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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055170	A. BUILDING _____ B. WING _____	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICO RIVERA HEALTHCARE CENTER	9140 VERNER STREET PICO RIVERA, CA 90660

(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification Survey. Representing the California Department of Public Health: Health Facilities Evaluator Nurse: 45009, HFEN, RN Health Facilities Evaluator Nurse: 47286, HFEN, RN Health Facilities Evaluator Nurse: 47679, HFEN, RN Health Facilities Evaluator Nurse: 47858, HFEN, RN Health Facility Evaluator, Occupational Therapy Consultant: 45382 Facility Census: 94 Resident Sample Size: 19 Highest Scope and Severity: G	F 000	Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law."	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550	F - 550 I. Corrective Action/s: a. On 01/28/24 IPN was provided a 1:1 in-service by the Administrator regarding " Feeding Residents" policy and procedure and "Dignity" policy and procedure, emphasizing the importance of sitting at eye- level while providing feeding assistance to provide a dignified dining experience. b. From 01/26/24-01/29/24 DSD provided an in-service to all licensed nurses and CNA's regarding "Feeding Residents" policy and procedure and "Dignity" policy and procedure, emphasizing the importance of sitting at eye- level while providing feeding assistance to provide a dignified dining experience.	02/04/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/03/24

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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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff were sitting at eye-level while providing feeding assistance to one of five sampled residents (Resident 10). This failure had the potential to result in affecting Resident 10's self-esteem and self-worth. Findings:	F 550	II. How to Identify Other Residents: a. On 01/25/24 DON and DSD made rounds during scheduled mealtimes to identify that all staff were sitting at eye level while providing feeding assistance, no additional discrepancies were identified with this same deficient practice. III. Systemic Changes: - Daily spot checks will be conducted by DSD and/or designee to ensure all staff providing feeding assistance are sitting at eye- level to provide a dignified dining experience. -Weekly spot checks will be conducted by DON and/or designee to ensure all staff providing feeding assistance are sitting at eye- level while providing a dignified dining experience. IV. Monitoring: - Daily spot checks will be conducted by DSD and/or designee to ensure all staff providing feeding assistance are sitting at eye- level to provide a dignified dining experience x 4 weeks -Weekly spot checks will be conducted by DON and/or designee to ensure all staff providing feeding assistance are sitting at eye- level while to provide a dignified dining experience x 2 months - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	

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F 550	Continued From page 2	F 550		

During a review of Resident 10's Admission Record (Face Sheet), the Admission Record indicated Resident 10 was initially admitted to the facility on 9/26/2017 and was readmitted to the facility on 7/11/2022, with diagnoses that included but not limited to type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), dementia (a condition characterized by progressive or persistent loss of intellectual functioning), and metabolic encephalopathy (problem in the brain caused by chemical imbalances in the blood).

During a review of Resident 10's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 10/19/2023, the MDS indicated Resident 10 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 10's cognition (process of thinking) was severely impaired. The MDS indicated Resident 10 was dependent in eating. The MDS indicated Resident 10 had a feeding tube (a flexible plastic tube placed into the stomach to assist in nutrition). The MDS indicated Resident 10 was receiving a mechanically altered diet (required change in texture in food or liquids due to difficulty chewing or swallowing).

During a review of Resident 10's History and Physical (H&P), dated 3/13/2023, the H&P indicated Resident 10 did not have the capacity to understand and make decisions.

During a review of Resident 10's Order Summary Report, dated 1/7/2024, the Order Summary Report indicated a Consistent Carbohydrate, No Added Salt Diet (diet that consists of the same about of carbohydrates [sugars] and no additional

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added salt), liquidized texture (foods that are smooth, moist, and lump-free and is moderately thick in consistency), small portions.

During a concurrent observation and interview on 1/8/2024 at 12:50 p.m. with the Infection Preventionist Nurse (IPN) in Resident 10's room, the IPN was observed standing on the right side of Resident 10's bed while providing feeding assistance. The IPN stated she was standing and was supposed to be sitting at eye-level with Resident 10 while assisting with feeding. The IPN stated sitting at eye-level showed respect and dignity to the resident.

During an interview on 1/11/2024 at 10:20 a.m., with the Director of Nursing (DON), the DON stated the staff were expected to sit next to the resident, at eye-level, when assisting with feeding. The DON stated sitting next to the resident provided the staff an optimal angle to assess the resident for choking and to provide dignity to the resident while they were being assisted. The DON stated the staff who provide feeding assistance were supposed to sit with the residents and talk with them as a sign of respect.

During a review of the facility's policy and procedure (P&P) titled, "Dignity", undated, the P&P indicated, "When assisting with care, residents are supported in exercising their rights. For example, residents are ... provided with a dignified dining experience."

During a review of the facility's P&P titled, "Feeding Residents", undated, the P&P indicated, "Staff should be sitting down and within eye level of resident."

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F 578 F 578 SS=D	Continued From page 4 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578 F 578	I. Corrective Action/s: a. On 01/10/24 Social Services Designee completed an updated Advance Directive Acknowledgement form for Resident 7 with niece Gloria Acosta. Per current H&P resident has capacity to understand and make decisions, but per SSD notes resident preferred niece Gloria to complete the Advance Directive Acknowledgement form for her and is agreeable with the decisions made by the niece Gloria. b. On 01/29/24 Administrator provided a 1:1 in-service with the Social Services Designee regarding policy and procedure" Lack of Capacity when Medical Interventions require informed consent", emphasizing the importance of ensuring a resident has the capacity to actively participate in decision making per H&P at the time the Advance Directive Acknowledgement form is being completed. II. How to Identify Other Residents: a. On 01/31/24 Social Services Designee reviewed all active Advance Directive Acknowledgment forms to ensure all residents who completed the Advance Directive Acknowledgment form have capacity to actively participate in decision making per current H&P. No additional discrepancies were found with the same deficient practice. practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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F 578	Continued From page 5 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide information and education regarding an Advance Directive (a written instruction, such as a living will or durable power of attorney for healthcare, recognized under State law, relating to the provision of healthcare when the individual is incapacitated) to one of six sampled residents' (Resident 7) Responsible Party (RP). This failure had the potential to result in Resident 7's preferences for care in an emergency, or in the event she became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions, would not be identified and/or carried out by the facility staff. Findings: During a review of Resident 7's Admission Record (Face Sheet), the Admission Record indicated Resident 7 was initially admitted to the facility on 9/24/2014 and readmitted to the facility on 7/7/2019 with diagnoses that included but not limited to epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), dementia (a condition characterized by progressive or persistent loss of intellectual functioning), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily	F 578	III. Systemic Changes: a. On 01/29/24 Administrator provided a 1:1 in-service with the Social Services Designee regarding policy and procedure" Lack of Capacity when Medical Interventions require informed consent", emphasizing the importance of ensuring a resident has the capacity to actively participate in decision making per H&P at the time the Advance Directive Acknowledgement form is being completed -Weekly spot checks will be conducted by the Medical Records Supervisor and/or designee to ensure all residents who completed the Advance Directive Acknowledgment form have capacity to actively participate in decision making per current H&P. IV. Monitoring: - Weekly spot checks will be conducted by Medical Records Supervisor and/or designee to ensure all residents who completed the Advance Directive Acknowledgment form have capacity to actively participate in decision making per current H&P x 4 weeks - Administrator will conduct monthly reviews of findings. Any deficient	02/04/24

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F 578	Continued From page 6	F 578		

life).

During a review of Resident 7's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 11/7/2023, the MDS indicated Resident 7 was able to understand and be understood by others. The MDS indicated Resident 7's cognition (process of thinking) was severely impaired.

During a review of Resident 7's History and Physical (H&P), dated 7/5/2018, the H&P indicated Resident 7 did not have the capacity to understand and make decisions.

During a review of Resident 7's Advance Directive Acknowledgement, dated 9/13/2018, the Acknowledgement indicated Resident 7 had not executed an Advance Directive and that Resident 7 was not capable of making preferred intensity of care decisions at the time. The Advance Directive Acknowledgment indicated Resident 7 had initialed and signed the form.

During a review of Resident 7's H&P, dated 1/18/2023, the H&P indicated Resident 7 had the capacity to understand and make decisions.

During an interview on 1/10/2024 at 3:21 p.m., with the Social Services Director (SSD), the SSD stated she was responsible for providing information regarding Advance Directives to the residents and/or their family. The SSD stated she would review the resident's H&P to determine if the resident was capable of understanding and deciding whether they would like to execute an Advance Directive. The SSD stated Resident 7 was not capable of making medical decisions at the time the previous SSD provided the Advance

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Directive information and Resident 7's family should have been the ones consulted. The SSD stated the Advance Directive was not reviewed with the appropriate person and there was no indication that it was reviewed with Resident 7's RP. The SSD stated a new Acknowledgement form should have been formulated because the previous was not valid. The SSD stated the purpose of informing the resident and their family about an Advance Directive was to give them the opportunity to have in writing their medical wishes for the resident.

During an interview on 1/11/2024 at 11:09 a.m., with the Administrator (ADM), the ADM stated a resident whose H&P indicated they did not have the capacity to understand and make decisions should not be provided any information regarding executing an Advance Directive and the information should be provided to the resident's RP. The ADM stated at the time the Advance Directive Acknowledgement form was completed, Resident 7 did not have the capacity, therefore, a new Acknowledgement form should have been reviewed with Resident 7's RP anytime from 2018 until present day. The ADM stated Resident 7's RP was not given the opportunity to have in writing their life sustaining decisions for Resident 7.

During a review of the facility's policy and procedure (P&P) titled, "Lack of Capacity- When Medical Intervention(s) Require Informed Consent", undated, the P&P indicated, "As soon as reasonably possible during the admission process, an inquiry should be directive to the adult resident or, if the patient is incapacitated, to the patients surrogate decision maker as to whether or not the patient has completed an

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F 578	Continued From page 8 advance directive."	F 578		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580	F - 580 I. Corrective Action/s: -Resident 95 is no longer residing at the facility. -On 1/26/24, DON notified LVN 6 of the findings stated under this deficiency and provided in-service regarding “Managing Diabetes” policy and procedure and “Change in condition” policy and procedure, emphasizing the importance of notifying the physician timely when a resident has critical abnormal blood sugar result and/or experiences signs/symptoms of respiratory distress. II. How to Identify Other Residents: -The DON and the RN supervisor notified the physicians of the blood sugar results for the past 30 days, for all residents who have blood sugar monitoring, to ensure that no other resident will be affected by this deficient practice. The DON and the RN supervisor reviewed all residents who had changes in condition for the past 3 weeks, and did not identify any issue.	02/04/24

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F 580	Continued From page 9 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services for one of seven sampled residents (Resident 95) by failing to: a. Notify the physician of a change of condition (COC) when Resident 95's blood sugar level (measure of glucose [sugar] in the blood [normal range 70- 100 milligrams [mg, unit of measurement] per (/) deciliter [dl, unit of measurement] mg/dl) was elevated on 11/8/2023. b. Notify the physician when Resident 95 began to experience congestion (an abnormal or excessive accumulation of a body fluid), gurgling (a hollow bubbling sound), wheezing, and an episode of emesis (vomiting) on 11/9/2023. These failures resulted in Resident 95 experiencing elevated blood sugar levels over a 24-hour period from 11/8/2023 to 11/9/2023, and respiratory distress and emesis on 11/9/2023. 911 (a phone number used to contact emergency services) was called one and a half hours after	F 580	III. Systemic Changes: -The DON provided in-service regarding “Managing Diabetes” policy and procedure and “Change in Condition” policy and procedure, emphasizing the importance of notifying the physician timely when a resident has critical abnormal blood sugar result and/or experiences signs/symptoms of respiratory distress. The DON will repeat the in-service every month for 3 months, and then quarterly and as needed. -The Medical Record will conduct a weekly audit on blood sugar monitoring and physician notification and present the findings to the DON for review and action as indicated. IV. Monitoring: -The DON will review residents who have changes in condition daily to ensure that MD is notified in a timely manner when resident experiences a change in condition. The DON will continue the daily review for 2 months or until the substantial compliance is achieved. -The DON and/or the RN supervisor will review residents who have blood sugar monitoring every week, and as needed, to ensure that any critical results will be communicated to the physicians. -The DON and the administrator will present the recapitulations of the findings to the monthly CQI/UR meeting for review and action as indicated.	02/04/24

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the resident had a COC and the paramedics pronounced the resident deceased in the facility.

Findings:

a. During a review of Resident 95's Admission Record, the Admission Record indicated Resident 95 was originally admitted to the facility on 9/20/2011 and readmitted on 11/7/2023. Resident 95's diagnoses included anemia (low level of red blood cells), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), gastrointestinal (stomach) bleed, status post percutaneous endoscopic gastrostomy ([PEG] - medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate)) replacement, and diabetes mellitus (abnormal blood sugar).

During a review of Resident 95's Minimum Data Set ([MDS]- a standardized resident assessment and care planning tool), dated 10/6/2023, the MDS indicated Resident 95's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 95 was completely dependent on staff for eating, oral hygiene, personal hygiene, toileting hygiene, bathing, and dressing. The MDS indicated Resident 95 had a feeding tube.

During a review of Resident 95's Care Plan titled, "Diabetes," revised on 7/3/2023, the care plan indicated Resident 95 was at risk for

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hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes mellitus. The care plan interventions indicated staff will initiate nursing measures for hyperglycemia immediately and notify physician promptly.

During a review of Resident 95's Blood Sugar Summary dated 11/8/2023, the blood sugar summary indicated the following blood sugar levels on 11/8/2023:
At 5:49 a.m.- 398 mg/dl.
At 6:00 a.m. - 398 mg/dl.
At 10:58 a.m. - 340 mg/dl.
At 5:12 p.m. - 283 mg/dl.
At 8:51 p.m. - 300 mg/dl.

During a review of Resident 95's Medication Administration Record (MAR), for the month of November 2023, the MAR indicated Resident 95 received the following units of Regular Insulin Injection Solution (a medication that helps your body turn food into energy and controls your blood sugar levels) on the following dates and times:
11/8/2023 at 6:30 a.m. - 10 units for a blood sugar level of 398 mg/dl.
11/8/2023 at 11:30 a.m. - 8 units for a blood sugar level of 340 mg/dl.
11/8/2023 at 4:30 p.m. - 6 units for a blood sugar level of 283 mg/dl.
11/8/2023 at 9:00 p.m. - 6 units for a blood sugar of 300 mg/dl.
11/9/2023 at 6:30 a.m. -10 units for a blood sugar of 398 mg/dl.

During further review of the MAR, there was no indication Resident 95's physician was notified.

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During a concurrent interview and record review, on 1/9/2024, at 3:18 p.m., with Registered Nurse (RN) 2, Resident 95's Blood Sugar Summary, dated 10/17/2023 to 11/8/2023, was reviewed. RN 2 stated Resident 95's blood sugar levels were elevated above 300 mg/dl over a 24-hour period. RN 2 stated blood sugar levels of above 300 (mg/dl) required intervention from the nurse. RN 2 stated Resident 95's physician should have been notified and an order for insulin obtained. RN 2 stated any blood sugar level above 275 mg/dl for more than four hours was dangerous, and nurses were expected to notify the physician. RN 2 stated the nurses should have informed the physician of Resident 95's elevated blood sugar levels so that a different medication regimen could been established. RN 2 stated elevated blood sugar levels for an extended amount of time could lead to altered mental status, a hyperglycemic coma (life-threatening disorder that can happen when blood sugar is very high), and eventually death.

During an interview on 1/10/2024, at 10:15 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 95's blood sugar levels were usually well controlled when she took care of the resident on the 7 a.m. to 3 p.m. shift. LVN 3 stated that elevated blood sugar levels could be a sign of a developing infection and that blood sugar levels consistently above 300 mg/dL should be reported to the physician. LVN 3 stated that prolonged elevated blood sugar levels could possibly lead to altered mental status, ketoacidosis (a serious diabetes complication where the body produces excess blood acids [ketones] and can be triggered by infection or other illness), and eventually, a coma. LVN 3 stated that LVN 6 did not inform her that Resident

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95's blood sugar levels were elevated prior to the start of her shift on 11/8/2023 (7 a.m. to 3 p.m.). LVN 3 stated she would have called the physician about Resident 95's elevated blood sugar levels.

During an interview on 1/10/2024, at 12:55 p.m. with LVN 6, LVN 6 stated she was Resident 95's assigned nurse on 11/7/2023 and 11/8/2023. LVN 6 stated when any resident's blood sugar level was 300 mg/dl and above, the physician should be notified because elevated blood sugar levels of 300 mg/dl or more for over 10 hours could possibly lead to altered mental status, breathing issues, and a hyperglycemic coma. LVN 6 stated on 11/8/2023 Resident 95 had a blood sugar level greater than 300 mg/dl but she (LVN 6) did not notify the physician. LVN 6 stated she did not do so, because she was busy passing medications to other residents and forgot to endorse the elevated blood sugar levels to LVN 3.

During a concurrent interview and record review on 1/10/2024, at 3:03 p.m., with LVN 7, Resident 95's Blood Sugar Summary, dated 10/17/2023 and 11/8/2023, were reviewed. LVN 7 stated Resident 95's blood sugar levels were elevated above 300 mg/dl for a 24-hour period. LVN 7 stated Resident 95's physician should have been notified of the resident's elevated blood sugar levels because the increase in blood sugar levels (above 300 mg/dl) could have been caused by an underlying developing infection and elevated blood sugars could cause altered mental status and coma.

During an interview, on 1/11/2024, at 10:30 a.m., with Physician 1 (the facility's Medical Director), Physician 1 stated he expected the nurses to notify the attending physician of any COC for all

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residents. Physician 1 stated he would have expected the nurses to notify the attending physician if the blood sugar of a resident was persistently above 300 mg/dl because elevated blood sugars caused proteins to leak into the urine. Physician 1 stated he was not notified of Resident 95's blood sugar levels.

During a concurrent interview and record review, on 1/11/2024, at 1:47 p.m., with the Director of Nursing (DON), Resident 95's Blood Sugar Summary, dated 10/17/2023 and 11/8/2023, were reviewed. The DON stated on 11/8/2023, Resident 95's blood sugar levels were above 300 mg/dl for over 24-hours. The DON stated elevated blood sugar levels could be caused by an underlying infection and should have been relayed to the physician because a rise in blood sugar levels was a change of condition. The DON stated delayed treatment of elevated blood sugar levels could possibly lead to altered mental status, sweating and coma.

During a review of the facility's policy and procedure (P&P) titled, "Managing Diabetes," undated, the P&P indicated the facility will monitor the blood sugar levels of residents who had diabetes mellitus to ensure the diabetes was managed, and stabilized in a manner that required the least number of finger sticks. The P&P indicated blood sugar testing during illness, surgery, stress or with COC will increase, according to physician's orders.

b. During a review of Resident 95's Care Plan titled, "Risk for Aspiration (choking)," revised on 7/3/2023, the care plan indicated Resident 95 was at risk for aspiration of food and liquids secondary to advanced dementia, Parkinson's

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disease, and gastrostomy (PEG). The care plan interventions indicated staff will notify the physician of changes of condition.

During a review of Resident 95's COC note, dated 11/3/2023 at 12:21 a.m., the COC indicated on 11/2/2023 at 11:45 p.m., Resident 95 exhibited congestion, wheezing and a gurgling sound. The COC indicated Resident 95 was transferred to the general acute care hospital (GACH).

During a review of Resident 95's GACH records titled, "Procedure Notes," dated 11/4/2023, the procedure notes indicated Resident 95 had an esophagogastroduodenoscopy ([EGD]- a test to examine the lining of the gastrointestinal tract) with a gastrostomy tube replacement. The procedure notes indicated there was evidence of gastric ulcers (open sores that develop on the lining of the stomach) with evidence of recent bleeding.

During a review of Resident 95's "Re-Admission Patient -Alert" Sheet, dated 11/7/2023, the sheet indicated Resident 95 was re-admitted to the facility from the GACH on 11/7/2023 at 7 p.m.

During a review of Resident 95's COC, dated 11/9/2023 at 7:17 a.m., the COC indicated on 11/9/2023 at 5 a.m., LVN 6 noticed Resident 95 had congestion, gurgling, and wheezing. The COC indicated at 5:15 a.m., LVN 6 administered a breathing treatment to the resident, and at 6 a.m., Resident 95 was suctioned due to vomiting a "whitish amount of emesis". The COC indicated at 6:15 a.m., Resident 95 did not respond to tactile (touch) and painful stimuli, appeared pale in color with an oxygen saturation (amount of oxygen in the blood, Normal

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Reference Range [NRR] 92 to 100 percent [%]) of 88%, and oxygen was administered. The COC indicated chest compressions (act of maintaining blood circulation throughout the body) were started at 6:30 a.m., and 911 was called. The COC indicated Paramedics arrived at the facility at 6:40 a.m., chest compressions were resumed, and Resident 95 was pronounced deceased "around 7:20 a.m."

During a review of Resident 95's Medication Administration Record (MAR), for the month of November 2023, the MAR indicated on 11/9/2023 at 5:56 a.m., LVN 6 administered Ipratropium -Albuterol Inhalation Solution (a breathing treatment medication) 0.5-2.5 (3) 3mg per (/) 3 millimeters ([ml]- a unit of measurement).

During an interview on 1/10/2024, at 12:41 p.m., with LVN 6, LVN 6 stated she noticed Resident 95's change in respiratory status around 2 a.m. on 11/9/2023. LVN 6 stated Resident 95 had labored breathing, was coughing, gurgling, and wheezing. LVN 6 stated she suctioned Resident 95 and administered a breathing treatment. LVN 6 stated she administered supplemental oxygen after one hour but Resident 95 was not getting better, so she suctioned the resident a second time. LVN 6 stated, "at 4:00 a.m., I gave another breathing treatment and continued with my medication pass for the other residents. When I came back, he (Resident 95) was already dying around 5 a.m." LVN 6 stated, "I was so busy at that time I was passing medications for 50 plus residents, and we caused a delay in care". LVN 6 stated there may have been a possibility that Resident 95 could have survived if the physician and 911 were notified or called earlier during the shift. LVN 6 stated, "We called 911 late already. It

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should have been right away when I first noticed he (Resident 95) was having labored breathing."

During a concurrent interview and record review, on 1/10/2023, at 3:03 p.m., with LVN 7, Resident 95's COC, dated 11/9/2023 at 7:17 a.m. was reviewed. LVN 7 stated the COC indicated on 11/9/2023 Resident 95's COC was identified at 5 a.m. by LVN 6, and the physician was not notified until Resident 95 had already expired. LVN 7 stated she would have checked Resident 95's vital signs immediately (at 5 a.m.), administered supplemental oxygen, and notified the physician right away. LVN 7 stated Resident 95's death could have been avoided had the physician been made aware of the elevation of Resident 95's blood sugars (on 11/8/2023) and Resident 95's symptoms of respiratory distress (on 11/9/2023).

During an interview, on 1/11/2024, at 10:30 a.m., with Physician 1, Physician 1 stated there should be no delay in physician notification, especially if a resident exhibited adverse changes in respiratory status such as wheezing, gurgling, congestion, or cough because it could lead to resident's harm.

During a concurrent interview and record review with the DON, on 1/11/2023, at 1:47 p.m., Resident 95's "COC" dated 11/9/2023 at 7:17 a.m., was reviewed. The DON stated the COC indicated on 11/9/2023 at 5 a.m., LVN 6 identified Resident 95's change of condition but the physician had not been notified of any changes until after Resident 95 expired. The DON stated she expected LVN 6 to notify the physician, and call 911, especially if Resident 95's COC was initially noticed by LVN 6 at 2 a.m., and if Resident 95 had not been responding to

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F 580	Continued From page 18 treatment. The DON stated the delay in physician notification of both Resident 95's elevated blood sugar levels and Resident 95's initial episode of respiratory distress could have contributed to Resident 95's demise. The DON stated, "If 911 was called sooner, it could have led to a better outcome for the resident". The DON stated it was the expectation of all licensed nurses to notify the physician of COC and to call 911 right away, especially if the care of a resident could not be managed at the facility. During a review of the facility's P&P, titled, "Change of Condition", dated 1/24/2017, the P&P indicated "chest congestion or shortness of breath" was considered a change of condition, and all changes of condition should be handled promptly, the physician shall be called promptly, and 911 should be called in cases of emergency.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582	F-582 I. Corrective Action/s: a. On 01/28/24 Administrator provided an in-service with the Business Office Manager and Business office assistant regarding instructions for the Notice of Medicare Non-coverage (NOMNC) and emphasizing that all NOMNC's must be delivered at least two calendar days before Medicare covered services end or the second to the last day of service if care is not being provided daily.	02/04/24

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F 582	Continued From page 19 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC, notice indicating when	F 582	II. How to Identify Other Residents: a. On 01/30/24 BOM reviewed all NOMNC's completed in the past 3 months to ensure all were delivered at least two calendar days before Medicare covered services ended, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. On 01/28/24 Administrator provided an in-service with the Business Office Manager and Business office assistant regarding instructions for the Notice of Medicare Non-coverage (NOMNC) and emphasizing that all NOMNC's must be delivered at least two calendar days before Medicare covered services end or the second to the last day of service if care is not being provided daily. -Monthly spot checks will be conducted by the Administrator and/or designee to ensure all NOMNC's were delivered at least two calendar days before Medicare covered services end. IV. Monitoring: - Monthly spot checks will be conducted by Administrator and/or designee to ensure all NOMNC's were delivered at least two calendar days before Medicare covered services end x 3 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	

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Medicare [federal health insurance for people 65 or older, and some people under 65 with certain disabilities or conditions] covered services are ending) to the resident's Responsible Party (RP) two days before their Medicare covered services ended for one of three sampled residents (Resident 27).

