When queried on what had been identified as incorrect, DON "B" stated that when speaking to LPN "O", she mentioned being asked about the compression ratio, and she was unaware. LPN			

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	"H" said breaths came before compressions. DON "B" acknowledged that LPN "H" had not been current on her CPR certification.			
F0684 SS= G	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: This citation pertains to intake M100134151 Based on observation, interview, and record review, the facility failed to monitor for ongoing/worsening bruising, inflammation, and monitor/treat pain timely; complete physician notification and additional testing for 1 (Resident # 8) of 17 sampled residents reviewed for quality of care resulting in delayed identification and treatment of a fractured femur, and increased pain. Findings include: Resident # 8 (R8) initially admitted to facility 8/4/2021 with most recent facility readmission 1/11/23 with diagnoses including COVID-19, unspecified fracture of left femur, muscle weakness, unspecified	F0684	1. Resident #8 continues to reside in the facility, no other change in condition identified, feels safe in the facility, and participates in facility life. 2. Current residents that develop a change in condition have the potential to be affected. The facility policy on Change in Status, identifying and communication, long term care, revised on 8/19/2022, has been reviewed and deemed appropriate. 3. DON/Designee will provide re-education to Licensed Nurses by the alleged date of compliance on the facility□s policy, Lippincott Procedures: Change in status, identifying and communicating, long term care, including communicating residents□ condition to appropriate practitioner, complete physical assessment and document the procedure/process. DON/designee will provide education to licensed nurses by the alleged date of compliance on: the use of Condition of Change & SBAR Interact Tools; Treatment and care in accordance with Standards of Practice related to changes from baseline and abnormal vital signs. 4. DON/designee will audit nursing documentation of residents with acute illness and changes of condition 5x/week for 4 weeks to ensure compliance and follow up care and treatment provided to residents as indicated. Variances will be corrected as identified and audit results forwarded to NHA weekly for review. Residents with changes of condition and acute illness will be reviewed in the	3/2/2023

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	atrial fibrillation, embolism and thrombosis of arteries of the upper extremities, and cognitive communication deficit. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/23 revealed that R8 had unclear speech, was usually understood and understands, and that a Brief Interview for Mental Status was not conducted. Staff assessment for mental status revealed short and long-term memory impairment and severely impaired cognitive skills for daily decision making. Section G of MDS revealed that R8 required two-person extensive assistance with bed mobility, personal hygiene, and toilet use; two-person total dependence with transfers; one-person extensive assistance with dressing; and set up assistance with eating. Review of the Discharge MDS dated 1/4/23, revealed that R8 had an unplanned discharge to an acute care hospital and that her return to the facility was anticipated. On 1/31/23 at 1:21 PM, R8 was observed sitting in wheelchair with meal tray positioned in front of her on over the bed table. R8 was dressed in personal clothing, well-groomed, and was noted to have consumed lunch meal with exception of rice. R8 denied pain "right now" but stated "I have pain in my legs" at which time resident was noted to point at left leg and began to rub left thigh with left hand. Irregular shaped fading purple bruise noted to dorsal left hand with R8 acknowledging stating "they took my blood there". R8 recalled recent		morning clinical meeting and physician notification verified with review of new orders as warranted. Continued compliance will be monitored through the morning clinical meeting, review of 24-hour report and nursing progress notes, review of new orders and changes of condition, routine record review and the facility□s quality assurance committee. Additional education and monitoring will be initiated for any identified concerns. The Administrator is responsible for sustained compliance	

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	hospitalization for "my left leg pain" but denied injury or surgery to extremity. Review of R8's medical record complete with the following findings noted: Nurses Note dated 12/27/2022 at 1:47 PM, stated "Writer informed Dr. (Doctor) of bruising and warmth to left upper thigh area. Patient denies pain/discomfort at this time. Dr. ordered venous ultrasound to LLE (left lower extremity) STAT (immediately) ..." No further assessment information noted within chart regarding size and color of bruise or range of motion of left lower extremity at time of identification with no additional entries on 12/27/2022 reflecting resident status or presentation of left lower extremity. Nurses Note dated 12/28/2022 at 8:33 AM, stated "Pt (patient) tested positive for covid 12/28/22. MD (Medical Doctor) notified and family member notified. Upon assessing pt and obtaining vital signs pt had a non productive cough and temp (temperature) ..." No documentation contained within note regarding assessment of left lower extremity. Venous Doppler with 12/28/22 1:05 PM examination date and 12/28/22 5:27 PM reported date, indicated "CONCLUSION: No evidence of deep venous thrombosis in the left lower extremity."			

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	No Nurses Note entry noted to be placed on 12/29/22. Nurses Note dated 12/30/2022 4:33 PM, stated "Message left for (name of family) to call facility. Call was placed to inform of patient's refusal to get out of bed today. Patient stated she would get out of bed "tomorrow." No documentation contained within note regarding assessment of left lower extremity. Nurses Note dated 12/30/2022 at 11:03 PM, stated "writer spoke to Dr. about hematoma/bruise left posterior leg and pain 1st reported on 12/27 continues to bother patient. He ordered to discontinue Eliquis." No additional documentation contained within note regarding characteristics (size and color) of the hematoma/bruise to left leg, range of motion assessment to extremity, or pain assessment. Skin/Wound Progress Note dated 1/2/2023 at 4:17 PM, stated "Cena (Certified Nurse Aide) (name of staff) raised concern over swelling and diffuse stages of bruising noted to lle (left lower extremity), vascular studies done and results negative for DVT (Deep Vein Thrombosis). Reassurance given to res. (resident) test results are negative." No additional documentation contained within note regarding characteristics (size and color) of the hematoma/bruise to left leg, range of motion assessment to extremity, or pain assessment.			

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Physician Note dated 1/4/2023 at 8:55 AM, stated " ...History of present illness: Currently lying in bed and complains of left leg/thigh pain. Left thigh is swollen and also painful to move ...ASSESSMENT AND PLAN Left thigh pain and swelling. No reported trauma. Could be spontaneous hematoma. Eliquis is on hold. Considering worsening pain, will send her to hospital for further evaluation ..."

