STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634530	A. BUILDING ______ B. WING ______	3/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION POINT NSG & PHY REHAB CTR OF CLAWSON	**535 N MAIN CLAWSON, MI 48017**

(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 Mission Point Nursing & Physical Rehab Center of Clawson was surveyed for a Recertification survey on 3/16/23. Intakes: MI00131421, MI00131489, MI00132075, MI00132503, MI00132811, MI00133287 Census=87	F0000		
F0561 SS= D	Self-Determinatio §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, the facility failed to ensure that resident	F0561	Element 1: R3 and R13 have been offered hot beverages on their trays. Element 2: All residents have potential to be affected by the stated deficiency. The facility will identify other resident having the potential to be affected by the deficient practice by competing an audit of current residents. Element 3: The self-determination policy (is this a policy) has been reviewed and deemed appropriate. Staff have been all educated on the policy. The systemic change will be that visual rounds will be completed to ensure that hot beverages are being served. Element 4: The Administrator/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Date of compliance: 4/13/23	4/13/2023

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

Electronically Signed — 04/05/2023

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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MISSION POINT NSG & PHY REHAB CTR OF CLAWSON	**535 N MAIN** **CLAWSON, MI 48017**

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preferences were honored for two (R3 and R13) of two residents reviewed for choices resulting in feelings of frustration and helplessness.

Findings include:

R3

A record review revealed R3 was admitted to the facility on 1/12/23. R3's diagnoses include multiple sclerosis, difficulty walking, and lack of coordination. R3 had a BIMS (Brief Interview of Mental Status) score of 15, indicative of an intact cognition, based on MDS (Minimum Data Set) assessment dated 12/26/22. R3 needed extensive assistance from staff for their bed mobility and to transfer in and out of their bed.

On 3/14/23, an observation was completed on R3, at approximately 9:30 AM. R3 was observed lying in their bed, eating breakfast. An interview was completed during this observation. When R3 was asked about the facility honoring their choices, R3 reported that they did not receive any hot beverage with their breakfast. R3 had a cup of juice on their breakfast tray. When queried further, R3 reported that they liked their hot tea during meals and their roommate liked their coffee, but they had not been getting any hot beverage. R3 reported that it had been over a week since they had received their hot beverage with their meals. When asked if staff were aware, R3 reported that staff were aware, and staff had informed R3 that there were hot water issues in the kitchen. A second observation was completed at approximately 12:30 PM during lunch time. R3 did not have any hot beverage on their lunch tray.

R13

R13 was admitted to the facility on 4/12/22. R13's admitting diagnoses include cellulitis, Raynaud's

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syndrome, and diabetes type II. R13 had a BIMS (Brief Interview of Mental Status) score of 13, indicative of an intact cognition, based on the MDS (Minimum Data Set) assessment dated 1/20/23. R13 needed limited staff assistance from staff for their bed mobility and transfers in and out of the bed. R13 was able to ambulate with a rolling walker with staff supervision.

On 3/14 23 at approximately 11:15 AM, an observation was completed on R13. R13 was observed sitting in their room in a chair next to the bed. When asked about the facility honoring their choices, R13 reported that they have not had any coffee for over a week, and they were served juice with all meals. R13 reported that they like two cups of hot coffee with every meal. R13 added that they were going to request their family member to bring some instant coffee from home so they could make their own coffee but R13 reported that they did not have hot water in their bathroom sink consistently. At approximately 12:30 PM, R13 received their lunch tray, and they were not served coffee with their lunch.

On 3/16/23 at approximately 11:50 AM, a second observation for R13 was completed. R13 reported that they were going out for their appointment. When queried about the coffee, R13 reported they did not receive any during breakfast.

A staff interview was completed with the staff member "F" on 3/14/23, at approximately 9:30 AM. Staff member "F" was assigned to care for the residents on the unit where R3 and R13 were residing. Staff member "F" reported that that facility had issues with hot water for over two weeks and reported that bathroom sinks did not have hot water consistently. Staff member "F" also added that water temperature varied in rooms and at times the water came out very cold. Staff member "F" confirmed that residents had not

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	received any hot beverage and it had been approximately one week. A staff interview was completed with staff member "I" on 3/15/23, at approximately 7:45 AM. Staff member "I" was queried on why residents were not served any hot beverages. Staff member reported that facility had power outage and their coffee machine had not been working. When queried on the specifics, staff member "I" reported that they received a call from kitchen staff on Sunday (3/12/23), about the coffee machine not working. Staff member "I" added that they had reported for service and the technician was waiting for a part. When queried further on their alternate plan to serve residents while the machine was waiting for service, staff member "I" reported that they had instant coffee, and they could serve to residents. Staff member "I" did not provide any further explanation was provided why residents were not served any hot beverage choices while the coffee machine was waiting for service. On 3/16/23, facility provided copies of service reports for the coffee machine from the vendor dated 3/10/23, 3/11/23, and 3/16/23. Most recent report dated 3/16/23 read the missing parts, needs service. Facility failed to provide any further explanation on why they did not implement their alternate plan to honor the needs of R3 and R13 while the machine was waiting for service. .			
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	F0578	Request/ Refuse/ Discontinue Treatment/Advance Directives Element 1: Residents #66 daughter is initiating on getting guardianship of her mother, the social worker is assisting in this process.	4/13/2023

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	right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual 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 observation, interview, and record review the facility failed to follow through on establishing a decision-maker for one (R66) of two residents reviewed for advance directives.		Element 2: All like-residents have potential to be affected by this deficient practice. An audit of like-residents was conducted to ensure residents requiring guardianship has an established decision-maker on the advance directives. Element 3: The Advance Directives Policy has been reviewed by the Administrator and was deemed appropriate. Social Services has been educated on the advance directives policy with emphasis on establishing a decision-maker for guardianship on their advance directives. The systematic change will be going over all new admits advance directives during morning clinical meeting. Element 4: The Administrator/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Date of compliance: 4/13/23	

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Findings include:

Review of the clinical record revealed that R66 was admitted to the facility on 11/04/2021. Diagnoses include metabolic encephalopathy (a brain disease), post-traumatic stress disorder, high blood pressure, hypothyroidism, high cholesterol, chronic kidney disease, anxiety, and dementia. Per the Quarterly MDS assessment dated 02/10/2023, R66 required limited one person assistance for bed mobility, transfers, toileting, and bathing. Per this assessment, R66 was moderately cognitively impaired.

Review of the clinical record revealed a document entitled "PHYSICIAN STATEMENT OF COMPETENCY." R66's name was written on the line before the statement "has been evaluated and deemed incompetent to make medical and financial decisions for the following reason(s). For reasons, the line next to "This person has a current diagnosis of mental illness or dementia" was checked, and the word "dementia" was circled. "Impaired memory and judgment" was handwritten under, "My observations of the above named person are as follows." The form was signed by a psychologist and physician on 01/19/2022.

Review of the R66's clinical record revealed that they consented to receiving the flu vaccine on 10/17/2022. Note that this was after R66 was determined to be incompetent

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	and unable to make medical decisions. Review of the clinical record revealed no note indicating follow-up from the social services department regarding identifying a decision-maker for R66, nor was there any medical durable power of attorney (MDPOA) or guardianship paperwork in the record. On 03/16/2023 at 02:45 AM, Social Services "D" was interviewed, and they confirmed that they are responsible for addressing/monitoring establishment of advance directives or guardianship. Social Services "D" indicated that they started working at the facility in January of 2023, and they indicated that they were told that several residents needed follow-up regarding guardianship. Social Services "D" confirmed that R66 had been deemed incompetent, and that R66 did not have an MDPOA on file. When asked if anything had been done to seek guardianship for R66, Social Services "DD" responded, "Not on my end."			
F0584 SS= D	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	F0584	F584 Safe/Clean/ Comfortable/ Homelike Environment Element 1: Resident R13 has had an appropriate temperature shower. Element 2: All Second-floor residents receiving showers have the potential to be affected by the deficient practice. An audit was conducted by the Maintenance Director to ensure the second-floor showers have appropriate water temperatures. Element 3: The water temperature policy has	4/13/2023

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	and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance 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 monitor hot water temperatures and ensure the hot water in the shower rooms was maintained at a comfortable temperature. This deficient practice had the potential to affect all residents that receive showers on the second floor. Findings include: On 3/14/23 at 9:32 AM, Certified Nurse Aide (CNA) "F" was queried, and stated that sometimes there is no hot water. CNA "F" further stated that sometimes the hot water will suddenly change to cold. On 3/14/23 at approximately 11:15 AM, R13		been reviewed by the Administrator and was deemed appropriate. All Certified Nursing Assistants (CNAs) have been educated on reporting to the administrator if water temperatures are too hot/ cold. The systemic change will be a schedule of environmental rounds was developed to ensure the second floor has appropriate water temperatures for showers. Element 4: The Administrator/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Date of compliance: 4/13/23	

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(Room 206) complained about the lack of hot water, and stated that the water at the sink in her room is always cold.

On 3/14/23 at 11:20 AM, Maintenance Supervisor "BB" was queried regarding monitoring water temperatures. Maintenance Supervisor "BB" provided a log book of hot water temperatures, which had last been checked July 2022. Maintenance Supervisor "BB" stated he has been at this facility since October 2022, and does not have any more current water temperature monitoring logs. Maintenance Supervisor "BB" stated "I need to start doing that."

On 3/14/23 at 12:30 pm, the hot water temperatures were checked in the shower rooms on the second floor, with the following results: Shower room located near the second floor dining room: 94 degrees Fahrenheit, North Hall shower room: 101 degrees Fahrenheit

Review of the facility's undated policy "Safe Water Temperatures" noted: "It is the policy of this facility to maintain appropriate water temperatures in resident care areas. ...4. Staff will report abnormal findings, such as complaints of water too cold or hot, burns or redness, or any problems with water temperature (ex. water is painful to touch or causes redness) to the supervisor and/or maintenance staff. ...6. Maintenance staff will check water heater temperature controls and the temperatures of tap water in all hot water

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	circuits weekly and as needed. 7. Documentation of testing will be maintained and kept in the maintenance office."			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00132503. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident involving two (R87 and R2) out of five residents reviewed for abuse. Findings include: Review of a facility policy entitled "Abuse, Neglect, and Exploitation" (revised on 06/2022) read, in part, "Definitions... 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or	F0600	F600 Free from Abuse and Neglect Element 1: R87 and R2 are free from abuse and neglect. Element 2: All residents have potential to be affected by the stated deficiency. The facility will identify other resident having the potential to be affected by the deficient practice by competing an audit of current residents. Element 3: The abuse policy has been reviewed and deemed appropriate. All staff have been educated on who the abuse coordinator is and reporting abuse immediately. The systemic change will be that visual rounds will be completed to ensure that abuse and neglect is not happening. Element 4: The Administrator/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Date of compliance: 4/13/23	4/13/2023

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punishment with resulting physical harm, pain or mental anguish...Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology...'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking..." The policy further read, in part, "Investigation of Alleged Abuse, Neglect, and Exploitation...Investigations may include but not limited to:...5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation."

Review of a facility reported incident (FRI) read, in part, "...On 9/28/22 at approximately 3:55 pm, it was reported to [the Administrator] that [R2] and [R87] had a physical altercation, in which [R2] held out his hands making physical contact with [R87]. [R87] fell and hit his head. The police were immediately contacted, and [R97] went out to the hospital."

Furthermore, the FRI read, "Based on the investigation, the facility was able to substantiate that the incident between [R2]

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and [R87] did happen, they did have physical contact, however [R2] did not have the intent of harming [R87], [R2] apologized and stated [they] just held out [their] hands to make [R87] leave [their] room. Based on a thorough investigation the facility could not substantiate abuse. A review of the facility systems confirmed that the facility followed appropriate procedures..."

R2

Review of the clinical record revealed that R2 admitted to the facility on 07/08/2021. Diagnoses include heart failure, atrial fibrillation (a heart condition), type two diabetes, anemia, chronic obstructive pulmonary disease (a lung disease), chronic respiratory failure, end stage kidney disease, depression, malnutrition, and high cholesterol. Per the most recent Quarterly Minimum Data Set (MDS) assessment dated 02/13/2023, R2 required supervision with setup assistance for activities of daily living (ADLs), excluding toileting for which he required limited one person assistance. Per this assessment, R2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that R2 was cognitively intact.

Per the FRI, R2 had a BIMs score of seven out of ten (a cognitive assessment), which indicated significant cognitive impairment. However, the Quarterly MDS assessment dated 08/13/2022, completed 46 days prior to the incident on 09/28/222, revealed that

R2 had a BIMs score of 14 out of 15, indicated that they were cognitively intact.

Review of R2's progress notes revealed the following note dated for 09/28/2022: The above resident had an altercation with the resident in room 203. The resident in room 203 went into the above resident room and hit the resident. The above resident pushed the resident in room 203 out of his wheelchair and the resident fell out of his w/c (wheelchair) and hit his head on the stand up lift that was in the hallway near room 212..."

R87

Review of the clinical record revealed that R87 was admitted to the facility on 08/30/2022. Diagnoses include heart failure, dementia, malnutrition, anemia, high blood pressure, psychotic disorder, anxiety, and chronic kidney disease. Per the Admission MDS assessment. R87 required extensive two person assist for ADLs. Per this assessment, R87 had a BIMS score of 10 out of 15, indicating moderate cognitive impairment. At the time of the survey, R87 was no longer residing at the facility, with a discharge date of 10/10/2022.

Review of R87's progress notes revealed multiple entries in which exhibit wandering behavior, including wandering in and out of other residents' rooms as evidenced by as progress noted dated 09/18/2022, which read, in part, "...resident observed coming out

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of another resident's room ambulating down the hallway without assistance. Unsteady gait/balance noted resident became agitated with staff lashing out yelling '[friend's name]', "'I need to find my best friend [friend's name]'. resident not easily redirected..."

Review of the progress notes regarding the 09/28/2022 incident with R2 reveal the following noted dated 09/28/2022: "Event occurred on 09/28/2022 2:00 PM. resident went into room 212 and hit the resident (R2), the resident (R87) was pushed out of his chair and fell onto the floor and hit his head by the resident in room 212. Physician and responsible party notified." Another progress note dated for 09/28/2022 at 04:19 PM read, in part, "Writer (Nurse 'T") was called to the hallway near room 212, [Housekeeper "DD"] informed writer that [they] witnessed the resident in room 212 (R2) push the above resident out of his chair. [R87] was observed lying on [their] left side with [their] head on the sit to stand lift. [R87] was observed bleeding from the back of [their] head with 2 lacerations. [R87] was given first aide care, transferred back into [their] wheelchair. [R87] was asked what happened, resident stated that [they] had punched [R2]. Staff remained with [R87] while writer called 911..." The size of the scalp laceration was not described, and it is also important to note that R87's scalp laceration was not disclosed in the FRI.

A progress note dated 09/28/2023 at 08:18 PM read, in part, "resident returned to facility

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from [Local Hospital] via stretcher accompanied by ems (emergency medical services) x2 s/p (status post) incident. dx/o (diagnosis of) closed head injury; initial encounter/laceration of scalp..." The size of the laceration was not described. An assessment entitled "Weekly Skin Sweep" dated 09/29/2022 (the day after the incident) revealed that R87 had a skin tear on the back of their head. Measurements of the injury were not provided.