This failure had the potential to result in Resident 27's RP not having ample time to exercise their right to file an appeal.

Findings:

During a review of Resident 27's Admission Record (Face Sheet), the Admission Record indicated Resident 27 was admitted to the facility on 7/17/2023 with diagnoses included but not limited to dementia (a condition characterized by progressive or persistent loss of intellectual functioning), type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life).

During a review of Resident 27's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 10/19/2023, the MDS indicated Resident 27 was able to understand and be understood by others. The MDS indicated Resident 27 cognition (process of thinking) was moderately impaired.

During a review of Resident 27's History and Physical (H&P), dated, 7/18/2023, the H&P indicated Resident 27 was able to make decisions for activities of daily living.

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During a review of Resident 27's NOMNC, undated, the NOMNC indicated Resident 27's coverage for his current skilled nursing services ended on 8/24/2023.

During a review of Resident 27's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN), undated, the SNFABN indicated Resident 27 and their RP were notified on 8/23/2023 that Resident 27's coverage was ending.

During an interview on 1/9/2024 at 11:11 a.m., with the Business Office Manager (BOM), the BOM stated Resident 27's last date of Medicare Part A coverage was 8/24/2023 and the NOMNC should have been provided to Resident 27 and their RP no later than 8/22/2023. The BOM stated Resident 27 and their RP were notified on 8/23/2023, which meant they were notified late. The BOM stated the purpose of notifying the resident and/or the RP two days prior to their last coverage date was to ensure they were given enough notice and time to send a request to appeal.

During an interview on 1/9/2024 at 1:40 p.m., with the Administrator (ADM), the ADM stated the resident and/or their RP should be provided the NOMNC no later than two days prior to their last coverage date to give sufficient time to appeal and to decide whether the resident will remain in the facility.

During a review of the facility document titled, "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123", undated, the document indicated, "The NOMNC must be delivered at least two calendar days before

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F 582	Continued From page 22 Medicare covered services end or the second to last day of service if care is not being provided daily."	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656	F - 656 I. Corrective Action/s: a. Resident 27 was re-assessed by DOR and an order was obtained to provide Occupational therapy services QD x 3x/wk x 4 wks as ordered on 01/10/2024 and care plan was revised to reflect residents current status. b. On 01/26/24 MDS Consultant provided a 1:1 in-service with MDS regarding “The Resident Care Plan” policy and procedure, emphasizing the importance of re- assessment and changes in the residents' care plan to reflect the resident’s current status. c. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “The Resident Care Plan” policy and procedure, emphasizing the importance of re-assessment and changes in the residents' care plan to reflect the resident’s current status. II. How to Identify Other Residents: a. From 01/26/24- 01/29/24 DON and MDS reviewed residents care plan to ensure it reflects resident’s current status. No additional discrepancies were identified with the same deficient practice.	02/04/24

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F 656	Continued From page 23 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement an individualized care plan with measurable objectives, timeframes, and interventions to improve, prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) for one of seven sampled residents (Resident 27) who was identified as having a decline in ROM to both arms. This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 27 and lead to contracture (loss of motion of a joint associated with stiffness and joint deformity) development and a decline in overall physical functioning such as the ability to move, eat and dress. Findings: During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 7/17/2023 with diagnoses including osteoarthritis (loss of	F 656	III. Systemic Changes: a. On 01/26/24 MDS Consultant provided a 1:1 in-service with MDS regarding “The Resident Care Plan” policy and procedure, emphasizing the importance of re- assessment and changes in the residents' care plan to reflect the resident’ s current status. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “The Resident Care Plan” policy and procedure, emphasizing the importance of re- assessment and changes in the residents' care plan to reflect the resident’s current status. c. DON and/ or designee will review resident care plans monthly to ensure all care plans reflect residents current status. IV. Monitoring: - DON and/ or designee will review resident care plans monthly to ensure all care plans reflect residents current status x 3 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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protective cartilage that cushions the ends of your bones), muscle weakness, and neuropathy (nerve damage).

During a review of Resident 27's Minimum Data Set (MDS, an assessment and care-screening tool), dated 7/21/2023, the MDS indicated Resident 27 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 27 required extensive assistance for bed mobility and eating and total assistance for transfers (moving from one surface to another), locomotion (ability to move from one place to another) on and off the unit, dressing, personal hygiene, and toilet use. The MDS indicated Resident 27 had no functional limitations in ROM in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot).

During a review of Resident 27's MDS, dated 10/19/2023, the MDS indicated Resident 27 required substantial/maximal assistance for eating, oral hygiene, toilet hygiene, and bathing and total assistance in dressing and personal hygiene. The MDS indicated Resident 27 had functional ROM limitations in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot).

During a review of Resident 27's care plans, the care plans did not indicate a care plan addressing the resident's decline in ROM of both arms.

During a concurrent observation and interview with Resident 27 on 1/9/2024 at 9:52 a.m., in Resident 27's room, Resident 27 was observed lying in bed with blankets covering the entire body. Resident 27 stated she had pain all over

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her body and requested pain medication. Resident 27 stated she has had more pain on the left side of the body for years and stated it was hard to move the left wrist and left shoulder. Resident 27 was unable to bring both arms overhead and was unable to make a full fist with both hands. Resident 27 stated she wished staff would assist with ROM exercises to both arms because they were painful and hard to move on her own.

During a concurrent observation and interview with Resident 27 on 1/9/2023 at 2:20 p.m., in Resident 27's room, Resident 27 was observed lying in bed with blankets covering the body. Resident 27 stated she felt much better because she was in less pain and removed the blanket from the upper half of the body using both arms. Resident 27 moved both arms to shoulder level and bent and straightened both elbows. Resident 27 was able to make 90 (percent) % of a full fist with both hands, bent the left wrist downwards, and had difficulty moving the left wrist upwards due to pain. Resident 27 stated she was able to feed herself and wash her face once nursing assisted with set-up.

During a concurrent interview and record review on 1/10/2024 at 2:08 p.m., with the Minimum Data Set Nurse (MDSN), Resident 27's MDS (dated 7/21/2023 and 10/19/2023), physician's orders, and care plan were reviewed. The MDSN stated the MDS was a comprehensive (inclusive, including everything necessary) assessment of a resident used to create individualized care plans. The MDSN confirmed Resident 27 had a decline in ROM to both arms and both legs according to the MDS. The MDSN stated Resident 27 was unable to demonstrate she was able to perform

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her activities of daily living (ADLs, basic activities such as eating, dressing, and toileting) using her arms during the MDS assessment on 10/19/2023 primarily because she was uncooperative. The MDSN stated an Interdisciplinary Team (IDT) meeting should have been initiated to ensure interventions were developed and implemented to address the limitations once the decline in ROM of Resident 27's arms and legs were identified but was not done. The MDSN stated Resident 27 should have been on therapy or RNA services to address the decline in ROM of both arms identified in the MDS but was not. The MDSN confirmed RNA services were ordered for PROM of both legs but was not ordered for the arms. The MDSN confirmed there were no interventions in place to address the change in ROM or prevent a further decline in ROM of Resident 27's arms. The MSDN stated Resident 27 was at risk for contractures because she did not get out of bed, required assistance with ADLs, and needed a lot of encouragement to participate in everyday activities.

During a concurrent interview and record review on 1/10/2024 at 2:47 p.m., with the Director of Rehabilitation (DOR) who was an Occupational Therapist (OT), Resident 27's OT notes, Rehabilitation screens, joint mobility screen, and physician's orders were reviewed. The DOR stated she was unaware nursing identified Resident 27 as having a decline in arm ROM in the MDS. The DOR stated the decline in Resident 27's arm ROM should have been communicated to the rehab department in an IDT meeting but was not. The DOR stated Resident 27 was at high risk for contracture development and a functional decline because Resident 27 had a diagnosis of osteoarthritis, required

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assistance with mobility and ADLs, and required encouragement to move on her own.

During a concurrent interview and record review on 1/11/2024 at 2:38 p.m., with the Director of Nursing (DON), Resident 27's IDT notes, MDS assessments, care plan, and physician's orders were reviewed. The DON confirmed Resident 27's had a decline in both arm ROM according to the MDS assessments. The DON confirmed Resident 27 did not have a care plan, interventions, and any services in place to address the decline in Resident 27's arm ROM. The DON stated residents with ROM impairments should be on therapy or RNA services to prevent a decline in function. The DON stated an IDT meeting should have been done, a care plan should have been created, and interventions should have been implemented once Resident 27's arm ROM decline was identified on the MDS but was not. The DON stated Resident 27 was at risk for contracture development and a functional decline because there were no interventions in place improve or prevent a decline in Resident 17's arm ROM.

During a review of the facility's undated policy and procedure (P&P) titled, "The Resident Care Plan," the P&P indicated the objective of comprehensive care plans was to provide individualized nursing care and to promote continuity of resident care. The P&P indicated the care plan was comprehensive in nature and generally included: identification of medical, nursing, and psychosocial needs, measurable goals, staff approaches to meet the goals, the discipline, or staff responsible for the interventions, and re-assessment and change as needed to reflect the resident's current status.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the resident-centered care plan (document that helps nurses and other team care members organize aspect of resident care) for one of six sampled residents (Resident 74) who had a change in her ability to carry out her activities of daily living (ADLs, term used to collectively describe fundamental skills required	F 657	F- 657 I. Corrective Action/s: a. On 01/10/24 Resident 74's care plan was revised to reflect residents current status. b. On 01/26/24 MDS Consultant provided a 1:1 in-service with MDS regarding "The Resident Care Plan" policy and procedure, emphasizing the importance of re-assessment and changes in the residents' care plan to reflect the resident's current status. c. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding "The Resident Care Plan" policy and procedure, emphasizing the importance of re- assessment and changes in the residents' care plan to reflect the resident's current status. II. How to Identify Other Residents: a. From 01/26/24- 01/29/24 DON reviewed residents care plan to ensure it reflects resident's current status. No additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. On 01/26/24 MDS Consultant provided a 1:1 in-service with MDS regarding "The Resident Care Plan" policy and procedure, emphasizing the importance of re-assessment and changes in the residents' care plan to reflect the resident's current status. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding "The Resident Care Plan" policy and procedure, emphasizing the importance of re- assessment and changes in the residents' care plan to reflect the resident's current status. c. DON and/ or designee will review resident care plans monthly to ensure all care plans reflect residents current status.	02/04/24

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F 657	Continued From page 29 to independently care for oneself, such as eating, bathing, and mobility). This failure had the potential to result in Resident 74's needs not be met due to the staff being unaware of the required assistance needed. Findings: During a review of Resident 74's Admission Record (Face Sheet), the Admission Record indicated Resident 74 was initially admitted to the facility on 3/24/2024 and readmitted to the facility on 4/8/2023 with diagnoses included but not limited to type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), and chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow). During a review of Resident 74's History and Physical (H&P), dated 4/24/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, comprehensive resident assessment and care screening tool), dated 12/14/2023, the MDS indicated Resident 74 was able to understand and be understood by others. The MDS indicated Resident 74's cognition was intact (ability to think and reason). The MDS indicated Resident 74 required moderate assistance with bed mobility, maximal assistance with toileting, bathing, and dressing, and required setup or clean-up assistance with personal hygiene. The MDS indicated Resident 74 had a fall with a	F 657	IV. Monitoring: - DON and/ or designee will review resident care plans monthly to ensure all care plans reflect residents current status x 3 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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major injury.

During a review of Resident 74's Care Plan, revised 4/5/2022, the Care Plan indicated Resident 74 had self-care deficits with bed mobility that required extensive one-person assist, dressing that required total one-person assist, toileting that required total one-person assist, personal hygiene that required extensive one-person assist, and bathing that required total one-personal assist.

During an interview on 1/10/2024 at 12:16 p.m., with the MDS Nurse (MDSN), the MDSN stated she was responsible for developing residents' care plans based on their MDS and to revise care plans if there were any changes in the residents' condition. The MDSN stated based on Resident 74's most current MDS on 12/14/2023 the resident's care plan on self-care deficits with bed mobility, dressing, toileting, personal hygiene, and bathing should have been revised to correctly portray her current status. The MDSN stated the residents' care plans was a communication tool with the staff and without an updated care plan for Resident 74, she potentially would not receive the proper care the required.

During an interview on 1/11/2024 at 10:24 a.m., with the Director of Nursing (DON), the DON stated the purpose of care plans was to direct the staff on how to care for the resident based on their needs and goals. The DON stated care plans were revised if a resident had a change in condition, the interventions were no longer appropriate, or new interventions needed to be added according to the needs of the resident. The DON stated Resident 74 had changes in her ability to carry out her ADLs and her care plan

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F 657	Continued From page 31 should have been updated to reflect those changes to ensure Resident 74 received the proper care. During a review of the facility's policy and procedure (P&P) titled, "Resident Assessment", undated, the P&P indicated, "Care plans shall be updated more often, as the resident's condition or needs change."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Registered Nurse (RN) 3 received report (oral communication between care providers to describe that status of the resident) for one of three sampled residents (Resident 74) who was readmitted to the facility from the general acute care hospital (GACH). This failure resulted in the nursing staff and physician being unaware of Resident 74's computed tomography (CT, imaging that helps detect internal injuries and diseases) scan results that showed a compression fracture (type of broken bone that can cause the vertebra [bone in the spine] to collapse) of the second lumbar vertebrae (L2, bone in the lower end of the spinal column). Findings:	F 658		

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F 658	Continued From page 32 During a review of Resident 74's Admission Record (Face Sheet), the Admission Record indicated Resident 74 was initially admitted to the facility on 3/24/2024 and readmitted to the facility on 4/8/2023 with diagnoses that included type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), and chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow). During a review of Resident 74's History and Physical (H&P), dated 4/24/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a standardized resident asssessment and care screening tool) dated 12/14/2023, the MDS indicated Resident 74 was able to understand and be understood by others. The MDS indicated Resident 82's cognition was intact (ability to think and reason). The MDS indicated Resident 74 required moderate assistance with bed mobility, maximal assistance with toileting, bathing, and dressing, and required setup or clean-up assistance with personal hygiene. The MDS indicated Resident 74 had a fall with a major injury. During a review of Resident 74's Change of Condition (COC), dated 11/6/2023, the COC indicated Resident 74 returned to her room from the shower room and was being assisted to bed by the certified nursing assistant (CNA). The COC indicated Resident 74 stood up to transfer	F 658	F - 658 I. Corrective Action/s: a. On 01/26/24 DON provided a 1:1 in-service with RN3 regarding “Out of facility therapeutic visit” policy, emphasizing the importance of receiving report for residents who are readmitted to the facility from the general acute hospital. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Out of facility therapeutic visit” policy, emphasizing the importance of receiving report for residents who are readmitted to the facility from the general acute hospital. II. How to Identify Other Residents: a. On 01/29/24 DON reviewed re-admissions from 01/12/24-01/28/24 to ensure report was received by admitting nurse from general acute care hospital, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. On 01/26/24 DON provided a 1:1 in-service with RN3 regarding “Out of facility therapeutic visit” policy, emphasizing the importance of receiving report for residents who are readmitted to the facility from the general acute hospital. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Out of facility therapeutic visit” policy, emphasizing the importance of receiving report for residents who are readmitted to the facility from the general acute hospital. c. DON will review all residents admitted to the facility from general acute care hospitals to ensure report is received by the admitting nurse. IV. Monitoring: - DON will review all residents admitted to the facility from general acute care hospitals to ensure report is received by the admitting nurse x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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to the bed, was unable to reach for the bed handles, and fell and landed on her back. The COC indicated Physician 2 was informed and orders for X-ray (imaging that creases pictures of the inside of the body) of the hip, spine, head, leg, and pelvis were received. The COC indicated Resident 74 complained of lower back and left hip pain.

During a review of Resident 74's Radiology Results Report, dated 11/6/2023, the Radiology Results Report indicated the X-ray result of the lumbar spine indicated a compression deformity at the L2 level, age indeterminate (not exactly known).

During a review of Resident 74's Progress Notes, dated 11/6/2023 and timed at 1:48 p.m., the Progress Note indicated Physician 2 was informed of Resident 74's X-ray results and Physician 2 ordered a CT scan of the head and lumbar.

During a review of Resident 74's COC, dated 11/28/2023, the COC indicated Resident 74 complained of lower back pain and another lumbar X-ray was done with result of a compression deformity at the L2 level, age determinate. The COC indicated Physician 2 was notified that Resident 74 had not received the CT scan of the head and lumbar due to insurance. The COC indicated Physician 2 ordered for Resident 74's transfer to the GACH for CT scan of the head and lumbar.

During a review of Resident 74's GACH Radiology Report, dated 11/28/2023, the Radiology Report indicated the report was faxed to the facility on 12/12/2023. The Radiology

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Report indicated the CT scan result of the lumbar indicated an acute compression fracture of L2.

During a review of Resident 74's (Re)Admission Assessment, dated 11/28/2023, the Admission Assessment indicated Resident 74 was transferred to the GACH for a CT scan of the head and lumbar and was readmitted to the facility. The Admission Assessment had no indication of report from the GACH being provided to the admitting nurse from the facility and of the results of the CT scan.

During a review of Resident 74's COC, dated 12/12/2023, the COC indicated the lumbar CT scan results were received from the GACH and Physician 2 was notified of the results. The COC indicated Physician 2 ordered for Resident 74 to see a neurosurgeon in one to six weeks for evaluation.

During an interview on 1/10/2024 at 8:59 a.m., with Registered Nurse (RN) 2, RN 2 stated she and the other nurses were unaware of Resident 74's compression fracture until the facility received the results from the GACH. RN 2 stated Resident 74 was transferred to the GACH on her shift and was readmitted to the facility the following shift. RN 2 stated she had not received any report regarding Resident 74 while the resident was at the GACH.

During an interview on 1/10/2024 at 3:46 p.m., with RN 3, RN 3 stated Resident 74 was transferred to the GACH on 11/28/2023 for a CT scan and was readmitted to the facility that same night. RN 3 stated the case manager from the GACH called her to inform her that Resident 74 would be returning to the facility, and someone

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F 658	Continued From page 35 would give her report. RN 3 stated normally when a resident was readmitted to the facility from the GACH, she would receive report prior to the resident's arrival. RN 3 stated she had not received report and Resident 74 was brought back to the facility. RN 3 stated she was curious what the CT scan results were, but she did not follow up with the GACH. RN 3 stated she could have called the GACH and spoken to the physician. RN 3 stated receiving report when a resident was admitted to the facility from the GACH was important in order to receive all the information that transpired at the GACH to care for the resident and collaborate with the physician. During an interview on 1/11/2024 at 10:28 a.m., with the Director of Nursing (DON), the DON stated the admitting nurse should receive report from the nurse at the GACH, especially if there were any abnormal results. The DON stated receiving report when a resident was admitted was important to know how to take care of the resident, if any precautions needed to be taken, to coordinate with other departments, in order to form a plan to care for the resident properly. During a review of the facility's policy and procedure (P&P) titled, "Out-of-Facility Therapeutic Visit", undated, the P&P indicated, "The facility will follow up on the recommendation from the out-of-facility therapeutic visit, if any."	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 675		

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F 675	Continued From page 36 residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff provided the necessary care and services to two sampled residents (Resident 85 and 35) when: 1. Certified Nursing Assistant (CNA) 2 failed to report Resident 85's change in condition to a licensed nurse. 2. CNA 2 failed to properly reposition Resident 85 in bed. 3. Staff did not reposition Resident 35 and Resident 85 every 2 hours. These deficient practices had the potential for Resident 85's health changes to become compromised and go unnoticed, and had the potential to result in skin breakdown or compromised skin integrity for Resident 35 and Resident 83. Findings: 1. During a review of Resident 85's Admission Record, the admission record indicated Resident 85 was originally admitted to the facility on 5/16/2023 with diagnoses including dysarthria (weakness in muscles used for speech, which often causes slowed or slurred speech) and	F 675	F - 675 I. Corrective Action/s: a. On 01/26/24 CNA2 was provided a 1:1 in-service by the DSD regarding “Change in Condition” policy and procedure and “ Positioning/ Repositioning Residents” policy and procedure, emphasizing the importance of reporting changes in condition to a licensed nurse and repositioning residents properly every 2 hours and as needed. b. From 1/26/24-1/29/24 DSD provided an in- service to all CNA’s regarding “Change in Condition” policy and procedure, emphasizing the importance of reporting changes in condition to a licensed nurse. c. From 1/26/24-1/29/24 DSD provided an in- service to all licensed nurses and CNA’ s regarding “Positioning/ Repositioning Residents” policy and procedure, emphasizing the importance of properly positioning and repositioning residents every 2 hours and as needed II. How to Identify Other Residents: a. On 01/26/24 DSD conducted facility rounds to ensure all residents were properly positioned/ repositioned every 2 hours, and ensured CNA’s reported any residents noted with a change in condition. No additional discrepancies were identified with this same deficient practice.	02/04/24

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F 675	Continued From page 37 dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). During a review of Resident 85's H&P dated 6/13/2023, the H&P indicated Resident 85 did not have the capacity to understand and make decisions. The H&P indicated Resident 85 had a diagnosis of chronic obstructive pulmonary disease ([COPD] group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs). During a review of Resident 85's MDS, dated 11/7/2023, the MDS indicated Resident 85's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 85 was dependent on staff for all ADLs. The MDS indicated Resident 85 had a diagnosis of hemiplegia (a condition caused by a brain injury, that results in a varying degree of weakness, stiffness, and lack of control in one side of the body). During a review of Resident 85's Care Plan for Skin, dated 5/16/2023, the care plan indicated Resident 85 was at risk for developing pressure ulcers and other skin breakdown related due to fragile skin, hemiplegia, and immobility. The Care Plan indicated Resident 85's goal was to minimize the risk of skin breakdown and pressure ulcer daily. The staff's interventions indicated to turn and position Resident 85 as needed when in bed or wheelchair. During a review of Resident 85's Care Plan for Respiratory System, dated 5/16/2023, the care plan indicated Resident 85 was at risk for	F 675	III. Systemic Changes: a. On 01/26/24 CNA2 was provided a 1:1 in-service by the DSD regarding “Change in Condition” policy and procedure and “ Positioning/ Repositioning Residents” policy and procedure, emphasizing the importance of reporting changes in condition to a licensed nurse and repositioning residents properly every 2 hours and as needed. b. From 1/26/24-1/29/24 DSD provided an in- service to all CNA’s regarding “Change in Condition” policy and procedure, emphasizing the importance of reporting changes in condition to a licensed nurse. c. From 1/26/24-1/29/24 DSD provided an in- service to all licensed nurses and CNA’s regarding “Positioning/ Repositioning Residents” policy and procedure, emphasizing the importance of properly positioning and repositioning residents every 2 hours and as needed -Weekly spot checks will be conducted by DSD and/or designee to ensure all staff position/ reposition residents properly every 2 hours and as needed. -Weekly Spot Checks will be conducted by DSD to ensure all CNA’s report any noted changes in condition to a licensed nurse. IV. Monitoring: -Weekly spot checks will be conducted by DSD and/or designee to ensure all staff position/ reposition residents properly every 2 hours and as needed x 2 months -Weekly Spot Checks will be conducted by DSD to ensure all CNA’s report any noted changes in condition to a licensed nurse x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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respiratory distress related to COPD. The care plan indicated Resident 85's goal was to not have unrecognized signs and symptoms of respiratory distress. The staff's interventions indicated to assess Resident 85 for shortness of breath, wheezing, coughing, weakness and to notify the physician promptly.

During an observation on 1/8/2024 at 10:19 a.m., in Resident 85's room, Resident 85 was observed lying on his left side facing the wall.

During an observation 1/8/2024 at 12:44 p.m., in Resident 85's room, Resident 85 was observed lying on his left side facing the wall.

During an observation on 1/9/2024 at 1:00 p.m., in Resident 85's room, Resident 85 was observed lying on his left side facing the wall with no pillows between his legs.

During an observation on 1/9/2024 at 3:28 p.m., in Resident 85's room, Resident 85 was observed lying on his left side facing the wall.

During an observation on 1/10/2024 at 7:44 a.m., in Resident 85's room, CNA 2 was observed at the resident's bedside during breakfast. Resident 85 was making grunting noises when breathing.

During an observation on 1/10/2024 at 8:00 a.m., in Resident 85's room, Resident 85 was observed lying on his back, his bilateral (both) lower extremities (BLE) were contracted (a fixed tightening or shorten of muscle, tendons, ligaments, or skin) and tucked underneath him with no pillow between the legs. Resident 85 was making loud grunting noises when breathing.