Nurses Note dated 1/4/2023 at 9:45 AM, stated "MD (Medical Doctor) notified of increased discoloration to LLE. Pt (patient) not currently on Eliquis. MD examined pt. Per MD: send pt to hospital for evaluation and tx (treatment) of spontaneous hematoma without trauma."

Review of notes titled "Skilled Care Note - COVID - 19" dated 12/29/22, 12/30/22, 12/31/22, 1/2/23, 1/3/23, and 1/4/23 reflected no documentation which pertained to the assessment or monitoring of left lower extremity, range of motion, pain, or size and shape of the bruising.

Hospital History and Physical dated 1/4/2023 indicated "Pt (patient) has bruising (yellowish-purple) to left lateral calf with knee swelling ...Pt complaining of pain to area, unknown if injury occurred as pt cannot give detailed description." CT (computerized tomography) scan results contained within same document reflected "MUSCULOSKELETAL FINDINGS: There is a

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	spiral fracture of the mid left femoral diaphysis. There is approximately three cm (centimeters) of medial displacement of the distal fracture fragment ..." Review of Medication Administration Record (MAR) dated 12/1/2022-12/31/2022 and 1/2/2023-1/31/2023 complete with an as needed dose of oxycodone (a strong opioid used medically for treatment of moderate to severe pain) noted to be administered x 1 on 12/1, 12/2, 12/5, 12/6, 12/7, 12/9, 12/11, 12/12, 12/16, 12/19, 12/21, 12/22, 12/24, 12/25, 12/27 with an increase frequency of administration noted to start on 12/30/22 as an as needed dose of oxycodone noted to be administered x 3 on 12/30, x 1 on 12/31, x 2 on 1/1/23, x 2 on 1/2/23, x 3 on 1/3/23 and x 1 on 1/4/23 prior to R8's hospital transfer. Comprehensive review of R8's medical record reflected that left thigh alteration identified on 12/27/2022 with physician notification on same date with no follow up assessment, documentation, or physician notification of left lower extremity status until 12/30/22, despite completion of negative left lower extremity venous doppler on 1/28/22, at which time physician order received for discontinuation of Eliquis. Further review reflected no documented assessment of left lower extremity status on 12/31/22, 1/1/23, and 1/3/23 with documentation contained within 1/2/23 Skin/Wound Progress Note indicating "swelling and diffuse stages of bruising noted to lle (left lower extremity)"			

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	with no follow-up physician notification despite reported ongoing pain with increased frequency of as needed oxycodone usage. Furthermore, no physician assessment complete from the time the alteration was initially identified on 12/27/22 until 1/4/23 at which time R8 was transferred to the Emergency Room with CT indicative of "spiral fracture of the mid left femoral diaphysis". In a telephone interview on 2/06/23 at 9:33 AM, Licensed Practical Nurse (LPN) "T" stated that from what she could recall, R8 was transferred to the second floor on 12/27/22 as prior roommate had tested positive for COVID. LPN "T" stated that upon R8's arrival to unit, was notified by assigned CNA that R8's left thigh was swollen. Per LPN "T", upon completion of assessment, noted swelling to left thigh and a bruise to middle aspect of left inner thigh which presented yellowish/blue to purple in color, irregular shaped and that area was inflamed and warm to touch. LPN "T" stated that R8 denied pain, known injury or fall and upon physician notification of leg presentation received orders for doppler of left lower extremity and labs. LPN "T" stated that her assessment led her to believe alteration was vascular in nature, denied that assessment included movement or range of motion of the left lower extremity, and did not even consider the need for an x ray. LPN "T" stated that she had not received report regarding any concerns to R8's left lower extremity and that to her knowledge, was the first to identify this change in status.			

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In a telephone interview on 2/6/23 at 9:35 AM, nurses note dated 12/28/22 8:33 AM reviewed with LPN "W" with LPN acknowledging completion. LPN "W" stated that she worked part time at the facility and floated throughout the building but from what she could recall, did not receive anything in shift report regarding acute changes in R8's status involving her left lower extremity. LPN "W" further stated that, from what she could recall, a respiratory assessment was complete based on R8's symptoms and that she tested positive for COVID. Per LPN "W", a skin assessment or a head-to-toe assessment was not completed and she did not recall the CNA reporting that R8 had any pain or skin alterations. LPN "W" stated, "whatever assessment I did, was what was documented".

In an interview on 2/02/23 at 2:30 PM, LPN "G" stated that she was a Unit Manager and therefore assisted in the oversight of all residents in the building. LPN "G" confirmed that on 12/30/22 she had worked as a nurse on the floor and was the nurse assigned to R8 from 7:00 AM to 7:30 PM. LPN "G" reviewed the 12/30/22 4:33 PM nurses note entry that she had completed regarding R8's refusal to get out of bed but stated that she did not complete a resident assessment or assess left lower extremity on the 12/30/22 shift. LPN "G" stated that she was unaware that R8 had concerns with her left leg or that a doppler had been completed previously as

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REGENCY AT BLUFFS PARK	355 HURON VIEW BLVD ANN ARBOR, MI 48103

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	did not receive this information in shift report. LPN "G" stated that assigned CNA did not report any concerns regarding pain or alterations in skin status on 12/30/22 but noted that at 1:17 PM she had administered an as needed dose of oxycodone for indication of "leg pain" but did not recall specific location of reported pain. LPN "G" further stated that R8 may have had tearful episodes during the shift and that these were indications of pain for her. In a telephone interview on 2/02/23 at 12:09 PM, LPN "I" confirmed familiarity with R8 and that she was the assigned nurse on 1/2/23 and 1/3/23 from 7:00 AM to 7:30 PM. LPN "I" stated that she was informed in shift report from prior nurse on both dates that R8 was experiencing ongoing pain despite negative doppler results. LPN "I" also stated that assigned CNA, on both dates, had informed her of R8's ongoing pain, most notably with movement of left leg. LPN "I" stated that she witnessed R8 to be "crying out in pain" and that as needed oxycodone had been administered on both dates for a pain level as high as "9". LPN "U" stated that as R8 was in an even numbered room (132), routine COVID assessment/documentation was assigned to night shift and therefore she did not complete. Although LPN "U" acknowledged resident to be in distress, denied completion of any resident assessment including that of the left lower extremity. LPN "U" stated that she tried to contact physician via phone once on 1/3/23			