Hospital discharge paperwork, entitled "After Visit Summary" and dated 09/28/2022, provided by the facility revealed that R87 was diagnosed with a "closed head injury" and "laceration of the scalp." No information regarding the extent of the injury was found in the hospital record.

A social services progress note dated 09/29/2023 at 02:50 PM read, in part, "Writer spoke with resident today while up in wheelchair rolling up and down in hallway. Writer conversed with resident regarding incident with another resident. Resident stated [they were] pushed but doesn't know what happen (sic) and who did it..." An activity progress note dated 09/29/2023 at 08:03 PM read, in part, "Activity Note: Spoke with resident regarding incident with another resident. Resident stated [they were] pushed but doesn't know what happen (sic)...".

The FRI read, in part, "On 9/28/22, [R2] was interviewed admitting [they] did put [their]

hands up when [R87] entered [their] room, [R2] said, it was an accident. [R2] said [they] did not mean for [R2] to fall." Review of investigation documents provided by the facility revealed a handwritten statement signed on 09/28/2022 by the Administrator and R2 attesting to this description of events.

On 03/15/2023 at 10:09 AM, at interview was attempted with R2. When asked if they had any physical altercations with other residents in the facility, they gave mumbled answered that could not be understood despite multiple attempts. When asked about the altercation with R87 on 09/28/2023, R2 indicated that they remembered the incident, but they did not recall details. When asked if R2 tried to enter their room, they responded, "Yeah, he (name of resident was not specified) was coming to my room." R2 indicated that the other resident was in a wheelchair. When R2 was asked how they responded to the resident coming into the room, R2 gave a mumbled answer that could not be understood, despite multiple attempts. At this point, it appeared that R2 was having trouble tracking conversation as they started talking about moving somewhere else. When R2 was asked if they pushed the other residents, they said yes, but the rest of the response was mumbled.

Per the FRI, "On 9/28/22 [Nurse "T"] was interviewed stating, [they were] called to the hallway near [R2's] room, and did not see nothing, [Nurse "T"] was told by

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[Housekeeper "DD"] that [they] witnessed [R2] being pushing (sic) [R87]. [R87] was observed lying on [their] left side with [their] head on the sit to stand lift. We immediately called 911." A handwritten statement signed on 09/28/2022 by [Nurse "T"] attested to this description of events.

On 03/16/2023 at 11:12 AM, Nurse "T" was interviewed. Nurse "T" recalled the incident, and they stated that they did not witness it. When asked what happened, Nurse "T" indicated that R2 "pushed R87 so hard that [they] flew out of the wheelchair." Nurse "T" stated that's why they spoke with R2, R2 reported that they were upset that R87 came into their room. In recalling this conversation with R2, Nurse "T" stated, "I think [R2] said that [R87] was the aggressor," and that R87 tired to push R2 or take something, and that's why R2 pushed R87. When asked what they did in response to R2 pushing R87, Nurse "T" stated that they provided care to R2 and the doctor ordered R87 to be sent to the hospital. When asked about R87's injury, Nurse "T" stated that R87 had a small laceration to their head, possibly back of head. When asked who they reported the incident to, Nurse "T" indicated the DON, Administrator, and doctor. When asked what information they reported, Nurse "T" indicated they reported that same information as described in this interview.

In addition, the FRI read, in part, "On 9/29/22, [Housekeeper "DD"] was interviewed, and

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[they] stated around 3:45 p.m., [they] witnessed, [R2] having physical contact with [R87]. Housekeeper "DD" stated, "It happened so quick I couldn't confirm if [R2] was holding [their] hands up, or [R2] pushed [R87]." A handwritten statement signed on 09/29/2022 by the Administrator and Nurse "T" read, in part, "9/29/22, Administrator contacted [Housekeeper "DD"] who reported that [R2] "pushed" [R87]. [Housekeeper "DD"] stated that at 3:45 PM, [they] witnessed [R2] push (sic) Administrator intervened an asked was it a push or did [R2] have [their] hands up. "It happened so quick I couldn't tell if [R2] pushed [R87] or had [their] hands up..." Note that the fact that Housekeeper "DD" independently said, before prompting, that R2 pushed R87. It was only after the Administered asked "was it a push or did [R2] have [their] hands up" that Housekeeper "DD" stated, "It happened so quick I couldn't tell if [R2] pushed [R87] or had [their] hands up..." Furthermore, it was not disclosed in the FRI that Housekeeper "DD" reported in this interview that R2 pushed R87.

On 03/16/2023 at 11:05 AM, Housekeeper "DD" was interviewed. When asked about R2 having any behavior issues, Housekeeper "DD" recalled the incident on 09/28/2022. When asked what happened, Housekeeper "DD" reported that R87 was in front of R2's door and R2 pushed R87 down. When asked where R2 pushing R87, Housekeeper "DD" indicated that R2 pushed R87 in the chest, and that R87 feel to the follow and hit a lift.

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Housekeeper "DD" stated that they reported to the nurse. When asked if residents were injured, Housekeeper "DD" reported that R87 was "bleeding from [their] head a bit." When asked who else beside the nurse they spoke with about the incident, Housekeeper "DD" indicated the DON and Administrator. When asked what they reported, Housekeeper "DD" stated, "What I just said to you."

Per the FRI, "On 9/29/22, [Administrator] asked [R87] what happened last night? [R87] explained that [R2] hit him in the chin. Immediate skin assessment was conducted with no concerns on his chin." A handwritten statement signed on 09/29/2023 by the Administrator and R2 confirmed the events, and it further added that they R87 was not able to say who hit them, other than that "it was a guy."

On 03/16/2023 at 11:58 AM, the Administrator was interviewed. When asked about what occurred on 09/28/2022 between R2 and R87, the Administrator reviewed the FRI submitted to the State Agency. The Administrator discussed R2's statement that they put their hands up and did not intend to harm R2. When asked if pushing someone suggests intent, the Administrator, again, talked about R2 putting their hands up to keep R2 from entering the room. When it was reported that staff interviewed reported the R2 pushed R87 and that there are multiple notes in R87's clinical record stating that they were pushed, the Administrator was not able

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	to offer an explanation. When asked if pushing someone suggests intent, the Administrator agreed. When asked if they were aware of reports that R87 had physical contact with R2, the Administrator stated that they were not and used what Housekeeper "DD" said for the investigation.			
F0607 SS= C	Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement written policies and procedures for their abuse policy in accordance with current	F0607	F607 Abuse and neglect policy Element 1: There was no specific residents were identified. The facility has reviewed and updated the abuse and neglect policy to affect the most current center for Medicare and Medicaid services. Element 2: Current residents residing in the facility have the potential to be affected by this deficient practice. The Abuse and Neglect Policy will ensure regulatory standards are being followed. Element 3: The Abuse and Neglect Policy has been reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The facility staff have been educated on the new abuse and neglect policy in accordance with current regulatory standards. Element 4: The Administrator/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance.	4/13/2023

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regulatory standards. This deficient practice has the potential to affect all 87 residents residing at the facility.

Findings include:

On 03/15/2023 a policy entitled "Abuse, Neglect, and Exploitation" (last revised in 06/2022) was found to not include/address all required CMS (Centers for Medicare & Medicaid Services) written policies and procedures that were effective 10/21/2022, implemented on 10/24/2022 as defined below:

III. Prevention:

The facility must have and implement written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves (but is not limited to):

-Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate

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relationship;

-Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes the implementation of policies that address the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any;

-Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently;

-The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as:

*Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;

*Physically aggressive behavior, such as hitting, kicking, grabbing, scratching,

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pushing/shoving, biting, spitting, threatening gestures, throwing objects;

*Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;

*Taking, touching, or rummaging through other's property;

*Wandering into other's rooms/space;

*Residents with a history of self-injurious behaviors;

*Residents with communication disorders or who speak a different language; and

*Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.

-Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions;

VIII. Coordination with QAPI: (Quality Assessment Process Improvement)

The facility must develop written policies and procedures that define how staff will communicate and coordinate situations of

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abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under §483.75.

Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action and tracking by the QAA Committee, at §483.75(g)(2).

This coordinated effort would allow the QAA Committee to determine:

*If a thorough investigation is conducted;

*Whether the resident is protected;

*Whether an analysis was conducted as to why the situation occurred;

*Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and

*Whether there is further need for systemic action such as:

*Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,

*Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about,

*Efforts to educate residents and their families about how to report any alleged

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	violations without fear of repercussions, *Measures to verify the implementation of corrective actions and timeframes, and *Tracking patterns of similar occurrences .... The Administrator was asked on 03/15/2023 at 10:45 AM and on 03/16/2023 at 4:01 PM if they had a more current policy, and no other information was provided by the end of the survey.			
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 State Survey Agency, within 5 working days of the incident, and if the alleged violation is	F0609	F609 Reporting of Abuse and Neglect Element 1: Residents # 45 and #76 still reside in the facility and are free from abuse and neglect. Element 2: All residents have the potential to be affected by the stated deficiency practice. An audit was conducted through an interview with residents ensuring any allegations of abuse or a suspicious crime and no concerns were identified. Element 3: The Abuse, Neglect and Exploitation/ Reporting Policy has been reviewed by the Administrator and was deemed appropriate. All staff have been educated on who the abuse coordinator is and reporting abuse immediately to them. The systemic change will be that visual rounds will be completed to ensure that abuse and neglect is not happening. Element 4: The Administrator/designee will complete an audit on 5 residents twice weekly x 4 weeks, then once weekly x 2 weeks. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Administrator will	4/13/2023

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	verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00133287 Based on observation, interview, and record review the facility failed develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for (R45 and R76) of five residents reviewed for abuse. Findings include: A facility policy entitled "Abuse, Neglect and Exploitation" (revised 06/2022) read, in part, "VII. Reporting/Response A. The facility will implement the following: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. 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 b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." Review of a facility reported incident (FRI) submitted to the State Agency (SA) on		be responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	

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12/08/2022 at 01:30 PM read, in part, "Approximately 1:25pm on 12/2/22 [Administrator] received notification from [PTA "EE"] that R45 had a physical altercation with [R76] in the passing in the hallway. [Administrator] interviewed [PTA "EE"] and [PTA "EE" stated, "[R45] was walking with [R76] in the hallway and witnessed [R45] slap [R76] in the stomach area." The FRI indicated that local police were not contacted until 12/05/2023 at 8:00 AM. Note that the incident occurred on 12/02/2022 at "approximately 1:25pm".

R45

Review of the clinical record revealed that R45 was admitted to the facility on 09/20/2017. Diagnoses include vitamin B12 deficiency, muscle weakness, ataxic gait, meibomian gland dysfunction of both eyes, dysphagia (a swallowing problem), schizoaffective disorder, and anxiety. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 02/11/2023 revealed that R45 required supervision with setup for near all activities of daily living (ADLs), other than limited one person assist for toileting. Per this assessment, they used a wheelchair and were severely cognitively impaired.

On 03/14/2023 at 02:11 PM, an interview as attempted with R45. R45 presented as confused. When asked if they had ever had any issues or altercations with other

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residents, they stated no. R45 indicated that they did not want to be interviewed further.

R76

Review of the clinical record revealed that R76 was admitted to the facility on 11/17/2022. Diagnoses include heart disease, dementia, anemia, high cholesterol, anxiety, and weakness. The most recent quarterly MDS assessment dated 02/23/2023 indicated that R76 required supervision with setup for most ADLs, other that limited one person assistance for dressing, toileting, and bathing. Per this assessment, R76 was severely cognitively impaired, and per progress notes, R76 was ambulatory.

On 03/14/2023 at 11:15 AM, an interview was attempted with R76. R76 presented as pleasantly confused. When asked if they had any alterations with other residents in the facility, they said no. When asked, they could not recall the incident that occurred on 12/02/2022.

A review of the Facility Reported Incident (FRI) further read, "On 12/2/22 [R45] was interviewed by administrator; [R45] turned [their] head and would not talk to [Administrator] while lying in the bed. On 12/5/22 [R45] was interviewed again stating [they] don't (sic) remember anything...On 12/2/22 [R76] was interviewed and stated [they] didn't remember anyone slapping [them]... Based on the investigation, the

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facility was able to substantiate the incident did happen, but there was no intend (sic) to harm, it was isolated incident in which resident's' (sic) don't remember it happening."

Review of the facilities investigation materials revealed a typed statement dated 12/02/2023 and signed by PTA "EE." The statement read, "Incident Report...Writer was walking with [R76] [room #] in hallway 2-south, as we walked by [R45], they slapped [R76] in her right abdominal area and started yelling (profanity). [R45] started yelling the words (racial profanity) at both of us while [they] rushed and laid in [their] bed. I spoke with the Certified Nurse Assistant (CNA) who was insight (sic) of about what just took place. The CNA and I both went to the nurse [name] and reported the incident to. In the mean (sic), immediately contacted my direct supervisor and reported the incident..."

On 03/15/2023 at 04:43 PM, PTA "EE" was interviewed. When asked about the incident between R45 and R76, PTA "EE" stated that they were walking with R76 when R45 slapped R76. When asked where R76 was slapped, PTA "EE" could not remember. PTA stated that R76 was calling PTA "EE" and R76 "profanity)." PTA "EE" stated that they reported the incident to the CNA and nurse on duty, though they could recall the staff's names, and they reported the incident to their supervisor. PTA "EE" confirmed that they were interviewed by the administrator.

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On 03/16/2023 at 11:39 AM, the Administrator was interviewed. When asked about the incident between R45 and R76, the Administrator reviewed the FRI as submitted to the State Agency (SA). The Administrator was asked to review the signed statement from PTA "EE." When asked why they did not include the racial slurs, the Administer stated that they were not aware that should provide the exact statement. When asked what they would consider the use of slurs, the Administrator stated, "A trigger." When asked if use of slurs could be considered verbal abuse, the Administrator agreed that it could. When asked if the use of the slurs should have been reported, the Administrator agreed that it should have been reported.

When asked how soon the facility should reported incidents such as that which occurred between R45 and R76, the Administrator reported two hours. When asked why the incident was reported late, the Administrator stated that he forgot to click the submit button, which they stated happened in the past, and, in that instance, the Administrator emailed the SA to report the error and had proof of the email. For this incident between R45 and R76, the Administrator did not contact the SA regarding not clicking the submit button. When asked why the police were not called until 12/05/2023, the Administrator stated that they could not recall why, though they stated that they thought the police had to be

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	contacted within five days of an incident. When asked about potential abuse situations like hitting someone in the stomach, the Administrator stated the police should be called right away.			
F0622 SS= D	Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility	F0622	F-622 Element 1: Resident #89 no longer resides in the facility. Element 2: All residents are at risk for this deficient practice. All residents who are their own responsible parties or have guardians and wish to leave the facility Against Medical Advice (AMA) will receive education on the risks and benefits of being discharged prematurely to ensure AMA protocols are being followed. Element 3: The Transfer and Discharge (including AMA) Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. Licensed nursing staff and the social services were educated on this policy with emphasis of following AMA discharge protocol. Any licensed nursing staff who have not received education will do so prior to their next workday. Systemic change: Unit Managers will ensure documentation of education of risks and benefits of discharging AMA and appropriate paperwork are signed. Element 4: The DON/designee will complete audits M-F weekly x 6 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of Nursing is responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	4/13/2023

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	pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need (s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,			

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consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

This citation pertains to Intake: MI00130881.

