STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015166	A. Building B. Wing	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dadeville Healthcare Center	351 North East Street Dadeville, AL 36853

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dignity in toileting for one of 23 sampled residents (Resident Identifier (RI) #8). The facility staff failed to provide RI #8 with interventions, such as assisting to the bathroom, a bedside commode, or bed pan, to remain continent but instead provided adult briefs for bowel and bladder function. Findings include: Review of the admission Record located in the paper medical chart revealed RI #8 was originally admitted to the facility on [DATE]. RI #8 was discharged back to the assisted living and was readmitted to the facility on [DATE] and on 10/16/20 after receiving care at the hospital for fractures. On 04/19/21 at 3:16 PM, RI #8 was observed lying in bed. This surveyor interviewed RI #8 who stated he/she wore a diaper, so he/she didn't have to get up to go to the bathroom. RI #8 stated, he/she had been continent, and it was awful being incontinent and having to wear an adult incontinence brief, but he/she was used to wearing the brief. RI #8 stated he/she knew when he/she needed to urinate and have a bowel movement. RI #8 stated once he/she voided, he/she activated the call button so staff could come and remove the soiled brief. When asked if staff could take him/her to the toilet since he/she knew when he/she needed to urinate and/ or have a bowel movement, RI #8 indicated a lift was now needed for transferring him/her and he/she had pain in his/her affected leg (that had been fractured). RI #8 stated, I put the call light on after I have voided. Then they come and change me. During a subsequent interview on 04/22/21 at 10:23 AM, RI #8 again stated he/she now had a diaper but would prefer to go to the bathroom and was previously continent. RI #8 stated he/she had a bedside commode chair when he/she was receiving rehab but had not seen it since his/her room changed after rehab was finished. RI #8 stated, There is not a bathroom in this room. There were bathrooms located across and down the hall from RI #8's room. RI #8 stated staff had not offered to take him/her to one of the bathrooms in the hallway. Review of the Nursing Assessment, dated 10/16/20 and located in the paper medical record, revealed RI #8 had a current diagnosis of Fall, femur (thigh bone) fracture, pain left femur. RI #8 was admitted from the hospital with an immobilizer on the left leg due to the fracture. RI #8 was non-weight bearing, bedfast, and chair fast. RI #8 was assessed as being continent of both bowel and bladder. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/20 revealed RI #8 had a Brief Interview for Mental Status Score (BIMS) of 15 out of 15, indicating the resident was cognitively intact. RI #8 was admitted with fractures and other trauma. RI #8 required (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extensive assistance from one person for bed mobility and dressing. RI #8 was assessed as totally dependent on one staff for toileting. Continued review of this admission MDS revealed the nursing staff assessed RI #8 as always incontinent of urine and always incontinent of bowel. A bowel and bladder toileting program had not been attempted. Review of the Care Plan, dated 10/29/20 and located in the paper medical record under care plan tab, identified the problem of, Incontinent of B & B (bowel and bladder). The goal was for the resident to have no skin breakdown. Approaches were: Provide brief as needed, Report signs and symptoms of UTI [urinary tract infection] . Report s/s (signs and symptoms) of skin breakdown . Provide incontinent care q (every) 2 hrs (hours) and PRN (as needed). No interventions were initiated to assist RI #8 to void in the toilet only to void both bowel and bladder in an adult brief. Review of the undated Total Plan of Patient Care (Certified Nursing Assistant (CNA) care plan) located in a binder at the nurses' station, indicated RI #8 was incontinent of bowel and bladder. Interventions such as checking and changing the resident's incontinence brief, going to the bathroom, use of a bed pan, or a toileting plan were not checked as being pertinent. The Total Plan of Patient Care did not direct staff what to do to address bowel and bladder function. During an interview on 04/20/21 at 1:34 PM, EI #19, CNA, stated RI #8 required a mechanical lift for transferring. EI #19 stated RI #8 was continent but wore a brief. EI #19 stated RI #8 used the call light if he/she was wet [urinated in the adult brief]. Otherwise, EI #19 checked and changed RI #8 (the adult brief) every