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	without success and that no follow up attempt was complete. In an interview on 2/02/23 at 3:12 PM, Certified Nurse Aide (CNA) "Q" confirmed familiarity with R8 and stated that had frequently been assigned to her for the approximate 4-5 months that had been employed at facility. CNA "Q" stated that sometime after Christmas (was unable to provide a more specific time frame), R8 was noted to require more assist with incontinency care and bed mobility as would cry out in pain with movement of the left leg. CNA "Q" also stated that he noted a small purple bruise (which he estimated to be about the size of a quarter) at the middle of the inner thigh region and that he reported both the increase in pain and the bruise to Licensed Practical Nurse (LPN) "U". CNA "Q" further stated that upon the start of shift on 1/2/23, as R8 was still painful and crying out when care was provided, was concerned and informed Registered Nurse (RN) "S". CNA "Q" stated that RN "S" assisted with incontinency care and repositioning of R8 and that he noted ongoing bruising to left thigh region now, from what he could recall, presented as a small area of yellow/purple fading discoloration about the same quarter size. In a telephone interview on 2/06/23 at 8:45 AM, LPN "U" confirmed familiarity with R8 and that she was the assigned nurse on 12/29/22, 12/30/23, 1/2/23, and 1/3/23 from 7:00 PM to 7:30 AM. LPN "U" stated that on			

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	12/29/22 she did not receive information in shift report regarding concerns with R8's left lower extremity or that a doppler had recently been complete. Per LPN "U", a focused COVID assessment was complete that included a respiratory assessment but that an assessment of R8's left lower extremity was not completed as stated that she did not assist the assigned CNA with resident care that night and received no concerns from the CNA regarding pain or skin presentation. During same interview, LPN "U" stated that 12/30/22 shift report did not include any concerns with R8's left lower extremity, but that CNA "Q" notified her of discoloration and pain to left upper leg. Nurses Note dated 12/30/22 at 11:03 PM reviewed with LPN "U" which included "writer spoke to Dr. about hematoma/bruise left posterior leg and pain 1st reported on 12/27 continues to bother patient ..." with LPN confirming to have completed. Per LPN "U", upon notification of alteration by CNA, assessment complete with approximate half dollar size red and purple hematoma noted at posterior left upper thigh region. LPN "U" denied inflammation at site and to surrounding area stating that surrounding skin was within normal limits. Per LPN "U", range of motion was not attempted as was using caution as R8 was not able to move extremity without being in pain. Per LPN "U", R8 was noted to have "moderate to severe" pain in left lower extremity and as R8 had an existing order for			

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	as needed oxycodone, administered a dose, which LPN "U" stated was unusual as R8 had not been previously noted to require oxycodone for pain management on the night shifts that she had worked. LPN "U" stated that she proceeded to review R8's medical record, noted that the alteration was first identified 12/27/22 and that the dopplers were negative. LPN "U" stated that upon physician notification of the hematoma presentation and ongoing pain, order received to discontinue Eliquis. Per LPN "U", physician was questioned if additional order changes were desired or if Emergency Room evaluation was warranted but that physician declined need as did not believe anything additional would be done. LPN "U" stated that she did not request additional testing, including a X Ray, from physician as had seen the negative doppler and did not make the connection that a fracture may be present. During the same interview, LPN "U" confirmed that she was the nurse assigned to R8 on 1/2/23 and 1/3/23 from 7:00 PM to 7:30 AM. LPN "U" confirmed that she completed and documented COVID assessments for these dates. Per LPN "U", on both 1/2/23 and 1/3/23, R8's left thigh presented much the same as on 12/30/22 as was noted to have same hematoma with no additional discoloration or inflammation. LPN "U" stated that R8 was noted to have "severe pain" on both days and that movement of R8's left leg was minimized as "movement of lower extremity was so painful for her". LPN			

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"U" stated that assessment of left lower extremity was not documented on 1/2/23 or 1/3/23 and that physician was not contacted as stated that it would have been her preference to send R8 to the Emergency Room on 12/30/22 but as physician declined, did not follow up again. LPN "U" stated that although assessment was not documented, left lower extremity assessment information was passed onto day shift nurse through report in the morning of 1/4/23.

In an interview on 2/02/23 at 3:07 PM, LPN "O" confirmed that on the morning of 1/4/23 she had received in shift report that the bruising at R8's left posterior thigh was extending anteriorly and that severe pain in the same extremity was ongoing. LPN "O" stated that she did not complete resident assessment on 1/4/23 and had never seen left lower extremity alteration as floated to various units and was not the assigned nurse when a skin assessment was due. LPN "O" stated that as the physician was at the facility in the morning of 1/4/23, she provided him with the assessment information that she had been provided in shift report and that the physician proceeded to assess resident and provided orders for R8's Emergency Room transfer.

In an interview on 2/06/23 at 11:42 AM, Director of Nursing (DON) "B" stated that she would have expected that a comprehensive assessment be completed with any change in resident condition and that follow up

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	assessment and documentation of resident status be completed thereafter. Per DON "B", would have expected to see descriptive documentation of any skin alteration including color, size, and shape of alteration as well as a corresponding assessment of surrounding tissue, extremity range of motion, and signs and symptoms of pain as well as physician follow-up for any ongoing symptoms. Review of "Lippincott Procedures - Change in status, identifying and communicating, long-term care" with an August 19, 2022 revision date that was provided by DON "B" and confirmed to be utilized by facility for a resident change in status, included " ...Introduction: In a long-term care setting, any change from baseline in a resident's status must be identified and addressed ...When a nurse recognizes a potentially life-threatening condition or significant change in a resident's status, the nurse must communicate with other health care providers to meet the resident's needs ...Implementation: Identify a suspected acute change in the resident, review the resident's medical record ...Perform a complete physical assessment, focusing on the identified change in status ...Communicate the change in the resident's condition to the appropriate practitioner ...Document the procedure ..."			
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -	F0689	2. Current residents that need assistance with bed mobility have the potential to be affected	3/2/2023