Based on interview and record review the facility failed to follow the protocol for an Against Medical Advice (AMA) discharge for one (R89) of two residents reviewed for discharge, when R89 left the facility shortly after having been transferred from the hospital to the facility for rehab care. Findings include:

On 3/14/23 at 4:32 PM, an interview was conducted with the complainant who stated in part, " ... (R89) had open heart surgery ... the facility was closest to his home. No one (facility staff) was there to receive us ... his room was filthy ... there was no television in there and the TV was not our main concern, the cleanliness and his care was our concern ... He chose not to stay there, and we called (hospital name) and talked to the head nurse who told us to go back to the ER (Emergency Room) ..."

Review of the hospital documentation provided to the facility upon R89's admission documented the resident was accepted to be transferred from the hospital to the facility with the primary diagnosis of Atherosclerosis

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of aorta, Atherosclerotic heart disease of native coronary artery.

Review of a "Nursing Progress Note" dated 7/29/22 at 6:58 PM, documented in part " ... Patient arrived ... at approx. 6:45 p.m. Vitals: BP (blood pressure) 129/74, HR (heart rate) 87, temp (temperature) 97.9, resp (respirations) 18 and sp02 (pulse ox) 96%... orientated to room and call light system. Resident concerned about TV being in room. He stated if room doesn't come with TV, he isn't staying ... DON (Director of Nursing) notified ... Patient took discharge instructions and exited facility, transferring back to hospital. DON notified."

Further review of the medical record revealed no documentation of the physician to have been notified of the resident to have requested to be discharged or of any staff member to have educated the resident on the risks concerns for their health regarding discharging from the facility prematurely.

On 3/16/23 at 2:32 PM, the Director of Nursing (DON) was interviewed and asked about R89's admission and resident-initiated discharge. The DON stated they were not the DON at the time of the incident but did not feel as if the resident was admitted to the facility because the facility nurse did not complete an assessment. The DON was asked how a resident was transferred from the hospital to the facility, entered into the facility, entered into the assigned room and

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	had vitals completed was not considered as an admission to the facility? The DON did not respond. The DON was then asked what the nurse should have done based on the facility's protocol for a resident who admits to the facility then requests to be discharged? The DON stated they would look into it and follow back up. At this time the facility's AMA protocol was requested from the DON. Review of a facility policy titled "Transfer and Discharge (including AMA)" dated "10/2021" documented in part, " ... Discharge Against Medical Advice (AMA) ... The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. The physician should be notified and encouraged to speak with the resident ... Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present ... Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly ..." No further information or documentation was provided by the end of survey.			
F0658 SS= E	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the	F0658	F-658 Wound Treatment Element 1: Both residents #21 and #47 still reside at the facility. The wound care nurse received 1:1 education immediately on	4/13/2023

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	comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure professional standards of practice were followed for two residents (R21 and R47) of 19 residents reviewed for professional standards. Findings include: R21 On 3/14/23 at 10:12 AM, R21 was observed lying in a bed with a low air loss mattress (used to prevent and treat pressure wounds). R21 was asked if he had any wounds or sores on his body. R21 explained he had several wounds. Review of the clinical record revealed R21 was admitted into the facility on 7/12/22 and readmitted on 11/18/22 with diagnoses that included: cerebral palsy, seizures and anxiety. According to the Minimum Data Set (MDS) assessment dated 1/18/23, R21 was cognitively intact and required the total dependence on staff for all activities of daily living (ADL's). The MDS assessment also indicated R21 had pressure wounds. Review of R21's Wound Doctor's progress note dated 3/7/23 read in part, "...Plan: WOUND TREATMENTS: PLEASE CLEANSE OPEN AREA(S) WITH NORMAL SALINE OR		following physician□s orders for treatment orders and resident□s treatment was completed correctly with no further concerns. The attending nurse for resident #47 received immediate 1:1 education with returned demonstration on how to draw insulin from a vial correctly. Element 2: All residents are at risk for this deficient practice. A medication observation was conducted to ensure professional standards of practice are met. Element 3: The Standard of Practice Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. Licensed nursing staff were educated on this policy with emphasis to meet professional standard of practice. Any licensed nursing staff who have not received education will do so prior to their next workday. Systemic change: pharmacy consultant will review monthly medication observations to ensure compliance. Element 4: The DON/designee will complete audits M-F weekly x 4 weeks, then M-W-F weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of Nursing is responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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	WOUND CLEANSING SOLUTION AND DRY. LEFT ISCHIUM (hip)---PLEASE APPLY DAKIN'S MOISTENED GAUZE INTO WOUND BED. COVER WITH GAUZE/ABD'S (abdominal pads) IN A WET TO DRY FASHION... LEFT BUTTOCK, RIGHT BUTTOCKS---PLEASE APPLY SANTYL AND COVER WITH DAKIN'S MOISTENED GAUZE TO WOUND SURFACE AND COVER..." On 3/16/23 at 10:02 AM, R21's wound care was observed with Registered Nurse (RN) "B". RN "B" explained R21 had three wounds, but the treatment was the same for all three wounds. RN "B" was observed to put Santyl ointment into a medicine cup, pour Dakin's Solution 0.5% into a water cup and pour Normal Saline into another water cup. RN "B" entered R21's room, and placed the treatment supplies on R21's over bed table. After preparing R21, and removing the old, soiled dressings, RN "B" opened a sterile 4x4 gauze dressing, folded the gauze and dipped it into the cup with the Dakin's solution, then opened the gauze and placed it on her flat, gloved hand then with her other gloved hand, took some of the Santyl ointment and smeared the ointment onto the wet gauze with her fingers. RN "B" then placed the wet gauze with Santyl smeared on it and placed it on R21's left ishium wound. RN "B" proceeded with the same procedure of wetting the gauze in the Dakin's solution, then smearing Santyl onto the wet gauze for R21's left buttock wound and right buttock wound. RN "B" was asked if this was how she			

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always changed R21's dressings. RN "B" agreed that was how she always did the wound care.

Review of R21's March 2023 Treatment Administration Record (TAR) revealed the treatments for both the right and left buttock included both Santyl ointment and Dakin's Solution, however the treatment for R21's left ishium was for Dakin's Solution alone, no Santyl ointment.

On 3/16/23 at 2:26 PM, the Director of Nursing (DON) was interviewed and informed of the observation of R21's wound treatment. The DON explained nurses should always follow physician orders for all wound treatments. When asked it was appropriate to use fingers to smear Santyl ointment onto a wet gauze pad, the DON had no answer.

Review of the manufacturers website, "santyl.com/how-to-apply" dated 2023 read in part, "...2. Apply: Apply SANTYL Ointment directly to the wound source once a day at a 2 mm (millimeters) thickness, or about the thickness of a nickel..."

R47

On 3/14/23 at 9:31 AM, an observation was conducted of Registered Nurse (RN) "S" prepping to administer morning medications for R47. RN "S" was observed to have obtained an opened Insulin Lispro vial that was not dated. The nurse was observed to

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have obtained an insulin syringe, removed the cap of the syringe and inserted the needle into the vial and withdrew 14 units into the syringe.

Review of a MedlinePlus "Drawing medicine out of a vial" dated 1/29/22, documented in part " ... With the cap still on (syringe), pull back the plunger to the line on your syringe for your dose. This fills the syringe with air ... Insert the needle into the rubber top ... Push the air into the vial. This keeps a vacuum from forming. If you put in too little air, you will find it hard to draw out the medicine. If you put in too much air, the medicine may be forced out of the syringe ... Turn the vial upside down and hold it up in the air. Keep the needle tip in the medicine ... Pull back the plunger to the line on your syringe for your dose ..." Drawing medicine out of a vial: MedlinePlus Medical Encyclopedia

At 9:51 AM, RN "S" was then observed to have obtained an opened Insulin Glargine vial that was not dated. The nurse was observed to have obtained an insulin syringe, removed the cap of the syringe and inserted the needle into the vial and withdrew 30 units into the syringe. The nurse failed to draw up air of the required dose into the syringe before inserting it into the vial and withdrawing the required Insulin Glargine dose.

At 9:55 AM, RN "S" stated per R47 insulin orders they had to draw up another 10 units

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	of Insulin Lispro. RN "S" was observed to have obtained the syringe that contained the already drawn 14 units and reinserted the same syringe into the Insulin Lispro vial again and withdrew another 10 units. On 3/16/23 at 8:52 AM, the Director of Nursing (DON) was interviewed and informed of the observation with RN "S" when asked the DON acknowledged that RN "S" technique for withdrawing insulin was not correct and stated they would provide the nurse with additional education.			
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: Based on interview and record review the facility failed to act on an identified change of condition for one (R86) of one resident reviewed for a closed record death in the facility, resulting in the resident to have a change of condition and the physician not being notified, and no transfer to the hospital for a higher level of care. Findings include:	F0684	F-684 Element 1: Resident #86 no longer resides at the facility. Element 2: All residents are at risk for this deficient practice. A facility audit was conducted on residents with Do Not Resuscitate (DNR) status that have other treatment options which may be utilized to maintain comfort and quality of life such as yes to hospitalization (addressing change in condition that may require hospitalization to a higher level of care), antibiotics, oxygen therapy, etc. and orders will be updated to reflect the residents wishes. Element 3: The Change in Condition Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. Licensed nursing staff were educated on this policy with emphasis on Do Not Resuscitate (DNR) with special instructions such as hospitalization, antibiotics, oxygen therapy, etc. Any licensed nursing staff who have not received education will do so prior to their next workday. Systemic change: Unit Manager will review the 24-hour	4/13/2023

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	Review of the medical record revealed R86 was initially admitted to the facility on 12/11/21, with a readmission date of 6/22/22 and diagnoses that included: systolic congestive heart failure, dysphagia, weakness and cellulitis of the left toe. A Minimum Data Set (MDS) assessment dated 11/23/22, documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition and required staff assistance for all Activities of Daily Living (ADLs). Further review of the medical record revealed a "Medical Treatment Decision Form" dated 5/12/22, which documented the wishes of R86's representative, " ... In the event that your heart and breathing should stop, we will provide emergency treatment based on your decision ... DNR (Do Not Resuscitate) ... Other Treatment Options ... These treatment options may be utilized to maintain comfort and quality of life, treat acute conditions, or describe what kind of care you want if you have an illness that you are unlikely to recover from ... YES- Hospitalization ... Pain Management ... Antibiotic Treatment ... Oxygen Therapy ..." the form was signed by the resident representative, two witnesses and the physician. Review of the progress notes documented the following: On 1/22/2023 at 11:40 PM, a "Nursing" note documented in part " ... resident lethargic at		report to ensure residents with change of conditions are addressed appropriately. Element 4: The DON/designee will complete audits M-F weekly x 4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of Nursing is responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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this time and not able to take medication ..."

On 1/23/2023 at "00:00" a "Nursing" note documented in part " ... Resident appears to be lethargic at this time, with 02 (oxygen) sat (saturation) 82% via NC (nasal cannula) at 4 lpm (liters per minute). In and out of sleep, respirations shallow."

Review of a physician oxygen order with a start date of 5/23/22, documented in part " ... Oxygen as needed with sterile water, 2 L (liters) NC (nasal cannula), as needed for SPO2<92%..." This note was documented by Registered Nurse (RN) "B".

Review of the medication record revealed no documentation of the nurse to have increased the resident's oxygen to maintain a safe oxygen level (92% or over), no documentation of the physician to have been informed of the resident's change in condition and no documentation of the resident to have been sent to the hospital following their change of condition.

A "Nursing" note dated 1/23/23 at 7:30 AM, documented by RN "B" noted in part " ... 01:00 BP (blood pressure) 98/60, T (temp) 97.3 RR (respirations) 16, 02 (oxygen saturation level) 82 % @ (at) 4L (liters) via NC, resident not verbally responding at this time or making eye contact; shallow breathing noted. 02:30 RR 16: no changes in patient status at this time. 04:00 RR 14; no other changes in patient status at this time.

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Resident not verbally responding at this time or making eye contact, showing no signs or symptoms of pain or discomfort. 05:30 RR 14; no changes in patient status at this time. 06:45 CNA (Certified Nursing Assistant) called RN (Registered Nurse) into room due to patient status at this time. RN noted no vital signs detected at this time; absent pulse, no rise and fall of chest. Time of death called at 06:45am. Physician, resident's son, and unit manager notified ..."

This indicated the resident change of condition was identified at 1:00 AM, and the facility staff failed to conduct follow-up monitoring of the resident's pulse oxygenation levels after having identified it as being abnormal, the facility staff failed to initiate treatment to improve R86's oxygen level, the facility staff failed to notify the physician of the change of condition and failed to send the resident out to the hospital for further care. This change of condition was first identified at 1:00 and left untreated for five hours and 45 minutes later when the resident was found with no vital signs and time of death was called.

Review of a facility policy titled "Change in Condition" revised "07/20" documented in part, " ... It is the policy of this facility to inform ... attending physician ... of a change in the resident's condition ... The facility will inform the resident; consult with the resident's physician ... A significant change in the resident's physical, mental, or

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psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications ..." The facility staff failed to follow the facility's policy.

On 3/16/23 at 2:46 PM, RN "B" was interviewed and asked to review their notes in the medical record on R86 as noted above. After reading their notes RN "B" was asked why no further assessments of R86's pulse ox levels were obtained, why their oxygen was not increased to maintain a level of 92%, why the physician was not notified of the change in condition and why the resident was not sent out to the hospital. RN "B" stated R86 was a DNR (do not resuscitate), which was acknowledged however it was pointed out to RN "B" that R86's advance directive documented the wishes of R86 to receive "hospitalization ... Pain Management ... Antibiotic Treatment ... Oxygen Therapy ..." if necessary. RN "B" stated they could not remember exactly back to that moment on why they did not increase the resident's oxygen, notify the physician or send the resident out to the hospital. RN "B" stated they could not remember the details of the incident.