two hours. During an interview on 04/22/21 at 11:14 AM, EI #8, a Licensed Practical Nurse (LPN), stated RI #8 turned on the call light after he/she voided in the brief, adding the resident knew when he/she was wet. EI #8 stated RI #8 could use a bed pan or be toileted but a lift would have to be used because the resident was non-weight bearing due to a fracture. EI #8 stated, I think at times (he/she) may know when he/she needs to go. EI #8 stated the Rehab Nurse would be the individual to put a resident on a toileting plan. EI #8 stated the nurses could make a referral for an evaluation of incontinence if a new problem was brought to their attention. EI #8 showed the surveyor where on the CNA care plan that indicated the resident was incontinent . Review of the Nursing Assessment, dated 10/16/20 and located in the paper medical record, revealed RI #8 was assessed as being continent of both bowel and bladder. During an interview on 04/21/21 at 1:31 PM, EI #4, the Rehab Registered Nurse (RN), stated the baseline assessment of continence/incontinence (three-day voiding record) was not completed when residents were admitted to the facility. EI #4 stated residents were asked if they were continent or there might be information coming from the hospital and that was the data nurses used when they completed the initial Nursing Assessment (Nursing Assessment, dated 10/16/20 and located in the paper medical record, revealed RI #8 was assessed as being continent of both bowel and bladder). EI #4 stated when the MDS was completed (about a week after the Nursing Assessment) the CNAs and nurses were asked if the resident was continent or not. EI #4 verified there was no evidence the resident had been assessed to determine the causes of incontinence or type of incontinence. During an interview on 04/21/21 at 3:00 PM, EI #6, the MDS Coordinator RN, stated she reviewed the Nursing Assessments and MDS Assessments for continence of bowel and bladder. She stated when the resident was first admitted the resident was assisted to the bathroom with a walker. She stated she thought the initial Nursing Assessment showing the resident was primarily continent was accurate. She stated upon the second admission, the resident had hip surgery and was using the bed pan. She stated (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in October 2020, the resident had another fall with femur fracture and became non-weight bearing and became more incontinent. EI #6 stated the CNA documentation did not indicate if a resident was continent or not and that this information was obtained from staff interviews. EI #6 verified voiding patterns were not determined and the resident was not assessed for a toileting program or for incontinence. During an interview on 04/22/21 at 12:29 PM, EI #2, the Director of Nursing (DON) stated the facility got report from the hospital on newly admitted residents and that was the information documented on the Nursing Assessment. EI #2 verified on the resident's first admission a bedside commode had been used but not on the second admission.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on record review and interview, the facility failed to provide written notice of a transfer for one of one resident (Resident Identifier (RI) #31) reviewed for hospital transfers to the resident and the resident representative when the resident was transferred to the hospital; and failed to notify the State office of the Ombudsman of resident transfers. Findings include: Review of RI #31's Face Sheet, dated 02/05/21, located in RI #31's paper medical record, showed a facility admission date of 10/26/20 and a re-admission date of 02/05/21. Review of RI #31's nursing Progress Notes, dated 01/31/21 at 11:45 AM, located in RI #31's paper record under the nurses notes tab, revealed Res [resident] still has had no results from Lactulose on 01/29/21 or MOM [Milk of Magnesia] + senna syrup on 01/30/21 . PC [placed call] to . CRNP [Certified Registered Nurse Practitioner], order received . to send to (local hospital) ER (Emergency Room) for eval [evaluation] of positive ABD [abdominal] x-ray for ileus. Review of RI #31's nursing Progress Notes, dated 01/31/21 at 12:35 PM, located in RI #31's paper record under the nurses notes tab, revealed PC to sponsor . to inform res being sent to (local hospital) ER for eval. In response to a request for the written notice of transfer, the facility did not provide any documented evidence that RI #31, his/her sponsor, or the state Ombudsman were provided written notice of the transfer. Review of the paper chart did not show any documentation RI #31, his/her sponsor, or the state Ombudsman had been provided written notice