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a fall from bed during resident care for one (Resident #60) of three reviewed for accidents, resulting in R60 being rolled away from staff and falling out of bed during care. Findings include: Review of the medical record reflected Resident #60 (R60) was admitted to the facility on 1/13/23, with diagnoses that included unspecified severe protein-calorie malnutrition, atherosclerosis of coronary artery bypass graft(s) without angina pectoris, hypertension (high blood pressure), kidney transplant status, malignant neoplasm of kidney (except renal pelvis) and acute kidney failure. The Minimum Data Set (MDS) history reflected R60 died in the facility on 1/14/23. Review of the medical record reflected R60 was a full code (full resuscitation and life sustaining treatment). The Miscellaneous tab of the Electronic Medical Record (EMR) reflected the code status document was effective 1/13/23 and was uploaded to the medical record on 1/17/23.		and have been reviewed, no other concerns noted. 3. DON/Designee will provide re-education to nursing staff/therapist, by alleged date of compliance, on proper bed mobility technique when preforming ADL care, including rolling patient towards you or obtaining co-worker to stay on the opposite side of the bed if rolling the resident away from you. 4. Don/Designee will observe 5 residents bed mobility 1x/weekly for 4 weeks, then 1x/monthly for 3 months, to assure proper techniques is used while rolling residents. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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A Progress Note for 1/14/23 at 11:16 AM reflected, "...CNA [Certified Nurse Aide] Trainee was changing resident, resident told trainee that she had difficulty breathing and as resident was on her side she rolled out of bed on to [sic] the floor. trainee [sic] aid came and notified nurse that resident fell to the floor and was non responsive, code blue was called at 10:56a [AM], paramedics was [sic] called at was called [sic] at 10:56a, compressions started at 11:00a, paramedics arrived @ [at] 11:05a took over cpr..."

A Progress Note for 1/14/23 at 11:55 AM reflected, "...Paramedics called time of death at 11:40..."

A Post Fall Evaluation for a fall date of 1/14/23 at 10:56 AM reflected R60 had a witnessed fall to the floor, while Certified Nurse Aide (CNA) "Z" was present, providing incontinence care. "...What did the guest/resident say they were trying to do just before they fell?" reflected, "Breathe". According to the Evaluation, R60 lost consciousness and became non-responsive. She was lying parallel to the bed, on her right side, with her face towards the wall. The section for re-enactment of the fall reflected that during incontinence care, the CNA rolled R60 onto her side to tuck her brief. R60 stated, "I can't breathe", lost consciousness and rolled out of the bed, onto the floor. Code blue (cardiac/respiratory arrest) was called, and Emergency Medical Services

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	(EMS) were called. An Incident Report for a fall on 1/14/23 at 11:16 AM reflected R60 was lying on her right side, on the floor, next to the bed. Bloody saliva was noted, and R60 was having difficulty breathing. The immediate action taken reflected, "Attempted to clear airway, 911 called, CPR started." During a phone interview on 02/02/23 at 08:55 AM, CNA "Z" reported she had been a CNA for 16 years and employed by the facility for about two weeks. Her training at the facility had been two weeks. When queried about the training process on the floor, CNA "Z" reported that being an "older" CNA, if she saw a call light on, she could answer it. Regarding R60, CNA "Z" stated she only cared for her that day (1/14/23). CNA "Z" described that as she was changing R60 and doing a complete bed change, it seemed to her like R60 went into cardiac arrest. CNA "Z" then reported she did not know for sure, as she was not a nurse. CNA "Z" described that R60 "launched" onto the floor. CNA "Z" stated she wanted to say R60 landed on her side or maybe even on her face. She looked at R60, then ran to get the nurse immediately. CNA "Z" reported the incident to Licensed Practical Nurse (LPN) "O", and all the nurses in the facility responded, and 911 was called. After that, R60's vital signs were being checked, she was being assessed, and CNA			

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"Z" went to call 911. The crash cart and suction were brought to the room, and maybe even the defibrillator, according to CNA "Z".

Just prior to R60 falling from the bed, CNA "Z" was putting the brief under R60. CNA "Z" reported R60 was facing towards the wall where the thermostat was and was turned away from her at that time. CNA "Z" reported she had never seen anything like that, and R60 "launched" out of the bed. According to CNA "Z", it was sudden, and she would not watch her patient roll out of bed. CNA "Z" reported she was training with someone that day, who was in the bathroom at the time, so she began doing rounds.

During an interview on 02/02/23 at 10:50 AM, LPN "O" stated it was reported to her that between 10:00 AM and 11:00 AM, the CNA was providing pericare, cleaning R60, turned R60 on her side and was putting on her brief. R60 told the CNA she could not breathe, then went limp and "went out of the bed". When LPN "O" responded to the room, R60 was non-responsive, lying on her side and still had a pulse and was still breathing. LPN "O" could see that it was difficult for R60, as she was using accessory muscles when breathing. LPN "O" called for another nurse and called a code. LPN "O" reported that she turned R60 over, and there was bloody saliva in her mouth, which she had tried to clear. 911 was called, and they were doing compressions when EMS arrived. LPN "O" reported it was

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	difficult to bag R60 (provide breaths via an ambu bag), and stated, "it was fighting". When LPN "O" responded to R60's room, she had to change her position, check her head and check for a pulse. R60 did not have any muscle tone. Except for bloody saliva, LPN "O" did not see any visible injuries to R60. She then stated it could have been bloody mucus that she saw. R60 was "kind of" rolled back on her side in attempt to clear her until they rolled R60 to her back to begin chest compressions. When asked how much time had passed until they had to perform chest compressions, LPN "O" stated maybe two minutes. LPN "O" reported R60 was still breathing and still had a pulse for that time. (According to the Progress Note for 1/14/23 at 11:16 AM, code blue (cardiac/respiratory arrest) was called at 10:56 AM, and chest compressions began at 11:00 AM) During a phone interview on 02/02/23 at 02:03 PM, RN "DD" stated a new CNA reported they were needed in a patient room. When she responded to the room, R60 was on the floor. The crash cart was already there. RN "DD" reported R60 was taking her last breaths when she walked in the room, and she had "pinkish stuff" coming out of her mouth. RN "DD" reported there were a "bunch" of people in the room. She asked the CNA what happened, and it did not make a lot of sense to her (RN "DD"). She described that R60 was sitting up, talking to her (CNA) while doing care, and she just rolled out of			

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the bed. The CNA told RN "DD" she had never seen anything like that and thought R60 had a heart attack or something. RN "DD" believed the CNA was supposed to be training with another CNA.