On 3/16/23 at 2:56 PM, the Director of Nursing (DON) was interviewed and asked to read nursing notes documented by RN "B" as noted above. Once completed, the DON was asked what should have been done for R86 and the DON replied that the nurse should

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	have increased the oxygen and called the physician. The DON stated if the interventions did not work in bring the resident's oxygen level back up then the resident would have been sent out to the hospital. The DON was then asked why the facility failed to complete all of the interventions and notify the physician of R86's change of condition and the DON stated they would look more into it and follow back up. At 3:54 PM, the DON returned and stated the nurse saw that R86 was an DNR, however failed to look at the resident wishes documented on the advance directive. When asked what a DNR had to do with treating a resident in respiratory distress, notifying the physician and sending the resident out for further treatment, the DON did not have a response. No further explanation or documentation was provided by the end of survey.			
F0693 SS= G	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the	F0693	F-693 Element 1: Resident #9 still resides at the facility. The attending nurse immediately received 1:1 education on timely administrating of tube feeding orders to prevent dehydration, weight loss, hospitalization, and psychosocial distress. Element 2: Like residents are at risk for this deficient practice. An audit was conducted on residents receiving enteral feedings to ensure they are receiving the right tube feedings, right rate, and right flushes per physician□s orders to ensure nutrition. Element 3: The Care and Treatment of Feeding Tube Policy was reviewed by the	4/13/2023

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	appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer the ordered amount of enteral tube feeding (liquid nourishment administered directly into the stomach through a feeding tube) and hydration (water) per physician order for (R9) of one resident reviewed for tube feeding, resulting in dehydration, weight loss, hospitalization, and psychosocial distress utilizing the reasonable person concept. Findings include: R9 was originally admitted to the facility on 11/21/22 and recently readmitted after hospitalization on 1/31/23 with primary diagnoses that includes Alzheimer's disease, anxiety disorder, pressure ulcer of the left heel, difficulty swallowing, diabetes mellitus, and respiratory failure. Based on the MDS (Minimum Data Set) assessment dated 2/6/23, R9 needs extensive assistance for repositioning in bed and totally dependent on staff assistance for transfers. Unable to complete resident interview with R9 to complete BIMS (Brief Interview of Mental Status) as they were non-verbal. Staff interview indicates severe cognitive impairment. R9's admission dated 11/23/22 was 156.3 lbs. and weight dated 3/7/23 (weight completed twice)		Administrator and the Director of Nursing and was deemed appropriate. Licensed nursing staff were educated on this policy with emphasis on timeliness of tube feeding administration and following physician�s orders. Any nurse who has not received education will do so prior to their next workday. Systemic change: Unit Managers will complete daily rounds to ensure the tube feedings are administered per physician�s orders. Element 4: The DON/designee will complete audits M-F weekly x 4 weeks, then M-W-F weekly x 2 weeks to assure the residents are receiving the right amount of tube feedings per physician�s orders. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of Nursing is responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	

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was 129 lbs.

On 3/14/23 at approximately, 9:50 AM, an initial observation of R9 was completed. During initial observation R9 was observed in bed with eyes closed. R9 had dry lips and sunken cheeks and did not respond when called his name. R9's head of bed was up at approximately 30 degrees. R9 was nonverbal and coughed during the observation. R9 had a wet cough. An unopened bottle of Glucerna 1.5 CAL (liquid nourishment) and a bag of water were hanging on the stand next to the bed. The label in the bottle had R9's name, dated for 3/14/23, start time 9:00 AM, with rate at 85 ml/hr. The water bag was dated for 3/14/23 and start time was marked as 9:00 AM. R9's tube feeding was not on during this observation.

On 3/14/23 at approximately, 11:20 AM, R9 was observed leaving the facility in via ambulance. At approximately, 12:30 PM, staff member "H" was queried regarding R9. Staff member "H" reported that they were sent out to hospital due to clogged PEG (Percutaneous Endoscopic Gastrostomy tube - a tube directly placed on stomach to provide nutrition and hydration) tube. R9's hospitalization was later confirmed by the staff member "L".

On 3/14/23 two subsequent observations were completed at approximately 2 PM and 3 PM, and R9 was not in their room. R9 was out of the facility, had not returned from the hospital.

On 3/15/23, three observations were made at approximately 8:15 AM, 9:15 AM, and 9:45 AM. R9 was in their bed with eyes closed. R9 was not getting any nutrition through the PEG tube during these three observations. The tube feed stand next to the bed did not have any tube feeding bottle during all three observations. R9's abdominal binder was laying in a chair next to the bed.

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Review of R9's EMR (Electronic Medical Record) revealed the following orders:

NPO (nothing through mouth) diet effective 1/31/23; enteral feed order-flush with 30 ml (milliliters) H2O (water) before/after meds, before initiating feeding or when there is an interruption of feeding to maintain tube patency effective 1/31/23; ONE TIME A DAY Glucerna 1.5 1360 ml (milliliter) @ 85 ml/hr. x 16 hrs. up 4 PM down 8 AM or UNTIL FORMULA INFUSED effective 1/31/23; and three times a day Bolus flush 200 ml H2O for hydration. Order also read, ensure that binder is in place to secure PEG tube in place except for showers/bed bath every shift.

R9 also had new physician orders for Albuterol (2.5 ml/3 ml) 3 ml nebulizer treatments four times/day for shortness of breath and secretions, Pulmicort inhaler 0.25 mg/2 ml once every 12 hours for secretions, Tussin-DM oral syrup 30 ml via PEG tube four times a day for cough and secretions. These medications were ordered on 3/13/23.

R9's care plan review revealed a focus area and goal as follows: "I am unable to meet nutritional needs by mouth as evidenced by: NPO status. I receive my fluids via PEG tube. I will maintain adequate nutritional and hydration status as evidenced by stable weight, no s/s of malnutrition or dehydration ...".

Further review of R9's EMR revealed the following:

A progress note dated 3/14/23 completed by the practitoner at 10:55 AM read, " ...seen for eval PEG clogged overnight, unable to be clogged by staff and myself .... will transfer to hospital for exchange as unsuccessful with removing old for

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exchange. chest congestion, immobility".

Nursing progress note did not indicate the amount of nutrition and water R9 received via PEG tube prior to the clogging that happened overnight per practitioner note. A review of R9's tube feeding administration record completed by staff member "H" revealed that R9 had not received his nutrition via tube feeding as ordered indicated by code "9". No other additional information was found on R9's EMR during the initial record review on 3/14/23 at approximately 15:00.

A progress note dated 3/14/23 at 15:30, completed by staff member "H" (assigned to care for R9 from 7 AM - 7 PM shift) read, "R9 transferred out to ---hospital per doctors orders for clogging of PEG tube, no s/s (signs and symptoms) of distress upon transfer, family member notified of transfer". Staff member's progress note clearly indicated that on 3/14/23 at 15:30 PM, R9 was out at the hospital during this time.

A progress note the same day, dated 3/14/23, completed at 19:03 by staff member "H" read, "Resident returned to facility via ambulance, no s/s any distress, peg tube working well, currently lying bed, VS stable, 138/62 74 16 97.6 98%, call light within reach, safety and comfort measures met, will continue to monitor".

A review of R9's tube feeding administration record completed by staff member "H" revealed that R9 did not receive their 200 ml of bolus flush on 3/14/23 at 12:00 and 15:00 as ordered as R9 was at the hospital, indicated by a code "6".

The administration record also revealed that R9 did not receive their tube feeding on 3/14/23 after returning from hospital, from a clogged PEG tube. The administration record signed by staff

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member "H" indicated that R9 was hospitalized by a code "6". No additional documentation on R9's EMR indicated that R9 received their nutrition and hydration upon return from hospital. Three observations were completed on 3/15/23 at approximately 8:15 AM, 9:15 AM, and 9:45 AM. During these observations R9 was not getting their feeding as recommended by the dietician and ordered by the physician.

A nutrition at risk note dated 3/14/23, completed at 8:26 AM, revealed that R9 had 15% weight loss in 30 days and nutritional needs of R9 are increased due to low BMI (Body Mass Index). R9 also had a pressure ulcer on left heel. R9 was receiving daily treatments to their left heel pressure ulcer.

A progress note dated 3/14/23 completed by the Director of Nursing (DON) at 21:33 read, "R9 has wt (weight). loss 19 lbs. (pounds) in 30 days. --- (practitioner) phoned and made aware of plan of care. Writer also text message family member 'M' requested phone conference, received response, scheduled for 3/15 at 9:30 AM".

An interview was completed with family member "M" on 3/14/23 at approximately, 7:05 PM. During the interview family member "M" indicated that they were at the facility most of the days. Family member "M" reported that they visited during late afternoons. Family member reported that they were at the facility on 3/13/23 late afternoon when R9's PEG tube was clogged. Family member "H" reported that R9 did not receive his nutrition and water. Family member was unsure if R9 received any of their medications that afternoon when the tube was clogged.

On 3/15/23 at approximately, 10:50 AM, an interview was completed with staff member "L".

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	Staff member was queried on discharge documents from 3/14/23 hospital emergency visit. Staff member "L" reported that there was no change in R9's orders and provided a copy of the discharge instructions from the hospital. Staff member reported that R9 returned late from the hospital on 3/14/23. Staff member was queried on the amount of tube feeding and duration. Staff member "L" reported that the staff were administering the tube feeding as ordered by the physician and R9's tube feeding ran until the ordered amount was completed. An interview was completed on 3/15/23, at approximately 10:40 AM, with staff member "H". Staff member "H" was assigned to care for R9 on 3/14/23 (from 7 AM to 7 PM). Staff member was queried about R9 returning from hospital late on 3/14/23 and their tube feeding status. Staff member was made aware that multiple observations in the AM were made on 3/15/23 when R9 was not receiving their nutrition. Staff member "H" reported that they disconnected the tube feeding around 8:30 AM. An interview with Staff member "K" was completed on 3/15/23 at approximately 11:00 AM. Staff member "K" identified themselves as a corporate support staff member covering the facility. Staff member "K" was queried on R9's status and tube feeding orders. Staff member "K" reviewed the EMR and reported that R9 had a significant weight loss and needed that nutrition as ordered, 1360 ml at 85 ml/hr. x 16 hrs., started at 4 PM and ran until it is fully administered. Staff member "K" reported that staff should have started after R9 returned from the hospital. A review of the tube administration record with staff member "K" for 3/14/23 revealed R9 was hospitalized. Staff member "K" reported that tube feeding should be running for 16 hours or until the ordered dose was administered and did not provide any further explanation.			

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A record review revealed a late entry progress for 3/14/23, completed on 3/15/23 at 16:48, by staff member "Q". Staff member "Q" was not assigned to R9, based on record review of staff schedules provided by the facility. Staff member "Q"'s late entry note read, "Resident arrived at 15:30 to the facility, PEG tube hung at 1600. PEG tube functioning well, meds given per doctors' orders, no s/s of distress, will continue to monitor".

An interview was completed with the staff member "Q" on 3/16/23 at approximately, 7:10 AM regarding the facility staffing. During the interview staff member "Q" had indicated they worked 12 hours from 7 PM to 7 AM. The staffing schedule provided by the facility did not have staff member "Q" on schedule to work for 3/14/23. Record review confirmed that staff member "Q" was not assigned to care for R9 on 3/14/23. This late entry note was completed after the concern regarding R9's tube feeding administration was brought up to the attention of facility's nursing administration.

An interview was completed with the DON on 3/15/23, at approximately 11:20 AM. The DON was queried on the orders, administration note for tube feeding, the nutrition administration duration of 16 hours and R9's late afternoon arrival from hospital on 3/14/23. The DON reported that R9 returned from hospital sometime before 7 PM on 3/14/23. This Surveyor notified the DON of the multiple observations made on 3/15/23 AM when R9 was not receiving their tube feeding. The DON agreed that if tube feeding was started after R9 returned from hospital, it should have been running in the AM during surveyor observations. The DON reported that they will follow up with the staff, calculate the missed dose and administer the missed dose to R9.

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	R9 also did not receive their ordered dose of nutrition and hydration on 3/13/23 due to a clogged PEG tube. An interview was completed with the staff member "CC" on 3/16/23, at approximately 12 PM, regarding R9's significant weight loss and most recent MDS assessment with a locked date of 3/10/23. Staff member "CC" reported that R9's significant weight loss was not coded in this MDS assessment as the weight loss was out the assessment reference date range.			
F0697 SS= D	Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a scheduled pain medication was made available timely for one (R5) of one resident reviewed for pain management, resulting in the potential for prolonged pain and reduced efficacy of the pain management regimen. Findings include: A record review revealed that R5 was initially admitted to the facility on 11/24/21. R5 was recently readmitted to the facility on 2/16/23 following a hospitalization. R5 was admitted with the diagnoses that include acute respiratory failure with hypoxia; difficulty walking; unspecified joint disorder; gout; major depressive disorder, bipolar disorder, and chronic heart	F0697	F-697 Element 1: Residents R5 still reside at the facility. The resident is currently receiving pain medication timely per physician�s order and has no concerns. Element 2 All residents are at risk for this deficient practice. An audit was conducted to ensure all residents receiving scheduled or prn narcotic pain medications are available for administration to ensure pain management is addressed. Element 3 The Pain Management Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. Licensed nursing staff were educated on this policy with emphasis on availability of pain medications. Any licensed nursing staff who have not received education will do so prior to their next workday. Systemic change: The Unit Managers will run a report to ensure the residents receive their pain medications. Element 4 The DON/designee will complete audits M-F weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of	4/13/2023

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	failure. According to the Minimum Data Set (MDS) assessment dated 12/01/22, R5 needed extensive assistance from staff members to assist with positioning and mobility in bed, and to transfer from bed to chair or wheelchair. On 3/15/23, at approximately 1:15 PM, an observation was completed in R5's room. R5 was observed lying in his bed. An interview with R5 was completed. During the interview R5 reported that they were in pain, and they were not receiving the pain medications as ordered by their doctor. R5 was frustrated and reported that staff had informed him that the facility had been waiting for the pain medications to arrive from the pharmacy. R5 reported that they did not understand why it was taking long time to get their pain medications. A review of R5's EMR (Electronic Medical Records) revealed that the practitioner had re-ordered Oxycodone 10 mg (milligrams) every 4 hours for pain on 3/14/23. The initial order for Oxycodone was for 10 mg every 4 hours was (initiated on 2/17/23, ended on 3/14/23). A review of R5's electronic Medication Administration Record (e-MAR) revealed that R5's oxycodone was scheduled for the following times: 00:00 (12 AM); 4:00 (AM); 8:00 (AM); 12:00 (PM); 16:00 (4 PM); and 20:00 (8 PM). R5 had missed four (8 AM, 12 PM, 4 PM and 8 PM) doses on 3/14/23, marked by chart code "9". Administration legend reads code "9" as "other/see nurses notes". R5 had missed four (4 AM, 8 AM, 12 PM, and 4 PM) out of six scheduled doses of pain medication on 3/15/23, marked by chart code "9". Further review of R5's nursing progress notes revealed that the ordered scheduled pain		Nursing is responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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medication were not administered as they were not available. Medication administration notes for scheduled Oxycodone 10 mg every 4 hours read as follows: notes dated 3/15/23 completed at 16:19 read, "awaiting pharmacy"; dated 3/15/23 at 12:12 read, "awaiting pharmacy"; dated 3/15/27 at 8:27 read, "awaiting pharmacy"; dated 3/15/23 at 7:06 read, "not available order from pharmacy"; dated 3/15/23 at 7:03 read, "not available order from pharmacy"; dated 3/15/23 at 7:02 read, "not available order from pharmacy"; dated 3/14/23 at 17:08 read, "awaiting pharmacy"; dated 3/14/23 at 9:38 read, "awaiting pharmacy".

A practitioner note dated 3/14/23 at 20:30 read, "...seen for evaluation. Percocet not available from pharmacy and is presently out". Note also read "D/W (discussed with) ...R5 to change to oxy 10 mg. Q (every) 4 hours due to pharm issues, and ..R5 agrees, script faxed".

R5 also had a physician order to receive Tylenol 325 mg 2 tablets every 8 hours PRN (as needed) for pain, initiated on 2/17/23. Based on e-MAR and nurses progress notes, R5 was not offered his PRN Tylenol on 3/14/23 and 3/15/23 when R5 did not receive their scheduled pain medication. There was no documentation on R5's EMR on why PRN Tylenol was not offered to the resident. Record review did not reveal that practitioner was contacted on 3/14/ 23 and 3/15/23 when the scheduled pain medications were not administered to R5.