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During an interview on 1/10/2024 at 8:14 a.m. with the Infection Preventionist Nurse (IPN), in Resident 85's room, the IPN stated Resident 85 should not have his legs in that position because it was uncomfortable and would create more of a contracture to the legs or it would cause a fracture (break in the bone) to the legs.

During an observation on 1/10/2024 at 8:20 a.m., in Resident 85's room, the IPN and CNA 2 attempted to reposition Resident 85. Resident 85 could not straighten out his legs. CNA 2 kept pulling on Resident 85's legs and placed a pillow under the resident's legs.

During an interview on 1/10/2024 at 8:29 a.m. with CNA 2, in Resident 85's room, CNA 2 stated she positioned Resident 85 on his back with the resident's BLE tucked under him. CNA 2 stated that positioning provided comfort to Resident 85. CNA 2 stated it was acceptable to place Resident 85 in that position without any support for his BLE because it did not cause any pain or discomfort. CNA 2 stated Resident 85 made beathing noises when she was with him.

During a concurrent observation and interview on 1/10/2024 at 8:40 a.m. with the IPN, in Resident 85's room, Resident 85 was grunting loudly and struggling to breath. The IPN stated she needed to check Resident 85's oxygen saturation (percentage of oxygen circulating in the blood). The IPN stated Resident 85's oxygen saturation was 91 percent (%) (Normal Reference Range, 95% to 100%) and that she would administer oxygen to Resident 85. The IPN stated CNA 2 should have realized that Resident 85 was having trouble breathing and she should have notified a nurse. The IPN stated CNAs received in-service

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training to look out for any changes in residents and to notify a licensed nurse.

During an interview on 1/10/2024 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 85's room, LVN 2 stated Resident 85 should be repositioned every 2 hours because the resident was bed bound. LVN 2 stated Resident 85 must be repositioned every 2 hours because the resident developed redness on his buttocks. LVN 2 stated Resident 85 would benefit from frequent position changes to relieve skin pressure and promote circulation.

During an interview on 1/11/2024 at 8:25 a.m. with LVN 5, LVN 5 stated residents that were bed bound must be repositioned every 2 hours or as needed. LVN 5 stated residents were repositioned to prevent pressure on their skin. LVN 5 stated if residents were not repositioned it would increase the risk of skin breakdown/wounds.

During an interview on 1/11/2024 at 11:02 a.m. with the DSD, the DSD stated CNAs were trained on what to look out for in residents when there was a change of condition. The DSD stated CNAs were instructed to observe residents for facial grimaces, body language, or anything out of the normal and report it to a nurse. The DSD stated CNA 2 should have reported Resident 85 was making loud noises when breathing.

During an interview on 1/11/2024 at 12:29 p.m. with the Director of Nursing (DON), the DON stated CNAs were trained to observe residents and trained to notify any change of conditions to the charge nurse. The DON stated CNA 2 should have notified a licensed nurse that Resident 85's breathing was not normal.

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2. During a review of Resident 35's Admission Record, the admission record indicated Resident 35 was originally admitted to the facility on 2/17/2017 and readmitted on 7/7/2023 with diagnoses including heart failure (progressive heart disease that affects pumping action of the heart muscles) and peripheral vascular disease ([PVD] a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).

During a review of Resident 35's History and Physical (H&P) dated 7/14/2023, the H&P indicated Resident 35 did not have the capacity to understand and make decisions. The H&P indicated Resident 35 had a diagnosis of quadriplegia (paralysis [inability to move] that affects all the limbs and body from the neck down).

During a review of Resident 35's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 11/6/2023, the MDS indicated Resident 35's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 35's speech was unclear. The MDS indicated Resident 35 was dependent on staff for all activities of daily living (ADLs, self-care activities performed daily such as dressing, personal hygiene, grooming, and toilet use). The MDS indicated Resident 35 was at risk for a pressure ulcer/injury (injury to the skin and underlying tissue due to prolonged pressure).

During a review of Resident 35's Care Plan for Skin, dated 8/30/2019, the care plan indicated Resident 35 was at risk for developing skin

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breakdown due to fragile skin, immobility, and history of skin alteration. The Care Plan indicated Resident 35's goal was to minimize the risk of skin breakdown/ bruising/pressure ulcer daily. The staff's interventions indicated to turn and position Resident 35 as needed when in bed or wheelchair.

During an observation on 1/8/2024 at 12:19 p.m., in Resident 35's room, Resident 35 was observed lying on his left side facing the door.

During an observation on 1/8/2024 at 2:56 p.m., in Resident 35's room, Resident 35 was lying observed on his left side facing the door.

During an observation on 1/9/2024 at 9:36 a.m., in Resident 35's room, Resident 35 was observed lying on his left side facing the door.

During an observation on 1/9/2024 at 1:52 p.m., in Resident 35's room, Resident 35 was observed lying on his left side facing the door.

During an observation on 1/9/2024 at 3:21 p.m., in Resident 35's room, Resident 35 was observed lying on his left side facing the door.

During an interview on 1/11/2024 at 10:48 a.m. with the Director of Staff Development (DSD), the DSD stated residents that had contractions, were weak and bedridden must get repositioned every 2 hours. The DSD stated residents were repositioned to prevent skin breakdown. The DSD stated CNAs received in-service training on repositioning residents and the CNAs should know that residents were to be repositioned every 2 hours.

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F 675	Continued From page 43 During an interview on 1/11/2024 at 12:17 p.m. with the DON, the DON stated bedridden resident should be repositioned every 2 hours and as needed. The DON stated CNAs have been told to reposition residents continuously throughout the day to prevent skin breakdown. The DON stated she expected all CNAs to assist all bedridden residents with repositioning at least every 2 hours to relieve skin pressure. The DON stated if residents did not get repositioned, they would be prone to skin breakdown and pain due to discomfort. During a review of the facility's policy and procedure (P&P) titled, "Positioning/repositioning Residents", undated, the P&P indicated a pillow must be placed under the resident's upper arm to support it. The P&P indicated the upper leg must be bent, pillows must be placed under the thigh, calf, and foot for support. During a review of the facility's P&P titled, "Change of Condition", undated, the P&P indicated its purpose was to ensure proper assessment and follow-through for any resident with a change condition. The P&P indicated a change of condition was a sudden or marked difference in residents: Vital signs (Temperature, pulse, heart rate, irregular pulse, shortness of breath). The P&P indicated all changes of condition in a resident shall be handled promptly.	F 675		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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	F 684		

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F 684	Continued From page 44 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure quality of care was provided for two of 23 sampled residents (Resident 74 and 297) when the following occurred: 1. Licensed staff failed to complete a 72-hour neurological check (a physical examination to identify signs of disorders affecting your brain, spinal cord and nerves) as ordered by the physician and as indicated within the facility's policy after Resident 297, who was admitted to the facility with a history of a fall which resulted in a subdural hemorrhage (bleeding in the area between the brain and the skull), had another fall (in the facility) with head trauma (physical injury). 2. Licensed staff documented thirty-seven (37) administrations of Lidocaine 5% patch (medicated patch applied to the skin for pain management) for Resident 74, when only fourteen (14) patches had been dispensed to the facility. These deficient practices had the potential to result in a missed assessment that could have led to an undetected, repeated subdural hemorrhage, which could have resulted in severe neurological (brain) impairment or death for Resident 297, and created the potential for Resident 74 to experience avoidable harm from pain related to non-administered pain medication.	F 684	F - 684 I. Corrective Action/s: a. On 01/08/24 LVN 7 performed a neurocheck on Resident 297, no changes in residents neurological condition were noted. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding " Incidents and Accidents" policy and procedure, emphasizing the importance of conducting a 72- hour neurological check after a residents fall with head trauma. c. a. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding "Medication Administration Guidelines" policy, emphasizing the importance of administering all medications as ordered by the physician. d. Resident 74 was immediately assessed for pain, and upon assessment verbalized she has no pain and refusal of lidocaine patch. Physician was notified and discontinued lidocaine patch. II. How to Identify Other Residents: a. On 01/26/24 DON reviewed all 72- hour neurochecks from January 2024 no additional discrepancies were identified with the same deficient practice. b. On 1/31/24 DON conducted a medication reconciliation for all facility medication carts to ensure all prescribed medications are being administered as ordered by the physician, no additional discrepancies were identified with the same deficient practice.	02/04/24

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F 684	Continued From page 45 Cross Reference: F-tag 726, F-tag 759, and F-tag 760 Findings: 1. During a review of Resident 297's Admission Record, the Admission Record indicated Resident 297 was admitted to the facility on 1/3/2024 with diagnoses that included traumatic subdural hemorrhage, malignant neoplasms (cancerous growths) of the lung, and history of falling. During a review of Resident 297's History and Physical (H&P), dated 1/3/2024, the H&P indicated Resident 297 had the capacity to understand and make decisions. During a review of Resident 297's care plan titled, "Actual Fall," initiated 1/7/2024, the care plan indicated Resident 297 had an actual fall related to balance deficit (difficulty), decreased strength and endurance (the body's physical capability to sustain an exercise for an extended period), history of falls, and unsteady gait (ability to walk). The staff's interventions were to conduct a "neurological assessment for 72 hours". During a review of Resident 297's Change of Condition (COC) Form, dated 1/7/2024, the COC form indicated Resident 297 had an unwitnessed fall and staff found Resident 297 "lying on his back". The note indicated Resident 297 stated that he "tried to get up to use the restroom ... slipped, and fell to the floor, hitting the posterior of his head." During a review of Resident 297's Order Summary, dated 1/9/2024, the Order Summary	F 684	IV. Monitoring: - DON and/ or designee will review all residents with 72- hour neurochecks daily to ensure completion x 2 months. - DON and/ or designee will conduct a medication reconciliation weekly to ensure all medications are being administered ordered by the physician x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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had indicated the facility was to perform a neurological check for 72 hours for an unwitnessed fall from 1/7/2024 to 1/10/2024.

During a concurrent review and interview, on 1/8/2024, at 3:58 p.m., with Licensed Vocational Nurse (LVN) 7, the "72 Hours Neuro- Check List", dated 1/7/2024 to 1/8/2024 was reviewed. LVN 7 verified the neurological check list indicated the section where Resident 297's vital signs and neurological function (blood pressure, temperature, pulse, respiratory rate, level of consciousness, the left and right pupils, left and right-hand grips) were to be documented had been left blank for the hours of 12:30 a.m., 4:30 a.m., 8:30 a.m., and 12:30 p.m. on 1/8/2024. LVN 7 stated the form was incomplete, and it should have been completed to indicate and ensure Resident 297's neurological function was intact. LVN 7 stated the importance of completing the form and documenting in "real time" was to ensure no assessments were missed and that Resident 297 did not experience signs of an internal brain bleed.

During a concurrent review and interview, on 1/8/2024, at 4:10 p.m., with the Infection Prevention Nurse (IPN), the "72 Hours Neuro-Check List", dated 1/7/2024 to 1/8/2024 was reviewed. The IPN verified the neurological check list indicated the section where Resident 297's vital signs and neurological function were to be documented was left blank for the hours of 12:30 a.m., 4:30 a.m., 8:30 a.m., and 12:30 p.m. on 1/8/2024. The IPN stated the form should have been completed and that if vitals were not taken, there would be a possibility the nurses would have missed an important change in Resident 297's condition, or a neurological assessment

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that could have indicated an internal brain bleed.

During a concurrent review and interview, on 1/11/2024, at 1:47 p.m., with the Director of Nursing (DON), the "72 Hours Neuro- Check List", dated 1/7/2024 to 1/8/2024, was reviewed. The DON verified the neurological check list indicated the section where Resident 297's vital signs and neurological function were to be documented was left blank for the hours of 12:30 a.m., 4:30 a.m., 8:30 a.m., and 12:30 p.m. on 1/8/2024. The DON stated the sheet had not been complete and should have been complete so that the nurses can properly assess the resident. The DON stated that there was a potential for the nurses to have missed an assessment, like a spike in the resident's blood pressure, unrelieved pain, and signs of a hemorrhage.

During a review of the facility's policy and procedure (P&P) titled, "Incidents and Accidents" (undated), the P&P indicated the facility was to ensure "vital signs are taken with neurocheck[s] on any head injury for 72 hours (use of Neurocheck form)".

2. During a review of Resident 74's Admission Record, the record indicated the facility originally admitted Resident 74 on 3/24/2022 and re-admitted Resident 74 on 4/8/2022. Resident 74's admitting diagnoses included type 2 diabetes mellitus, stage 3 chronic kidney disease (mild to moderate damage of the kidneys, making them less able to filter waste and fluid out of the blood), and a compression fracture (broken bone) of the lumbar vertebra (spinal bone in the lower back), and anemia (low red blood cell count).

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During a review of Resident 74's H&P, dated 4/25/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions.

During a review of Resident 74's active physician orders, the orders indicated staff were supposed to administer a Lidocaine 5% patch to Resident 74's right lower back, once a day, for pain management, starting on 11/25/2023.

During a review of Resident 74's care plans, the care plans indicated Resident 74 had a recent fracture. The goals of the care indicated Resident 74's pain would be managed and kept within a tolerable level. The staff's interventions indicated to administer pain medication as ordered by the physician.

During a concurrent observation and interview on 1/9/2024 at 9:04 a.m., LVN 4 administered two medications to Resident 74. LVN 4 did not apply a Lidocaine 5% patch to Resident 74's right lower back.

During a review of Resident 74's MAR, for the month of November 2023, the MAR indicated licensed staff documented Resident 74's Lidocaine 5% patch as administered on: 11/25/2023, 11/26/2023, 11/27/2023, 11/28/2023, 11/29/2023, and 11/20/2023. The MAR indicated a total of six administrations of Resident 74's Lidocaine 5% patch for the month of 11/2023, by five different licensed nursing staff.

During a review of Resident 74's MAR, for the month of December 2023, the MAR indicated licensed staff documented Resident 74's Lidocaine 5% patch as administered on: 12/1/2023, 12/2/2023, 12/3/2023, 12/4/2023,

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12/5/2023, 12/6/2023, 12/7/2023, 12/8/2023, 12/9/2023, 12/10/2023, 12/11/2023, 12/12/2023, 12/13/2023, 12/14/2023, 12/17/2023, 12/20/2023, 12/21/2023, 12/22/2023, 12/23/2023, 12/24/2023, 12/26/2023, 12/27/2023, 12/28/2023, and 12/31/2023. The MAR indicated a total of 24 administrations of Resident 74's Lidocaine 5% patch for the month of 12/2023, by seven different licensed nursing staff.

During a review of Resident 74's Medication Administration Record (MAR), for the month of January 2024, the MAR indicated LVN 4 documented Resident 74's Lidocaine 5% patch as administered on 1/9/2024. Further review of the MAR indicated other licensed staff documented the Lidocaine 5% patch as administered on: 1/1/2024, 1/2/2024, 1/3/2024, 1/4/2024, 1/5/2024, and 1/7/2024. The MAR indicated a total of 7 administrations of Resident 74's Lidocaine 5% patch for the month of 1/2024, by five different licensed nursing staff.

During a concurrent observation and interview, on 1/9/2024 at 1:00 p.m., at Resident 74's bedside, Resident 74 rolled into a left-facing position in her bed. No Lidocaine 5% patch was observed to Resident 74's right lower back or displaced in Resident 74's bed linens. Resident 74 stated she did not receive the Lidocaine 5% patch that day and stated the patch had not been offered to her.

During a concurrent observation and interview on 1/9/2024 at 1:08 p.m., with LVN 5, LVN 5 opened the medication cart and removed the current inventory of Resident 74's Lidocaine 5% patches. LVN 5 stated the label affixed to the bag containing Resident 74's inventory of Lidocaine 5% patches was dated 11/24/2023 and indicated

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a total of 14 patches had been dispensed. LVN 5 stated there were two patches remaining in Resident 74's inventory. LVN 5 stated no additional patches had been requested or dispensed from the pharmacy.

During an interview on 1/9/2024 at 1:44 p.m., with facility's contracted pharmacy, the pharmacy staff stated a total of 14 Lidocaine 5% patches had been dispensed to the facility on 11/25/2023 for Resident 74. Pharmacy staff stated no refills had been requested or delivered. The pharmacy staff stated that when a medication was dispensed to the facility, the staff receiving the medication sign a receipt to confirm the medication was received.

During a review of a document titled, "Manifest: [Facility Name]", dated 11/25/2023, the document indicated LVN 6 signed the document on 11/25/2023 at 4:14 a.m., confirming receipt of 14 Lidocaine 5% patches for Resident 74.

During a concurrent record review and interview on 1/11/2024 at 3:35 p.m., with the Director of Nursing (DON), Resident 74's physician orders, MARs for 11/2023, 12/2023, 1/2024, and the Lidocaine 5% patch delivery records from the contracted pharmacy were reviewed. The DON stated medications were supposed to be administered as ordered by the physician. The DON stated only 14 Lidocaine 5% patches had been delivered to the facility, and stated there were not enough patches delivered to account for the 37 administrations documented from 11/25/2023 to 1/9/2024. The DON stated the medications had not been administered as ordered and stated that a resident's pain could go unaddressed if they did not receive their pain medication as ordered.

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F 684	Continued From page 51 During a review of the facility's P&P titled, "Medication Administration - General Guidelines", dated 10/2017, the P&P indicated: a. "Medications are administered in accordance with written orders of the attending physician." b. "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure precautions were maintained to prevent the development of pressure ulcers (PU, an injury that breaks down the skin and underlying tissue, caused when an area of skin is placed under prolonged pressure) for one of five sampled residents (Resident 73) by failing to: 1. Ensure Resident 73's weight was accurately	F 686	F - 686 I. Corrective Action/s: a. On 01/26/24 DON provided a 1:1 in-service with LVN1 regarding “Pressure Sore Management” policy and procedure, emphasizing the importance of ensuring precautions are maintained to prevent the development of pressure ulcers, such as adjusting the low air loss mattress to the weight/ pressure level of the residents' specific requirements. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Pressure Sore Management” policy and procedure, emphasizing the importance of ensuring precautions are maintained to prevent the development of pressure ulcers, such as adjusting the low air loss mattress to the weight/ pressure level of the residents' specific requirements. c. Resident 73's low air loss mattress was immediately programmed to the correct weight/ pressure level per residents' specific requirements. II. How to Identify Other Residents: a. On 01/29/24 DON reviewed all low air loss mattresses in the facility to ensure all mattresses were set to the weight/ pressure level of the residents' specific requirements, no additional discrepancies were identified with the same deficient practice.	02/04/24

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F 686	Continued From page 52 set on the low air loss mattress (LALM, a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown). These failures had the potential to result in the development of skin breakdown and/or pressure ulcers which could result in complications associated with impaired skin integrity for Residents 73. Findings: During a review of Resident 73's admission record, the record indicated the facility originally admitted Resident 73 on 7/29/2022 and re-admitted Resident 73 on 10/14/2023. Resident 73's admitting diagnoses included abnormal posture, generalized muscle weakness, and lack of coordination. During a review of Resident 73's progress note by Registered Nurse (RN) 1, dated 9/28/2023, the progress note indicated "New orders for low air loss mattress [LALM] for wound [management] and prevention per [Medical Doctor] noted and carried out". During a review of Resident 73's medical record titled "Wound Risk Assessment", dated 10/14/2023, the record indicated Resident 73 was at high risk for skin breakdown based on her medical conditions, and indicated Resident 73 was willing to participate in the plan of care for wound management. During a review of Resident 73's History and Physical (H&P), dated 11/2/2023, the H&P	F 686	III. Systemic Changes: a. A sticker indicating “Do Not Touch” will be placed on the low air loss mattress panel. c. DON and/or designee will conduct weekly spot checks ensuring all low air loss mattresses are set to the weight/ pressure level of the residents' specific requirements. IV. Monitoring: - DON and/or designee will conduct weekly spot checks ensuring all low air loss mattresses are set to the weight/ pressure level of the residents' specific requirements x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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indicated Resident 73 did not have the capacity to understand and make decisions.

During a review of Resident 73's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 12/26/2023, the MDS indicated Resident 73 experienced cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 73 required partial to moderate assistance from staff when rolling from her back to a side-lying position in bed and was fully dependent on staff assistance to transition from a sitting position to a lying position, and a lying position to a sitting position. The MDS further indicated Resident 73 was at risk for developing PUs.

During a review of Resident 73's care plans, the care plans indicated Resident 73 was at risk for developing PUs, and goals of care included reducing Resident 73's risk of experiencing skin breakdown/PUs through appropriate interventions. Staff's interventions indicated to ensure skin treatments and management as ordered.

During an observation, on 1/8/2023 at 10:34 a.m., at Resident 73's bedside, Resident 73 was observed lying on a Proactive brand "Protekt Aire 4000DX/5000DX" Low air loss mattress (LALM). The weight settings on the pump that inflated the LALM indicated the LALM was set for a resident that weighed 280 pounds (lbs., a unit of measuring weight).

During an observation, on 1/10/2023 at 9:16 a.m., at Resident 73's bedside, Resident 73 was

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observed lying on a Proactive brand "Protekt Aire 4000DX/5000DX" LALM. The weight settings on the pump that inflated the LALM indicated the LALM was set for a resident that weighed 280 lbs.

During a concurrent interview and record review, on 1/10/24 at 9:42 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 73's monthly weight measurements for 1/2024. LVN 1 stated Resident 73's records indicated Resident 73 weighed 141.0 lbs. on 1/2/2024. LVN 1 stated she was responsible for adjusting the LALM settings. LVN 1 stated resident 73's LALM settings had not been changed within the last few months.

During a concurrent observation and interview, on 1/10/2024 at 9:49 a.m., at Resident 73's bedside, with Licensed Vocational Nurse (LVN) 1, LVN 1 observed the LALM Resident 73 was lying on. LVN 1 stated Resident 73's LALM was set for a resident that weighed 280 lbs. LVN 1 stated the settings for Resident 73's LALM were not correct. LVN 1 stated it was important to ensure the weight settings were correct to ensure the pressure to Resident 73's skin was offloaded effectively. LVN 1 stated that incorrect settings increased risk for the resident to develop a PU.

During an interview on 1/11/2024 at 1:09 p.m., with the Director of Nursing (DON), the DON stated the air in the LALM was used to relieve pressure on the skin. The DON stated LALMs were used for PU prevention in residents who were at high risk for developing PUs. The DON stated it was important to ensure the weight settings were correct to ensure accurate pressure in the mattress and stated facility staff were

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F 686	Continued From page 55 supposed to use and operate the mattress according to the manufacturer's guidelines. During a review of the facility policy and procedure (P&P) titled, "Pressure Sore Management", undated, the P&P indicated "all available measures shall be taken to reduce skin breakdown and pressure [ulcers]" and that individual care plans for management of skin condition would be developed as indicated. During a review of the facility document titled, "Proactive Medical Products Operation Manual for Protekt Aire 4000DX/5000DX", undated, the document indicated facility staff were supposed to "press the up/down buttons on panel to adjust the weight/pressure level to the patient's specific requirements".	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688	F - 688 I. Corrective Action/s: a. On 01/10/24 Resident 27 was re-assessed by DOR and an order was obtained to provide Occupational therapy services QD x 3x/wk x 4 wks and care plan was revised to reflect residents current status. b. Resident 82 did not experience a decline in overall function, mobility, and ADLs and continued with physical therapy per physician order. c. From 01/26/24- 01/30/24 DSD provided an in-service with all RNA's regarding "Joint Mobility and Contracture Management" and "Restorative Nursing Program" policy and procedure, emphasizing the importance of ensuring all residents are provided their exercise with the RNA's as ordered by the physician to help maintain their function and mobility.	02/04/24

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F 688	Continued From page 56 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide treatments and services to two of seven sampled residents (Residents 27 and 82) to prevent and/or limit a decline in joint (where two bones meet) range of motion (ROM, full movement potential of a joint) and mobility (ability to move) when the facility failed to: 1. Provide ROM services for Resident 27 to improve or prevent a decline in both of Resident 27's arms. 2. Provide Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and mobility) ambulation (walking) exercise five times a week as ordered for Resident 82. These deficient practices had the potential to cause residents to have a decline in mobility (ability to move), lead to contractures (loss of motion of a joint), and have a decline in physical functioning such as the ability to eat, dress, and walk. Findings: 1. During a review of Resident 27's Admission Record, the Admission Record indicated the facility admitted Resident 27 on 7/17/2023 with diagnoses including osteoarthritis (loss of protective cartilage that cushions the ends of your bones), muscle weakness, and neuropathy (nerve damage).	F 688	II. How to Identify Other Residents: a. On 01/30/24 DSD reviewed all residents with RNA orders to ensure all residents were provided their exercises as ordered by the physician, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. All residents concluding rehab services will be transitioned to an exercise program suitable to their functional needs as ordered by the physician. b. DOR to conduct weekly review to ensure all residents discontinuing from rehab services will be transitioned to an exercise program suitable to their functional needs. c. DSD and/or designee will conduct weekly spot checks ensuring all residents with RNA orders are provided with their exercises as ordered by the physician. IV. Monitoring: -DOR to conduct weekly review to ensure all residents discontinuing from rehab services will be transitioned to an exercise program suitable to their functional needs x 2 months. -DSD and/or designee will conduct weekly spot checks ensuring all residents with RNA orders are provided their exercises as ordered by the physician x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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During a review of Resident 27's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Admission Rehabilitation Screening, dated 7/18//2023, the OT admission rehabilitation screening indicated Resident 27 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand).