RN "DD" stated if a patient was being rolled, they should be coming towards you, not away from you. RN "DD" conveyed that when rolling a patient towards you, your body would be protecting the patient, and they would not roll out of bed.

During an interview on 02/02/23 at 02:49 PM, LPN "H" reported that as far as she heard when asking the CNA, the CNA was changing R60, and R60 told the CNA she was feeling weird, not feeling good, was on her side and rolled out of bed. LPN "H" reported the CNA was new.

During an interview on 02/06/23 at 01:32 PM, Director of Nursing (DON) "B" reported believing CNA "Z" was on orientation at that time. When asked if the facility permitted an orientee/trainee to provide care alone, DON "B" reported they wanted them with work with CNAs for the first couple days. Positioning for care in bed would depend on what was going on with the patient, according to DON "B". She reported each patient would be different based on what they were at the facility for. DON "B" denied knowledge of how care and rolling was done for R60. She reported CNAs were usually in training for a week before getting their own

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	assignment, but it depended on the CNA and if they were new and needed more time. On 02/06/23 at 02:14 PM, DON "B" provided information that CNA "Z"'s date of hire to the facility was 1/3/23. Day two of her CNA orientation was 1/5/23, and her training dates on the floor were 1/7/23, 1/8/23, 1/14/23, 1/15/23 and 1/27/23.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of six medication	F0761	Resident #26 undated/expired medications were immediately disposed of at the time of survey: Lispro (Humalog) Kwikpen, Erythromycin Eye ointment and Omeprazole, medication reordered from pharmacy, resident remains in facility with no adverse effects noted. Resident #30 expired medication was immediately disposed of at the time of survey: Intravenous Cefepime, resident remains in facility in stable condition. Tuberculin vial that was outdated was immediately disposed of at the time of survey. 2. Current resident have the potential to be affected. No other issue noted with medication carts or medication rooms reviewed. 3. DON/Designee will provide re-education to licensed nursing, by alleged date of compliance, on LTC Facility□s Pharmacy Services and the Medication storage guidance. 4. DON/Designee will audit Medication Carts and Nursing Station Medication rooms 1x/weekly x 4 weeks, then 1x/monthly x 3 months to assure that there is no expired medications and medications are dated appropriately. Audit results will be forwarded to the facility	3/2/2023

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	carts and two of four medication rooms reviewed were free of expired medications resulting in the potential for decreased medication efficacy and adverse side effects. Findings include: On 2/1/23 at 10:29 AM, Jefferson Hall Medication Cart was reviewed in the presence of Licensed Practical Nurse (LPN) "FF". During the review, it was noted that R26 had an Insulin Lispro (Humalog) Kwikpen with the date opened indicated to be 12/26/22 and an Erythromycin 0.5% (percent) Eye Ointment with the date opened indicated to be 10/13/22. In an interview with LPN "FF" at the time of the medication cart review, LPN "FF" referenced the "Omnicare Insulin Storage Recommendation Sheet" that was found within a white binder on the medication cart that indicated that a Humalog Kwikpen was good for 28 days at room temperature after opening. During the same interview, LPN "FF" stated that she would have to double check but believed that all eye ointments were good for 1 month after opening and then should be disposed of. On 2/1/23 at 10:56 AM, Washington Hall Medication Room was reviewed in the presence of Director of Nursing (DON) "B". During the review, it was noted that the medication refrigerator within the medication room contained an open Tuberculin vial with		QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	a date opened of 11/28/22 indicated on both the medication box and vial. DON "B" confirmed the opened date on the vial and confirmed that it should have been disposed of 30 days after opening. Additionally, two Intravenous Cefepime 2gm (gram) bags labeled with R30's name with the medication expiration date indicated to be 1/23/23 were noted within the medication refrigerator. DON "B" confirmed the expiration date on the intravenous bags as well as the need for the medication to be disposed of. DON "B" further stated that it would be the expectation that upon completion of an intravenous antibiotic course that any remaining dosage would be removed from the refrigerator and disposed of within the facility as these medications could be sent back to the Pharmacy. On 2/1/23 at 11:07 AM, Jefferson Hall Medication Room was reviewed in the presence of Director of Nursing (DON) "B". During the review, it was noted that the medication refrigerator within the medication room contained an opened bottle of Omeprazole 2gm/ml (grams per milliliter) suspension labeled with R26's name. The tamper resistant seal on the bottle was broken but no open date was noted on the container. The label indicated "use by: 1/10/2023" with DON confirming expiration of mediation as well as the need for the medication to be disposed of. A second bottle of Omeprazole 2gm/ml labeled with R26's name noted within same refrigerator			

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	with tamper resistant seal remaining intact with use by date indicated to be 2/27/23. Review of the policy titled "LTC (Long Term Care) Facility's Pharmacy Services and Procedures Manual" and the "Medication Storage Guidance" dated 2022 provided by DON "B" and confirmed to be utilized by facility for all pharmacy services indicated, "Tuberculin Tests: ...Aplisol Injection; Tubersol Injection ...Date when opened and discard unused portion after 30 days ...Ophthalmic Products ...Date when opened and discard unused portion after 28 days ...Humalog Pen ...indicated to be good for 28 days at room temperature after opened".			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i) (1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i) (2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F0812	1. Identified outdated Items were discarded at time of survey: cottage cheese, container Italian dressing, container applesauce, box of onions, box of oranges, box lemons, box cucumbers, box of pork and nectar water, adverse effects were noted for any resident. 2. Current residents have the potential to affected, no other concerns noted. 3. Administrator/designee will provide re-education to dietary staff, by alleged date of compliance, on facility policy Food Purchasing and storage, revised date 11/11/2021 related to dating of food and discarding when expired. 4. Dietary Manager/designee will audit food storage area 3x/week x 4 weeks, then weekly for 3 months to assure the food is not expired and has appropriate dates.	3/2/2023