An interview was completed with staff member "J" on 3/16/23, at approximately 12 PM. Staff member "J" was assigned to care for R5 during that shift. Staff member "J" was queried on the facility's pain medication administration protocol. Staff member "J" reported that they will do a pain assessment before administration and check

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	effectiveness after administration. When queried further on the new pain medication order, staff member "J" reported that the facility had a medication backup box, and they will follow the facility protocol and retrieve from the backup box. Staff member "J" added that the backup box did not have the ordered medication and they will call the physician and get an alternate medication to address resident's pain. An interview was completed with the Director of Nursing (DON) on 3/16/23, at approximately 12:10 PM. The DON was queried on the facility protocol on new orders for pain medication. The DON reported that if they received a new pain medication order that staff followed up with the pharmacy to order the medication. If the pharmacy needed a script, facility staff were following up with the practitioner. The practitioner then signed and faxed the scripts to the pharmacy. The DON also reported that the facility has a backup box and they had oxycodone, Tylenol 3 etc. and added they would check the backup box to see what was available.The DON agreed that staff should have followed up with the physician to get an alternate if the ordered medication was unavailable in the backup box. The DON reported that they were going to follow up to see what had happened. A review of the updated backup box medication list provided by the facility on 3/16/23 revealed that ordered pain medication was available in the facility's medication backup box. The facility did not provide any further explanation on why R5 had missed eight doses of their scheduled pain medication between 3/14/23 and 3/15/23, why PRN pain medication was not offered, and why there was no follow up with the physician.			
F0727 SS= F	RN 8 Hrs/7 days/Wk, Full Time DO §483.35(b) Registered nurse §483.35(b)(1)	F0727	F-727 Element 1 The facility failed to accurately	4/13/2023

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	Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a Registered Nurse (RN) provided advanced care activities and coordination of care at least 8 consecutive hours/day, 7 days a week, and failed to accurately document the hours and maintain records for the services provided by the RNs resulting in a potential for negative clinical outcomes for all 86 residents residing in the facility. Findings include: Review of the facility's staffing schedule for 3/11 and 3/12 revealed no documented consecutive RN hours. A review of the facility's PBJ (Payroll Based Journal) reporting revealed that facility did not have 8 consecutive hours of RN services on 07/02/22, 8/13/22, 8/27/22, and 9/10/22. These hours are self-reported by the facility. . An interview was completed with staff member "O" on 3/16/23 at approximately 8:20 AM. Staff member "O"was queried on the facility process to ensure 8 hours of RN coverage. Staff member		document the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week due to the facility□s oversight. The facility now has accurate documentation of the services of a Registered Nurse (RN) coverage for 8 hours per day, 7 days a week to ensure coordination of care and positive clinical outcomes. Element 2 All residents are at risk for this deficient practice. The nursing staff information will be posted daily and will contain the following information: Facility name, current date, current resident census, the total number, and actual hours worked by the following categories of licensed staff directly responsible for resident care per shift. Registered Nurses, Licensed Practical Nurses, and Certified Nurse□s Aides. Element 3 The Nurse Staff Posting Information Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The Administrator, Director of Nursing, and Staffing Coordinator were educated on this policy with emphasis on daily 8 hours Registered Nurse (RN) coverage 7 days a week. The facility will have daily posting of staffing information visible to residents, visitors, and staff. Element 4 The DON/designee will audit daily posting of staffing information to include 8 hours of Registered Nurse (RN) coverage daily x 6 weeks to ensure proper coordination of care for the residents. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. The Director of Nursing is responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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"O" reported that they had completed the schedule and notified the DON (Director of Nursing) via e-mail when the facility did not have RN coverage. The DON had arranged for the RN coverage for the days they needed coverage. When queried on the missing RN coverage for 3/11/23 and 3/12/23 based on the staffing sheet, staff member "O" reported that they had arranged for an RN manager to cover for 3/11/23 and the DON covered 3/12/23. Staff member "O" was requested to provide documentation that the RN manager and DON provided 8 consecutive hours of service at the facility. Staff member "O" reported that they did not have any documentation for the hours that RN services were provided by their nurse managers and requested to get hours from the Administrator.

Staff member "O" was queried on the four days (7/2/22, 8/13/22, 8/27/22, and 9/10/22) that the facility did not have 8 consecutive hours of RN services, from PBJ report, from 7/1/22 to 9/30/22.Staff member "O" reported that on 7/2/22 and 8/13/22 they had arranged RN nurse managers to cover, and on 9/10/22 they had scheduled a RN staff member from agency. Staff member "O" added that they cannot verify the time that these staff members were at the facility on any of these dates. Staff member "O" reported that they had no RN services on 8/27/22.

An interview was completed with the Administrator on 3/16/23, at approximately 8:55 AM and they were queried on the missing RN service hours on the above listed dates and to provide documentation for the hours covered by the RN. The administrator reported that RN managers did not clock in, and they did not have documentation to verify that 8 consecutive hours of RN services were provided on these dates.

A request to provide the facility policy on RN

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	coverage was requested and not received by the end of the survey.			
F0730 SS= F	Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that regular in-service training was provided every 12 months to four Certified Nurse Aides (CNAs) resulting in the potential for physical, psycho-social harm and diminished quality of care for all 86 residents residing at the facility. Findings include: On 3/16/23 at approximately 9:25 AM, an interview was completed with staff member "R". During the interview, the staff member "R" was requested to provide annual performance evaluations and in-service records for staff members "U", "V", "W", and "X" with the following hire dates. Staff member "U" - DOH (Date of Hire) - 3/2/22 Staff member "V" - DOH - 10/8/12 Staff member "W" - DOH - 12/8/21 Staff member "X" - DOH - 6/23/15	F0730	F-730 Element 1 Performance reviews/in-service education have been completed for 4 CNAs, staff member UVW, and X to ensure the required 12 hours annual in-service training within the required time frame to assure educational needs and resident care needs. This occurred due to oversight of annual CAN in-service training. Element 2 All residents are at risk for this deficient practice. CNA staff have received performance reviews. In-service training has been scheduled. Element 3 The Director of Nursing has reviewed the federal rules and regulations, 483.36(d) and 483.95(g). The Certified Nursing Assistants (CNAs) have been educated on the yearly performance review and 12-hour in-service education regulations. A schedule has been developed to provide the 12-hour in-service training for all CNAs. The Human Resource Manager/designee will be responsible for monitoring the CNA in-service schedule for compliance. The Human Resource Manager will present a compliance report in the monthly QAPI meeting. Element 4 The Director of Nursing will audit the progress of CNA in-service training weekly x 6 weeks to ensure completion of the required 12-hour in-service training. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. The Director of Nursing is responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	4/13/2023

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	Staff member "R" reported that they did not maintain the training records and had notified the Director of Nursing (DON) and Administrator. A second request was sent to the Administrator at 12:35 PM. The Administrator reported that the DON and staff member "R" were working on retrieving the records. At approximately 3:30 PM, the Administrator reported that if the records were not provided by the DON the facility did not have any records of annual performance evaluations and in-services. At approximately 3:50 PM, the DON confirmed that they did not have the records on annual performance evaluation and in-service training for CNAs. A facility policy on CNA competency evaluation and in-service training was requested and the Administrator reported that the facility did not have a policy.			
F0756 SS= E	Drug Regimen Review, Report Irregular, Act O §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician	F0756	F-756 Element 1 Residents #28, #21, #6, #24, and #63 still reside at the facility. All pharmacy recommendations were reviewed from the last 30 days and were addressed. Element 2 All residents are at risk for this deficient practice. An audit of pharmacy recommendations was conducted in the last 30 days, were reviewed with the physician and orders implemented as needed. Element 3 The Medication Regime Review Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The Director of Nursing was educated on this policy with emphasis on the attending physician reviewing and acknowledging recommendations and irregularities. Systemic change will be that	4/13/2023

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	and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the attending physician reviewed and acknowledged recommendations and irregularities for five (R28, R21, R6, R24 and R63) of five residents reviewed for Medication Regimen Review (MRR). Findings include: According to the facility's policy titled, "Medication Regimen Review" dated 3/2022 documented: " ...The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities ...The pharmacist shall communicate any irregularities to the		physicians will be notified of all pharmacy recommendations upon receiving the recommendations, document in the progress notes until the physician is available to sign recommendations, once signed the document can be uploaded to the residents□ charts. Element 4 The DON/designee will complete 5 pharmacy recommendations twice weekly x 4 weeks, then weekly x 2 weeks that all recommendations are being followed through per physician□s orders. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	

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facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing ...Written communications from the pharmacist shall become a permanent part of the resident's medical record ...Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities... Written communications from the pharmacist shall become a permanent part of the resident's medical record..."

R28

Review of the clinical record revealed R28 was admitted into the facility on 12/14/22 and readmitted on 2/13/23 with diagnoses that included: diabetes, anxiety disorder and major depressive disorder.

According to the Minimum Data Set (MDS) assessment dated 2/19/23, R28 was cognitively intact, had no mood concerns, no hallucinations or delusions, no behaviors, received antianxiety for four of the seven days, and received anticoagulant, antibiotic and opiod medications for six of the seven days during this assessment period.

Review of the pharmacy recommendations revealed an irregularity identified on 12/16/22, 1/17/23 and 2/14/23. There was no

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documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed.

On 3/15/23 at 12:50 PM, the Director of Nursing (DON) was interviewed and asked about the MRR documentation. The DON explained they had a binder they kept the MRR's in, but she was not able to find all the requested MRR's, she would try to find out what the recommendations were. The DON was asked why not all MRR's were kept in the binder, the DON explained if there was no irregularity, they did not keep the MRR, they would throw it away.

Review of documentation provided by the DON revealed R28's recommendation dated 12/16/22 was for a laboratory test, a Digoxin level. The Digoxin level had not been ordered. The recommendations on 1/17/23 and 2/14/23 were for prior authorization for an antibiotic. No physician/prescriber response was provided for these recommendations.

R21

Review of the clinical record revealed R21 was admitted into the facility on 7/12/22 and readmitted on 11/18/22 with diagnoses that included: seizures, anxiety disorder, depression, psychosis, bipolar disorder, and schizoaffective disorder.

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According to the MDS assessment dated 1/18/23, R21 was cognitively intact, had no hallucinations or delusions, no behaviors, received antipsychotic, antianxiety and antidepressant medications for seven days and received opiod medication for five of the seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication.

Review of the pharmacy recommendations revealed an irregularity identified on 7/15/22, 9/21/22, 12/5/22 and 1/7/23. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed.

Review of documentation provided by the DON revealed a Note to Attending Physician/Provider that recommended on 7/15/22 for a stop date of 14 days for a PRN (as needed) dose of Ativan (antianxiety). The physician signed the MRR on 10/10/22, almost three months after the recommendation.

Additional documentation provided by the DON revealed the 12/5/22 recommendation included: to change medications from PO (by mouth) to PEG (percutaneous endoscopic gastrostomy - a feeding tube) tube; clarification for Tylenol 650 mg (milligrams) q (every) 6 h (hours) prn, Ibuprofen 400 mg prn and Ultram 50 mg q8h prn; clarification of dosage of Voltaren gel. No

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physician/prescriber response was provided for these recommendations. No documentation of the irregularities for 9/21/22 or 1/7/22 was provided by the end of the survey.

R6

Review of the clinical record revealed R6 was admitted into the facility on 8/26/15 and readmitted on 1/30/23 with diagnoses that included: anxiety disorder, bipolar disorder, major depressive disorder and schizoaffective disorder.

According to the MDS assessment dated 2/5/23, R6 had severely impaired cognition, had no mood concerns, no hallucinations or delusions, no behaviors, received antipsychotic and antibiotic medications for five and antidepressant, diuretic and opiod medications for seven days during this assessment period, had not had a gradual dose reduction (GDR) for the antipsychotic medication.

Review of the pharmacy recommendations revealed an irregularity identified on 3/27/22, 5/11/22, and 1/4/23. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed.

Review of documentation provided by the DON revealed one of the recommendations

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for R6 had been to clarify a blood pressure medication, no date for this recommendation was given. The recommendation on 1/4/23 had been for an AIMS (Abnormal Involuntary Movement Scale - to detect tardive dyskinesia) test to be done. No physician/prescriber response was provided for these recommendations. No documentation of the irregularities for 9/21/22 or 1/7/22 was provided by the end of the survey.

R24

Review of the clinical record revealed R24 was admitted into the facility on 3/6/16 and readmitted 1/31/23 with diagnoses that included: major depressive disorder, anxiety disorder and diabetes.

According to the MDS assessment dated 2/3/23, R24 was cognitively intact, had no hallucinations or delusions, no behaviors, received antianxiety medications for one day, received antidepressant, antibiotic and opiod medications for three days, and anticoagulant medication for two days of the seven days during this assessment period.

Review of the pharmacy recommendations revealed an irregularity identified on 1/6/23 and 2/1/23. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed.

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On 3/16/23 at 3:55 PM, the DON explained she did not have any documentation of the MRR's for R24 for 1/6/23 or 2/1/23.

R63

Review of the clinical record revealed R63 was admitted into the facility on 4/5/21 and readmitted 1/18/23 with diagnoses that included: bipolar disorder, pseudobulbar affect, and anxiety disorder.

According to the MDS assessment dated 2/5/23, R63 had severely impaired cognition, had no hallucinations or delusions, no behaviors, received antipsychotic and antidepressant medications for seven of the seven days during this assessment period, and had not had a gradual dose reduction (GDR) for the antipsychotic medication.

Review of the pharmacy recommendations revealed an irregularity identified on 4/26/22, 12/9/22 and 2/23/23. There was no documentation available in the clinical record of what the specific irregularities/recommendations were and whether they had been addressed.

On 3/16/23 at 3:55 PM, the DON explained she did not have any documentation of the MRR's for R63 for 4/26/22, 12/9/22 or 2/23/23. The DON was asked what the process was for MRR's. The DON explained she was going to have to create a process as they did not have one.