During a review of Resident 27's OT Joint Mobility Screening, dated 7/18/2023, the OT joint mobility screening indicated Resident 27 had full ROM in both wrists, both hands, both elbows, and severe (>50% loss) ROM limitations in both shoulders and recommended Resident 27 be evaluated by OT.

During a review of Resident 27's OT Evaluations and Plan of Treatment, dated 7/18/2023, the OT evaluations and plan of treatment indicated Resident 27 had ROM impairments (state of being weakened or damaged) in both shoulders and had decreased strength in both shoulders, both elbows, both wrists, and both hands.

During a review of Resident 27's Minimum Data Set (MDS, an assessment and care-screening tool), dated 7/21/2023, the MDS indicated Resident 27 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 27 required extensive assistance for bed mobility and eating and total assistance for transfers (moving from one surface to another), locomotion (ability to move from one place to another) on and off the unit, dressing, personal hygiene, and toilet

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use. The MDS indicated Resident 27 had no functional limitations in ROM in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot).

During a review of Resident 27's OT Discharge Summary, dated 8/24/2023, the OT discharge summary indicated Resident 27 was discharged per case manager with no recommendation for RNA services because Resident 27 was able to move both arms actively and independently. During a review of Resident 27's Order Summary Report, the order summary report indicated for RNA to perform passive ROM exercises (PROM, movement at a given joint with full assistance from another person) to Resident 27's both legs.

During a review of Resident 27's MDS, dated 10/19/2023, the MDS indicated Resident 27 required substantial/maximal assistance for eating, oral hygiene, toilet hygiene, and bathing and total assistance in dressing and personal hygiene. The MDS indicated Resident 27 had functional ROM limitations in both arms (shoulder, elbow, wrist, hand) and both legs (hip, knee, ankle, foot).

During a review of Resident 27's OT Rehabilitation Screen, dated 10/20/2023, the OT rehabilitation screen indicated OT recommended an RNA program to prevent a decline in function.

During a review of Resident 27's Order Summary Report, the order summary report did not include an RNA order for ROM to Resident 27's arms.

During a concurrent observation and interview with Resident 27 on 1/9/2024 at 9:52 a.m., in Resident 27's room, Resident 27 was observed

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lying in bed with blankets covering the entire body. Resident 27 stated she had pain all over her body and requested pain medication. Resident 27 stated she has had more pain on the left side of the body for years and stated it was hard to move the left wrist and left shoulder. Resident 27 was unable to bring both arms overhead and was unable to make a full fist with both hands. Resident 27 stated she wished staff would assist with ROM exercises to both arms because they were painful and hard to move on her own.

During a concurrent observation and interview on 1/9/2023 at 2:20 p.m., in Resident 27's room, Resident 27 was observed lying in bed with blankets covering the body. Resident 27 stated she felt much better because she was in less pain and removed the blanket from the upper half of the body using both arms. Resident 27 moved both arms to shoulder level and bent and straightened both elbows. Resident 27 was able to make 90% of a full fist with both hands, bent the left wrist downwards, and had difficulty moving left wrist upwards due to pain. Resident 27 stated she was able to feed herself and wash her face once nursing assisted with set-up.

During an interview on 1/10/2024 at 10:02 a.m., Restorative Nursing Aide 1 (RNA 1) stated she provided PROM exercises to Resident 27's legs and did not provide ROM exercises to the arms. RNA 1 stated Resident 27 frequently asked RNA to assist with arm exercises, but RNA 1 was unable to because the RNA order indicated to provide exercises to both legs only. RNA 1 stated she informed the Director of Rehabilitation (DOR) and the Director of Nursing (DON) in a weekly meeting about Resident 27's request for arm

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exercises, but the DOR stated Resident 27 did not need assistance with arm exercises. During a follow up interview on 1/10/2024 at 2:45 p.m., RNA 1 stated she felt Resident 27 could benefit from RNA services for arm exercises because Resident 27 frequently requested assistance with arm exercises and had the potential to do more for herself if her arms were stronger and moved better.

During a concurrent interview and record review on 1/10/2024 at 2:08 p.m., with the MDS Nurse (MDSN), Resident 27's MDS (dated 7/21/2023 and 10/19/2023), physician's orders, and care plan were reviewed. The MDSN confirmed Resident 27 had a decline in ROM to both arms and both legs according to the MDS. The MDSN stated Resident 27 was unable to demonstrate she was able to perform her activities of daily living (ADLs, basic activities such as eating, dressing, and toileting) using her arms during the MDS assessment on 10/19/2023 primarily because she was uncooperative. The MDSN stated an Interdisciplinary Team (IDT, group of different disciplines working together for a common goal of a resident) meeting should have been initiated to ensure interventions were developed and implemented to address the limitations once the decline in ROM of Resident 27's arms and legs were identified but was not done. The MDSN stated Resident 27 should have been on therapy or RNA services to address the decline in ROM of both arms identified in the MDS but was not. The MDSN confirmed RNA services were ordered for PROM of both legs but was not ordered for the arms. The MDSN confirmed there were no interventions in place to address the change in ROM or prevent a further decline in ROM of Resident 27's arms. The

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MSDN stated Resident 27 was at risk for contractures because she did not get out of bed, required assistance with ADLs, and needed a lot of encouragement to participate in everyday activities.

During a concurrent interview and record review on 1/10/2024 at 2:47 p.m., with the Director of Rehabilitation (DOR) who was an Occupational Therapist (OT), Resident 27's OT notes, Rehabilitation screens, joint mobility screen, and physician's orders were reviewed. The DOR stated she did not write an RNA order for arm exercises because Resident 27 was able to use both arms for ADLs during the Rehabilitation Screening but required a lot of encouragement due to guarded and self-limiting behavior. The DOR stated nursing and RNA reported Resident 27 had been increasingly asking for assistance for care that required the use of the arms but felt that issue was more related to Resident 27's behavior rather than physical abilities. The DOR stated she was unaware nursing identified Resident 27 as having a decline in arm ROM in the MDS. The DOR stated the decline in Resident 27's arm ROM should have been communicated to the rehab department in an IDT meeting but was not. The DOR stated RNA arm exercises should have been ordered when nursing staff identified the functional decline in the MDS, at the time of the Rehabilitation Screening since Resident 27 required encouragement to use both arms for ADLs, and when Resident 27 requested arm exercises from RNA, but was not. The DOR stated Resident 27 was at high risk for contracture development and a functional decline because Resident 27 had a diagnosis of osteoarthritis, required assistance with mobility and ADLs, and required

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encouragement to move on her own.

During a concurrent interview and record review on 1/11/2024 at 2:38 p.m., with the Director of Nursing (DON), Resident 27's IDT notes, MDS assessments, care plan, and physician's orders were reviewed. The DON confirmed Resident 27's had a decline in both arm ROM according to the MDS assessments. The DON confirmed Resident 27 did not have a care plan, interventions, and any services in place to address the decline in Resident 27's arm ROM. The DON stated residents with ROM impairments should be on therapy or RNA services to prevent a decline in function. The DON stated an IDT meeting should have been done, a care plan should have been created, and interventions should have been implemented once Resident 27's arm ROM decline was identified on the MDS but was not. The DON stated Resident 27 was at risk for contracture development and a functional decline because there were no interventions in place improve or prevent a decline in Resident 17's arm ROM.

2. During a concurrent observation and interview on 1/11/2024 at 2:05 p.m., in Resident 82's room, Resident 82 was observed sitting at the edge of the bed wearing a right leg prosthesis (artificial device used to replace a missing or impaired part of the body). A cane (mobility device used for walking) and wheelchair were observed next to the bed. Resident 82 stated he needed help putting on and taking off the right leg prosthesis, was able to walk short distances with a cane, and used a wheelchair for mobility when he got tired from walking.

During a review of Resident 82's Admission

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Record, the Admission Record indicated the facility initially admitted Resident 82 on 5/2/2023 and re-admitted the resident on 6/12/2023 with diagnoses including peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel) and acquired absence of the right leg below the knee (amputation of the leg below the level of the knee).

During a review of Resident 82's MDS dated 11/17/2023, the MDS indicated Resident 82 was cognitively intact. The MDS indicated Resident 82 required supervision or touching assistance for eating, dressing, oral hygiene, toileting hygiene, bathing, rolling, and transfers and partial/moderate assistance for walking ten feet. The MDS indicated Resident 82 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) on one leg (hip, knee, ankle, foot).

During a review of Resident 82's Order Summary Report, the order summary report indicated for RNA to perform walking exercises with Resident 82 on an even surface using crutches (mobility device used to provide support while walking), five times a week.

During a review of Resident 82's RNA flowsheets for December 2023, the RNA flowsheets indicated for the RNA to perform walking exercises with Resident 82 on an even surface using crutches, five times a week. The squares on the RNA flowsheet were blank on the following days: 12/8/2023, 12/11/2023, 12/14/2023, 12/18/2023, and 12/21/2023.

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During a concurrent interview and record review on 1/11/2024 at 9:26 a.m., with the Director of Staff Development (DSD), Resident 82's RNA December 2023 flowsheets and physician's orders were reviewed. The DSD confirmed Resident 82 had physician orders for RNA to provide RNA services five times a week. The DSD stated a blank square on the RNA flowsheet grid indicated the resident was not seen for RNA treatment that day. The DSD confirmed Resident 82 missed five days of scheduled RNA services for the month of December. The DSD stated Residents 82 did not receive RNA treatments as ordered by the physician. The DSD stated it was important for RNA to provide services as prescribed by the physician because missed treatments could place residents at risk for a functional decline.

During an interview on 1/11/2024 at 2:28 p.m., with the Director of Nursing (DON), the DON stated the purpose of the RNA program was to maintain a resident's current level of function. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function, mobility, and ADLs.

During a review of the facility's undated Policy and Procedure (P&/P), titled "Restorative Nursing Program," the P&P indicated the purpose of the RNA program was to maintain the resident's functional abilities and to reduce further declines. The P&P indicated each resident would be given care to reduce the risk of pressure sore (injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) formations, contractures, deformities (disfigured), and a decline in functional activities that include ROM exercises, strengthening, and ambulation

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F 688	Continued From page 65 activities. During a review of the facility's undated P&P, titled "Joint Mobility Contracture Management Program," the P&P indicated the purpose of the facility's Contracture Management Program was to reduce contractures in the arms and legs and to promote function and skin integrity. The P&P indicated all resident's ROM was to be assessed and reviewed quarterly by the nursing staff. Any ROM changes or concerns were to be noted, therapy interventions for a ROM program would be recommended, appropriate physician's orders would be obtained by nursing, a care plan would be developed, and the recommended ROM program would be implemented.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure fall precautions were maintained for two of five sampled residents (Resident 22 and Resident 73) when the following occurred: 1. Resident 22 did not have fall mats placed at her bedside, and call light was not within her reach.	F 689	F - 689 I. Corrective Action/s: a. From 01/26/24- 01/29/24 DON/ DSD provided an in-service with all nursing staff regarding “Promoting Safety and Reducing Falls” policy and procedure, emphasizing the importance of all fall precautions being maintained to prevent accidents. b. From 01/26/24- 01/29/24 DON/DSD provided an in-service with all nursing staff regarding “The Resident Care Plan” policy and procedure, emphasizing the importance of ensuring all interventions are implemented and it is the responsibility of the licensed nurse to ensure the plan of care is initiated. c. From 01/26/24- 01/29/24 DSD provided an in- service to all staff regarding the importance of all resident’s call lights being within reach at all times while in bed. d. Upon identification of floor mats not being in place resident 22 had floor mats placed on her bedside. e. Upon identification of floor mats not being in place resident 73 had floor mats placed on her bedside.	02/04/24

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F 689	Continued From page 66 2. Resident 73 did not have a fall mat placed at her bedside. These failures had the potential to cause avoidable harm to Resident 22 and Resident 73 related to repeat falls and the potential injuries related to sustaining a fall. Findings: 1. During a review of Resident 22's Admission Record, the admission record indicated the facility originally admitted Resident 22 on 12/5/2015 and re-admitted Resident 22 on 8/13/2021. Resident 22's admitting diagnoses included osteoarthritis (wearing down of the protective tissue at the ends of bones that occurs gradually and worsens over time), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), aphakia in both eyes (not having a lens inside the eye, causing lack of focus and blurry vision), difficulty walking, and generalized muscle weakness. During a review of Resident 22's History and Physical (H&P), dated 8/30/2023, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS, a standardized assessment and care screening/planning tool), dated 12/14/2023, the MDS indicated Resident 22 experienced severe cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 22 also exhibited inattention and disorganized thinking. The MDS indicated Resident 22 required partial	F 689	II. How to Identify Other Residents: a. On 01/26/24 DON conducted facility rounds ensuring all residents with floor mats were placed at bedside as ordered, no additional discrepancies were identified with the same deficient practice. b. On 1/26/24 DSD conducted facility rounds to ensure all residents had their call lights within reach at all times while in bed, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DON and/ or designee will conduct facility rounds daily to ensure all floor mats are placed at bedside as ordered. b. DSD and/ or designee will conduct facility rounds daily to ensure all call lights are within residents reach while in bed. IV. Monitoring: - DON and/ or designee will conduct facility rounds daily to ensure all floor mats are placed at bedside as ordered x 2 weeks. - DSD and/ or designee will conduct facility rounds daily to ensure all call lights are within residents reach while in bed x 2 weeks. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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to moderate assistance from staff when rolling in bed from her back to a side-lying position, transitioning from a sitting position to lying position and vice versa, and transferring between surfaces (chair to bed and vice versa, on and off the toilet, and in and out of the shower).

During a review of Resident 22's medical records, the records indicated Resident 22 sustained two falls in the facility on 10/26/2021 and 2/26/2022.

During a review of Resident 22's medical record titled, "Fall Risk Assessment", dated 12/14/2023, the record indicated Resident 22 was high risk for falls. The record indicated staff were required to develop a care plan to reduce falls and injuries.

During a review of Resident 22's care plans regarding falls, the care plans indicated Resident 22 was at risk for falls and injury. The goals of care included a reduction of the risk for falls and injury daily. Staff's interventions indicated to place floor mats at the bedside and keep the call light within easy reach.

During a review of Resident 22's physician orders, dated 5/26/2023, the orders indicated staff were to place floor mats at Resident 22's bedside to "decrease potential injury".

During an observation on 1/8/2024 at 11:22 a.m., at Resident 22's bedside, Resident 22 was observed lying at the foot-end of her bed, with a gap of two (2) feet between her head and the headboard. Resident 22's legs were dangling at the right edge of the bed. Resident 22's call light was at the head of the bed and not within reach. No fall mats observed to either side of the bed.

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During an observation on 1/11/2024 at 10:45 a.m., at Resident 22's bedside, Resident 22 was observed lying in bed. Call light was not observed in Resident 22's bed or placed near Resident 22.

During a concurrent observation and interview, on 1/11/2024 at 10:53 a.m., at Resident 22's bedside, with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 22 had a history of falls and was high risk for repeat falls. LVN 2 stated Resident 22 tended to get out of bed without assistance and required fall mats for injury prevention. LVN 2 stated Resident 22's call light was on the floor behind Resident 22's bed, and out of Resident 22's reach.

2. During a review of Resident 73's Admission Record, the record indicated the facility originally admitted Resident 73 on 7/29/2022 and re-admitted Resident 73 on 10/14/2023. Resident 73's admitting diagnoses included left knee osteoarthritis, abnormal posture, generalized muscle weakness, and lack of coordination.

During a review of Resident 73's H&P, dated 11/2/2023, the H&P indicated Resident 73 did not have the capacity to understand and make decisions.

During a review of Resident 73's MDS, dated 12/26/2023, the MDS indicated Resident 73 experienced cognitive impairment. The MDS indicated Resident 73 required partial to moderate assistance from staff when rolling from her back to a side-lying position in bed and was fully dependent on staff assistance to transition from a sitting position to lying position, and a lying

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position to a sitting position. The MDS further indicated Resident 73 required substantial to maximal assistance with performing hygiene activities, getting dressed, and bathing.

During a review of Resident 73's medical records, the records indicated Resident 73 sustained a fall on 9/15/2023. Resident 73's radiology report, dated 9/15/2023, indicated Resident 73 sustained a proximal right humerus fracture (broken arm bone) and swelling of the soft tissue (muscles, fat, blood vessels, nerves, tendons, and tissues that surround the bones and joints). The records further indicated Resident 73 was hospitalized from 9/18/2023 to 9/22/2023.

During a review of Resident 73's medical record titled, "Fall Risk Assessment," dated 9/15/2023, the record indicated Resident 73 sustained a change of condition and was high risk for falls. The record indicated staff were required to develop a care plan to reduce falls and injuries.

During a review of Resident 73's care plans regarding falls, the care plans indicated Resident 73 was at risk for falls and injury. The goals of care included a reduction of the risk for falls and injury daily.

During a review of Resident 73's physician orders, dated 10/14/2023, the orders indicated staff were supposed to keep Resident 73's bed in a low position with a floor mat at the bedside to "decrease potential injury".

During a concurrent observation and interview, on 1/8/2024 at 10:32 a.m., with Resident 73 at Resident 73's bedside, Resident 73 observed with a sling to her right arm. Resident 73 stated

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she had sustained a fall in the facility. Resident 73 stated that following the fall, staff placed a fall mat at her bedside, and could not state when the mat was removed. Resident 73 stated it had been gone "a while". No fall mat observed at Resident 73's bedside.

During an interview on 1/10/2024 at 11:01 a.m., with LVN 3, LVN 3 stated fall mats were for prevention of injury related to falls. LVN 3 stated that if a resident has orders for fall mats, and they are indicated in the care plan, and the floor mats should be at the resident's bedside. LVN 3 stated the facility had enough floor mats to ensure that all residents who require them have them available. LVN 3 stated not having fall mats at the bedside could increase the potential for injury if a resident sustained a fall. LVN 3 stated a resident could fall and sustain a broken bone.

During an interview on 1/11/2024 at 1:13 p.m., with the Director of Nursing (DON), the DON stated fall precautions and interventions should be implemented when assessments indicate the resident is at risk for falls. The DON stated the purpose of fall mats was to reduce injury if a resident were to fall. The DON also stated the purpose of a call light was to allow residents to call for help when needed, and stated the call light should always be within the resident's reach. The DON stated the call light should not be on the floor behind the resident's bed. The DON stated that failure to implement the fall prevention interventions on a resident's care plan, or as ordered, increased the risk for residents to sustain falls and injury.

During a review of the facility's policy and procedure (P&P) titled, "Promoting Safety,

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F 689	Continued From page 71 Reducing Falls", undated, the P&P indicated major risk factors for falls included a history of falls, and intrinsic factors such as the age of a resident, vision losses, and medical conditions such as neurological deficits, and gait and balance disturbances. The P&P further indicated that staff were supposed to "keep call-lights within easy reach of residents". During a review of the facility's P&P titled, "The Resident Care Plan", undated, the P&P indicated "the nursing care plan acts as a communication instrument between nurses and other disciplines". The P&P further indicated "the resident care plan shall be implemented for each resident" and "it is the responsibility of the Licensed Nurse to ensure that the plan of care is initiated".	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the resident's nasal cannula (device used to deliver supplemental oxygen or increased airflow through the nose) and the oxygen concentrator humidifier bottle (medical devise that increases the humidity in the nostrils while using supplemental oxygen) were labeled with the date, time, and initials of the	F 695		

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F 695	Continued From page 72 nurse when initially used for Resident 10 and Resident 51. This deficient practice had the potential to cause a negative respiratory outcome and increased the risk for Resident 10 and Resident 51 to acquire a respiratory infection. Findings: 1. During a review of Resident 10's Admission Record (Face Sheet), the Admission Record indicated Resident 10 was initially admitted to the facility on 9/26/2017 and was readmitted to the facility on 7/11/2022, with diagnoses that included but not limited to type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), dementia (a condition characterized by progressive or persistent loss of intellectual functioning), and metabolic encephalopathy (problem in the brain caused by chemical imbalances in the blood). During a review of Resident 10's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 10/19/2023, the MDS indicated Resident 10 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 10's cognition (process of thinking) was severely impaired. During a review of Resident 10's History and Physical (H&P), dated 3/13/2023, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Order Summary Report, dated 1/7/2024, the Order Summary	F 695	F - 695 I. Corrective Action/s: a. On 1/11/24 Resident 10's oxygen tubing and humidifier bottle were changed and labeled with the date, time and initials of the nurse when initially used. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding "Oxygen Administration" policy and procedure, emphasizing the importance of ensuring the resident's nasal cannula and the oxygen humidifier bottle are labeled with the date, time and initials of the nurse when initially used. II. How to Identify Other Residents: a. On 01/31/24 DON conducted rounds to ensure all residents utilizing oxygen as ordered by the physician had a date, time, and initial of a nurse on the oxygen supplies utilized, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. All oxygen tubing and humidifier bottles will be changed weekly by NOC shift nurse and as needed. This will be documented in the MAR. b. DON and/ or designee will conduct facility rounds to ensure all residents utilizing oxygen as ordered by the physician have a date, time, and initial of a nurse on the oxygen supplies utilized weekly. IV. Monitoring: - DON and/ or designee will conduct facility rounds to ensure all residents utilizing oxygen as ordered by the physician have a date, time, and initial of a nurse on the oxygen supplies utilized weekly x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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Report indicated to administer oxygen at two (2) liters (unit of measurement) per minute (L/min) via nasal cannula, may titrate (change rate) up to five L/min for oxygen saturation (amount of oxygen circulating in the blood, normal value 95% to 100%) less than 95%. The Order Summary Report indicated to change the humidifier and nasal cannula every Sunday during the night shift.

During an observation on 1/8/2024 at 9:15 a.m., in Resident 10's room, Resident 10 was receiving 2 L/min of oxygen. Resident 10's oxygen concentrator humidifier bottle was dated, 1/8/2024, and the nasal cannula tubing did not have a label.

During an observation on 1/9/2024 at 1:55 p.m., in Resident 10's room, Resident 10 was receiving 2 L/min of oxygen. Resident 10's oxygen concentrator humidifier bottle was dated, 1/8/2024, and the nasal cannula tubing did not have a label.

During an observation on 1/11/2024 at 7:43 a.m., in Resident 10's room, Resident 10 was receiving 2 L/min of oxygen. Resident 10's oxygen concentrator humidifier bottle was dated, 1/8/2024, and the nasal cannula tubing was dated, 1/10/2024.

During an interview on 1/11/2024 at 7:51 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the nurses had to label the nasal cannula and humidifier bottle with the date and time it was opened. LVN 3 stated the nasal cannula and humidifier bottles were to be changed every week or as needed. LVN 3 stated dating these items ensured that they would not be used past the date because using the nasal cannula and

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humidifier bottle longer than ordered could be an infection control issue. LVN 3 stated if the nasal cannula and humidifier bottle were not dated, the staff would be unsure when they were opened and should be thrown away. LVN 3 stated there was a potential for the nasal cannula and humidifier bottle to be used longer than intended if they were not dated and that could lead to infection from growth of bacteria that could enter through the nose and into the body.

During an interview on 1/11/2024 at 9:48 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated the nasal cannulas and humidifier bottles were changed weekly but could be changed more frequently. The IPN stated the labels on the nasal cannula and humidifier bottle would notify the nurses if they were old and if they needed to be changed. The IPN stated germs and bacteria could develop in the tubing over time and if those germs and bacteria were to be administered to the resident, they could become sick.

During a concurrent interview and record review on 1/11/2024 at 12:02 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, "Oxygen Administration", undated, was reviewed. The P&P indicated, "The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed." The DON stated the nasal cannula, humidifier bottle, and any other oxygen equipment used for the residents must be labeled with the date, time, and initials when initially opened and changed. The DON stated if the equipment were not labeled correctly, the nurse must remove them and change with a brand-new set. The DON stated without the label, the

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equipment could be used for an unknown duration of time and organisms could develop inside. The DON stated oxygen was administered directly into the residents' nose and when they inhale, they could potentially inhale harmful organisms that could make them sick.

2. During a review of Resident 51's Admission Record, the admission record indicated Resident 51 was originally admitted to the facility on 4/29/2022 and readmitted on 8/27/2023 with diagnoses that included pneumonia (lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid) and pulmonary hypertension (a condition that affects the blood vessels in the lungs which develops when the blood pressure in your lungs is higher than normal).

During a review of Resident 51's Order Summary report, dated 8/27/2023, the Order Summary Report indicated Resident 51 had an order for oxygen therapy at 2 L/min via nasal cannula. During a review of Resident 51's H&P dated 8/28/2023, H&P indicated Resident 51 had the capacity to understand and make decisions.