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	Based on observations, interviews, and record reviews, the facility failed to remove/discard expired ready-to-eat food products, effecting 59 residents that consume meals from the facility kitchen, resulting in the increased likelihood for cross-contamination, bacterial harborage, and resident foodborne illness. Findings include: On 01/30/23 at 09:13 A.M., A tour of the food production kitchen was conducted with Chef "C", the walk in cooler was observed to have cottage cheese with a "Best by used date of 1/15/23" individual cottage cheese cups pre made and ready for delivery were made from that container per Chef "C". A large container of Italian dressing was labeled with an open date of 11/23 and a discard date of 12/23. Opened applesauce container with handwritten date of 1/15, box of onions dated 1/17, box oranges dated 12/20, box lemons dated 12/13, box of cucumbers dated 1/24, box pork hand written on outside of the box dated 1/17, in the box 4 separate vacuumed packed packages pf pork was observed. An undated wrapped pre made salad was observed along with a clear plastic container that contained approximately 20 ounces of clear liquid, the container was not labeled or dated, but was identified by Chef "C" as nectar water, and stated all the fruit, vegetable and box of pork dates were the discard date, Chef "C" could		Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	not elaborate for the open date or explain why foods were not discarded per the discard date. Chef "C" reported the dated boxes of fruits, vegetables , the applesauce were the dates the items were to be discarded. Chef "C" further reported the cottage cheese with a best by used date was delivered a few days prior. When queried who accepted the delivery of expired foods, Chef "C" stated she didn't know it was expired the food delivery gets dropped off in crates. There was no explanation for why there were no open dates, why discarded food was not discarded. Dietary Manager "D" arrived by the end of the initial tour where concerns were reviewed. Dietary Manager "D" offered no explanation for the food storage findings. The "2017 FDA Model Food Code" section 3-501.17 states: "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1."			

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	According to the facility policy titled "Food Purchasing and Storage"date 08/01/11 with a revision date of 11/11/21, the facility identified the following attachment as part of their policy: "Use by Date Storage Chart" The attachment read in part: " All unopened prepackaged processed products should be used or discarded by the Manufacturers' Expiration Date." "Dairy Products Milk / Yogurt Opened 7 Days or expiration date (soonest) Cheese / Sour Cream Opened 14 Days or expiration date (soonest)" "Prepackaged and Processed Meats Meat & Poultry Cook within 5 days" "Cut or Prepared Fruits / Vegetables 7 Days or expiration date (soonest). Commercially Prepared Dressings / Condiments /Sauces (refrigeration required) 30 Days after opening." "All food items in must be properly dated and labeled, and must be stored in either containers with lids, foil / film wrapped, sealed food storage bags or their original			

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	container. Foods should not be refrozen" "Refrigeration Date Storage Chart All unopened products should be used or discarded by the Manufacturers' Expiration Date Day 1 is the date the item is opened or prepared." "Cook within 5 Days Meat & Poultry - unopened raw pulled from freezer" "7 days - Or Manufacturers Date (Soonest) Opened Frozen Liquid eggs / Egg substitutes / Boiled eggs Milk / Yogurt Whipped Topping Pudding, canned Opened Hot dogs, Deli Meats (turkey/ham/roast beef) Raw Bacon pulled from freezer Raw sausage links / patties pulled from freezer Fully cooked imitation crab meat pulled from			

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	freezer Cut or Prepared Fruits / Vegetables (Uncut produce is to be marked with received date and discarded as needed)" "30 days Margarine / Butter Frozen Leftovers Commercially Prepared Dressings / Condiments /Sauces (refrigeration required)" "All food items in must be properly dated and labeled, and must be stored in either containers with lids, foil / film wrapped, sealed food storage bags or their original container."			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a	F0880	Regency at Bluffs Park must include the following in their POC for the deficient practice cited at F880: The facility□s Quality Assessment and Assurance (QAA) Committee must conduct a Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. Information about how to perform RCA can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf	3/2/2023

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	contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:		" The QAA Committee must report the results of RCA and the plans for corrective action to the Governing Body. " The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies may be helpful in completing the RCA and can be found at https://qioprogram.org/covid-19. The facility must take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR ¿ 483.80 that includes corrective action for the affected residents identified in the CMS-2567, identification of other residents that may have been impacted by the noncompliant practices, and implementation of systemic changes. As a part of the corrective action plan, the facility must provide training to all staff providing direct care to residents and all staff entering residents□ rooms, whether for residents□ dietary needs or cleaning and maintenance services. The training must cover the following topics, in addition to training needs identified by facility□s completed the RCA: " Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig " Clean Hands - https://youtu.be/xmYMUly7qiE " Disinfecting Medical Equipment More trainings and updates are available on the CDC YouTube channel https://www.youtube.com/c/CDC/.	

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	During observation, interview, and record review the facility failed to change oxygen tubing and nebulizer oxygen mask for one resident (#26) and failed to keep a urinary collection bag off the floor for one resident (#6) out of a facility census of 67 residents reviewed for infection control standards resulting in an increased risk of residents acquiring facility acquired infections. Findings included: Resident #26 (R26) Review of the medical record revealed R26 was admitted to the facility 09/11/2020 with diagnoses that include abdominal aortic aneurysm (enlargement of aorta) , disorder of bone, dysphagia (difficulty swallowing),hematuria (blood in urine), anemia (low red blood cells), hypomagnesemia (low magnesium levels in blood), anxiety, type 2 diabetes, epilepsy (disrupted nerve cell activity in brain), neuromuscular dysfunction (dysfunction of muscle), morbid obesity, sever protein-calorie malnutrition, depression, thoracic aortic ectasia (enlargement of aorta), chronic pulmonary edema, chronic respiratory failure, diverticulosis (small pouches in digestive tract), abscess of liver, chronic pancreatitis (inflammation of the pancreas), rheumatoid arthritis (chronic inflammatory disease affecting bone joints), collapsed vertebra, chronic kidney disease, cystitis (inflammation of the bladder), hyperlipidemia (high fat		Trainings can be completed by staff directly or by train the trainer (Director of Nursing, Infection Preventionist, Medical Director, or Infection Control Consultant). The facility may also use training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics. If the facility employs or contracts staff with limited English proficiency (LEP), the facility will ensure education is provided in a language that the LEP staff member(s) can understand. Upon completion of the training, the facility must validate staff competency using a post-training test. The facility must develop a plan for monitoring progress of the corrective action plan and tracking performance improvement. In accordance with 42 CFR ¿ 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, CMS will not direct the state agency to conduct a revisit prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide CMS with all of the following documentation: Checklist: Documents Required for Successful Completion of the DPOC:	