of transfer. During an interview on 04/22/21 at 12:50 PM, Employee Identifier (EI) #1, the Director of Nursing (DON), stated, the facility calls the family to notify them of the transfer but does not notify the Ombudsman of the transfer. The facility only provides verbal notification and does not provide written notification to families, residents, or the Ombudsman. During an interview on 04/22/21 at 1:05 PM, EI #16, Social Services (SS), stated, the facility calls the family to notify them of the transfer but does not notify the Ombudsman of the transfer. The facility only provides verbal notification and does not provide written notification to families, residents, or the Ombudsman. During a phone interview on 04/22/21 at 3:05 PM, the State Ombudsman (SO), stated there are no records of resident transfers on file from the facility. The facility should be reporting the transfers, but we have not received any reports. During an interview on 04/22/21 at 3:15 PM, EI #1, the DON stated, the facility does not have any policy that addresses providing written notification of transfers/discharges to the resident, their sponsor, or the State Ombudsman.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to provide services to three of eight residents (Resident Identifier (RI) #67, #11, and #73) reviewed for limitations in range of motion (ROM) in a total sample of 23. The facility failed to assess residents with ROM impairments and provide services to maintain function or prevent declines. In addition, the facility failed to implement established restorative programs for residents with programs in place. Findings include: A policy for the Functional Maintenance Plan (FMP)/Restorative Nursing was requested. The Rehab Nurse, Employee Identifier (EI) #4, brought a policy to the surveyor dated 04/21/21. EI #4 stated she just wrote the policy; there was no policy previously. Review of the policy revealed therapy staff would give the FMP to the restorative nurse who would initiate the plan as recommended on the FMP. The policy read, After approx (approximately) 2 weeks the nurse will forward the FMP to the therapy department staff member, who will give the FMP to the restorative nurse who will obtain and included (sic) in the activities of daily living (ADLs). The restorative nurse will follow resident's progress. The therapy department on discharge of the resident provides functional maintenance plans as determined by therapist and resident's progress. If the FMP cannot be carried out due to decline in the resident, the restorative nurse will discuss this with the appropriate therapy staff member and proceed accordingly with new goals and interventions. 1. Review of RI #67's paper medical record Face Sheet revealed RI #67 was originally admitted to the facility on [DATE]; the most recent readmission was on 01/28/21 from the hospital. Review of the paper medical record Physician Orders for April 2021 revealed the RI #67's diagnoses included cerebral infarction (stroke), spastic hemiplegia, and other specified paralytic syndromes. During the initial tour of the facility on 04/19/21 at 10:22 AM, RI #67 was sitting in a chair in his/her room. RI #67 stated he/she was no longer able to walk, although he/she had been having therapy previously. RI #67 stated he/she was not currently receiving any therapy or an exercise program to help improve function and/or to try to get to walk. RI #67 stated he/she had left sided limitations to the hand and leg. RI #67's left hand was observed curled into a fist. RI #67 stated the facility staff knew he/she desired to have therapy or an exercise program (restorative). Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/21, revealed RI #67's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. RI #67 required extensive staff assistance with activities of daily living (ADLs) such as bed mobility, transfers, and dressing. RI #67 had not walked during the assessment period. RI #67 was not steady and could only stabilize with staff assistance for moving from a seated to standing position, moving on and off the toilet and surface to surface transfer (between bed and hair or wheelchair). RI #67 had ROM limitations on one side to both her upper and lower extremities (arms, hands, legs, feet). Review of the Care Plan, dated 04/06/21 and located in the paper medical record under the care plan tab, revealed RI #67's requirement for extensive assistance with ADLs. The goal was for the resident's needs to be met. The Care Plan did not include provision of therapy or restorative services to assist the resident to maintain or improve ROM limitations to the left side. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Physician Progress Note, dated 04/16/21 and located in the paper medical record, revealed RI #67 was alert and oriented, with medical problems including CVA with left sided hemiparesis, severe spastic left hemiplegia (paralysis), and Todd's paralysis. Staff were to continue with the current plan of care. Review of physician progress notes, dated 01/19/21 through 04/16/21, revealed no documentation concerning RI#67's left hand contracture (permanent shortening and fixation of joints) or services/devices to address the limitations in ROM. Observations during the survey included: On 04/19/21 11:37 AM, RI #67 was observed wheeling him/herself slowly in the wheelchair using his/her right hand and foot and minimal movement with the left leg/foot. On 04/19/21 at 4:49 PM the resident wheeled him/herself back to the room slowly from an outdoor courtyard. On 04/20/21 at 01:57 PM the resident wheeled him/herself out of the dining room where an ice cream activity had taken place. The resident used his/her right foot and hand primarily to wheel slowly down the hall. During a second interview on 04/22/21 at 10:42 AM, RI #67 showed the surveyor his/her left hand. RI #67's fingers were curled with the fingertips nearly touching the palm. RI #67 stated he/she could not use the left hand and he/she could not straighten his/her fingers. RI #67 stated he/she did not have a splint or any other device for the contracted hand. RI #67 stated he/she could not remember being evaluated for one. RI #67 stated he/she felt he/she had declined. RI #67 stated, I cannot use my [left] leg at all. RI #67 stated he/she needed some exercises or something so she could improve. During an interview on 04/20/21 at 1:41 PM, EI #19, Certified Nursing Assistant (CNA), stated RI #67 needed staff assistance for ADLs. EI #19 stated RI #67 had a stroke and did not have use of one of his/her hands. EI #19 stated RI #67 could use the toilet, could stand, and could feed self with staff assistance, but the resident could not walk. EI #19 stated she was not aware of RI #67 receiving any restorative nursing services. During an interview on 04/22/21 at 10:34 AM, EI #18, CNA, stated RI #67 needed help with everything. EI #18 stated RI #67 could not move his/her left leg much, the resident could only toss it a little bit. EI #18 stated RI #67 could not use the affected arm at all. During an interview on 04/20/21 at 2:10 PM, EI # 12, Licensed Practical Nurse (LPN) stated RI #67 had left sided paralysis and needed help with dressing, transfers, and the resident could not walk. EI #12 stated RI #67 told staff he/she wanted to go home all the time and wanted to exercise to get stronger physically. EI # 12 stated RI #67 rolled his/her wheelchair using one arm and one leg (non-affected side). EI #12 stated RI # 67 had not received restorative services. During an interview on 04/22/21 at 10:52 AM, EI #8, LPN, stated RI #67 exhibited difficulty with transfers recently. EI #8 stated the resident could stand before getting COVID (coronavirus) but now some days RI #67 needed maximum assistance from staff. EI #8 stated she was not sure if RI #67 had ever worn a splint or other device in his/her contracted hand. EI #8 stated the nurses could inform the physician of limitations in ROM and obtain an order for a restorative program or for physical therapy. EI #8 stated RI #67 had expressed a desire to walk. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/21/21 at 10:14 AM, EI #20, Physical Therapy Assistant (PTA), stated RI #67 had not received therapy services. EI #20 stated therapy had not been recommended or come to their attention there was a need. EI #20 stated she assisted with developing specific restorative programs for residents and passed the information along to nursing staff at the start of a new program. During an an interview on 04/21/21 at 12:26 PM, EI #21, Occupational Therapist (OT), stated staff had not talked to him about RI #67. EI #21 stated, We [therapy] have never talked to her [R#67]. EI #21 stated therapy could do an evaluation of a resident and provide therapy services with a physician's order. EI #21 stated the therapists could refer residents for restorative nursing without the resident receiving treatment from physical or occupational therapy. During an interview on 04/21/21 at 11:02 AM, EI #4, the Rehabilitation Registered Nurse (RN), stated she oversaw the restorative nursing program. EI #4 stated she was not aware of RI #67's desire for therapy/exercise program. EI #4 verified that R#I #67 had not been referred for therapy since readmission on [DATE] and did not have a restorative program. During an interview on 04/22/21 12:23 PM, EI #1, the Director of Nursing (DON), stated the Rehab Nurse could make some suggestions for a restorative program. EI #1 stated if a resident had a contracture, it should be addressed on the care plan. 2. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/21, revealed RI #73 had diagnoses which included a fracture of the left ankle and hemiplegia (paralysis on one side of the body). In addition, the assessment indicated RI #73 was cognitively intact for daily decision-making skills and required extensive assistance from one staff person for transfers and ambulation. During an initial resident observation and interview on 04/19/21 at 11:03 AM, RI #73 was observed to be seated in a wheelchair in his/her room. The resident's left arm/hand was resting in his/her lap with the two middle fingers observed to be contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints.). No splint or brace was observed on the hand. During the interview on 04/19/21 at 11:03 AM, RI #73 was asked if he/she had a brace or splint for his/her hand. RI #73 stated yes, he/she had one in 2010 when he/she was at home, however had not used the splint since admission to the facility in 2018. RI #73 was asked if he/she received any restorative therapy (a form of physical therapy designed to restore or maintain function) while at the facility. RI #73 stated he/she had physical therapy for his/her ankle, upon admission, but when he/she was discharged from therapy, nursing was to walk with him/her. RI #73 further stated that someone would walk with him/her on occasion. RI #73 answered, yes when asked if he/she felt that his/her ability to use his/her arm or walk had declined. A review of RI #73's current care plan, with an admit date of 05/11/18, did not show specific interventions, exercises and/or restorative therapy, to maintain or improve the resident's range of motion [ROM]. During an interview on 04/21/21 at 10:50 AM, EI # 4, Rehab Nurse, was asked about the process when a resident was discharged from physical therapy and started their maintenance program. EI #4 stated that once therapy was completed, the therapist would set up a plan, called an FMP. EI# 4 stated that she would go through the plan within the first two weeks, put the exercises on the Activities of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#4 was asked if she was aware of RI #11's contracted left hand and if there was a splint or brace for the resident. EI #4 stated she was not aware of any contracture or splint. A review of the CNA documentation book did not show interventions or exercises to maintain or improve RI #11's range of motion ability, however, did show documentation that RI #11 had left arm paralysis. In an interview on 04/21/21 at 12:23 PM, EI #20, Physical Therapy Assistant (PTA), stated that she had wanted staff to continue walking with RI #11 as she did not want the resident to lose the ability but was aware that it happened only on an as needed basis. EI #20 was asked if she was aware the resident had stated he/she had a brace for his/her hand. She stated she was aware that RI #11 had a brace, and had repeatedly asked family to bring it in, but they had not done so yet.

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Dadeville Healthcare Center	351 North East Street Dadeville, AL 36853

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an effective system to identify safety risks related to side rails for one of one resident (Resident Identifier (RI) #11) reviewed for side rails. The facility failed to ensure the correct assessed side rail was utilized to prevent potential accidents hazards. Findings include: Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/21, Resident Identifier (RI) #11 was admitted to the facility on [DATE] with diagnoses which included seizures and a fracture of the left leg. This MDS showed RI #11 was cognitively intact for daily decision-making skills and required extensive assistance with bed mobility and transfers. Review of the Care Plans, located in the paper medical chart under the care plan tab, revealed a Risk for Falls care plan, dated 01/21/21, with an approach for side rails up x 2 for turning and repositioning. Review of the Physicians Orders, dated 01/21/21 and located in the paper medical chart under the orders tab, revealed an order for Siderails up x 2 for turning and repositioning. Review of an Evaluation for the use of Bed Rails, dated 01/22/21 and located in the paper medical record, revealed the diagnosis related to bed rail use was CVA (Cerebral Vascular Accident .stroke). The assessment showed the bed rails were to be used for turning and repositioning purposes, due to the resident's balance deficit. The evaluation determined the resident would have ½ side