During a review of Resident 51's MDS, dated 12/13/2023, the MDS indicated Resident 51's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 51 required substantial assistance (staff does more than half the effort) for personal hygiene and toileting hygiene and required set up assistance for eating.

During an observation on 1/8/2024 at 11:18 a.m., in Resident 51's room, Resident 51's nasal cannula was not labeled with the date and time it

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was opened and did not have the initials of nurse that set up the oxygen administration.

During an observation on 1/9/2024 at 8:08 a.m., in Resident 51's room, Resident 51's nasal cannula was not labeled with the date and time it was opened and did not have the initials of nurse that set up the oxygen administration.

During an observation on 1/10/2024 at 7:46 a.m., in Resident 51's room, the Resident 51's nasal cannula was not labeled with the date and time it was opened and did not have the initials of nurse that set up the oxygen administration.

During an observation on 1/11/2024 at 2:56 p.m., in Resident 51's room, Resident 51's nasal cannula was not labeled with the date and time it was opened and did not have the initials of nurse that set up the oxygen administration.

During an interview on 1/10/2024 at 10:15 a.m. with LVN 2, LVN 2 stated oxygen equipment must be dated when it was opened. LVN 2 stated oxygen equipment was dated to prevent infections.

During an interview on 1/11/2024 at 11 a.m. with the Director of Staff Development (DSD), the DSD stated nasal cannulas should be changed weekly. The DSD stated the nasal cannula must be labeled with the date and the nurses' initials. The DSD stated it was important to date the nasal cannulas to know how old the nasal cannula was and served as an infection control measure.

During an interview on 1/11/2024 at 12:03 p.m. with the DON, the DON stated the nasal cannula should be changed every 7 days. The DON

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F 695	Continued From page 77 stated the nasal cannula must be labeled with the date and the time the nasal cannula was opened and with the initials of the nurse that set up the oxygen administration. The DON stated if a nurse noticed an undated nasal cannula, the nurse must get rid of it and place a new one because there was no way of knowing how old the nasal cannula was. The DON stated it was important to date the nasal cannula to prevent using an old nasal cannula because it had the potential to cause an infection because it went directly into the resident's nose. During a review of facility's P&P titled, "Oxygen Administration", undated, the P&P indicated the date, time and initials should be noted on oxygen equipment when it is initially used and when changed.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 interview and record review, the facility failed to ensure a resident who received dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) treatment was assessed before and after dialysis treatment and the assessment was documented in the Dialysis Communication Records for one of one sampled resident (Resident 81).	F 698		

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F 698	Continued From page 78 This deficient practice had the potential for unidentified complications after dialysis treatment such as swelling, pain, bleeding, and bruising. Findings: During a review of Resident 81's Admission Record, the admission record indicated Resident 81 was originally admitted to the facility on 7/29/2022 and readmitted to the facility on 12/15/2023 with diagnoses including dependence on renal dialysis and end stage of renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). During a review of Resident 81's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/25/2023, the MDS indicated Resident 81's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 81 required assistance with setup or cleanup for eating, and required supervision or touching assistance for oral hygiene, toileting hygiene and personal hygiene. The MDS indicated Resident 81 had a diagnosis of diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). During a review of Resident 81's History and Physical (H&P) dated 12/15/2023, the H&P indicated Resident 81 was not able to make his	F 698	F - 698 I. Corrective Action/s: a. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “Care of Resident receiving Dialysis” policy and procedure, emphasizing the importance of ensuring residents who receive dialysis treatment are assessed before and after dialysis treatment and document in the Dialysis Communication Record. II. How to Identify Other Residents: a. On 02/01/2024 DON reviewed all Dialysis Communication Records to ensure residents are assessed before and after dialysis treatment and it is documented in the Dialysis Communication Record, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DON and/ or designee will review all Dialysis Communication Records to ensure residents are assessed before and after dialysis treatment and it is documented in the Dialysis Communication Record. IV. Monitoring: - DON and/ or designee will review all Dialysis Communication Records to ensure residents are assessed before and after dialysis treatment and it is documented in the Dialysis Communication Record x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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own decisions but was able to make needs known.

During a review of Resident 81's Order Summary Report dated 12/15/2023, the order summary report indicated to monitor Resident 81's dialysis access site (right upper chest) for pain, itching, bleeding, and swelling on every shift.

During a review of Resident 81's Dialysis Communication Records, for the months of December 2023 and January 2024, indicated the pre-dialysis assessment and post dialysis assessment were inaccurately performed or were not performed, under the following sections on the following dates:

On 12/18/2023 - The pre dialysis assessment and post dialysis assessment indicated Resident 81's graft (access) site location was on the right forearm. The record indicated Resident 81 did not have a central line and indicated Resident 81's access site was not checked for bleeding.

On 12/20/2023 - The pre dialysis assessment and post dialysis assessment indicated Resident 81's graft site location was on the right forearm. The record indicated Resident 81's access site was not checked for bleeding.

On 12/22/2023 - The pre dialysis assessment and post dialysis assessment indicated Resident 81's graft site location was on the right forearm. The record indicated Resident 81 did not have a central line.

On 12/27/2023 - The pre dialysis assessment indicated Resident 81's graft site was on the right arm.

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On 12/29/2023 - The pre dialysis assessment indicated Resident 81 did not have a central line. The post dialysis assessment indicated the central line section was not addressed.

On 1/3/2024 - The record indicated Resident 81's access site was not checked for bleeding pre and post dialysis treatment.

On 1/5/2024 - The pre dialysis assessment and post dialysis assessment indicated Resident 81's access site was not assessed. The record indicated Resident 81's access site was not checked for bleeding post dialysis treatment.

On 1/10/2024 - The pre dialysis assessment and post dialysis assessment indicated Resident 81's access site location was on the right forearm. In the pre dialysis assessment and post dialysis assessment the access site was not assessed. The record indicated Resident 81's access site was not checked for bleeding pre and post dialysis treatment.

During an interview on 1/8/2024 at 2:33 p.m. with Resident 81, in Resident 81's room, the Resident 81 stated he received dialysis treatment through his right perma catheter (a flexible tube placed into the blood vessel in your neck or upper chest and is threaded to the right side of the heart). Resident 81 stated he used to get dialysis treatment to his right arm but it was not working. Resident 81 stated he had to keep reminding the nurses that his dialysis treatment was done through his chest and not his arm.

During an interview on 1/11/2024 at 4:02 p.m. with Director of Nursing (DON), the DON stated

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F 698	Continued From page 81 she expected nursing staff to assess residents before they leave for dialysis treatment. The DON stated she expected nurses to take the residents vital signs, and assess the dialysis access site for bleeding, redness and pain before the residents leave to dialysis treatment. The DON stated she expected nurses to assess the residents when they returned from dialysis treatment. The DON stated nurses must assess the resident's cognitive status, assess the access site for bleeding, redness, and pain, and check for a bruit (an audible vascular sound associated with turbulent blood flow) and thrill (an abnormal vibration that is felt on the skin overlying a loud cardiac murmur or an arteriovenous fistula) if applicable. The DON stated she expected nurses to completely fill out the dialysis communication record. The DON stated assessing residents pre and post dialysis was a preventive measure and it must be done. During a review of the facility's policy and procedure (P&P) titled, "Care of Resident Receiving Renal Dialysis", undated, the P&P indicated a Dialysis Communication record must be completed during dialysis days. The P&P indicated to send the form with the resident to dialysis and complete the post dialysis section when the resident returns from dialysis. The P&P indicated a complete pre-dialysis assessment includes cognitive status, vital signs, access site (central line, shunt, graft site), document presence or absence of bruit and/or thrill, bleeding at site, and breathing patterns/breathing sounds.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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F 726	Continued From page 82 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to perform a competency assessment for Licensed Vocational Nurse (LVN) 4 upon hire as per the facility's policy and procedure (P&P), which resulted in LVN 4 failing to competently administer medications and supplements as ordered by the physician for	F 726	F - 726 I. Corrective Action/s: a. Resident 74's physician was notified of the medication error. No changes in residents condition was noted, no new orders were obtained. b. On 01/09/24 DON conducted a 1:1 in-service with LVN4 regarding "Medication Administration Guidelines" policy, emphasizing the importance of administering all medications as ordered by the physician and DON conducted a corrective action. c. On 01/15/24 a competency was performed on LVN4. d. On 1/28/24 DON conducted a 1:1 in-service with LVN4 regarding "Medication Administration Guidelines" policy, emphasizing the importance of administering all medications as ordered by the physician. e. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding " Medication Administration Guidelines" policy, emphasizing the importance of administering all medications as ordered by the physician. II. How to Identify Other Residents: a. On 02/01/24 DSD reviewed all licensed nurses to ensure a competency was completed, no additional discrepancies were identified with the same deficient practice. b. On 02/01/24 DON conducted a medication reconciliation or all facility medication carts and MAR review to ensure all prescribed medications are being administered as ordered by the physician, no additional discrepancies were identified with the same deficient practice.	02/04/24

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F 726	Continued From page 83 three out of five sampled residents (Resident 81, 74, and 7), including one significant medication administration error, during the medication administration observations. This deficient practice had the potential to place Resident 81, 74, and 7, and other residents at risk for harm related to improper administration of medication, and delays in provision of care related to missed administrations of ordered medications and supplements. Cross Reference: F-tag 726, F-tag 760, and F-tag 684 Findings: 1. During a review of Resident 81's Admission Record, the record indicated the facility originally admitted Resident 81 on 7/29/2022 and re-admitted Resident 81 on 12/15/2023. Resident 81's admitting diagnoses included end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (a treatment for people whose kidneys are failing), type 2 diabetes mellitus (DM, a chronic condition that affects the way the body processes blood sugar), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood, creating risk of heart attack and stroke). During a review of Resident 81's History and Physical (H&P), dated 12/15/2023, the H&P indicated Resident 81 did not have the capacity to make his own decisions. During a review of Resident 81's Physician Orders, dated 12/15/2023, the orders indicated	F 726	III. Systemic Changes: a. DSD and/or designee will ensure a competency is completed for all staff prior to being placed on the schedule for independent work duties, Administrator will conduct review of new hire competencies weekly. b. DON and/or designee will perform random medication administration spot checks to ensure all prescribed medications are being administered as ordered by the physician. IV. Monitoring: - DSD and/ or designee will ensure a competency is completed for all staff prior to being placed on the schedule for independent work duties, Administrator will conduct review of new hire competencies weekly x 2 months - DON and/ or designee will conduct a medication reconciliation weekly to ensure all medications are being administered ordered by the physician x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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staff were to administer a total of seven (7) medications and four (4) supplements at 9:00 a.m. on 1/9/2024.

During an interview on 1/9/2024 at 8:20 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she was preparing to administer medications for Resident 81 and had not administered any medications yet.

During a concurrent observation and interview on 1/9/2024 at 8:34 a.m., outside of Resident 81's room, LVN 4 confirmed a total of three (3) medications were being administered to Resident 81. LVN 4 did not prepare any supplements for administration. LVN 4 then entered Resident 81's room and Resident 81 took all three (3) medications with water. The three medications administered were Labetalol HCl (used to treat high blood pressure), Amlodipine besylate (used to treat high blood pressure), and hydralazine HCl (used to treat high blood pressure). LVN 4 did not offer or administer any further medications or supplements to Resident 81.

During a concurrent observation and interview on 1/9/2024 at 8:41 a.m., outside of Resident 81's room, with LVN 4, LVN 4 prepared one (1) injection of Lantus (insulin glargine, a medication for controlling blood sugar levels) for Resident 81 and confirmed a total of one (1) medication was to be administered. LVN 4 did not prepare any supplements for administration. LVN 4 then entered Resident 81's room and Resident 81 refused the insulin glargine administration. LVN 4 exited the room with the one (1) unadministered medication and returned the medication to the medication cart. LVN 4 did not offer or administer any further medications or supplements to

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Resident 81.

During a review of Resident 81's Medication Administration Record (MAR), for the month of January 2024, the MAR indicated LVN 4 documented she had administered six (6) medications and four (4) supplements scheduled for the 9 a.m. administration. There were four (4) medications and four (4) supplements documented as administered by LVN 4 that were not observed as administered. Hydralazine HCl was administered at 8:34 a.m. by LVN 4 was not documented on the MAR. The MAR further indicated the Hydralazine HCl was supposed to be given at 6 a.m.

During a concurrent interview and record review on 1/10/2024 at 10:30 a.m., with LVN 5, Resident 81's progress notes and MAR for the month of January 2024 was reviewed. LVN 5 stated there was no documentation of Hydralazine HCl administration on 1/9/2024 at 8:34 a.m. by LVN 4 on Resident 81's MAR or in Resident 81's progress notes. LVN 5 stated Resident 81 received another dose of Hydralazine HCl on 1/9/24 at 2 p.m. LVN 5 stated that if multiple doses of a blood pressure medication were administered too close together, there was potential for the resident to experience hypotension (low blood pressure) and potential changes in their level of consciousness (a medical term used to describe how awake, alert, and aware someone is). LVN 5 stated nursing staff were to call the doctor and document if they were administering a medication outside of the scheduled administration time.

During an interview on 1/10/2024 at 3:35 p.m. with the Director of Nursing (DON), the DON

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stated medications were required to be administered as ordered by the physician. The DON stated staff have one hour before and one hour after the scheduled administration time to administer the medication. The DON stated if a medication is administered outside of the permitted timeframe, the physician needs to be contacted to ensure that it is safe to proceed with the next scheduled dose. The DON also stated the administration should be documented on the progress note.

2. During a review of Resident 74's Admission Record, the admission record indicated the facility originally admitted Resident 74 on 3/24/2022 and re-admitted Resident 74 on 4/8/2022. Resident 74's admitting diagnoses included type 2 diabetes mellitus, stage 3 chronic kidney disease (mild to moderate damage of the kidneys, making them less able to filter waste and fluid out of the blood), and a compression fracture (broken bone) of the lumbar vertebra (spinal bone in the lower back), and anemia (low red blood cell count).

During a review of Resident 74's H&P, dated 4/25/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions.

During a review of Resident 74's current Physician Orders, the orders indicated staff were to administer a total of nine (9) medications and one supplement at 9 a.m. on 1/9/2024.

During an interview on 1/9/2024 at 8:59 a.m., with LVN 4, LVN 4 stated she was preparing to administer medications for Resident 74.

During a concurrent observation and interview on 1/9/2024 at 9:02 a.m., inside Resident 74's room,

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LVN 4 checked Resident 74's blood sugar. LVN 4 stated Resident 74's blood sugar was 110. No medications or supplements were administered.

During a concurrent observation and interview on 1/9/2024 at 9:04 a.m., outside of Resident 74's room, LVN 4 stated a total of two (2) medications were being administered to Resident 74 and restated that Resident 74's blood sugar was 110. LVN 4 did not prepare any supplements for administration. LVN 4 then entered Resident 74's room and Resident 74 took one medication with water while LVN 4 administered Lantus into Resident 74's left lower abdomen by injection. LVN 4 did not offer or administer any further medications or supplements to Resident 74.

During a review of Resident 74's Medication Administration Record (MAR), for the month of January 2024, the MAR indicated LVN 4 documented she administered nine (9) medications and one supplement scheduled for the 9 a.m. administration. There were seven (7) medications and one supplement documented as administered by LVN 4 that were not observed as administered. The MAR further indicated the Lantus was not supposed to be administered if Resident 74's blood sugar was less than 120, and further indicated LVN 4 documented a blood sugar of 110 and administered the Lantus.

During a concurrent interview and record review, on 1/09/2024 at 9:33 a.m., with LVN 4, Resident 74's MAR and physician orders were reviewed. LVN 4 stated the physician order was to not administer the Lantus injection if Resident 74's blood sugar was less than 120. LVN 4 stated she misread the physician order. LVN 4 stated the blood glucose was 110 and the Lantus was

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administered. LVN 4 stated administration of Lantus put Resident 74 at risk for hypoglycemia and could cause harm to the resident.

During a review of Resident 74's care plan dated 1/9/2024, the care plan indicated Resident 74 was at risk for an adverse reaction or change in condition due to the incorrect Lantus administration.

3. During a review of Resident 7's Admission Record, the record indicated the facility originally admitted Resident 7 on 9/24/2014 and re-admitted Resident 7 on 7/7/2019. Resident 7's admitting diagnoses included spinal stenosis (narrowing of the spinal canal that can put pressure on the spinal cord and the nerves within the spine), right shoulder contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), and cognitive communication deficit.

During a review of Resident 7's H&P, dated 11/24/2021, the H&P indicated Resident 7 did not have the capacity to understand and make decisions.

During a review of Resident 7's current Physician Orders, the orders indicated staff were to administer a total of eleven (11) medications and two supplements at 9 a.m. on 1/9/2024.

During an interview on 1/9/2024 at 9:14 a.m., with LVN 4, outside of Resident 7's room, LVN 4 stated she was preparing to administer medications for Resident 7.

During a concurrent observation and interview on 1/9/2024 at 9:21 a.m., outside of Resident 7's

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room, LVN 4 stated a total of seven (7) medications were being administered to Resident 7. LVN 4 did not prepare any supplements for administration. LVN 4 then entered Resident 7's room and Resident 7 took six (6) medications with water, and LVN 4 administered one (1) medication to Resident 7's eyes. LVN 4 did not offer or administer any further medications or supplements to Resident 7.

During a review of Resident 7's MAR, for the month of January 2024, the MAR indicated a total of eleven (11) medications and two supplements were scheduled for 9 a.m. administration. The MAR indicated LVN 4 documented she had administered eleven (11) medications and two supplements scheduled for 9 a.m. administration. There were four (4) medications and two supplements documented on the MAR as administered by LVN 4 that were not observed as administered.

During a concurrent interview and record review on 1/11/2024 at 3:54 p.m., with the DON, LVN 4's employee file was reviewed. The DON stated the facility policy was to ensure that a competency assessment was completed for licensed nurses upon hire, stating the facility practice was to have an experienced licensed nurse follow and observe the new licensed nursing staff to assess competency. The DON stated a competency assessment was not completed for LVN 4, and stated there was no documentation in her employee file to indicate an assessment had been done. The DON stated it was not safe for LVN 4 to administer medication to facility residents without the required competencies, and stated it was not correct nursing practice for LVN 4 to document medications or supplements as

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administered if they were not administered.

During a review of the facility's undated, policy and procedure (P&P) titled, "Competency Assessment", the P&P indicated "Employees will be assessed for competency upon hire and annually."

During a review of the facility document, titled "Job Description, Job Title: Licensed Vocational Nurse (LVN)", dated 8/2011, the document indicated essential duties and responsibilities included:
a. Preparing and passing medication as indicated and administering medications according to policy and procedure.
b. Contacting the attending physician for required orders as needed.
c. Ensuring medications are documented in a timely fashion and in accordance with company policies and procedures.
d. Assuring that documentation is accurate.

During a review of the facility P&P titled, "Medication Administration - General Guidelines", dated 10/2017, the P&P indicated:
a. "Medications are administered in accordance with written orders of the attending physician."
b. "Medications are administered within 60 minutes of the scheduled time (1 hour before and 1 hour after)."
c. "Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility."
d. "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given."

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F 755 SS=E	Continued From page 91 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedure (P&P) for medication administration for six out of 10	F 755 F 755	F - 755 I. Corrective Action/s: a. Residents 28,35,51,68,81 and 82's physicians were notified upon receiving information on med errors. Physicians with no new orders due to no changes in resident's condition. b. On 01/09/24 DON conducted a 1:1 in-service with LVN4 regarding "Medication Administration General Guidelines" policy, emphasizing the importance of following hold parameters for medication. c. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding "Medication Administration Guidelines" policy, emphasizing the importance of administering all medications as ordered by the physician (following the pour, pass, sign method) and are following hold parameters. d. Upon identification of missed medications for residents 28, 35, 68, 81 residents were assessed, no changes in condition were noted and the primary physicians and responsible parties for those residents were notified. e. Resident 82 was discharged home on 01/12/24, physician and resident were notified. f. Upon identification of medications administered outside of parameters for Residents 28, 35, 81 and 51 residents were assessed, no changes in condition were noted, and the primary physicians and responsible parties for those residents were notified. II. How to Identify Other Residents: a. On 02/01/24 DON conducted a medication reconciliation for all facility medication carts and MAR review to ensure all prescribed medications are being administered as ordered by the physician, no additional discrepancies were identified with the same deficient practice.	02/04/24

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F 755	Continued From page 92 sampled residents (Resident 28, 35, 51, 68, 81, 82) when: 1. Licensed Vocational Nurse (LVN) 4 did not administer the routine 9:00 a.m. dose of medication to Resident 28, 35, 68, 81, and 82 on 1/9/2024. 2. Resident 28, 35, and 81 was administered Tenormin, Diltiazem, Amlodipine, Labetalol, and Hydralazine (medications used to treat high blood pressure) despite meeting the hold parameters (when a medication is not administered based on a specific condition) for having a heart rate lower than 60. 3. Resident 51 was administered Midodrine (medication used to treat low blood pressure) despite meeting the hold parameters for having a systolic blood pressure (SBP, the maximum blood pressure during contraction of the ventricles [the two lower chambers of the heart responsible for pumping blood out of the heart]) more than 110. These deficient practices caused Resident's 28, 35, 68, 81, and 82 to have an interruption with their medication therapy, and exposed Resident's 28, 35, 51, and 81 to a potential adverse effect to their medications. Findings: 1. During a review of Resident 28's Admission Record, the admission record indicated Resident 28 was originally admitted to the facility on 1/13/2021 and readmitted on 4/9/2021 with diagnoses that included heart failure (progressive	F 755	III. Systemic Changes: a. DON and/or designee will perform random medication administration spot checks to ensure all prescribed medications are being administered as ordered by the physician and all licensed nurses are following the hold parameters. IV. Monitoring: - DON and/or designee will conduct a medication reconciliation weekly to ensure all medications are being administered ordered by the physician and all licensed nurses are following the hold parameters x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	

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heart disease that affects pumping action of the heart muscles) and kidney failure (occurs when kidneys become unable to filter waste products from the blood, kidneys lose their filtering ability).

During a review of Resident 28's History and Physical (H&P) dated 9/10/2023, the H&P indicated Resident 28 did not have the capacity to understand and make decisions. The H&P indicated Resident 28 had a diagnosis of Non-ST-elevation myocardial infarction ([NSTEMI] is a type of heart attack that usually happens when your heart's need for oxygen can't be met).

During a review of Resident 28's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/5/2023, the MDS indicated Resident 28's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 28 required substantial/maximal assistance from staff for all activities of daily living (ADLs, activities performed daily such as personal hygiene, grooming, dressing, and toileting).

During a review of Resident 28's Order Summary Report, the order summary report indicated Resident 28 was to receive:

1. Aspirin 81 milligrams (mg, unit of measurement), by mouth, one time a day, for cerebral vascular disease ([CVA] an interruption in the flow of blood to cells in the brain, when cells in the brain are deprived of oxygen, they die) prophylaxis (to prevent).
2. Colace 100 mg, by mouth, one time a day, for stool softener.

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3. Hydroxychloroquine sulfate 200 mg, by mouth, 2 times a day, for rheumatoid arthritis (body's immune system attacks its own tissue, affects joint linings, causing painful swelling).
4. Lasix tablet 20 mg, 1 tablet a day, by mouth, for congestive heart failure (CHF, chronic condition in which the heart doesn't pump blood as well as it should).
5. Tenormin 50 mg, give 1 tablet, by mouth, one time a day, for high blood pressure, hold medication if SBP was less than 110, and to hold if heart rate was less than 60.
6. Uloric 80 mg, by mouth, one time a day, for gout (form of arthritis characterized by severe pain, redness, and tenderness in joints).
7. Cranberry 2 capsules 425 mg, by mouth, two times a day, for urinary tract infection (UTI, infection of the bladder) prophylaxis.
8. Potassium chloride 10 Milliequivalent per liter (MEQ) by mouth, one time a day, for supplement.
9. Rena-vita tablet, by mouth, one time a day, for renal (kidney) supplement.

During a review of Resident 28's Medication Administration Record (MAR), for the month of January 2024, the MAR indicated on 1/2/2024, Resident 28 received Tenormin however the resident's heart rate was 58.

During a review of Resident 28's MAR, for the month of January 2024, the MAR indicated on 1/9/2024, Resident 28 did not receive his 9:00 a.m. dose of Aspirin 81 mg, Colace 100 mg, Lasix 20 mg, potassium chloride 10 MEQ, rena-vite tablet, Tenormin 50 mg, uloric 80 mg, cranberry capsule 425 mg and hydroxychloroquine sulfate 200 mg.

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2. During a review of Resident 35's Admission Record, the admission record indicated Resident 35 was originally admitted to the facility on 2/17/2017 and readmitted on 7/7/2023 with diagnoses that included of heart failure and peripheral vascular disease ([PVD] a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).

During a review of Resident 35's H&P dated 7/14/2023, the H&P indicated Resident 35 did not have the capacity to understand and make decisions.

During a review of Resident 35's MDS, dated 11/6/2023, the MDS indicated Resident 35's cognitive skills daily decision making was severely impaired. The MDS indicated Resident 35 was dependent on staff for all ADLs. The MDS indicated Resident 35's speech was unclear. The MDs indicated Resident 35 had a diagnosis of PVD.