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	content in blood), hypertension, atherosclerotic heart disease, chronic obstructive pulmonary disease, and chronic vascular disorder of intestine. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/23/2022, revealed R26 had a Brief Interview of Mental Status (BIMS) of 15 (intact cognitive response) out of 15. During observation and interview on 01/31/2023 at 09:11 a.m. R26 was observed laying down in her bed. R26's oxygen tubing connected to the face mask nebulizer was dated 12/28/2022 and the nebulizer mask was laying on the floor. R26 explained that she received nebulizer treatments, which were initiated by the nurses, when she had difficulty breathing. She explained that the nebulizer treatments helped her breath more easily. R26 could not recall the last time she received a nebulizer treatment or the last time she had used the mask. During record review of R26's physician orders it was demonstrated that she was to receive nebulizer treatments of ipratropium-albuterol solution (0.5 milligrams ipratropium bromide; 2.5 milligrams albuterol) 3 milliliters for wheezing every 6 hours as needed. R26's medication administration record demonstrated that she had last received the above nebulizer medication and treatment on 01/16/2023. During observation and interview on		1. Documentation of the completed RCA as well as the intervention or corrective action plan developed from the RCA with signatures of the QAA Committee members and members of the Governing Body 2. Documentation that the intervention and corrective action plan that resulted from the RCA were fulling implemented 3. Content of the training provided to staff, including a syllabus, outline or agenda, as well as the qualifications of the individual leading the training and any other materials used or provided to staff for the training 4. Typed list of names and position of all staff that attended the trainings, including signed and dated staff training sign-in sheets 5. Summary of staff training post-test results, to include facility actions in response to any failed post-tests 6. Documentation of efforts to monitor and track progress of the interventions and corrective action plan In order to speed up our review, label all required documents with the number indicated above. DPOC documentation should be emailed directly to the health survey team manager, whose contact information can be found below. Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies. The F880 corrective action plan must include, but is not limited to, the DPOC language found in this notice. POC submissions must be submitted within 10 days after receipt of the written CMS Form-2567. 1. Resident #26 oxygen tubing/nebulizer mask was replaced during the survey, no adverse effects noted for the resident. Resident #6	

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	02/01/2023 at 02:15 p.m. R26 was observed laying in bed. It was observed that the oxygen tubing connected to the face mask nebulizer was still dated 12/28/2022 and the nebulizer mask was still laying on the floor at the head of her bed. R26 explained that she had not had any difficulty in breathing and had not used her nebulizer since the last time this surveyor visited with her. In an interview on 02/01/2023 at 02:21 p.m. the Director of Nursing (DON) "B" explained that it is the facility policy that oxygen tubing and nebulizer mask was to be replaced weekly. DON "B" explained that oxygen tubing connected to the face mask nebulizer should not be on a resident's floor but is to be cleaned and placed in a bag at the bedside after use. During observation and interview on 02/01/2023 with Director of Nursing "B" at the bedside of R26, DON "B" confirmed that the nebulizer mask was laying on the floor and that the oxygen tubing connected to the face mask nebulizer was dated 12/28/2022. DON "B" explained that the tubing and the mask should be discarded, and that new oxygen tubing and mask should have been replaced weekly. DON "B" proceeded to discard the oxygen tubing connected to the face mask nebulizer and the face mask nebulizer. DON "B" was observed placing new tubing and a new nebulizer mask at the bedside of R26.		catheter bag were corrected positioning and placed in privacy bag during the survey, no adverse effects noted for the resident. 2. Current residents that use nebulizers and oxygen have the potential to be affected and have been reviewed with no further concerns noted. Current residents with indwelling catheters have the potential to be affected and have been reviewed with no further concerns noted. 3. DON/Designee will provide re-education to Licensed nurses by alleged compliance date, on the facility□s policy, Use of Oxygen, including that O2 cannula or mask should be changed weekly and dated on the facility□s policy and Lippincott Procedures-Indwelling urinary catheter and management, including not placing drainage bag on floor and to be kept concealed with dignity bag. 4. DON/designee will audit 5 residents with nebulizers and/or oxygen and 5 residents with indwelling catheters 1x/week for 4 weeks, then 1x/month for 3 months to ensure oxygen and nebulizer tubing/mask are properly dated and that catheters are properly positioned and kept within a privacy bag. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	814040A	A. BUILDING _____ B. WING _____	2/6/2023

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	During review of facility policy entitled "Use of Oxygen", origination date of 08/01/20210 and a review date of 08/17/2021, demonstrated (number 1) "The O2 cannula or mask should be changed weekly and dated". Resident # 6 (R6) Resident # 6 (R6) was admitted to facility 4/8/22 with diagnoses including infection and inflammatory reaction due to indwelling urethral catheter, neuromuscular dysfunction of bladder, urinary tract infection, site not specified, and retention of urine. Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/23 revealed that R6 did not have a Brief Interview for Mental Status conducted. MDS reflected that a staff assessment for mental status was conducted with indication that both short- and long-term memory was intact with resident able to recall current season, location of own room, and staff names and faces as well as indication that resident was able to make decisions regarding tasks of daily life with modified independence. Section G of MDS revealed that R6 required two-person extensive assist with bed mobility, two-person total dependence with transfers, and one-person extensive assist with dressing, toilet use, and personal hygiene. Section H of same MDS indicated that R6 had an indwelling catheter. In an observation and interview on 1/30/23 at 1:01 PM, R6 was observed sitting in bed with			