rails on the upper portion of the bed, both sides and that they were recommended to be up at all times when the resident was in bed. In an initial observation/interview with RI #11 on 04/20/21 at 9:22 AM, one full-length padded side rail was observed on the left side of the bed next to the wall. The right full-length padded side rail was observed in the down position. RI #11 was asked if he/she could get him/herself out of bed when the side rail was up. RI #11 stated when he/she wanted to get out of bed, he/she would slide to the bottom of the bed and squeeze him/herself out at the opening between the bed and the side rail. RI #11 confirmed that he/she had not fallen due to the side rails being up. When asked if he/she needed to have padded side rails, RI #11 stated, no. In an observation on 04/21/21 at 2:37 PM, RI #11 was observed in bed with his/her eyes closed and the room lights off. The right-sided full-length padded side rail was in the down position. During an interview on 04/21/21 at 12:29 PM, Employee Identifier (EI) #20, Physical Therapy Assistant (PTA), was asked if therapy was involved in the assessment, for the use of side rails, for RI #11. She stated that therapy could be involved, but not necessarily was. EI #20 further stated that she had told RI #11 multiple times, while the resident was on the rehab unit, not to get up by him/herself without help, but was not aware that the resident was trying to get up without staff assistance. During an interview on 04/21/21 at 3:13 PM, EI #4, Rehab Nurse, was asked how she came to the conclusion that RI #11 needed full-length padded side rails. EI #4 stated that RI #11 had only ½ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side rails used for positioning and turning. EI #4 was told that during observations RI #11 had full-length, bilateral, padded side rails. EI #4 stated that RI #11 did not need full-length padded side rails. On 04/22/21 at 2:00 PM, the Director of Nursing was asked for a facility policy regarding side rail assessments and safety. She stated there was no facility policy on side rails however, she presented the survey team with a facility In-Service on Side Rail and Bed Safety, dated September 25, 2017. The in-service did not address identification, evaluation, and implementation of the correct side rail usage, monitoring of side rail effectiveness, or the need for modifications of the intervention, if necessary.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one out of five residents reviewed for unnecessary medications (Resident Identifier (RI)# 47) had a medication regimen free of unnecessary medications. The resident was prescribed as needed (PRN) antipsychotic medication without a stop order and without a physician re-evaluation after 14 days. Findings include: Review of the facility's Anti-Psychotic Drugs policy (undated) revealed antipsychotic medication would be used only when it was necessary to treat a specific condition. The only guidance regarding PRN antipsychotic medications was, PRN anti-psychotic drugs should not be used more than five (5) times in any seven (7) day period without a review of the resident's condition by a physician. The requirement for a PRN antipsychotic prescription of no more than 14 days and the requirement for Physician reassessment was not included in the policy. Review of the admission Face Sheet, dated 01/29/21 and located in the paper medical record, RI #47 was admitted to the facility on [DATE] with diagnoses that included in pertinent part insomnia, cerebrovascular accident (stroke), and dementia without behavioral disturbance Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/20 revealed RI #47 was admitted to the facility from home. The MDS indicated RI #47 did not have a serious mental illness; however, was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. This MDS revealed that RI #47 did not exhibit any mood or behaviors during the look back period. Review of this MDS revealed RI #47 had not taken any antipsychotic medication during the seven-day lookback period. Review of the quarterly MDS with an ARD of 03/07/21 revealed RI #47 had the following mood indicators: little interest or pleasure in doing things, feeling down or depressed or hopeless, trouble falling or staying asleep or sleeping too much, poor appetite or overeating, and trouble concentrating on things. RI #47 exhibited no behavioral indicators. Review of this MDS revealed RI #47 took antipsychotic medication three times during the seven-day assessment lookback period. Review of the Care Plan, dated 02/05/21 and located in the paper medical record, revealed RI #47 was wandering up and down the hall in search of his/her son. The