During a review of Resident 35's Order Summary Report, the order summary report indicated Resident 35 was to receive:

1. Aspirin 81 oral tablet chewable, give 1 tablet, via G-tube, one time a day, for CVA prophylaxis.
2. Cholecalciferol 25 micrograms (mcg, unit of measurement), give via gastrostomy tube (G-tube, tube surgically inserted into the stomach for nutrition, hydration, and medications), in the morning, for supplement.
3. Colace 100 mg, via G-tube, for stool softener.
4. Cranberry tablet 450 mg, give 1 tablet, via G-tube, for UTI prophylaxis.
5. Cyanocobalamin tablet 10000 mcg, 1 time a day, for supplement.

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6. Multivitamins with mineral, 1 tablet, via G-tube, one time a day, for supplement.
7. Vitamin C tablet 500 mg, give 1 tablet, via G-tube, one time a day, for supplement.
8. Apixaban tablet 2.5 mg, give one tablet, via G-tube, two times a day, for PVD.
9. Diltiazem 30 mg, one tablet, via G-tube, every 8 hours, for high blood pressure, hold if SBP was less than 105 and hold if heart rate was less than 65.

During a review of Resident 35's MAR, for the month of January 2024, the MAR indicated on 1/9/2024, Resident 35 did not receive his 9:00 a.m. dose of Aspirin 81 mg, Colace 100 mg, cholecalciferol 25 mcg, cranberry 450 mg, cyanocobalamin 1000 mcg, multivitamin, vitamin C 500 mg, and Apixaban 2.5 mg.

During a review of Resident 35's MAR, for the month of January 2024, the MAR indicated Resident 35's heart rate was the following on the following dates and times:

On 1/1/2024 at 2 p.m., Resident 35's heart rate was 62.
On 1/2/2024 at 2 p.m., Resident 35's heart rate was 63.
On 1/3/2024 at 10 p.m., Resident 35's heart rate was 60.
On 1/7/2024 at 10 p.m., Resident 35's heart rate was 63.

According to the MAR, Resident 35's heart rate met the hold parameters however Diltiazem was given.

3. During a review of Resident 51's Admission

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Record, the admission record indicated Resident 51 was originally admitted to the facility on 4/29/2022 and readmitted to the facility on 8/27/2023 with diagnoses that included pneumonia (lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid) and pulmonary hypertension (a condition that affects the blood vessels in the lungs which develops when the blood pressure in your lungs is higher than normal).

During a review of Resident 51's H&P dated 8/28/2023, H&P indicated Resident 51 had the capacity to understand and make decisions. The H&P indicated Resident 51 had a diagnosis of rheumatoid arthritis (body's immune system attacks its own tissue, affects joint linings, causing painful swelling).

During a review of Resident 51's MDS, dated 12/13/2023, the MDS indicated Resident 51's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 51 required substantial assistance with personal hygiene and toileting hygiene and required set up assistance for eating. The MDS indicated Resident 51 had a diagnosis of coronary artery disease (CAD, artery disease that is caused by plaque buildup in the wall of the arteries that supply blood to the heart, causes coronary arteries to narrow, limiting blood flow to the heart).

During a review of Resident 51's Order Summary report, dated 8/27/2023, the Order Summary Report indicated to administer Midodrine 10 mg, give 1 tablet, by mouth, two times a day for low blood pressure, hold if SBP more than 110.

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During a review of Resident 51's MAR, for the month of January 2024, the MAR indicated the following:

On 1/3/2024 at 5:00 p.m., Resident 51's SBP was 137.
On 1/7/2024 at 9:00 a.m., Resident 51's SBP was 116.
On 1/9/2023 at 9:00 a.m., Resident 51's SBP was 115.

The MAR indicated Resident 51's SBP met the hold parameters however Midodrine was administered.

During a concurrent interview and record review on 1/10/2024 at 2:21 p.m. with the MDS Nurse (MDSN), Resident 51's MAR, for the month of January 2024 was reviewed. The MAR indicated on 1/7/2024, for the 9:00 a.m. administration time, Resident 51's SBP was 116. Resident 51's SBP met the hold parameters however Midodrine was administered. The MDSN stated she should not have administered Midodrine medication to Resident 51 because the resident's SBP was higher than 110. The MDSN stated she did not know why she gave the medication to Resident 51. The MDSN stated it was important to follow the medication parameters to prevent a negative outcome for residents.

4. During a review of Resident 68's Admission Record, the admission record indicated Resident 68 was originally admitted to the facility on 6/21/2021 with diagnoses that included cardiomyopathy (acquired or hereditary disease of heart muscle, this condition makes it hard for

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the heart to deliver blood to the body and can lead to heart failure) and atherosclerosis of aorta (a material called plaque [fat and calcium] built up in the inside wall of a large blood vessel [aorta]).

During a review of Resident 68's H&P dated 10/11/2023, the H&P indicated Resident 68 did not have the capacity to understand and make decisions. The H&P indicated Resident 68 had a diagnosis of hypertension (high blood pressure).

During a review of Resident 68's MDS, dated 12/13/2023, the MDS indicated Resident 68's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 68 required substantial assistance for all ADLS. The MDS indicated Resident 68 had a diagnosis of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).

During a review of Resident 68's Order Summary Report, the order summary report indicated Resident 68 was to receive:

1. Aspirin 81 mg, give 1 tablet by mouth, one time a day.
2. Benazepril tablet 20 mg, give 1 tablet by mouth, one time a day, for high blood pressure.
3. Colace 100 mg, by mouth, one time a day.
4. Lactulose solution 20 gram (gm, unit of measurement) per (/) 30 milliliters (ml, unit of measurement), by mouth, one time a day, for elevated ammonia level (waste product normally processed in the liver and removed through the urine).
5. Multivitamin with mineral 1 tablet, by mouth, one time a day, for supplement.

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6. Vitamin B12 oral tablet 500 mcg, give 1 tablet by mouth, one time a day, for supplement.
7. Vitamin D3 25 mcg, give 2 tablets by mouth, one time a day, for low vitamin D level.
8. Carvedilol 12.5 mg, give 1 tablet by mouth, 2 times a day, for high blood pressure.
9. Cranberry tablet 450 mg, give 2 tablets by mouth, two times a day.
10. Namenda 10 mg tablet, give 1 tablet by mouth, two times a day, for dementia.

During a review of Resident 68's MAR, for the month of January 2024, the MAR indicated on 1/9/2024 Resident 68 did not receive his 9:00 a.m. dose of Aspirin 81 mg, Benazepril 20 mg, Colace 100 mg, lactulose solution 20 gm/ml, multivitamin with mineral, Vitamin B12 500 mcg, Vitamin D3 25 mcg, Carvedilol 12.5 mg, cranberry 10 mg, and Namenda 10 mg.

5. During a review of Resident 81's Admission Record, the admission record indicated Resident 81 was originally admitted to the facility on 7/29/2022 and readmitted to the facility on 12/15/2023 with diagnoses that included dependence on renal dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood) and end stage of renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life).

During a review of Resident 81's MDS, dated 10/25/2023, the MDS indicated Resident 81's cognitive skills for daily decision making was

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intact. The MDS indicated Resident 81 required assistance with setup or cleanup for eating, and supervision or touching assistance for oral hygiene, toileting hygiene and personal hygiene. The MDS indicated Resident 81 had a diagnosis of diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).

During a review of Resident 81's H&P dated 12/15/2023, H&P indicated Resident 81 was not able to make his own decisions however was able to make needs known. The H&P indicated Resident 81 had a history of benign prostatic hyperplasia (BPH, a condition in men in which the prostate gland is enlarged).

During a review of Resident 81's Order Summary Report, the order summary report indicated Resident 81 was to receive:

1. Amlodipine besylate tablet 10 mg, give 1 tablet, by mouth, one time a day, for high blood pressure, hold if SBP is less than 110 and heart rate is less than 60.

2. Hydralazine tablet 25 mg, give 1 tablet, by mouth, every 8 hours, for high blood pressure, hold medication if SBP less than 110 and if heart rate less 60.

3. Labetalol tablet 200 mg, give 1 tablet by mouth, every 12 hours, for high blood pressure, hold if SBP less than 110 and heart rate less than 60.

During a review of Resident 81's MAR, for the month of January 2024, the MAR indicated the

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following:

On 1/2/2024 at 2:00 p.m., Resident 81's heart rate was 57, however Amlodipine administered.
On 1/2/2024 at 9:00 a.m., Resident 81's heart rate was 57, however Labetalol was administered.
On 1/2/2024 at 2:00 p.m., Resident 81's heart rate was 57, however Hydralazine was administered.

6. During a review of Resident 82's Admission Record, the admission record indicated Resident 82 was originally admitted to the facility on5/2/2023 and readmitted to the facility on 6/12/2023 with diagnosis that included heart failure (progressive heart disease that affects pumping action of the heart muscles) and nonrheumatic aortic valve stenosis (a thickening and narrowing of the valve between the heart's main pumping chamber and the aorta, creates a smaller opening for blood to pass through and reduces or blocks blood flow from the heart to the rest of the body).

During a review of Resident 82's H&P dated 6/12/2023, the H&P indicated Resident 82 was able to give appropriate consent based on adequate decision-making capacity. The H&P indicated Resident 82 had a history of kidney transplant (a surgery to placing a healthy kidney from a living or deceased donor into a person whose kidneys no longer function).

During a review of Resident 82's MDS, dated 11/17/2023, the MDS indicated Resident 82's cognitive skills for daily decision making was intact. The MDS indicated Resident 82 required

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supervision for all ADLs. The MDS indicated Resident 82 had a diagnosis of diabetes mellitus.

During a review of Resident 82's Order Summary Report, the order summary report indicated Resident 82 was to receive:

1. Cinacalcet oral tablet 30 mg, give 1 tablet, by mouth, in the morning for chronic kidney disease (CKD, gradual loss of kidney function. Kidneys are unable to filter wastes and excess fluids from blood).
2. Furosemide oral tablet 40 mg, give 1 tablet, by mouth, one time a day, for high blood pressure, hold if SBP less than 110 and if heart rate less than 60.
3. Lisinopril oral tablet 10 mg, give 1 tablet, by mouth, one time a day, for high blood pressure, hold if SBP less than 110 and if heart rate less than 60.
4. Prednisone oral tablet 5 mg, give 1 tablet, by mouth, one time a day, for renal transplant.
5. Valacyclovir oral tablet 50 mg, give 1000 mg by mouth, one time a day, for warts.
6. Colace give 100 mg, by mouth, two times a day.
7. Prograf oral capsule 0.5 mg, give 1 capsule, by mouth, every 12 hours, for renal transplant.
8. Ketorolac tromethamine ophthalmic solution 4%, instill 1 drop in left eye, four times a day, for status post (S/P) cataract (a clouding of the lens of the eye) surgery.
9. Ofloxacin ophthalmic solution 0.3 %, instill 1 drop in left eye, four times a day, for status post (S/P) cataract surgery.
10. Prednisolone acetate ophthalmic suspension 1 %, instill 1 drop in left eye, four times a day, for S/P cataract surgery.

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During a review of Resident 82's MAR, for the month of January 2024, the MAR indicated the following:

On 1/2/2024 at 9:00 a.m., Resident 82's SBP was 104.

The MAR indicated Resident 82's SBP met the hold parameters however Furosemide and Lisinopril were administered.

The MAR indicated on 1/9/2024, Resident 82 did not receive his 9:00 a.m. dose of Cinacalcet 30 mg, Colace 100 mg, Furosemide 40 mg, Lisinopril 10 mg, Ketorolac tromethamine 4%, Ofloxacin 0.3 %, Prednisone 5 mg, Prednisolone acetate 1 %, Prograf oral capsule 0.5 mg, and Valacyclovir 50 mg.

During an interview on 1/11/1014 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated on 1/9/2024 she took over LVN 4's assignment when LVN 4 went home for the day. LVN 5 stated LVN 4 did not give her report before leaving. LVN 5 stated she did not remember what time she took over LVN 4's assignment but administered the resident's lunch time medications. LVN 5 stated LVN 4 did not inform LVN 5 the resident's 9:00 a.m. meds were not administered. LVN 5 stated medications that have hold parameters must be held if the resident met the parameters. LVN 5 stated if medication was administered it could cause a resident to have a negative response to medication.

During an interview on 1/11/2024 at 3:45 p.m. with the Director of Nursing (DON), the DON stated she expected the licensed nurses to pass all resident medications at their assigned times.

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F 755	Continued From page 105 The DON stated if the MAR was blank, it meant the medication was not given. The DON stated that if a medication was not given, the nurse must document the reason why it was not given. The DON stated it was not acceptable to leave the MAR blank. The DON stated if a resident's heart rate or blood pressure met the hold parameters the medication should not be administered to the resident. The DON stated that if the medication was administered to the resident, it could cause the resident harm instead of helping them. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration", dated 10/2017, the P&P indicated the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administrating the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. The P&P indicated medications are administered in accordance with written orders of the attending physician.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §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:	F 759		

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F 759	Continued From page 106 Based on observation, interview, and record review, the facility failed to ensure their medication error rate was less than five (5) percent (%) when Licensed Vocational Nurse (LVN) 4 failed to competently administer medications to three (3) of five (5) randomly selected residents (Residents 81, 74, and 7) during the medication administration observation. The outcome was 16 medication errors out of thirty opportunities for errors, which resulted in a Medication Administration Error Rate of fifty-three (53) percent, based on the following: 1. Resident 81 did not receive four (4) ordered medications that were documented as administered, and Resident 81 received one (1) medication more than one hour after the permitted administration time. 2. Resident 74 did not receive seven (7) ordered medications that were documented as administered, and Resident 74 received one (1) medication outside of the ordered holding parameters (specific instructions for when and when not to administer a medication based on measurable values). 3. Resident 7 did not receive four (4) ordered medications that were documented as administered. These deficient practices created the potential for residents to experience harm from pain related to non-administered pain medication, low blood pressure related to blood pressure medication being administered outside of the schedule time and too close to the next scheduled dose, and low blood sugar related to insulin administered	F 759	F - 759 I. Corrective Action/s: a. On 01/09/24 DON conducted a 1:1 in-service with LVN4 regarding “Medication Administration General Guidelines” policy, emphasizing the importance of medications being administered in accordance with written orders of the attending physician and then documenting in the MAR as administered. d. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Medication Administration General Guidelines” policy, emphasizing the importance of medications being administered in accordance with written orders of the attending physician and then documenting in the MAR as administered. e. Upon identification of missed medications for residents 81,74 and 7, residents were assessed, no changes in condition were noted and the primary physicians for those residents were notified. II. How to Identify Other Residents: a. On 02/01/24 DON conducted a medication reconciliation for all facility medication carts and MAR review to ensure all prescribed medications are being administered as ordered by the physician, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DON and/or designee will perform random medication administration spot checks to ensure all prescribed medications are being administered as ordered by the physician and all licensed nurses are documenting in the MAR once administered. IV. Monitoring: - DON and/or designee will conduct a medication reconciliation weekly to ensure all medications are being administered ordered by the physician and all licensed nurses are documenting in the MAR once administered. x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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outside of the ordered parameters. The deficient practice also created the potential for interruptions in health maintenance and improvement related to missed administrations of necessary medications.

Cross Reference: F-tag 726, F-tag 760, and F-tag 684

Findings:

1. During a review of Resident 81's Admission Record, the admission record indicated the facility originally admitted Resident 81 on 7/29/2022 and re-admitted Resident 81 on 12/15/2023. Resident 81's admitting diagnoses included end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (a treatment for people whose kidneys are failing), type 2 diabetes mellitus (DM, a chronic condition that affects the way the body processes blood sugar), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood, creating risk of heart attack and stroke).

During a review of Resident 81's History and Physical (H&P), dated 12/15/2023, the H&P indicated Resident 81 did not have the capacity to make his own decisions.

During a review of Resident 81's Physician Orders, dated 12/15/2023, the orders indicated staff were supposed to administer medications a total of seven (7) medications at 9 a.m. on 1/9/2024. The medications were as follows:

1. Aspirin 81 milligram (mg, a unit of dose measurement) tablet, by mouth, once a day, for

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stroke prevention.
2. Polyethylene glycol 3350, one packet, by mouth, one time a day, for bowel (intestine) management.
3. Nephro-vite tablet, once a day, for supplement.
4. Docusate sodium 100 mg, by mouth, once a day, for stool softener.
5. Labetalol 200 mg, by mouth, every 12 hours, for high blood pressure.
6. Amlodipine besylate 10 mg, by mouth, once a day, for high blood pressure.
7. Insulin glargine 15 units subcutaneously (under the skin), every 12 hours, for DM.

During an interview on 1/9/2024 at 8:20 a.m., with LVN 4, LVN 4 stated she was preparing to administer medications for Resident 81 and had not administered any medications yet.

During an observation on 1/9/2024 at 8:24 a.m., inside Resident 81's room, LVN 4 checked Resident 81's heart rate and blood pressure. No medications were administered.

During a concurrent observation and interview on 1/9/2024 at 8:34 a.m., outside of Resident 81's room, LVN 4 prepared a total of three (3) medications for Resident 81. After dispensing the medications, LVN 4 confirmed a total of three (3) medications were being administered to Resident 81. LVN 4 then entered Resident 81's room and Resident 81 took all three (3) medications with water. The three medications administered were abetalol HCl, amlodipine besylate, and hydralazine HCl (medication to treat high blood pressure). No further medications were administered.

During an observation on 1/9/2024 at 8:36 a.m.,

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at Resident 81's bedside, LVN 4 checked Resident 81's blood sugar then exited the room. No medications were administered.

During a concurrent observation and interview on 1/9/2024 at 8:41 a.m., outside of Resident 81's room, with LVN 4, LVN 4 prepared one (1) injection of insulin glargine for Resident 81 and confirmed a total of one (1) medication was to be administered. LVN 4 then entered Resident 81's room and Resident 81 refused the insulin glargine administration. LVN 4 exited the room with the one (1) unadministered medication and returned the medication to the medication cart. No further medications were offered to or administered to Resident 81.

During a review of Resident 81's Medication Administration Record (MAR), for the month of January 2024, the MAR indicated a total of seven (7) medications were scheduled for 9 a.m. administration. The MAR indicated LVN 4 documented she had administered six (6) scheduled 9 a.m. medications, and one (1) refusal of the insulin glargine. The MAR further indicated Resident 81's hydralazine HCl was scheduled for administration at 6 a.m., 2 p.m., and 10 p.m. The hydralazine HCl administered at 8:34 a.m. by LVN 4 was not documented on the MAR. There were four (4) medications documented as administered by LVN 4 on the MAR that were not observed as administered.

During a review of document titled, "Medication [Administration] Audit Report", dated 1/9/2024, the document indicated Resident 81 had a total of seven (7) medications scheduled for administration at 9 a.m. The document indicated LVN 4 documented she administered a total of

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seven (7) medications to Resident 81 between 8:22 a.m. and 8:43 a.m. The hydralazine HCl administered at 8:34 a.m. by LVN 4 was not documented.

2. During a review of Resident 74's Admission Record, the record indicated the facility originally admitted Resident 74 on 3/24/2022 and re-admitted Resident 74 on 4/8/2022. Resident 74's admitting diagnoses included type 2 diabetes mellitus, stage 3 chronic kidney disease (mild to moderate damage of the kidneys, making them less able to filter waste and fluid out of the blood), and a compression fracture (broken bone) of the lumbar vertebra (spinal bone in the lower back), and anemia (low red blood cell count).

During a review of Resident 74's H&P, dated 4/25/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions.

During a review of Resident 74's current physician orders, the orders indicated staff were supposed to administer a total of nine (9) medications at 9 a.m. on 1/9/2024. The medications were as follows:

1. Ferrous sulfate 325 mg tablet, twice a day, for anemia.
2. Cholecalciferol (Vitamin D3) 1000 unit, once a day, for supplement.
3. Multivitamin, once a day, for supplement.
4. Vitamin C 500 mg tablet.
5. Rena-Vite (vitamin), one a day, for renal integrity.
6. Eliquis (apixaban) 5 mg, by mouth, once a day, for atrial fibrillation (abnormal heartbeat).
7. Magnesium-oxide 400 mg tablet, twice a day, for supplement.

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8. Insulin glargine (Lantus) 10 units subcutaneously, once a day, for DM, with orders to not administer if Resident 74's blood sugar was less than 120.
9. Lidocaine 5% patch, applied above right pelvis and low back, once a day, for pain management.

During an interview on 1/9/2024 at 8:59 a.m., with LVN 4, LVN 4 stated she was preparing to administer medications for Resident 74.

During a concurrent observation and interview on 1/9/2024 at 9:02 a.m., inside Resident 74's room, LVN 4 checked Resident 74's blood sugar. LVN 4 stated Resident 74's blood sugar was 110. No medications were administered.

During a concurrent observation and interview on 1/9/2024 at 9:04 a.m., outside of Resident 74's room, LVN 4 prepared a total of two (2) medications for Resident 74. After preparing the medications, LVN 4 confirmed a total of two (2) medications were being administered to Resident 74 (Eliquis and Lantus) and restated that Resident 74's blood sugar was 110. LVN 4 then entered Resident 74's room and Resident 74 took the Eliquis with water while LVN 4 injected 10 units of Lantus into Resident 74's left lower abdomen. No further medications were offered to or administered to Resident 74, and LVN began preparing medications for the next resident at 9:14 a.m.

During a review of Resident 74's MAR, for the month of January 2024, the MAR indicated a total of nine (9) medications were scheduled for 9 a.m. administration. The MAR indicated LVN 4 documented she had administered nine (9) scheduled 9 a.m. medications. There were

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seven (7) medications documented as administered by LVN 4 on the MAR that were not observed as administered. The MAR also indicated LVN 4 documented a blood sugar of 110 and documented that the Lantus had been administered despite the order to not administer the medication if the blood sugar was less than 120.

During a review of a document titled, "Medication [Administration] Audit Report", dated 1/9/2024, the document indicated Resident 74 had a total of nine (9) medications scheduled for administration at 9 a.m. The document indicated LVN 4 documented she administered a total of nine (9) medications to Resident 74 between 8:58 a.m. and 9:12 a.m.

During a concurrent interview and record review, on 1/09/2024 at 9:33 a.m., with LVN 4, Resident 74's MAR and physician orders were reviewed. LVN 4 stated the physician order was to not administer the Lantus injection if Resident 74's blood sugar was less than 120. LVN 4 stated she misread the physician order. LVN 4 stated the blood glucose was 110 and the Lantus was administered. LVN 4 stated administration of Lantus put Resident 74 at risk for hypoglycemia and could cause harm to the resident.

3. During a review of Resident 7's Admission Record, the record indicated the facility originally admitted Resident 7 on 9/24/2014 and re-admitted Resident 7 on 7/7/2019. Resident 7's admitting diagnoses included spinal stenosis (narrowing of the spinal canal that can put pressure on the spinal cord and the nerves within the spine), right shoulder contracture (shortening and hardening of muscles, tendons, or other

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tissue, often leading to deformity and rigidity of joints), and cognitive communication deficit.

During a review of Resident 7's H&P, dated 11/24/2021, the H&P indicated Resident 7 did not have the capacity to understand and make decisions.

During a review of Resident 7's current physician orders, the orders indicated staff were to administer a total of eleven (11) medications at 9 a.m. on 1/9/2024. The medications were as follows:

1. Multivitamin with minerals, one tablet, once a day, for supplement.
2. Lidocaine-Prilocaine external cream 2.5%, applied to right shoulder, twice a day, for pain management.
3. Cholecalciferol (Vitamin D3) two 1000-unit tablets, once a day, for low vitamin D levels.
4. Potassium chloride 50 milliequivalents (mEq, a unit of dose measurement), in the morning, for supplement secondary to furosemide (medication that makes you urinate) use.
5. Docusate sodium 100 mg, in the morning, for stool softener.
6. Furosemide 40 mg tablet, in the morning, for extremity edema (swelling).
7. Sodium chloride solution 5% instillation of one drop to the right eye, twice a day, for corneal edema (swelling of the outermost layer of the eye).
8. Gabapentin 100 mg capsule, twice a day, for pain management.
9. Artificial tears instillation of one drop to both eyes, four times, a day for dry eyes.
10. Divalproex sodium 500 mg, twice a day, for seizure (a sudden, uncontrolled burst of electrical

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activity in the brain that can cause changes in behavior, movements) disorder.
11. Levetiracetam 750 mg, twice a day, for seizure disorder.

During an interview on 1/9/2024 at 9:14 a.m., with LVN 4, outside of Resident 7's room, LVN 4 stated she was preparing to administer medications for Resident 7.

During a concurrent observation and interview on 1/9/2024 at 9:21 a.m., outside of Resident 7's room, LVN 4 prepared a total of six (6) medications for Resident 7. After preparing the medications, LVN 4 confirmed a total of 6 (6) medications were being administered to Resident 7. LVN 4 then entered Resident 7's room and Resident 7 took 5 medications with water, and LVN 4 administered one (1) medication (artificial tears) to both of Resident 7's eyes. No further medications were offered to or administered to Resident 7.