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	head of bed elevated at an approximate 90-degree angle feeding self lunch. Urinary catheter tubing was noted to extend out from under blankets at left side of bed and was attached to a urinary collection bag that was observed to be laying directly on carpeted floor. Cloudy yellow urine noted in catheter tubing and collection bag with approximately 300 ml (milliliters) of urine noted within collection bag. A black "privacy bag" was noted to be attached to the bed frame. R6 stated that she has had the catheter for "quite some time", that she goes to a Urologist "every now and then", and that was on antibiotic treatment for a urinary tract infection "that keeps coming back". In an observation on 2/01/23 at 1:54 PM, R6 was observed laying in bed positioned toward left side with left upper extremity positioned on pillow. R6's urinary collection bag was noted to be hanging loosely on bed frame toward foot of the bed with bottom of the bag resting on carpeted floor. A black "privacy bag" was observed to be attached to the bed frame just to the left of the collection bag. In an interview on 2/06/23 at 11:43 AM, Director of Nursing (DON) "B" stated that a urinary collection bag should be maintained below the level of the bladder and attached to the bed frame or the underside of the wheelchair in a manner so that the collection bag does not come in contact with the floor. DON "B" stated that the urinary collection			

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	bag should also be placed inside a "privacy bag" for protection and dignity purposes. Review of R6's medical record complete with the following findings noted: Order dated 9/30/2022 which stated, "20 F (French) Foley catheter r/t (related to) neurogenic bladder". Review of Care Plan Focus created 10/24/2022 stated, "(Resident name) is at risk for urinary tract and catheter-related trauma: has indwelling suprapubic catheter r/t (related to) neurogenic bladder" with Care Plan Interventions which included "Ensure catheter tubing is secured" with 10/24/2022 created date, "Ensure the drainage bag is secured properly with a dignity cover in place" with 10/24/2022 created date, and "Position catheter bag and tubing below the level of the bladder. Check tubing for kinks each shift" with 10/24/2022 created date. Review of the Kardex reflected Care Plan Intervention to "Position catheter bag and tubing below the level of the bladder. Check tubing for kinks each shift" with no further interventions listed which would guide the Certified Nurse Aide in the Care Plan Intervention to "Ensure the drainage bag is secured properly with a dignity cover in place". Review of "Lippincott Procedures - Indwelling urinary catheter (Foley) care and			

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	management" with a 12/2/2022 facility review date that was provided by DON "B" and confirmed to be utilized by facility for urinary catheter management, included "Critical Notes! Ensure urinary drainage bag is concealed with a dignity bag ...Implementation ...Clinical alert ...Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder ...However, don't place the drainage bag on the floor to reduce the risk of contamination and subsequent CAUTI (catheter associated urinary tract infection) ..."			
F0887 SS= D	COVID-19 Immunizatio §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks	F0887	2. New admission/Readmission have the potential to affected, residents COVID-19 Consents/Declination for the vaccination have been reviewed with no other concerns. 3. DON/Designee will provide re-education to Licensed Nurses, by the alleged compliance date, on the facility□s policy: Guest/Resident COVID-19 Vaccination, including that all new and re-admissions will be offered the vaccine if appropriate/available and to complete Consent/Declination accurately, including date. 4. DON/Designee will audit 5 new admissions/re-admissions to the facility 1x/weekly for 4 weeks, then 1x/monthly for 3 months, to assure that the Consent/Declination was completed accurately, including being dated. Audit results will be forwarded to the facility QAPI Committee for review and further recommendations. Additional education and	3/2/2023

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	and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Preventio's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to offer COVID-19 Immunization and obtain complete declination for COVID-19 Immunization for one resident (#4) out of 5 residents reviewed for vaccinations resulting in the potential for miscommunication and misunderstanding of		monitoring will be initiated for identified concerns. The Administrator is responsible for sustained compliance	

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	resident COVID-19 Immunization preferences. Findings Include: Resident #4 (R4) Review of the medical record revealed R4 was originally admitted to the facility 09/26/2013 and re-admitted to the facility 01/15/2022 with diagnoses that include senile degeneration of brain, vertigo (feeling of spinning), arthropathic psoriasis (form of arthritis), encephalopathy (brain disease), sever protein calorie malnutrition, angina pectoris (chest pain), neuromuscular dysfunction of bladder, atherosclerotic heart disease, hypotension (low blood pressure), congestive heart failure (CHF), insomnia, type 2 diabetes, hyperlipidemia (high levels of fat in the blood), major depression, anxiety, atrial fibrillation, and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/2022, revealed R4 had a Brief Interview of Mental Status (BIMS) of 13 (intact cognitive response) out of 15. R4 was receiving Hospice services and died at the facility 02/06/2023. During record review of R4's COVID-19 Vaccination states it was revealed that R4 had signed a facility "Consent/Declination of COVID-19 Vaccination" that she declined the COVID-19 Vaccination. The document reviewed did not include a date for which she			

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	had signed or received the information regarding the risk or benefits of the COVID-19 Vaccination. During an interview on 02/06/2023 at 08:44 a.m. the Director of Nursing (DON) "B" reviewed the "Consent/Declination of COVID-19 Vaccination" for R4. DON "B" confirmed that R4 had signed the document but that a date was not entered on the document. DON "B" explained that she could not determine the date the document was signed or the date that R4 had received information regarding the risk or benefits of the COVID-19 Vaccination. DON "B" explained that it was the facility expectation that the date be entered when the signature was completed. The DON "B" could not explain if R4 had been offered the COVID-19 Vaccination when she was re-admitted because a date was not on R4's "Consent/Declination of COVID-19 Vaccination". Review of the facility policy entitled "Guests/Resident COVID-19 Vaccination" with the origination date of 03/04/2021 and a last reviewed date of 04/09/2022, was found to include (number 10) which stated, "All new and re-admissions will be evaluated by the nurse and/or physician for previous immunization and will be offered the vaccine if appropriate and available."			