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F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than five percent during the medication administration observation, resulting in a 17.86 % medication error rate. Findings include: On 3/14/23 at 9:13 AM, Registered Nurse (RN) "S" was observed administering the residents' morning medications. At 9:24 AM, RN "S" began to prepare the morning medications for R66. Included with the medications prepared for R66 was a senna plus tab (two tabs), review of the bottle documented the active ingredients as docusate sodium 50 mg (milligram) and sennoside 8.6 mg. At 9:31 AM, RN "S" was observed to have administered all of the morning medications to R66. Review of the R66's physician orders documented the following: Docusate Sodium Capsule 100 MG, Give 1 capsule by mouth two times a day for constipation.	F0759	F-759 Element 1: Residents #66 and #47 still reside at the facility. Resident #66 received Docusate Sodium Capsule 100mg by mouth twice a day for a total amount 200mg administered, which is 100mg over the prescribed physician dose. The resident□s order have been clarified and updated per physician□s orders. Resident #47 the attending nurse did not know the proper technique of drawing up insulin and was given 1:1 education with return demonstration. The famotidine 20mg and the Furosemide 40mg was not available at the time to administer to the resident. All house stock medications and pharmacy ordered medications will be available as needed for the residents. Element 2: All residents are at risk for this deficient practice. An audit was conducted to question verbal residents with a BIM score of 11+ about satisfaction with receiving their medications. Any residents with a BIM score under 10, Unit Manager will review their MARs to ensure they received their medications per physician□s orders. Element 3: The Medication Administration Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The licensed nursing staff were educated on this policy with emphasis on the 5 Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Frequency). Any licensed nursing staff who have not received education will do so prior to their next workday. Systemic change will be that during Guardian Angel Rounds, the IDT will question the residents about their satisfaction regarding medication administration. Element 4: The DON/designee will complete medication administration audits on 5 residents twice weekly x 4 weeks, then once weekly x 2 weeks. Results of audits will be	4/13/2023

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	Sennosides Tablet 8.6 MG, Give 2 tablets by mouth two times a day for constipation. This indicated the staff administered a total of 200 mg of Docusate Sodium for the morning administration. This is 100 MG over the prescribed physician dose. At 9:34 AM, RN "S" was observed preparing the morning medications for R47. RN "S" stated the R47's famotidine 20 mg was not in stock and had to be ordered. RN "S" was observed to have obtained an opened vial of Insulin Lispro from the medication cart and withdrew 14 units of insulin. Observation of the insulin vial revealed no date documented on the vial or the vial container of when the insulin was opened. RN "S" was then observed to have obtained an opened and undated vial of Insulin Glargine from the medication cart and withdrew 30 units of insulin. RN "S" stated the resident required 10 more units of the Insulin Lispro and proceeded to obtain the undated vial and withdraw 10 more units into the same syringe as the 14 previously drawn units. At 10:10 AM, RN "S" was observed to have administered R47's oral medications and insulin. After RN "S" signed off of all R47's morning medications and it was confirmed with RN "S" that all of R47's morning medications was administered as ordered with the exception of the residents Famotidine, Bactrim & Descovy medications due to the facility staff to have allowed the medications to run out of stock and had to		brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	

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be reordered from the pharmacy.

Review of R47's March 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed RN "S" failed to administer R47's Furosemide 40 MG tablet. Further review of the MAR revealed RN "S" signed they administered R47's Famotidine 20 MG, however RN "S" was unable to find this medication during the observation and stated they had to reorder the medication from the pharmacy.

Review of a facility policy titled "Medication Administration - General Guideline" dated June 2019, documented in part " ... Medications are administered as prescribed in accordance with the good nursing principles and practices and only by persons legally authorized to do so ... The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) are applied for each medication being administered ... If the medication and/or dosage schedule on the label and the MAR are different, and the container has not already been Flagged ... the physician's orders are checked for the correct dosage ..."

Review of a facility policy titled "Vials and Ampules of Injectable Medications" revision date "08-2020", documented in part " ... Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record

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	on multi-dose vials. At a minimum, the date opened must be recorded ... guidelines recommend discarding multi-dose vials at 28 days after opening. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial ..."			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to date two opened insulin vials in one of three medication carts	F0761	F-761 Element 1: All insulins that are opened are dated, expired medications are discarded in all medication carts, and the storage medication rooms does not have expired over-the-counter medications and the refrigerator temperatures are at normal range (36-46 Degrees Fahrenheit) to prevent residents receiving expired medications, less effective insulins, and tuberculin solutions. Element 2: All residents are at risk for this deficient practice. An audit was completed for all medication carts for expired medications and proper labeling, storage rooms for expired medications, refrigerator temperatures within normal range. Element 3: The Vitals and Ampules of Injectable Medications Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The licensed nursing staff were educated on this policy. Any licensed nursing staff who did not receive education will do so prior to their next workday. Systemic change is a schedule was developed to ensure the proper labeling of medications, medication storage rooms do not have expired medications, and the refrigerator temperatures are within normal range. Element 4: The DON/designee will complete audits for medication carts and medication storage areas M-W-F weekly x 4 weeks, then twice weekly x 2weeks. Results of audits will	4/13/2023

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	reviewed, date two tuberculin (tubersol) solution vials, discard of one expired tuberculin solution vial, all identified in unit one's medication storage room and discard of an expired medication and ensure the correct temperatures of two medication refrigerators all identified in 2 South's medication storage room, two of four medication storage rooms reviewed, resulting in the resident's to have potentially been administered expired/less effective insulin, medications and tuberculin solution. Findings include: On 3/14/23 at 9:51 AM, Registered Nurse (RN) "S" was observed preparing the morning medications for R47. RN "S" was observed to have obtained an opened vial of Insulin Lispro from the medication cart and withdrew the required amount of insulin. Observation of the insulin vial revealed no date documented on the vial or vial container of when the insulin was opened. At 9:55 AM, RN "S" was observed to have obtained an opened and undated vial of Insulin Glargine from the medication cart and withdrew the required amount of insulin. RN "S" stated the resident required 10 more units of the Insulin Lispro and proceeded to obtain the undated vial again and withdraw 10 more units. At 10:10 AM, RN "S" was observed to have administered the prepared insulin to R47. Review of a facility policy titled "Vials and Ampules of Injectable Medications" revision date "08-2020", documented in part " ...		be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5: Date of Compliance: 4/13/23	

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	Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to record on multi-dose vials. At a minimum, the date opened must be recorded ... guidelines recommend discarding multi-dose vials at 28 days after opening. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial ..." On 3/16/23 at 3:14 PM, an observation of the unit 1 medication storage room was conducted with Licensed Practical Nurse (LPN) "T". Identified in the refrigerator designated for medications, vaccines and tubersol solution, was two opened tubersol solution vials that were not dated and one tubersol solution vial that was dated 11/22/22. LPN "T" obtained and reviewed all three vials and stated the vials should have been discarded. At 3:27 PM, an observation of the 2 South medication storage room was conducted with LPN "J". Identified in the storage cabinets was a bottle of Zinc 50 mg (milligrams) with an expiration date of 2/23. LPN "J" stated the medication should not be in the cabinet and obtained the medication to discard. The observation of the 2 South medication storage room was continued and revealed two refrigerators located in the storage room. One refrigerator contained multiple insulin pens and vials. The thermometer of the refrigerator was noted to be at 30 degrees Fahrenheit. LPN "J" was			

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	asked to verify the temperature and confirmed the 30 degrees Fahrenheit. LPN "J" stated they will try to readjust the temperature and check in an hour. LPN "J' also stated they will contact the facility's maintenance personnel. Observation of the second refrigerator noted 20 degrees Fahrenheit, however no medications were observed in that refrigerator. Observed on both refrigerators was a document that instructed staff to monitor and record the refrigerator temperature daily, both refrigerators were recorded within a normal temperature range by the staff for the date of 3/16/23. Review of a facility policy titled "Medication Storage In The Facility" dated "June 2019" documented in part " ... Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopeia (USP) and the Centers for Disease Control (CDC) guidelines for temperature ranges ... Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees F (Fahrenheit) to 46 degrees F ... with a thermometer to allow temperature monitoring ..." Review of the Tuberculin Purified Protein Derivative (TUBERSOL) package insert documented in part, " ... A vial of TUBERSOL which has been entered and in use for 30 days should be discarded ..."			

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F0791 SS= D	Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to act on a dentist's	F0791	F791 Routine/ Emergency Dental Services Element 1: R24 and R14 appointments have been scheduled to see Dental services. Element 2: Audit was conducted that any resident that wants dental services will be added to the dental list. Element 3: The Ancillary services policy has been reviewed and deemed appropriate. Social worker been educated. The systemic change will be that visual rounds will be completed to ensure that residents are seeing the dentist. Element 4: The Social work/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Compliance Date: 4/13/23	4/13/2023

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recommendations for an oral surgery follow up for teeth extraction in preparation for dentures for one (R24) of one resident reviewed for dental services.

Findings include:

Review of the clinical record revealed that R24 was admitted to the facility on 06/06/2016. Diagnoses include hemiplegia and hemiparesis (paralysis and/or limited movement) affecting the left side following a stroke, acute respiratory failure, neuropathy (nerve pain), amputation of both legs above the knee, morbid obesity, type two diabetes, atrial fibrillation (a heart problem), acute kidney failure, stage four sacral pressure ulcer, dysphagia (a swallowing problem), insomnia, fatty liver disease, muscle wasting, bladder disfunction, high cholesterol, depression, anxiety, high blood pressure, and heart failure. Per a quarterly Minimum Data Set (MDS) assessment dated 02/03/2023, R24 required extensive assistance of one to two or more people for activities of daily living, including person hygiene such as brushing teeth. Per this assessment, R24 was cognitively intact.

On 03/14/2023 at 10:57 AM, R14 was interviewed. When asked if they had any dental issues, they reported that the have some "bad ones (teeth)" and missing teeth. When R24 was asked when they last saw a dentist, they indicated a couple months ago. R24 shared that they were supposed to have

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teeth pulled/removed and get dentures, though this has not happened. When asked if they knew why not, R24 stated that the dentist often switches.

Another interview was conducted with R66 on 03/15/20236 at 9:06 AM. When asked about their ability to eat due to dental issues, R24 indicated that they have some pain, so they try to avoid the painful spots. When asked if the facility offered them a soft diet, R24 indicated they did, but declined as they do not want such a diet.

Review of the record revealed a dental consult note dated 03/09/2022, and it was signed by Dentist "FF." Review of the "Tooth Grid" reveal that R25 was missing 13 top teeth, and two out of the remaining teeth were marked as "Non Restorable." R25 was noted as missing nine lower teeth. Five of the remaining lower teeth were marked as "Non Restorable," with two noted to be fractured. The "Treatment Notes" read, in part, "...Clinical findings: Multiple fractured and grossly decayed teeth. Recommended remaining teeth to be extracted (non-restorable). Patient agrees with treatment plan. Refer patient to Oral Surgeon for extraction #11, 13-14, 21-22, 26-27, 29-31. Recommend fabrication of [dentures] after extractions have been completed to restore dentation and mastication...xrays taken to confirm diagnosis and treatment plan..." Under the section "Recommended treatment," the boxes for "Refer to Oral

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Surgeon" and "Prior Approval Completed."

Reviewed of R25's clinical record did not reveal any indication that they saw an oral surgeon or that the facility made a referral to or sought out care following the above recommendation.

Review of the "Tooth Grid" on dental consult note dated 07/12/2022, signed by a different dentist, Dentist "GG," revealed that R25 was missing 13 top teeth, and two of the remaining teeth were marked as "Non Restorable." R25 was noted as missing nine lower teeth. Five of the remaining lower teeth were marked as "Non Restorable," with two noted to be fractured. Under the "Teeth" section, R25's periodontal condition was noted to be "poor." The "Treatment notes" read, in part, "...Patient doing fine without dentures...," yet Dentist "GG" did not make any mention regarding the previous dental exam that clearly stated the recommendation for extraction/removal in preparation for dentures. It should also be noted that, per the "Tooth Grid," the condition of R25's teeth was the same as the consult on 03/09/2022.

Review of the "Tooth Grid" on the most recent dental consult note dated 10/07/2022, signed by a different provider, Registered Dental Hygienist "HH," revealed that R25 still had 13 missing top teeth, with two out of the remaining teeth marked as "Non Restorable." Again, R25 was noted as missing nine lower teeth. Five of the remaining lower teeth were

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marked as "Non Restorable," with two noted to be fractured. Again, Under the "Teeth" section, R25's periodontal condition was noted to be "poor." The "Treatment notes" read, in part, "...gen breakdown of teeth; pt uncomfortable during prophy when scaling ; gen breakdwon (sic) of teeeth (sic); pt in pain #11 & #22; pt requestd (sic) DDS for eval of #11 & #22." Dentist "HH" did not address the consult from 07/12/2022 where the plan of care recommendation was for extraction/removal of all remaining teeth in preparation for dentures.

Review of a Nutrition Summary note dated 02/01/2023 that read, in part, "...Resident reports no swallowing difficulties, but reports he has many missing teeth which can occasionally make chewing more difficult. Offered a softer diet, but resident declined..."

On 03/16/2023 at 02:48 PM, at interview was conducted with Social Services "D." Social Services "D" reported that they were responsible for coordinating dental care for residents. When asked about R25, Social Services "D" was not aware of a plan for R25 to get dentures.

On 03/16/2023 at 03:34 PM, Social Services "D" was interviewed again regarding dental care for R25. The recommendations/plan of care from the dental consult dated 03/09/2023 regarding oral surgery referral for extraction of all remaining teeth and getting dentures were reviewed. When asked about

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	follow-up, Social Services "D" was not aware of R25 seeing an oral surgeon.			
F0800 SS= E	Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that meals were served at a palatable temperature. On 3/15/2023 a resident council meeting was held with 12 residents. All those in attendance, representing all floors in the facility, reported that they eat meals in their rooms. All in attendance reported that meals are served "cold." On 03/16/2023 at approximately 8:15 AM, the cart arrived to the first floor to pass breakfast trays. At approximately 8:45 AM the items (the last tray to be passed), on the tray were temped for the resident in room 112. The French toast had an internal temperature of 113, and the sausage links had an internal temperature of 101.5. CNA "II" agreed that the food should be warmer. Review of a facility policy entitled "Food Quality and Palatability" (implemented on	F0800	F800 Provide Diet Meets of Each Resident Element 1: No specific residents was identified. Food will be served at the appropriate temperature and served. Element 2: All residents have potential to be affected by the stated deficiency. The facility will identify other resident having the potential to be affected by the deficient practice by competing an audit of current residents. Element 3: The Food quality and palatability policy has been reviewed and deemed appropriate. Dietary department has been educated. The systemic change will be that the dietary manager will have appropriate temperature of food before being served. Element 4: The Dietary Director/designee will complete audits weekly x4 weeks, then twice weekly x 2 weeks. Results of audits will be reported to QAPI committee monthly x 3 months and ongoing as needed to assure compliance. Any concerns identified will be addressed immediately. Administrator is responsible for sustained compliance. Element 5: Date compliance 4/13/23	4/13/2023

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	07/31/2021 with no revision date) read, in part, "Policy: Food will be prepared in methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature...Definitions...Proper (safe and appetizing) temperature": food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen, ensure food items were labeled and dated, and failed to monitor the dish machine for adequate	F0812	F812 Sanitation ELEMENT 1: There were no residents identified in this citation. The sugar and flour bins were emptied, cleaned, and labeled and dated appropriately. The soiled floor in the dry storage, the ice scoop and container were all cleaned. The cheese in the walk-in cooler was discarded and the lettuce was properly stored and dated. The tray of sandwiches and fruit were label and dated. The floor in the washroom was cleaned and lids put on the garbage cans. ELEMENT 2: All residents eating meals from the kitchen have the potential to be affected by this deficit practice of wet dishes and Sanitation rounds were corrected immediately. ELEMENT 3: It was identified that these items were not on a check list schedule and were assigned to be monitored. The dish machine policy and food storage policy were reviewed by the administrator and deemed appropriate. The dietary manager was terminated. The new dietary manager and dietary staff were educated on the dish machine and Food Storage policies. ELEMENT #4 The dietary manager or designee will complete sanitation rounds 3	4/13/2023

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	sanitization. This deficient practice had the potential to affect all residents that receive food from the kitchen. Findings include: On 3/14/23 between 8:30-9:30 AM, during an initial tour of the kitchen with Certified Dietary Manager (CDM) "Y", the following items were observed: There was a bin of white granules that was unlabeled with the contents inside, and there were several scoops stored inside the bin. In addition, there was a bin of white powder that was unlabeled with the contents inside. CDM "Y" confirmed that the bins were sugar and flour, and that they should be labeled. According to the 2017 FDA Food Code section 3-302.12 Food Storage Containers, Identified with Common Name of Food, "Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD." The floor inside the dry storage room was soiled with a dried up ketchup spill. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, "(A) Physical facilities shall be		times a week for 2 weeks, then weekly for 4 weeks. Items found will be addressed immediately. Results of the audits will be reported to facility QAPI committee for review and recommendations. Audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved. This plan of correction will be monitored at the monthly Quality Assurance (QAPI) meeting until such time consistent substantial compliance has been achieved. Element 5: Date of compliance: 4/13/23	

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cleaned as often as necessary to keep them clean."