During a review of Resident 7's MAR, for the month of January 2024, the MAR indicated a total of eleven (11) medications were scheduled for 9 a.m. administration. The MAR indicated LVN 4 documented she had administered eleven (11) scheduled 9 a.m. medications. There were four (4) medications documented as administered by LVN 4 on the MAR that were not observed as administered.

During a review of a document titled, "Medication [Administration] Audit Report", dated 1/9/2024, the document indicated Resident 7 had a total of eleven (11) medications scheduled for administration at 9 a.m. The document indicated LVN 4 documented she administered a total of

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F 759	Continued From page 115 eleven (11) medications to Resident 7 between 9:15 a.m. and 9:20 a.m. During an interview on 1/11/2024 at 3:35 p.m., with the Director of Nursing (DON), the DON stated medications are to be administered as ordered by the physician. The DON stated staff have one hour before and one hour after the scheduled administration time to administer medications. The DON stated medication administered outside of the scheduled time required prior physician notification to ensure it was safe, and stated there should be documentation in the resident's medical record to indicate when the medication was administered. The DON also stated documentation of medication administration is supposed to be done immediately at time of administration and should be accurate. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration - General Guidelines", dated 10/2017, indicated: a. "Medications are administered in accordance with written orders of the attending physician." b. "Medications are administered within 60 minutes of the scheduled time (1 hour before and 1 hour after)." c. "Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility." d. "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given."	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		

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F 760	Continued From page 116 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 74) was free of significant medication errors by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 4 did not administer 10 units (a unit of measurement for insulin) of Lantus (insulin glargine, a medication used to control blood sugar levels) when resident 74's blood sugar was outside of the holding parameters (specific instructions for when and when not to administer a medication based on measurable values). 2. Ensure Licensed staff did not document administration of thirty-seven (37) of Lidocaine 5% patches (medicated patch applied to the skin for pain management) for Resident 74, when only fourteen (14) patches had been dispensed to the facility. These deficient practices had the potential to result in avoidable harm from pain related to non-administered pain medication, and low blood sugar related to insulin being administered outside of the ordered parameters. Cross Reference: F-tag 726, F-tag 759, and F-tag 684 Findings: During a review of Resident 74's Admission	F 760	F - 760 I. Corrective Action/s: a. On 01/09/24 DON conducted a 1:1 in-service with LVN4 regarding “Medication Administration General Guidelines” policy, emphasizing the importance of administering medications as ordered by the prescribing physician and following hold parameters for medication. d. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Medication Administration Guidelines” policy, emphasizing the importance of administering all medications as ordered by the prescribing physician and following hold parameters. e. Resident was immediately assessed for pain, and upon assessment verbalized she has no pain and refusal of lidocaine patch. Physician was notified and discontinued lidocaine patch. II. How to Identify Other Residents: a. On 02/01/24 DON conducted a medication reconciliation for all facility medication carts and MAR review to ensure all prescribed medications are being administered as ordered by the physician, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DON and/or designee will perform random medication administration spot checks to ensure all prescribed medications are being administered as ordered by the physician and all licensed nurses are following the hold parameters. IV. Monitoring: - DON and/or designee will conduct a medication reconciliation weekly to ensure all medications are being administered ordered by the physician and all licensed nurses are following the hold parameters x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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Record, the admission record indicated the facility originally admitted Resident 74 on 3/24/2022 and re-admitted Resident 74 on 4/8/2022. Resident 74's admitting diagnoses included type 2 diabetes mellitus, stage 3 chronic kidney disease (mild to moderate damage of the kidneys, making them less able to filter waste and fluid out of the blood), and a compression fracture (broken bone) of the lumbar vertebra (spinal bone in the lower back), and anemia (low red blood cell count).

During a review of Resident 74's History and Physical (H&P), dated 4/25/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions.

During a review of Resident 74's active Physician Orders, the orders indicated staff were to administer 10 units of Lantus subcutaneously (injected beneath the skin) once a day for DM, with orders to not administer the medication if Resident 74's blood sugar was less than 120. The orders also indicated staff were to apply a Lidocaine 5% patch to Resident 74's right lower back, once a day, for pain management, starting on 11/25/2023.

During a concurrent observation and interview on 1/9/2024 at 9:02 a.m., inside Resident 74's room, LVN 4 checked Resident 74's blood sugar. LVN 4 stated Resident 74's blood sugar was 110.

During a concurrent observation and interview on 1/9/2024 at 9:04 a.m., outside of Resident 74's room, LVN 4 prepared Resident 74's Lantus injection for administration and restated that Resident 74's blood sugar was 110. LVN 4 then entered Resident 74's room and injected the 10 units of Lantus into Resident 74's left lower

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abdomen. LVN 4 did not apply a Lidocaine 5% patch to Resident 74's right lower back.

During a concurrent interview and record review, on 1/09/2024 at 9:33 a.m., with LVN 4, Resident 74's Medication Administration Record (MAR) and physician orders were reviewed. LVN 4 stated the physician order was to not administer the Lantus injection if Resident 74's blood sugar was less than 120. LVN 4 stated she misread the physician order. LVN 4 stated Resident 74's blood sugar level was 110 and the Lantus was administered. LVN 4 stated the administration of Lantus put Resident 74 at risk for hypoglycemia and could cause harm to the resident.

During a review of Resident 74's MAR, for the month of November 2023, the MAR indicated licensed facility staff documented Resident 74's Lidocaine 5% patch as administered on 11/25/2023, 11/26/2023, 11/27/2023, 11/28/2023, 11/29/2023, and 11/20/2023. The MAR indicated a total of six administrations of Resident 74's Lidocaine 5% patch for the month of 11/2023.

During a review of Resident 74's MAR, for the month of December 2023, the MAR indicated licensed facility staff documented Resident 74's Lidocaine 5% patch as administered on: 12/1/2023, 12/2/2023, 12/3/2023, 12/4/2023, 12/5/2023, 12/6/2023, 12/7/2023, 12/8/2023, 12/9/2023, 12/10/2023, 12/11/2023, 12/12/2023, 12/13/2023, 12/14/2023, 12/17/2023, 12/20/2023, 12/21/2023, 12/22/2023, 12/23/2023, 12/24/2023, 12/26/2023, 12/27/2023, 12/28/2023, and 12/31/2023. The MAR indicated a total of 24 administrations of Resident 74's Lidocaine 5% patch for the month of 12/2023.

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During a review of Resident 74's MAR, for the month of January 2024, the MAR indicated LVN 4 documented Resident 74's Lidocaine 5% patch as administered on 1/9/2024. Further review of the MAR indicated other licensed facility staff documented the Lidocaine 5% patch as administered on: 1/1/2024, 1/2/2024, 1/3/2024, 1/4/2024, 1/5/2024, and 1/7/2024. The MAR indicated a total of 7 administrations of Resident 74's Lidocaine 5% patch for the month of 1/2024.

During a concurrent observation and interview, on 1/9/2024 at 1 p.m., at Resident 74's bedside, Resident 74 rolled into a left-facing position in her bed. No Lidocaine 5% patch was observed on Resident 74's right lower back or displaced in Resident 74's bed linens. Resident 74 stated she did not receive the Lidocaine 5% patch that day and stated the patch had not been offered to her.

During a concurrent observation and interview on 1/9/2024 at 1:08 p.m., with LVN 5, LVN 5 opened the medication cart and removed the current inventory of Resident 74's Lidocaine 5% patches. LVN 5 stated the label affixed to the bag containing Resident 74's inventory of Lidocaine 5% patches was dated 11/24/2023 and indicated a total of 14 patches had been dispensed. LVN 5 stated there were two patches remaining in Resident 74's inventory. LVN 5 stated no additional patches had been requested or dispensed from the pharmacy.

During an interview on 1/9/2024 at 1:44 p.m., with the facility's contracted pharmacy, the pharmacy staff stated a total of 14 Lidocaine 5% patches had been dispensed to the facility on 11/25/2023 for Resident 74. Pharmacy staff stated no refills had been requested or delivered. The pharmacy

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staff stated that when a medication is dispensed to the facility, the staff receiving the medication sign a receipt to confirm the medication was received.

During a review of a document titled, "Manifest: [Facility Name]", dated 11/25/2023, the document indicated LVN 6 signed the document on 11/25/2023 at 4:14 a.m., confirming receipt of 14 Lidocaine 5% patches for Resident 74.

During a concurrent record review and interview on 1/11/2024 at 3:35 p.m., with the Director of Nursing (DON), Resident 74's physician orders, MARs for November 2023, December 2023, January 2024, and the Lidocaine 5% patch delivery records from the contracted pharmacy were reviewed. The DON stated medications were supposed to be administered as ordered by the physician. The DON stated that not following physician orders for Lantus administration could cause an alteration in Resident 74's blood sugar, and a potentially harmful change in condition. The DON further stated only 14 Lidocaine 5% patches had been delivered to the facility, and stated there were not enough patches delivered to account for the 37 administrations documented from 11/25/2023 to 1/9/2024. The DON stated the medications had not been administered as ordered and stated that a resident's pain could go unaddressed if they did not receive their pain medication as ordered.

During a review of the facility's policy and procedure (P&P) titled, "Medication Administration - General Guidelines", dated 10/2017, indicated:
a. "Medications are administered in accordance with written orders of the attending physician."

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F 760	Continued From page 121 b. "The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given."	F 760		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain the results for one of two sampled residents (Resident 74) computed tomography (CT, imaging that helps detect internal injuries and diseases) scan in a timely manner when Resident 74 was readmitted to the facility from the general acute care hospital (GACH). This failure resulted in Resident 74's physician being notified two weeks after the CT scan was completed with results that indicated a compression fracture (type of broken bone that can cause the vertebra [bone in the spine] to collapse) of the second lumbar vertebrae (L2, bone in the lower end of the spinal column). Findings:	F 777		

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F 777	Continued From page 122 During a review of Resident 74's Admission Record (Face Sheet), the Admission Record indicated Resident 74 was initially admitted to the facility on 3/24/2024 and readmitted to the facility on 4/8/2023 with diagnoses including type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), and chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow). During a review of Resident 74's History and Physical (H&P), dated 4/24/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a comprehensive resident assessment and care screening tool,) dated 12/14/2023, the MDS indicated Resident 74 was able to understand and be understood by others. The MDS indicated Resident 74's cognition was intact (ability to think and reason). The MDS indicated Resident 74 required moderate assistance with bed mobility, maximal assistance with toileting, bathing, and dressing, and required setup or clean-up assistance with personal hygiene. The MDS indicated Resident 74 had a fall with a major injury. During a review of Resident 74's Change of Condition (COC), dated 11/6/2023, the COC indicated on 11/6/2023, Resident 74 returned to her room from the shower room and was being assisted to bed by the certified nursing assistant (CNA). The COC indicated Resident 74 stood up to transfer to the bed, was unable to reach for the	F 777	F - 777 I. Corrective Action/s: a. On 01/26/24 DON provided a 1:1 in-service with RN3 regarding “Change of Condition” policy, emphasizing the importance of obtaining lab or radiology results timely to ensure all changes of condition in a resident are handled promptly. b. From 01/26/24- 01/29/24 DON provided an in-service with all licensed nurses regarding “ Change of Condition” policy, emphasizing the importance of obtaining lab radiology results timely to ensure all changes of condition in a resident are handled promptly. II. How to Identify Other Residents: a. On 01/30/24 DON reviewed all radiology orders to ensure results were obtained and any changes in condition in a resident were handled promptly, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DON and/or designee will review all radiology orders to ensure results are obtained timely to ensure all changes of condition are handled promptly weekly. IV. Monitoring: - DON and/or designee will review all radiology orders to ensure results are obtained timely to ensure all changes of condition are handled promptly weekly x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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bed handles, and fell and landed on her back. The COC indicated Physician 2 was informed and gave orders for an X-ray (imaging that creases pictures of the inside of the body) of the hip, spine, head, leg, and pelvis. The COC indicated Resident 74 complained of lower back and left hip pain.

During a review of Resident 74's Radiology Results Report, dated 11/6/2023, the Radiology Results Report indicated the lumbar spine X-ray indicated a result of a compression deformity at the L2 level, age indeterminate (not exactly known).

During a review of Resident 74's Progress Notes, dated 11/6/2023 and timed at 1:48 p.m., the Progress Note indicated Physician 2 was informed of Resident 74's X-ray results and Physician 2 ordered a CT scan of the head and lumbar.

During a review of Resident 74's COC, dated 11/28/2023, the COC indicated Resident 74 complained of lower back pain and another lumbar X-ray was done which indicated a result of a compression deformity at the L2 level, age determinate. The COC indicated Physician 2 was notified that Resident 74 had not received the CT scan of the head and lumbar due to insurance. The COC indicated Physician 2 ordered for Resident 74's transfer to the GACH for CT scan of the head and lumbar.

During a review of Resident 74's GACH Radiology Report, dated 11/28/2023, the Radiology Report indicated the report was faxed to the facility on 12/12/2023. The Radiology Report indicated the lumbar CT scan result

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indicated an acute compression fracture of L2.

During a review of Resident 74's Admission Assessment, dated 11/28/2023, the Admission Assessment indicated Resident 74 was transferred to the GACH for a CT scan of the head and lumbar and was readmitted to the facility. The Admission Assessment had no indication of the report provided to the admitting nurse and of the results of the CT scan.

During a review of Resident 74's COC, dated 12/12/2023, the COC indicated the lumbar CT scan results were received from the GACH and Physician 2 was notified of the results. The COC indicated Physician 2 ordered for Resident 74 to see a neurosurgeon in one to six weeks for evaluation.

During an interview on 1/10/2024 at 8:59 a.m., with Registered Nurse (RN) 2, RN 2 stated Resident 74 was transferred to the GACH on her shift and was readmitted to the facility the following shift. RN 2 stated she and the other nurses were unaware of Resident 74's compression fracture until the facility received the results from the GACH two weeks later. RN 2 stated when Resident 74 was brought back to the facility, the GACH did not send any paperwork with the resident regarding the CT scan results. RN 2 stated the facility's medical personnel followed up with the GACH in obtaining the CT scan results.

During an interview on 1/10/2024 at 11:55 a.m., with the Medical Record Director (MRD), the MRD stated he requested Resident 74's CT scan results on 12/4/2023 but did not receive them until 12/12/2023.

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During an interview on 1/10/2024 at 1:10 p.m., with Physician 3, Physician 3 stated she expected to be notified of abnormal results of any kind promptly to develop a plan of care based on those results.

During an interview on 1/10/2024 at 3:46 p.m., with RN 3, RN 3 stated Resident 74 was transferred to the hospital on 11/28/2023 for a CT scan and was readmitted to the facility that same night. RN 3 stated normally when a resident was readmitted to the facility from the hospital, she would receive report prior to the residents' arrival. RN 3 stated she had not received report and Resident 74 was brought back to the facility. RN 3 stated she was curious what the CT scan results were, but she did not follow up with the GACH. RN 3 stated she could have called the GACH and spoken to the physician. RN 3 stated she should have obtained the CT scan results and informed the physician so Resident 74 could receive the proper care.

During an interview on 1/11/2024 at 10:36 a.m., with the Director of Nursing (DON), the DON stated the admitting nurse should have received the results of the CT scan, however, all the nurses had the responsibility to follow-up on diagnostic tests for the residents. The DON stated obtaining the results and notifying the physician was important to provide the appropriate care for the resident.

During a review of the facility's Registered Nurse (RN) Job Description, dated 1/27/2022, the Job Description indicated, "Essential duties and responsibilities include ... Makes actual patient rounds, assessing and observing the following at

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(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
F 777	Continued From page 126 least three times per day: Monitoring lab and x-ray values related to patient's condition." During a review of the facility's policy and procedure (P&P) titled, "Change of Condition", revised 1/24/2017, the P&P indicated, "A change of condition is a sudden or marked different in resident's ... lab or x-ray results... All changes of condition in a resident shall be handled promptly."	F 777		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 kitchen staff failed to wash their hands prior to becoming in contact with food, failed to check food temperatures, and failed to store food under sanitary conditions when the following	F 812	F - 812 I. Corrective Action/s: a. All food identified without appropriate dates: date- upon receipt, open date, and thaw date were discarded immediately by dietary supervisor. b. On 01/26/24 Administrator conducted a 1: 1 in-service to DSS regarding “Daily Food Temperature Control” policy and procedure emphasizing the of the temperature of all hot and cold food being taken prior to every meal service and recorded on the temperature log. c. From 01/29/24- 01/31/24 the Registered Dietician and DSS provided an in-service with dietary staff regarding “Daily Food Temperature Control” policy and procedure emphasizing the of the temperature of all hot and cold food being taken prior to every meal service and recorded on the temperature log. d. From 01/29/24- 01/31/24 the Registered Dietician and DSS provided an in-service with dietary staff regarding “Refrigerator/ Freezer Storage” policy and procedure emphasizing the importance of food items having the following appropriate dates: date- upon receipt, open date, and thaw date.	02/04/24

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F 812	Continued From page 127 occurred: 1. The Dietary Supervisor (DS) did not wash their hands before checking food temperatures. 2. The refrigerator stored food without a use by date. 3. The refrigerator stored food that was spoiled. 4. The freezer stored food without the date that it was placed in the freezer and did not have a use by date. 5. Food temperatures were not checked prior to serving food to residents. These deficient practices had the potential to result in the transmission of infectious agents that could lead to food borne illnesses in vulnerable residents. Findings: During a concurrent initial kitchen tour observation and interview on 1/8/2024 at 8:55 a.m. with Cook 1, in the dry storage room, Cook 1 stated items placed in the storage room were dated with the received date (date item was placed on the shelf), the date the item was opened, and a use by date (date item must be removed or the expiration date). During an observation on 1/8/2024 at 9:05 a.m. in the dry storage room, there was an open container of browning and seasoning sauce with no use by date. Observed graham cracker crumbs, buttermilk boxes, cheesecake mix, gelatin powder mix and apple sauces with no	F 812	II. How to Identify Other Residents: a. On 01/29/24 the DSS reviewed all items in the Freezer and Refrigerator to ensure all items were labeled accordingly, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DSS and/or designee to conduct spot checks weekly to ensure the temperature of all hot and cold food being taken prior to every meal service and recorded on the temperature log. b. DSS and/or designee to perform daily checks ensuring all items in the Freezer and Refrigerator are labeled accordingly. IV. Monitoring: - DSS and/or designee to conduct spot checks weekly to ensure the temperature of all hot and cold food being taken prior to every meal service and recorded on the temperature log x 4 weeks - DSS and/or designee to perform daily checks ensuring all items in the Freezer and Refrigerator are labeled accordingly x 4 weeks - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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F 812	Continued From page 128	F 812		

received date. Observed an open jar of peanut butter and an open bag of cornflakes without a received date, opened date, or use by date.

During an interview on 1/8/2023 on 9:02 a.m. with the Dietary Supervisor (DS), in the dry storage food, the DS stated that all items needed to be labeled with the received date, open date, and use by date. The DS stated these items needed to be labeled with these dates to help staff know which items were older, which items needed to be used next, and when the item could no longer be used.

During an observation on 1/8/2024 at 9:29 a.m. in the walk-in refrigerator, observed an open bag of sliced carrots with no use by date. Observed open and unopened bags of green grapes that contained spoiled grapes. Observed an undated bag of green peppers.

During an observation on 1/8/2023 at 9:41 a.m. at the kitchen's freezer, observed multiple bags of frozen mixed vegetables and multiple bags of frozen broccoli, multiple bags of frozen zucchini, a package of hamburger patties, a bag of bacon, a bag of sausage links, and a bag of waffles with no date indicating when those items were put in freezer. The items were not labeled with a use by date or expiration date. Observed turkey sausages saran wrapped and labeled with the date of 1/5/2024, unable to identify what that date was for.

During an interview on 1/10/2024 at 11:35 a.m. with the DS, in the kitchen, the DS stated once an item has been opened, it must be dated with the open date and a use by date.

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During an interview on 11/10/2024 at 11:40 a.m. with the DS, in the walk-in refrigerator, the DS stated the green grapes were spoiled and should not be in the refrigerator. The DS stated it was important not to keep spoiled food in the refrigerator to prevent staff from serving them to residents.

During a concurrent observation and interview on 1/10/2024 at 11:48 a.m. with the DS, in the kitchen, the freezer had food items with no dates. The DS stated all food in the freezer must be labeled with the date it was put in the freezer. The DS stated the opened food in the freezer did not have a use by date and stated the items should have been dated. The DS stated there was no way of knowing if the bag of frozen burritos and a frozen bag of raviolis were still good to be served to residents because it did not have an open date and a use by date. The DS stated it was important to accurately date all food items to make sure the facility served unexpired and safe food to the residents.

During an observation on 1/10/2024 at 12:15 p.m. in the kitchen, observed the DS removing potentially expired food from the freezer. The DS then went and began checking the temperatures of food that was currently being plated and served to the residents for lunch. The DS did not their wash hands before checking food temperatures. Observed the DS log temperatures on the temperature log form. Observed kitchen staff serving lunch plates for residents and delivering to the floor without first checking food temperatures.

During an interview on 1/10/2024 at 12:29 p.m. with the DS, in the kitchen, the DS stated he

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F 812	Continued From page 130 should have washed his hands before becoming in contact with the resident's food. The DS stated he should have washed his hands before touching the food to prevent food contamination. The DS stated food temperatures were checked by the cook or himself only before plating food. During a review of the facility's policy and procedure (P&P) titled, "Refrigerator/Freezer Storage", dated 2019, the P&P indicated leftover food or unused portions of packaged foods should be covered, dated, and labeled to ensure they will be used first. The P&P indicated food items should have the following appropriate dates: Delivery date- upon receipt, Open date- opened containers, and thaw date - any frozen items. During a review of the facility's P&P titled, "Daily Food Temperature Control", dated 2019, the P&P indicated the temperature of all hot and cold food shall be taken prior to every meal service and recorded on the temperature log.	F 812		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of	F 847		

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F 847	Continued From page 131 his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure three of three sampled residents	F 847	F-847 I. Corrective Action/s: a. On 01/28/24 Administrator provided a 1: 1 in-service with the designated person responsible for presenting the Binding Arbitration agreements to residents emphasizing the importance of presenting the Arbitration Agreement in a language the resident and/ or responsible party understands and ensuring all residents and/ or the responsible party understand the Arbitration Agreement is not necessary as a condition of admission to the facility. b. On 2/1/24 Resident 41's daughter was re- educated of the Arbitration Agreement and informed that it is optional and not required to be completed to have resident admitted and reside in the facility. c. On 2/2/24 Resident 74's son was re-educated of the Arbitration Agreement and informed that it is optional and not required to be completed to have resident admitted and reside in the facility. d. Resident 82 was discharged home on 01/12/24. II. How to Identify Other Residents: a. On 02/01/2024 the front office reviewed all Binding Arbitration Agreements to ensure the signed Arbitration Agreements are in a language the resident and/ or responsible party understands and ensured all residents and/ or the responsible parties understand the Arbitration Agreement is not necessary as a condition of admission to the facility. No additional discrepancies were identified with the same deficient practice	02/04/24

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F 847	Continued From page 132 (Resident 41, 74, and 82) understood the Arbitration Agreement (an agreement between the facility and the resident where they would resolve any disputes through a neutral person rather than going to court) when entering a binding contract by failing to: 1. Present the Arbitration Agreement in a language Resident 82 understood. 2. Ensure Resident 82, Resident 41's Family Member (FM) 1, and Resident 74's Family Member (FM) 2 understood that signing the Arbitration Agreement was not necessary as a condition of admission to the facility. These failures resulted in Resident 82 not understanding in the language he understood and Residents 41, 74, and 82 entering the binding agreement as a pretense that it was mandatory. Findings: a. During a review of Resident 82's Admission Record (Face Sheet), the Admission Record indicated Resident 82 was initially admitted to the facility on 5/2/2023 and readmitted to the facility on 6/12/2023 with diagnoses included but not limited to type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), hypertensive heart disease (heart conditions caused by complications of high blood pressure), and heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs). During a review of Resident 82's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 11/17/2023, the MDS	F 847	III. Systemic Changes: a. The designated individual presenting the Binding Arbitration Agreement will ask the resident or responsible party what language they prefer to have the agreement presented. b. The Arbitration Agreement will be kept separate from the Admission Packet and will be presented after the admission packet is completed to ensure the resident and/ or responsible party are aware it is not necessary as a condition of admission to the facility. IV. Monitoring: - Administrator will conduct monthly reviews of new Binding Arbitration Agreements to ensure it is presented in the language preferred and understood in it not necessary as a condition of admission to the facility by the resident or responsible party x 2 months. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	

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indicated Resident 82 was able to understand and be understood by others. The MDS indicated Resident 82's cognition (process of thinking) was intact.

During a review of Resident 82's Facility Arbitration Agreement, undated, the Facility Arbitration Agreement indicated Resident 82 signed and entered into the binding agreement.

b. During a review of Resident 41's Admission Record (Face Sheet), the Admission Record indicated Resident 41 was admitted to the facility on 11/5/2023 with diagnoses that included but not limited to type 2 diabetes mellitus, end stage renal disease (a stage where the kidneys can no longer support the body's needs for waste removal and fluid balance), and atrial fibrillation (an irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure).