The ice scoop holder was observed with black debris at the bottom inside surface, and the ice scoop was resting on top of the black debris.

According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch."

In the walk in cooler, there was an opened package of sliced provolone cheese dated 2/8-2/12, an opened package of yellow cheese slices that was undated, and 2 bags of chopped salad mix that were opened and undated. CDM "Y" confirmed that all items should be dated when opened.

In the Raetone reach-in cooler, there was a tray of undated deli sandwiches, and a tray of individual bowls of sliced fruit that were undated.

According to the 2017 FDA Food Code section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less

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for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety."

In the chemical room/cart washing room, there was standing water on the floor, with an accumulation of black mold on the surface of the tiles. There was an uncovered garbage can inside the chemical room, with discarded food inside, and numerous gnats were observed flying about.

According to the 2017 FDA Food Code section 5-501.113 Covering Receptacles, "Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use;".

According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and

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Restrictions, "(A) Physical facilities shall be cleaned as often as necessary to keep them clean."

According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, "The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: ...4. (D) Eliminating harborage conditions."

At 9:15 AM, Dietary Staff "Z" began washing soiled dishware in the low temperature, chemical sanitizing dish machine. Dietary Staff "Z" did not check the sanitizer level of the dish machine before use. This surveyor tested the low temperature chemical (chlorine) dish machine, after 4 separate cycles, with a chlorine test kit strip. None of the 4 test strips changed color to denote the presence of chlorine sanitizer. When queried, CDM "Y" confirmed that staff should be checking the sanitizer level of the dish machine before use. CDM "Y" confirmed the absence of chlorine sanitizer, as tested with the chlorine test strips, and stated she would call an outside company to come and take a look at it.

Review of the dish machine log revealed that the last documented entry was on 3/10/23. CDM "Y" confirmed that staff should be checking the temperature and sanitizer level of the dish machine 3 times daily.

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	According to the 2017 FDA Food Code section 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration, "Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device." According to the 2017 FDA Food Code section 4-701.10 Food-Contact Surfaces and Utensils, "Equipment food-contact surfaces and utensils shall be sanitized." Dietary Staff "AA" was observed taking wet dishware that had just come out of the dish machine, stacking it while still wet, and placing the stacked dishware onto the clean dishware rack. When queried, CDM "Y" confirmed that the dishware should be dry before stacking. According to the 2017 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, "(B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying;".			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe,	F0880	POC FOR F 880 In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility will contract with an	4/13/2023

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	sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) 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.		infection control consultant to provide consultation and oversight for infection prevention and control for the facility no later than April 5, 2023. Infection control consultant contracted responsibilities will include: Work with the QAPI Committee (including the Infection Preventionist) to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS 2567. Take immediate action to implement an infection prevention plan consistent as listed below. Element #1: While no residents were identified in the statement of deficiencies, the facility will continue to implement systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases including maintaining accurate and timely logs to track and map infections, properly and timely identify infections, clusters and outbreaks among staff members. Additionally, it is the policy of this facility to establish, maintain and implement an active policy to reduce the risk of Legionella and/or other opportunistic pathogens of precise plumbing. Element #2: The Infection Preventionist will implement infection surveillance and analysis in accordance with facility policy and standards of infection prevention and control. The Infection Preventionist in coordination with the Maintenance Supervisor will implement Water Safety policies and ensure that a system is implemented to keep them current. Element #3 The IP, consultant, and QAPI committee, after conducting the root cause analysis and facility self-assessment using the COVID Infection Control Survey Protocol, will improve the procedures to assure that: The facility develops, implements, and maintains and effective infection control program that	

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	§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: This citation contains two Deficient Practice Statements (DPS). DPS #1 Based on interview and record review the facility failed to implement a policy that addressed the reporting, monitoring and tracking of staff illnesses, which resulted in the facility to have failed to rapidly, accurately and thoroughly complete an outbreak investigation to identify, intervene and potentially prevent further viral transmission, potentially affecting all 87 residents that resided in the facility at the time of the survey and the ability to affect staff, volunteers and visitors. Findings include: Review of the facility's Infection Surveillance Program contained no documentation of any COVID positive staff or residents for the last 90 days as of 3/14/23. On 3/14/23 at 3:34 PM, the Infection Control Nurse (ICN) "A" (who also served as the		includes surveillance; Staff have the tools and abilities to ensure residents practice effective infection control; Shared medical equipment is properly disinfected after each use; COVID-19 testing is completed pre manufacturer recommendations/instructions; Required staff will receive instruction and demonstrate understanding; A plan for monitoring corrective action progress and tracking performance improvement; and All relevant facility infection control policies and procedures are reviewed and recommendations for revisions based on the RCA are made. Based on the above, the Consultant, DON, Infection Preventionist, and Inservice Director/designee will develop trainings specific to the result(s) of the RCA and cover the following topics, at a minimum: Targeted COVID-19 Training for Nursing Homes - https://qsep.cms.gov/ProvidersAndOthers/home.aspx Closely Monitor Residents - https://youtu.be/1ZbT1Niv6xA Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Lessons - https://youtu.be/YYTATw9yay4 The Consultant, DON, Infection Preventionist and In-service Director/designee will base the content, agenda, and handouts for the trainings on changes as a result of the RCA and consultant review and incorporate programs developed by well-established centers of geriatric health services education such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics, or CDC. The Infection Preventionist will determine the appropriate audience for each training based	

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	facility's Infection Control Preventionist) was interviewed and asked about the facility's surveillance of the COVID positive residents and staff and ICN "A" stated that documentation was located in another binder. At that time ICN "A" was asked to provide the COVID surveillance binder. Review of a typed document regarding a COVID -19 outbreak in the facility for December of 2022, documented in part " ... The facility experienced a Covid - 19 outbreak that started on 12/15/22. The initiation of a staff - outbreak investigation was triggered related to one single positive Covid- 19 case, which was confirmed with an Ag rapid testing kit. The staff member was only located in the testing designated area and was instructed to evacuated <sic> the facility immediately. Stat testing was implemented for all employees; no other positive test was noted at this <sic> ..." Review of the "Respiratory Surveillance Line List" dated 12/15/22, documented three COVID positive staff, however the document contained blank sections for the following areas- symptom onset date, symptoms identified for each staff member, the type of COVID- 19 test completed, the date of collection of the test, the symptom resolution date, the pathogen detected and if the person was hospitalized etc. This line list documented the names of Dietary Staff (DS) "NN" and Certified Nursing Assistant(s) (CNA) "LL" & "MM".		on the job description and contact the employee has with the residents. This will include the Director of Nursing, Infection Preventionist, all staff that provide direct resident care, as well as staff that enter into resident rooms to provide for dietary needs or to perform therapy, social worker, activities, housekeeping, laundry, or maintenance services. After completion of the training, the Infection Preventionist will assure that staff competency is validated by a post-test. If the facility employs staff or contract staff with limited English proficiency (LEP), the facility will ensure education is provided in a language understandable to the LEP staff member(s). The In-service Director will provide sign-in sheets for all trainings. The In-service Director will develop a plan for those on excused leaves of absence to make-up the trainings upon their return to work. Element #4 Based on the training provided, the QAPI Committee, including the IDT and Infection Preventionist and the consultant, will design a scheduled, objective format for the facility to implement for follow-up employee supervision and work performance appraisal. Facility supervisors will be scheduled to observe and appraise employee implementation of the knowledge, skills and procedures on a weekly basis and report to the Infection Preventionist. The Infection Preventionist will take immediate corrective as needed and report monthly to the QAPI Committee for further recommendations. Date of compliance: 4/13/23	

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Further review of the Respiratory Surveillance did not identify the first positive staff member that initiated the outbreak investigation. The typed covid outbreak investigation report did not identify or acknowledge the other two staff members documented on the 12/15/22 "Respiratory Surveillance Line List". Further review of the COVID surveillance binder revealed no documentation of the test results and the time the test was performed for either staff documented on the line list.

Review of the typed document regarding the COVID -19 outbreak in the facility for January of 2023, documented in part " ... Two staff members tested positive <sic> Covid-19 on the following dates: 1/24/23 and 1/26/23, the results were confirmed with an Ag rapid testing kit. The following affected employees work in the dietary department ... The initiation of a staff- outbreak investigation was triggered and carried out. The staff members were only located in the testing designated area and they were instructed to evacuate the facility immediately ..."

Review of the "Respiratory Surveillance Line List" for January 2023 documented DS "KK" as COVID positive on 1/24/23 and DS "JJ" as COVID positive two days later on January 26, 2023. The line list document contained blank sections for the following areas- symptom onset date, symptoms identified for each staff member, the type of COVID- 19 test

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completed, the date of collection of the test, the symptom resolution date, the pathogen detected and if the person was hospitalized.

Review of DS "KK" timecard revealed on 1/22/23 and 1/23/23, DS "KK" called into work sick. Further review of the timecard documented on 1/24/23 DS "KK" worked from 11:36 AM until 3:00 PM.

Review of the COVID surveillance binder revealed no documentation of DS "KK" signs or symptoms when they called into work sick on 1/22/23 and 1/23/23. Further review of the surveillance binder revealed no documentation of DS "KK" to have been tested for COVID 19 upon entry into the facility after having been reported sick two days prior. This resulted in DS "KK" to enter into the facility on 1/24/23 and work for more than three hours while being COVID positive as verified by the 1/24/23 documentation on the Surveillance Line List. There was no documentation in the surveillance binder that noted why DS "KK" was tested for COVID in the middle of their shift. It is unknown if the staff member became symptomatic during their shift or if they were symptomatic upon arrival of their shift. The facility had another dietary staff DS "JJ" become COVID positive two days later on 1/26/23.

Review of a facility policy titled "Coronavirus Prevention and Response" revised "9/22" documented in part " ... This facility will

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	respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus ... Establishing a process to make everyone entering the facility aware of recommended actions to prevent transmission to other if they have any of the following three criteria ... a positive viral test for SARS-CoV-2 ... Symptoms of COVID-19 ... Close contact with someone with SARS-CoV-2 infection for resident and visitors or a higher-risk exposure for healthcare personnel (HCP) ... The facility will instruct HCP to report any of the 3 above criteria to the infection preventionist or designee for proper management ..." The facility failed to obtain and maintain documentation of the staff reported signs and symptoms when DS "KK" called into work "sick" on 1/22/23 and 1/23/23. Further review of the COVID surveillance binder revealed no documentation of an outbreak investigation to have been conducted after the first identification of DS "KK" COVID positive result on 1/24/23. Documented on the outbreak investigation report was the following in part, " ... Nursing staff began communicating about residents experiencing respiratory difficulties such as flu and cold signs and symptoms to the infection control nurse. On 1/26/23 the facility organized STAT testing for all residents ..." The investigation failed to identify any close contacts that DS "KK" had while in the facility for more than three hours			

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and failed to complete contact or broad testing of staff and residents that were potentially exposed.

Review of the January 2023 outbreak investigation indicates the facility did not rapidly and accurately investigate, identify and intervene to prevent further viral transmission.

Review of a Centers for Medicare & Medicaid Services (CMS) memo revised 9/23/22, (Ref: QSO-20-38-NH), documented in part " ... Newly identified COVID-19 positive staff ... in a facility that can identify close contacts, test all staff, regardless of vaccination status, that has a higher-risk exposure with a COVID-19 positive individual ... Test all residents, regardless of vaccination status, that had close contact with a COVID-19 positive individual ... Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts ... Test all staff, regardless of vaccination status, facility wide or at a group level if staff are assigned to a specific location where the new case occurred ... e.g., unit, floor, or other specific area(s) of the facility ... Test all residents ... facility-wide or at a group level ... Staff with symptoms or signs of COVID-19 , regardless of vaccination status, must be tested as soon as possible and are expected to be restricted from the facility pending the results ... An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have

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been exposed ... In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately ... Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based ... testing ..."

The facility's COVID -19 typed outbreak investigation for January 2023 documented the COVID 19 positive "staff members were only located in the testing designated area" and were instructed to evacuate the facility immediately. After review of DS "KK" timecard that revealed DS "KK" worked in the facility for more than three hours on 1/24/23 (the day DS "KK" tested positive), revealed the outbreak investigation completed was an inaccurate investigation.

On 3/16/23 at 1:14 PM, the Infection Control Nurse (ICN) "A" (who also served as the facility's Infection Control Preventionist and Assistant Director Of Nursing) was interviewed with the Director of Nursing (DON) present. When asked about the January 2023 Outbreak investigation and which approach (contact or broad) the facility decided to use for the investigation, ICN "A" stated on the 26th all residents were tested for COVID-19. When asked if all staff were tested or if contact tracing was completed for staff, ICN "A" did not have a reply. When

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asked about the staff that were identified and where their test results were, the DON replied all staff was tested. At this time both the ICN "A" and DON was asked to provide the test results of the staff tested. When asked why an outbreak investigation and testing was not completed after the first identified COVID 19 positive case on 1/24/23, ICN "A" explained the staff member was tested in the testing area and did not enter into the facility. When stated that DS "KK" timesheet was reviewed and ICN "A" and the DON was asked how the dietary staff had called in sick for the dates of 1/22/23, 1/23/23 with no documentation of the staff signs or symptoms noted in the staff surveillance log, was permitted to return to work on 1/24/23 and worked for more than three hours in the facility before testing positive for COVID and being sent home. ICN "A" and the DON was then asked why DS "KK" was tested for COVID in the middle of their shift and if DS "KK" became symptomatic? ICN "A" and the DON stated they did not have the answers but would look into it and follow back up.

On 3/16/23 at approximately 5:30 PM, ICN "A" provided additional documentation at the exit conference.

Review was completed of the additional documentation provided at exit, however none of the information provided an explanation or answers for the above concerns. Further review of the additional documentation provided did not contain test

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results of any staff tested for the outbreak investigation.

Deficient Practice #2

Based on interview and record review, the facility failed to ensure an active plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP) was being implemented. This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the 87 residents in the facility. Findings include:

On 3/14/23 at approximately 11:20 AM, Maintenance Supervisor "BB" was queried about the facility's water management plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing. Maintenance Supervisor "BB" was unaware of any water management program, and stated that I should check with the Administrator. When queried about any water temperature monitoring, Maintenance Supervisor "BB" provided a log book of water temperatures, that had last been done July 2022. When asked if he had any more current water temperature documentation, Maintenance Supervisor "BB" stated no and said "I need to start doing that."