During a review of Resident 41's MDS, dated 11/9/2023, the MDS indicated Resident 41 was able to understand and be understood by others. The MDS indicated Resident 41's cognition was moderately impaired.

During a review of Resident 41's History and Physical (H&P), dated 11/8/2023, the H&P indicated Resident 41 had the capacity to understand and make decisions.

During a review of Resident 41's Facility Arbitration Agreement, dated 11/28/2023, the Facility Arbitration Agreement indicated FM 1 signed and entered the binding agreement on behalf of Resident 41.

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c. During a review of Resident 74's Admission Record (Face Sheet), the Admission Record indicated Resident 74 was initially admitted to the facility on 3/24/2024 and readmitted to the facility on 4/8/2023 with diagnoses included but not limited to type 2 diabetes mellitus, heart failure, and chronic obstructive pulmonary disease (COPD, a lung disease characterized by long-term poor airflow).

During a review of Resident 74's MDS, dated 12/14/2023, the MDS indicated Resident 74 was able to understand and be understood by others. The MDS indicated Resident 82's cognition was intact.

During a review of Resident 74's H&P, dated 4/24/2023, the H&P indicated Resident 74 had the capacity to understand and make decisions.

During a review of Resident 74's Facility Arbitration Agreement, dated 4/11/2022, the Facility Arbitration Agreement indicated FM 2 signed and entered the binding agreement on behalf of Resident 74.

During an interview on 1/9/2024 at 10:35 a.m., with Resident 82, Resident 82 stated he spoke primarily Spanish and could understand "very little English". Resident 82 stated, "When signing important forms, I would like it in Spanish." Resident 82 stated he remembered signing the form; however, he was not told signing was voluntary and he thought he had to sign to continue living at the facility.

During an interview on 1/9/2024 at 10:44 a.m., with FM 1, FM 1 stated she understood the binding arbitration agreement, however, when

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she came to the facility to sign Resident 41's paperwork, she was not told that entering the binding arbitration agreement was not necessary and she felt that she had to sign the agreement for Resident 41 to be admitted to the facility.

During an interview on 1/9/2024 at 10:54 a.m., with FM 2, FM 2 stated when he came to the facility to sign paperwork for Resident 74, the staff member who assisted him had given him everything he had to sign. FM 2 stated, "They gave me all the paperwork they needed in my mom's record, and I had to sign them. I did not know I did not need to sign the agreement."

During an interview on 1/9/2024 at 1:20 p.m., with the Business Office Manager (BOM), the BOM stated when a resident was admitted to the facility, the admission packet was reviewed with the resident and/or their family members. The BOM stated the Arbitration Agreement was available in many languages, including Spanish. The BOM stated Resident 82 was spoke primarily Spanish and should have been provided the Arbitration Agreement in Spanish for him to understand the form and decide if he wanted to enter the binding agreement. The BOM stated the Arbitration Agreement was not mandatory and it was an issue if the residents and family members were under the impression that it was. The BOM stated the Arbitration Agreement was not properly explained. The BOM stated the residents, and their family members had the right to be aware that entering a binding arbitration was not mandatory because if they did not agree with the terms, they would not have to enter it.

During an interview on 1/9/2024 at 1:44 p.m., with the Administrator (ADM), the ADM stated the

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F 847	Continued From page 136 Arbitration Agreement should always be presented to the resident and their family members in the language they understood. The ADM stated Resident 82 should have been presented with the Spanish version of the Arbitration Agreement so he could understand and comprehend the information. The ADM stated the Arbitration Agreement was not mandatory and it was an issue if those who entered into the binding agreement were under the impression that it was mandatory for admission into the facility. The ADM stated everyone should be able to make an informed decision and to understand their options.	F 847		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	Continued From page 137 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	F-880 I. Corrective Action/s: a. On 01/10/24 the enteral hydration administration kit was immediately changed upon identifying the change date be greater than 24 hours. b. On 01/26/24 DON conducted a 1:1 in-service with IPN regarding “Infection Control” policy and procedure, emphasizing the importance to ensure there is posted signage in and around residents’ rooms with Enhanced Standard Precautions (ESP) to inform staff providing direct care to residents to utilize infection control interventions such as using a gown and gloves during high contact resident care activities. c. On 01/26/24 DON performed a 1:1 in-service with treatment nurse regarding “Hand Washing” policy and procedure emphasizing the importance of performing hand washing in between performance of routine procedures such as dressing changes. d. From 01/26/24-01/29/24 the IPN conducted an in-service with all staff regarding “Infection Control” policy and procedure, emphasizing the importance of understanding Enhanced Standard Precautions (ESP). Education was provided regarding the ESP signage utilized to inform staff providing direct care to residents to utilize infection control interventions such as using a gown and gloves during high contact resident care activities. e. From 01/26/24- 01/29/24 DON performed an in-service to all licensed nurses regarding “ Infection Control” policy and procedure emphasizing the importance of ensuring all enteral hydration administration kits are changed within 24 hours. Education was provided on the manufacturer’s guideline to “ discard administration set and transition connector when delivery is complete within a maximum of 24 hours, do not re-use.”	02/04/24

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F 880	Continued From page 138 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement effective infection prevention measures for three of seven sampled residents (Resident 2, 10, and 46) when the facility failed to: 1. Post signage in and around Resident 2's room to ensure staff providing direct resident care activities were aware of Resident 2's Enhanced Standard Precautions (ESP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug resistant organisms). 2. Ensure the Treatment Nurse (TN) performed hand hygiene (a way of cleaning one's hands that substantially reduces the potential germs on the hands) throughout Resident 46's wound treatment. 3. Ensure Resident 10's enteral hydration (water provided through a feeding tube [a flexible plastic tube placed into the stomach to assist in nutrition and hydration) administration kit (tubing system that delivers the water into the body) was changed within 24 hours. These failures had the potential to result in the transmit of infectious microorganisms and increase the risk of infection. Findings:	F 880	II. How to Identify Other Residents: a. On 01/29/24 IPN conducted facility rounds to ensure all residents on Enhanced Standard Precautions had signage posted around residents' rooms to inform staff providing direct care to residents to utilize infection control interventions such as using a gown and gloves during high contact resident care activities. No additional discrepancies were identified with the same deficient practice. b. On 01/29/24 IPN conducted spot checks during facility rounds to ensure all staff are performing hand hygiene/ washing in between performance of routine procedures with residents. No additional discrepancies were identified with the same deficient practice. c. On 01/29/24 IPN reviewed all enteral hydration kits to ensure all enteral hydration administration kits have been changed within 24 hours. No additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. IPN and/ or designee will have ESP signage printed in color and posted in and around residents' rooms on Enhanced Standard Precautions to ensure all staff are aware of the interventions utilized during high contact resident care activities. b. IPN and/ or designee will conduct spot checks during facility rounds to ensure all staff are performing hand hygiene/ washing in between performance of routine procedures with residents weekly. c. IPN and/ or designee will check all enteral hydration kits to ensure all enteral hydration administration kits have been changed within 24 hours weekly.	02/04/24

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F 880	Continued From page 139 1. During a review of Resident 2's Admission Record, the Admission Record indicated the facility initially admitted Resident 2 on 12/14/2017 and re-admitted the resident on 5/17/2019 with diagnoses including cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture) and contractures (loss of motion of a joint associated with stiffness and joint deformity). During an observation on 1/10/2024 at 10:19 a.m., in the resident's room, Resident 2 was observed lying in bed. No signage indicating Resident 2 was on ESP was observed above the bed, in the room, on the door, or outside of the room. A pole holding a gastrostomy tube (G-tube, tube inserted through the abdomen that brings nutrition directly to the stomach) machine was observed to the right of Resident 2's bed. A container with drawers containing yellow isolation gowns (protective apparel used to prevent the transfer of microorganisms and body fluids from one person to another) was in the corner of the room against the wall in front of Resident 2's bed. During an interview on 1/10/2023 at 10:40 p.m., Restorative Nursing Aide (RNA) 1 stated she just finished performing exercises to Resident 2's both legs and both arms and applying a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to the left hand. RNA 1 stated she did not know what type of precautions Resident 2 was on because there was no signage in or around the room to indicate the precaution type. RNA 1 stated she thought Resident 2 might be on ESP precautions because Resident 2 had a G-tube but was unsure.	F 880	IV. Monitoring: - IPN and/ or designee will have ESP signage printed in color and posted in and around residents' rooms on Enhanced Standard Precautions to ensure all staff are aware of the interventions utilized during high contact resident care activities. - IPN and/ or designee will conduct spot checks during facility rounds to ensure all staff are performing hand hygiene/ washing in between performance of routine procedures with residents weekly x 4 weeks. - IPN and/ or designee will check all enteral hydration kits to ensure all enteral hydration administration kits have been changed within 24 hours weekly x 4 weeks. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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During an interview on 1/10/2023 at 11:08 a.m., Certified Nursing Assistant (CNA) 1 stated he was unsure what type of precautions Resident 2 was on because there was no signage in or around the room to indicate the precaution type. CNA 1 stated he thought Resident 2 might be on ESP precautions or on droplet precautions (procedures to reduce risk of spread of infections transmitted by respiratory droplets generated by coughing, sneezing, talking) but was unsure. CNA 1 stated he only knew Resident 2 required an isolation gown and gloves for direct resident care activities because he had worked with him several times in the past. CNA 1 stated there was a potential for spreading infection if staff providing direct resident care activities to Resident 2 were not aware he was on precautions.

During an interview on 1/10/2024 at 12:32 p.m., the Infection Preventionist Nurse (IPN) confirmed Resident 2 was on ESP precautions but did not have any signage in or around the room to ensure staff providing direct care activities were aware of his precautions. The IPN stated all staff providing any direct care activities to Resident 2 must wear an isolation gown and gloves. The IPN stated ESP precautions were important because it protected the residents from bacteria or viruses that may cause infections (a condition in which bacteria or viruses that care disease enter the body). The IPN stated all residents on ESP precautions should have signage with a number "6" over the resident's bed and signage indicating "Enhanced Standard Precautions" above the personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses)

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container in the room to ensure staff knew what type of precautions the residents were on and what type of PPE to wear. The IPN stated staff may forget or may not know a resident was on ESP precautions if there was no precaution signage in or around the room which could potentially lead to the spread of infection.

During a review of the facility's undated Policy and Procedure (P&P), titled "Infection Control," the P&P indicated the facility had established and will maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

2. During a review of Resident 46's Admission Record (Face Sheet), the Admission Record indicated Resident 46 was initially admitted to the facility on 4/1/2019 and readmitted to the facility on 6/13/2019 with diagnoses that included but not limited to type 2 diabetes mellitus (condition that results in too much sugar circulating in the blood), stage 4 pressure ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) of sacral region (area at the end of the spine), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).

During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 12/8/2023, the MDS indicated Resident 46 was able to understand and be understood by others. The MDS indicated

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Resident 46's cognition (process of thinking) was intact. The MDS indicated Resident 46 required supervision when rolling left to right on the bed. The MDS indicated Resident 46 had a colostomy (an operation that redirects the colon [large intestine] to a new opening, called a stoma, on the abdomen for the expulsion of stool). The MDS indicated Resident 46 had a Stage IV (4) pressure ulcer (injury to skin and underlying tissue due to prolonged pressure) that was present upon admission.

During a review of Resident 46's History and Physical (H&P), dated 9/10/2023, the H&P indicated Resident 46 had the capacity to understand and make decisions.

During a review of Resident 46's Order Summary Report, dated 1/9/2024, the Order Summary Report indicated the following daily wound care orders:

a. Left posterior (back side) thigh excoriation (skin damage from injury such as scratching or picking at the skin), cleanse with normal saline (NS, solution made of salt and water to cleanse wounds), pat dry, apply Calazime cream (a skin protectant), and cover with bordered gauze.

b. Right posterior thigh excoriation, cleanse with NS, pat dry, apply Calazime cream, and cover with bordered gauze.

c. Stage IV sacrococcyx (at the area of the tailbone) pressure injury, cleanse with NS, pat dry, apply collagen powder (contains essential building blocks of the skin that assists with wound healing), and cover with bordered foam dressing.

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d. Colostomy site, cleanse with NS, pat dry, apply colostomy bag (bag that covers the stoma to collect stool).

During an observation on 1/9/2024 at 9:02 a.m., with the TN, in Resident 46's room, the TN explained that she would be doing Resident 46's wound treatment. Resident 46 stated she did not have any pain and consented for the TN to continue with the wound treatment. The TN prepared her supplies, performed hand hygiene, and applied new gloves. The TN removed the dressing on Resident 46's left thigh, removed her gloves, and applied new gloves. The TN cleansed the area of the left thigh with NS, patted dry, removed her gloves, and applied new gloves. The TN applied Calazime cream, covered with bordered gauze, removed her gloves, and applied new gloves. The TN removed the dressing on Resident 46's right thigh, removed her gloves, applied new gloves. The TN cleansed the area of the right thigh with NS, patted dry, removed her gloves, and applied new gloves. The TN applied Calazime cream, covered with bordered gauze, removed her gloves, and applied new gloves. The TN removed the dressing on Resident 46's sacrococcyx area, removed her gloves, and applied new gloves. The TN cleansed the area with NS, patted dry, removed her gloves, and applied new gloves. The TN applied collagen powder to the area, removed her gloves, and applied new gloves. The TN covered the area with the padded dressing, removed her gloves, and stated, "I was supposed to wash my hands." The TN walked to the sink to perform hand hygiene.

During an interview on 1/9/2024 at 9:24 a.m., with the TN, the TN stated she was supposed to

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perform hand hygiene throughout the wound treatment any time she removed her gloves, removed an old dressing, and moved to a new wound area. The TN stated hand hygiene was done to prevent contamination of other wounds and prevent infection.

During an interview on 1/11/2024 at 10:39 a.m., with the Director of Nursing (DON), the DON stated hand hygiene was "the number one way to control the spread of infection". The DON stated throughout a wound treatment, the nurse had to perform hand hygiene after removing a dirty dressing, after providing the treatment, before proceeding to the next wound site, and after the conclusion of the treatment. The DON stated there was a potential for cross contamination and infection if hand hygiene was not performed during a wound treatment.

During a review of the facility's policy and procedure (P&P) titled, "Hand Washing", undated, the P&P indicated, "Hand washing must also be performed as follows ... in between performance of routine procedures (i.e. [that is] handling urinals, bedpans, catheters, changing dressings, collecting specimens, etc. [et cetera, and other similar things]."

During a review of the facility's P&P titled, "Infection Control", undated, the P&P indicated, "Some situations that require hand hygiene, include ... before and after changing a dressing."

3. During a review of Resident 10's Admission Record (Face Sheet), the Admission Record indicated Resident 10 was initially admitted to the facility on 9/26/2017 and was readmitted to the facility on 7/11/2022, with diagnoses included but

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not limited to type 2 diabetes mellitus dementia (a condition characterized by progressive or persistent loss of intellectual functioning), and metabolic encephalopathy (problem in the brain caused by chemical imbalances in the blood).

During a review of Resident 10's MDS, dated 10/19/2023, the MDS indicated Resident 10 was able to sometimes understand and sometimes be understood by others. The MDS indicated Resident 10's cognition severely impaired. The MDS indicated Resident 10 was dependent in eating. The MDS indicated Resident 10 had a feeding tube (a flexible plastic tube placed into the stomach to assist in nutrition). The MDS indicated Resident 10 was on a mechanically altered diet (required change in texture in food or liquids due to difficulty chewing or swallowing).

During a review of Resident 10's H&P, dated 3/13/2023, the H&P indicated Resident 10 did not have the capacity to understand and make decisions.

During a review of Resident 10's Order Summary Report, dated 1/7/2024, the Order Summary Report indicated to administer Jevity 1.5 (type of enteral feeding [a special liquid food mixture containing protein, carbohydrates, fats, vitamins, and minerals]) at 45 milliliters per hour (mL/hr, a unit of measurement) for 12 hours. The Order Summary Report indicated for continuous water flush through the enteral tube with 35 mL/hr for 20 hours.

During an observation on 1/8/2024 at 9:15 a.m., in Resident 10's room, Resident 10's enteral hydration administration bag was dated 1/4/2024.

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During an interview on 1/10/2024 at 2:53 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the enteral hydration administration kit was supposed to be changed every 24 hours. LVN 5 stated the hydration tubing was connected to the resident and if the administration kit was hung for over 24 hours, bacteria could grow inside and be transmitted to the resident. LVN 5 stated if the hydration administration kit was dated 1/4/2024, it was hung for four days, which could mean the nurses were opening the bag and refilling the water instead of changing it. LVN 5 stated that was an issue because there would be a higher chance of contamination every time the administration kit would be opened to the air.

During an interview on 1/10/2024 at 2:47 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated the enteral hydration administration kit was supposed to be changed every 24 hours to prevent infection in the resident. The IPN stated after the administration kit was initially opened and the water poured in, once the water was depleted, the whole system had to be changed. The IPN stated using the same administration kit for four days was an issue because that meant the system was opened multiple times and was exposed to the environment. The IPN stated the potential for contamination increased every time the kit was opened and every day it was not changed.

During an interview on 1/11/2024 at 10:45 a.m., with the DON, the DON stated the administration kit was supposed to be changed every 24 hours. The DON stated the administration kit should not have been hung for four days because the whole kit should have been changed when it was empty or when the 24 hours has elapsed, whichever

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F 880	Continued From page 147 came first. The DON stated cross contamination could have occurred, which had the potential to make the resident sick. During a review of the manufacturer's guideline for the "AMSINO AMSure Enteral Administration Kit", the guideline indicated "Discard administration set and transition connector when delivery is complete within a maximum of 24 hours ... Do not re-use."	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain and calibrate (process that ensures the reading and functionality of a device is accurate and in full working order) the ultrasound/electrotherapy modality machine (medical device that includes both ultrasound, a method to produce high-frequency sound waves that can travel deep into tissue and create therapeutic heat and electrotherapy, a method that sends electrical pulses through the skin) for resident use in the rehabilitation department. This deficient practice had the potential to cause injury to any resident who used this equipment as part of their therapy treatment. Findings: During a concurrent observation and interview on	F 908	F - 908 I. Corrective Action/s: a. On 01/26/24 the electrical equipment Dynatron Solaris 700 series ultrasound/ electrotherapy machine was calibrated by MKH Electronics. b. On 01/26/24 Administrator provided a 1:1 in-service with DOR regarding " Rehabilitation Service Safety" policy and procedure, emphasizing the importance of ensuring electrical equipment utilized for resident needs be calibrated annually. c. From 01/29/24 DOR provided in- service to all rehab staff regarding "Rehabilitation Service Safety" policy and procedure, emphasizing the importance of ensuring electrical equipment utilized for resident needs be calibrated annually.	02/04/24

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F 908	Continued From page 148 1/10/2024 at 1:41 p.m., in the rehab gym, the Director of Rehabilitation (DOR) stated the rehab department had one electrical modality machine that provided both ultrasound and electrotherapy treatment. A sticker on the ultrasound/electrotherapy machine indicated the device was last inspected in 6/2022 and was due for reinspection in 6/2023. The DOR stated the ultrasound/electrotherapy machine was supposed to be calibrated yearly and was overdue. During a concurrent observation and interview on 1/11/2024 at 11:00 a.m., in the rehab gym, the Maintenance Director (MD) examined the ultrasound/electrotherapy machine and confirmed the device was due for inspection and calibration on 6/2023. The MD stated the ultrasound/electrotherapy machine should have been calibrated yearly and was overdue. The DOR stated an outside company calibrated the machine and was not sure why it was not done timely. The MD stated it was important the device was maintained and calibrated according to manufacturer's guidelines and recommendations to ensure the device worked properly and did not cause harm to the residents. During a follow up interview on 1/11/2024 at 11:20 a.m., the DOR stated the purpose of calibrating and maintaining equipment routinely and according to manufacturer's recommendations was to ensure the device was safe for resident use and working properly. During a review of the manufacturer's user's manual (revised 9/2008) for the Dynatron Solaris 700 Series ultrasound/electrotherapy machine, the user's manual indicated the calibration process must be performed by a qualified	F 908	II. How to Identify Other Residents: a. On 01/30/24 All electronic equipment in the rehabilitation room was reviewed to ensure annual calibration has been completed timely. No additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. DOR to conduct monthly review on all electronic equipment in the rehabilitation room is calibrated annually and has been completed timely. IV. Monitoring: - DOR to conduct monthly review on all electronic equipment in the rehabilitation room is calibrated annually and has been completed timely x 2 months. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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	055170	A. BUILDING _____ B. WING _____	01/11/2024

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F 908	Continued From page 149 technician using the proper equipment with recommended calibration every six to twelve months. The user's manual further indicated the soundheads (part of the machine that converts energy from one for to another) of the ultrasound device must be calibrated with the device every six months to a year to ensure proper operation and accuracy of the device. During a review of the facility's undated policy and procedure (P&P) titled, "Rehabilitation Services," the P&P indicated equipment would be safe and adequate for resident needs and electrical equipment would be calibrated annually.	F 908		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a call light that was maintained in proper working condition and without a frayed cord with inner wires exposed for one out of 24 sampled residents (Resident 69). This deficient practice resulted in Resident 69 using an unsafe call light and the potential to not have needs met. Findings: During a review of Resident 69's Admission Record, the admission record indicated Resident 69 was originally admitted to the facility on	F 921	F - 921 I. Corrective Action/s: a. On 01/11/24 the call light for resident 69 was immediately changed by maintenance staff. b. On 01/29/24 Administrator conducted 1: 1 in-service with maintenance supervisor regarding “Resident and Medical equipment check” policies and procedures emphasizing the importance of maintaining a call light with proper working condition. c. From 01/26/24- 01/29/24 Maintenance supervisor provided in- service to all staff regarding “Resident and Medical equipment check” policies and procedures emphasizing the importance of maintaining a call light with proper working condition and reporting any damaged call lights to maintenance staff for immediate repair.	02/04/24

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F 921	Continued From page 150 6/26/2023 with diagnoses including chronic kidney disease (CKD, gradual loss of kidney function) and benign prostatic hyperplasia (BPH, enlarged prostate gland). During a review of Resident 69's History and Physical (H&P) dated 6/28/2023, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/3/2023, the MDS indicated Resident 69's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 69 required supervision for activities of daily living (ADLs, daily self-care activities such as grooming, personal hygiene, dressing, and toileting). During an interview on 1/8/2024 at 11:18 a.m., in Resident 69's room, Resident 69 stated his call light cord was frayed and he was afraid to use it because he thought it would catch on fire. Resident 69 stated it was not safe to have him use the call light because the inner cables were exposed. Resident 69 stated had notified staff about the frayed cord and staff told him it was ok because the call light still worked. Resident 69 stated staff did not want to help him because they said the call light still worked but the call light sometimes did not work. Resident 69 stated he wanted the call light replaced because it was unsafe and because the call light did not work all the time. During an observation on 1/9/2024 at 9:06 a.m. in Resident 69's room, Resident 69's call light cord	F 921	II. How to Identify Other Residents: a. On 01/24/24 Maintenance Supervisor conducted facility rounds to ensure all call lights are in proper working condition, no additional discrepancies were identified with the same deficient practice. III. Systemic Changes: a. Maintenance Supervisor will facility rounds to ensure all call lights are in proper working condition weekly x 2 months. IV. Monitoring: - Maintenance Supervisor will facility rounds to ensure all call lights are in proper working condition weekly x 2 months, then monthly thereafter. - Administrator will conduct monthly reviews of findings. Any deficient practices identified will be discussed during the monthly CQI/ QA meeting for further recommendation.	02/04/24

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F 921	Continued From page 151	F 921		

was observed frayed and attached to the resident's bed.

During an observation on 1/10/2024 at 2:32 p.m. in Resident 69's room, Resident 69's call light cord was observed frayed and attached to the resident's bed.

During an interview on 1/11/2023 at 10:14 a.m. with the Maintenance Supervisor (MS), the MS stated he did resident room rounds every day. The MS stated he checked residents call lights every day because that was part of his job. The MS stated that he was not aware that Resident 69's call light cord was frayed. The MS stated nurses report items to be repaired in the maintenance logbook and he did not see that Resident 69's call light needed to be replaced. The MS stated it was important to have all residents with a call light in a good condition.

During a concurrent observation and interview on 1/11/2024 at 11:38 a.m. with the MS and Resident 69, in Resident 69's room, Resident 69's call light cord was frayed. The MS stated he had checked on Resident 69's call light every day that week and did not see the frayed cord and he had checked that the call light worked. Resident 69 stated the call light did not work all the time and there were times where it did not work. The MS stated he did not know it was not working.

During a review of the facility's policy and procedure (P&P) titled, "Resident and Medical equipment Check", undated, the P&P indicated the purpose of the policy was to have staff make routine resident and environment checks to help maintain resident safety and well-being. The P&P indicated the maintenance department will check

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F 921	Continued From page 152 medical equipment such as call lights.	F 921		