On 3/14/23 at approximately 1:30 PM, the Administrator provide a binder titled "Water Management Plan". It was noted that the plan was last updated 3/1/21, and the list of names on the "Water Safety Team Members" list, were all staff members that were no longer at the facility (Administrator, Maintenance Supervisor, Director of Nursing). In addition, the plan noted: "Monitoring: Monitor the hot water system to verify temperatures are being maintained within

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	the established control limits...5. Water Safety Team shall meet regularly to review water safety program including: Review of monitoring logs...". A separate policy provided titled "Water Management Program", implemented 04/17 and reviewed/revised 12/20 noted: "1. A water management team has been established to develop and implement the facility's water management program...a. Team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role...8. The water management team shall regularly verify that the water management program is being implemented as designed."			
F0881 SS= E	Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to continuously implement an antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for two (R's 187 and 43) of five residents reviewed for the antibiotic stewardship program. Findings include:	F0881	F-881 Antibiotic Stewardship Element 1: Resident #187 no longer resides at the facility. The resident #30 and #43 still reside at the facility. An antibiotic stewardship program will be in place for proper use of antibiotics. Element 2: All residents receiving antibiotics are at risk for this deficient practice. An audit was conducted on current residents on antibiotics to ensure consistent implementation of protocols for appropriate antibiotic use. Element 3: The Antibiotic Stewardship Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The Infection Control Preventionist was educated on this policy. Systemic change is the Director of Nursing will review appropriate protocols for antibiotic use to ensure compliance of the antibiotic stewardship program. Element 4: The DON/designee will complete	4/13/2023

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	According to the Center for Disease Control's (CDC) "The Core Elements of Antibiotic Stewardship for Nursing Homes," dated 2015: "...Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Antibiotic stewardship refers to a set of commitments and actions designed to "optimize the treatment of infections while reducing the adverse events associated with antibiotic use...Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year...studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic- resistant organisms...Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections...Identify clinical situations which may be driving inappropriate courses of antibiotics such as		audits M-F weekly x 4 weeks, then twice weekly x 2 weeks. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use..."

R187

Review of the January 2023 "Monthly Infection Control Log" documented in part, " ... (R187) ... Type- Foley UTI (Urinary Tract Infection) ... Body Site- Bladder ... Date of Onset 1-18-23 ... Organism- Blood 200, Protein 30, Escherichia ... Antibiotic Resistant- Yes ... Antibiotic- Cephalexin ... Infection Definition Met- Yes ... Date resolved- 1-28-23 ..." Further review of the log revealed no documentation of signs or symptoms documented for R187.

Review of the medical record documented no signs and symptoms identified for this resident regarding the UTI diagnosis.

Review of a "Nursing" note dated 1/18/23 at 12:27 PM, documented in part " ... Resident Labs cam <sic> back from (lab name). (doctor name) was notified video visit was conducted resident <sic>. (doctor name) has ordered Cephalexin 500mg (milligram) 3x a day for 10 days ..."

Review of a "Physician" note dated 1/18/23 at 1:08 PM, documented in part " ... Patient was seen by video conferencing-with help of the nurse on duty ... POSITIVE UA (urinalysis) AND Culture growing EColi- increased WBC (white blood cell) in CBC (complete blood

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count) - Wound on sacrum with increased necrosis/ slough - ? pain/ pt (patient) not very communicative ... UA- POS (positive) Leukocyte/nitrite, Cx (culture)- E Coli - > 100,000 colonies ... Vital signs stable ... UTI/E Coli ... KEFLEX 500 milligrams TID (three times a day) for 10 days ... Sacral and left buttock wounds- Sacral wound w (with)/ inc (increased) necrosis ... Leukocytosis likely a response to a big problems - may repeat in a week after abx (antibiotic) treatment initiated ..."

Review of a Urinalysis completed on 1/13/23 and reported to the facility on 1/16/23, documented Escherichia coli detected in R187's urine. This indicated the facility had the results of the urinalysis two days before the follow up with the physician, who started the antibiotic with no signs and symptoms identified with the resident.

Review of a CBC lab report dated 1/19/23 at 4:48 AM, documented a WBC (white blood cell) count of 8.05 (reference range- 3.53-9.52). This documented a normal range.

Review of the January 2023 Medication Administration Record (MAR) documented "Cephalexin Oral Capsule 500 MG ... Give 1 capsule by mouth three time a day for infection for 10 days ..." This order started on the 18th and was completed on the 28th.

Review of a CBC lab report dated 1/26/23 at 7:00 AM, documented a WBC count of 6.0.

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On 3/16/23 at 1:41 PM, the Infection Control Nurse (ICN) "A" who also served as the facility's Assistant Director of Nursing (ADON) and the facility's Infection Control Preventionist (ICP) was interviewed (with the Director of Nursing present) and asked about the signs and symptoms identified of a UTI for R187 and how their infection met the McGeer criteria (the infection surveillance protocol utilized by the facility), ICN "A" stated they would look into it and follow back up. ICN "A" was also asked about R187's urinalysis and the organism identified in the resident's urine and ICN "A" was asked how they determined that the organism was not already colonized, ICN "A" stated they would look into it and follow back up.

On 3/16/23 at approximately 5:30 PM, ICN "A" provided additional documentation at the exit conference.

Review of the additional documentation provided at the exit conference was the urinalysis and culture report dated 1/13/23. On the report ICN "A" highlighted that Escherichia coli was detected in R187's urine. ICN "A" did not provide documentation of R187 to have been symptomatic, how the resident met criteria or an explanation on how they determined the organism identified in the UA was not already colonized.

No further explanation or documentation was provided.

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R30

Review of the facility " ... Stewardship Line Listing Resident Infections" for October 2022 was reviewed and revealed no documentation of R30 to have had an infection. Further review of the Infection Surveillance documentation revealed an October 2022 analyzation report completed by the Infection Control Nurse that documented in part, " ... (R30 initials) - UTI (Urinary Tract Infection) treated with Cipro initially, continued treatment with Bactrim x days ..."

Review of an "Order Listing Report" dated 11/2/22 at 5:25 PM, documented Ciprofloxacin 500 MG tablet, every 12 hours for an acute UTI for five days. This was started on 10/19/22 until 10/22/22. Bactrim DS 800-160 MG tablet, one tablet in the morning for UTI for three days. This order was started on 10/22/22 until 10/26/22. Further review of the documents revealed no documentation of R30 signs and symptoms or documentation of the infection to have met the criteria for antibiotics.

Review of a "Nursing" note dated 10/18/22 at 11:49 AM, documented in part " ... Patient presenting with increased confusion ... New order for UA C+S (culture and sensitivity), CBC and CMP (comprehensive metabolic profile) ..."

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Review of a "Nursing" note dated 10/19/22 at 2:57 PM, documented in part " ... Patient has a new order for Ciprofloxacin 500mg q (every) 12 hours x5 days for Acute UTI ..."

Review of a urinalysis report with a received dated of 10/19/22, documented two organisms identified in R30's urine 1) Proteus mirabilis and 2) Providencia stuartii and contained two separate culture results for each organism identified.

Review of the October 2022 MAR revealed the Ciprofloxacin administration stopped on 10/22/22 and Bactrim DS started on 10/23/22 and stopped on 10/25/22.

Review of a "Nursing" note dated 10/22/22 at 7:04 PM, documented in part " ... Writer notified NP (Nurse Practitioner) of resident's lab results. NP ordered Bactrim 800/160mg QD (every day) x 3 days and d/c (discontinue) Cipro ..."

Further review of the urinalysis report dated 10/19/22, documented the following culture and sensitivity results:

Organism 1- Proteus Mirabilis- Ciprofloxacin "I" (Intermediate), Sulfamethoxazole/Trimethoprim (Bactrim)- "S" (Sensitive).

Organism 2- Providencia stuartii- Ciprofloxacin "R" (Resistant), Sulfamethoxazole/Trimethoprim (Bactrim)-

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(Resistant).

This indicated that although the change of the antibiotic was made from Ciprofloxacin to Bactrim, the second organism identified was still Resistant to that antibiotic.

Further review of the medical record revealed no documentation from the ICN "A", physicians or nurse practitioner to have identified the culture results and no justification for the antibiotics ordered.

On 3/16/23 at approximately 1:55 PM, ICN "A" was interviewed (with the Director of Nursing present) and asked about R30's UTI in October 2022 and if it met criteria for an antibiotic. ICN "A" stated they would look into it and follow back up. ICN "A" was then asked about the culture report and the change of the antibiotics still not being effective for the second organism identified in R30's urine. ICN "A" was asked if they review these reports when reviewing the infections in the facility and ICN "A" stated they do review the reports. ICN "A" was then asked why the second organism was not treated appropriately and ICN "A" stated they would look into it and follow back up.

On 3/16/23 at approximately 5:30 PM, ICN "A" provided additional documentation at the exit conference.

Review of the additional documentation provided revealed the "nursing" note from

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	10/22/22 at 7:04 PM (documented above) and the urinalysis and culture and sensitivity reports from 10/19/22 (noted above). No further explanation or documentation was provided. Review of a facility policy titled "Antibiotic Stewardship Program" revised "12/20" documented in part, " ... It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use ... The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the Antibiotic Stewardship Program ... Infection Preventionist - Coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff ... The program includes antibiotic use protocols and a system to monitor antibiotic use ... Nursing staff shall assess residents who are suspected to have an infection ... Laboratory testing shall be in accordance with current standards of practice ... The facility uses the McGeer to define infections ... narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized ..."			
F0887	COVID-19 Immunizatio §483.80(d) (3)	F0887	F-887	4/13/2023

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SS= D	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 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		Element 1: Resident #188 no longer resides at the facility. Element 2: All residents are at risk for this deficient practice. An audit was conducted to ensure every resident that consented to receive the COVID-19 vaccine will receive education regarding the benefits and potential risks associated with the vaccine. Element 3: The Coronavirus Prevention and Response Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The Infection Control Preventionist was educated on this policy with emphasis on offering the COVID-19 vaccine to the residents and education provided regarding benefits and potential risks associated with the vaccine. Systemic change is to offer the COVID-19 vaccines and education to the residents upon admission. Element 4: The DON/designee will complete audits M-F weekly x 6 weeks. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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	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 educate and offer the COVID 19 vaccine and/or booster to one (R188) of five residents reviewed for the COVID 19 vaccine. Findings include: R188 Review of the medical record revealed R188 was admitted to the facility on 3/9/23. Review of the Immunizations documented "No immunizations found". Review of the medical record revealed no education or a consent to have been offered to R188 for the COVID 19 vaccine and/or booster. On 3/16/23 at 1:56 PM, the Infection Control Nurse (ICN) "A" who also served as the facility's Infection Preventionist was asked when the residents are educated and offered			

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	the COVID 19 vaccine and/or booster. ICN "A" stated they are asked upon admission. When asked if the facility educated and offered R188 the COVID 19 vaccine and/or booster, ICN "A" stated they would look into it and follow back up. On 3/16/23 at approximately 5:30 PM, ICN "A" provided additional documentation at the exit conference. Review of the additional documentation provided revealed a "Nursing" note dated 3/15/23 at 10:50 AM, of the resident to have been offered the Pneumococcal and Influenza vaccine, however the note contained no documentation of the nurse to have assess the resident's COVID 19 vaccine status or to have educated and offered the resident the COVID 19 vaccine and/or booster. Review of a facility policy titled "Coronavirus Prevention and Response" revised "9/22" documented in part " ... The facility should offer resources and counseling to ... residents ... on the importance of receiving the COVID-19 vaccine ..." **No additional explanation or documentation was provided.**			
F0888 SS= F	COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for	F0888	F-888 Covid-19 Vaccination of Facility staff Element 1: The facility failed to obtain and provide the vaccination status of one contracted non-direct care staff member and did not implement a COVID-19 plan for staff	4/13/2023

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	COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the		who are not fully vaccinated due to the facility□s oversight. A process of obtaining COVID-19 vaccination status for contracted non-direct care staff members will be implemented. Element 2: All residents are at risk for this deficient practice. An audit was conducted to identify the contracted non-direct care staff members to ensure their vaccination status if on file. Element 3: The COVID-19 Vaccination Mandate Policy was reviewed by the Administrator and the Director of Nursing and was deemed appropriate. The Infection Control Preventionist was educated on this policy. Systemic change is the Infection Control Preventionist (ICP) will implement a file with these contracted staff members for their COVID vaccine status. Element 4: The DON/designee will complete audits weekly x 4 weeks. Results of audits will be brought to QAPI monthly x 3 months to assure sustained compliance. Any concerns identified will be addressed immediately. The Director of Nursing will be responsible for sustained compliance. Element 5 Date of Compliance: 4/13/23	

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

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	contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain and provide the vaccination status of one contracted non-direct care staff member and failed to implement a COVID 19 contingency plan for staff who are not fully vaccinated, this had			

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the ability to affect all 87 residents that resided in the facility at the time of the survey. Findings include:

Review of a contracted company list provided by the facility, documented a non-direct care contracted food service company. The food service company was sampled and the facility's Administrator and Infection Control Nurse "A" (who also served as the facility's Infection Control Preventionist) was asked to provide the contracted staff vaccination status of the food service company delivery personnel.

On 3/15/23 at 4:48 PM, the Administrator forwarded an email to the surveyor which documented the contracted food service company refused to provide the facility with the COVID 19 vaccination status of their personnel that enters into the facility to deliver the facility's food supply.

Review of a CMS (Centers for Medicare and Medicaid Services) memo (Ref: QSO-23-02-ALL) dated 10/26/22, documented in part " ... Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents ... Individuals who provide ... other services for the facility and/or its residents, under contract or by other arrangement ..."

Review of a facility policy titled "COVID-19

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Vaccination Mandate" revised "9/22" documented in part, " ... If an exemption is ... Granted ... The employee who is granted an exemption will be required to wear PPE (Personal Protective Equipment) as a source control measure when in the facility and perform at minimum a weekly Rapid COVID testing ..."

On 3/16/23 at 1:19 PM, ICN "A" was asked about the contingency plan for the facility's staff who are not fully vaccinated and ICN "A" stated in part " ... We don't have extra precautions in place for unvaccinated staff members ..." When asked about the policy provided regarding the facility's contingency plan and the weekly testing of their staff who are not fully vaccinated, ICN "A" replied they had a different policy that they follow, and they no longer test their staff unless an outbreak investigation is initiated, or the staff member is symptomatic. At that time the policy that ICN "A" referred to was requested.

On 3/16/23 at approximately 5:30 PM, ICN "A" provided an additional policy at the exit conference.

Review of the additional policy provided titled "Coronavirus Testing" revised "9/22", revealed a highlighted section regarding "Routine testing ... Not generally recommended". Further review of the policy revealed no contingency plan documented for the facility's unvaccinated staff.

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	Review of a "Infection Control QAPI (Quality Assessment Process Improvement) report for January 2023" that was provided at the exit was reviewed and revealed the following in part, " ... Weekly Covid-19 testing for staff and daily Covid- 19 testing for residents will be discontinued effectively 2/25/23 ..." This indicated the first policy that was provided which documented a contingency plan for the facility's unvaccinated staff was not being implemented by the ICN "A". The second policy provided contained no documentation of a contingency plan for the facility's unvaccinated staff. Review of a CMS (Centers for Medicare and Medicaid Services) memo (Ref: QSO-23-02-ALL) dated 10/26/22, documented in part " ... The policies and procedures must include, at a minimum, the following components ... A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19 ... Contingency plans for staff who are not fully vaccinated for COVID-19 ..."			