goals were for RI #47 to be free of harm or injury to him/herself from wandering and for no elopement to occur. Approaches included in pertinent part explaining to the resident what you were doing, providing reassurance, walking with the resident and conversing with him/her, calling his/her family, offering him/her a baby doll, assessing for comfort, encouraging activities, notifying the physician and administering prescribed medications. Review of Physician's Orders, for April 2021 and located in the paper medical record under the physician's orders tab, revealed an order initiated on 03/01/21 for Haldol .5 mg every four hours, PRN was prescribed related to increased anxiety; in addition, Haldol .5 mg at bedtime (HS) was prescribed on 03/23/21 for anxiety. Haldol is an antipsychotic medication used to treat serious mental illness such as schizophrenia. There was no stop date on the prn Haldol order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Certified Registered Nurse Practitioner Psych Progress Note, dated 03/23/21 and located in the paper medical record under the physician progress notes tab, revealed RI #47 was evaluated for dementia with behavior disturbance. RI #47 had been restless and agitated a few times a week. RI #47 had packed his/her belongings in anticipation of going home. Haldol .5 mg every four hours PRN was prescribed for agitation. The note indicated the resident denied psychiatric admission or treatment. The order indicated staff was to continue PRN Haldol and to use it as a last resort (after nonpharmacological interventions attempted). Review of the Medication Administration Record (MAR) for March 2021 revealed PRN Haldol was administered for agitation on 03/02/21, 03/03/21, 03/04/21 03/05/21, 03/09/21, 03/13/21, and on 03/23/21. Review of the MAR for April 2021 revealed PRN Haldol was administered once for agitation on 4/11/21. Observations during the survey revealed: On 04/19/21 at 10:29 AM and at 10:41 AM the resident was in bed lying on his/her left side with his/her walker next to the bed. The blankets covered the resident's body and his/her eyes were closed. On 4/19/21 at 11:25 AM the resident was sitting on the edge of the bed with the overbed table above his/her lap. RI #47 was feeding him/herself lunch The resident responded pleasantly to the surveyor's introduction and stated the meal was good. On 04/19/21 at 2:29 PM the resident was lying on the right side in bed with blankets covering his/her body and his/her eyes closed. On 04/19/21 at 4:54 PM the resident was up and out of bed. On 04/20/21 at 8:56 AM the resident was lying in bed on the left side with his/her eyes closed. On 04/20/21 11:20 AM the resident was sitting up in bed feeding him/herself; RI #47 stated he/she was doing okay. On 04/20/2l at 1:55 PM the resident was lying in the bed on the left side with his/her eyes closed and blankets covering him/her. On 04/21/21 08:39 AM the resident was lying in bed on the left side, wearing a bathrobe. The resident was partially covered by the blankets with his/her eyes closed. During an interview on 04/20/21 at 1:42 PM, EI #19 Certified Nurse Assistant (CNA), stated RI #47 had removed Wanderguard (alarm system to help protect residents from elopement out specific doors) bracelet by cutting it off with a butter knife. EI #19 stated the resident walked back and forth in the unit and tried to elope by trying to push open the door. EI #19 stated this behavior had decreased and did not occur much anymore. During an interview on 04/22/21 at 10:37 AM, EI #18 CNA, stated RI #47 had moments of agitation; the resident exhibited behaviors of wanting to call his/her kids to take him/her home. During an interview on 04/20/21 at 2:15 PM, EI #12, a Licensed Practical Nurse (LPN), stated RI #47 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was on hospice for a diagnosis of cerebrovascular accident (stroke). EI #12 stated RI #47 had a hard time adjusting and could not understand why his/her family put him/her in the facility. EI #12 stated RI #47 had three sons who tried to keep the resident at home. EI #12 stated RI #47 slept a lot during the day and was up at night with sundowning behavior which made it difficult for them to care for the resident. EI #12 stated within the past month RI #47 had started to settle down, indicating RI #47 used to go to door and try to get out repeatedly. EI #12 stated that the antipsychotic medication had been necessary because the resident became so exhausted from the distress, walking and trying to find a way out, RI #47 needed to rest. EI #12 reviewed the Haldol order in the record and verified there was no stop date for the PRN medication. During an interview on 04/22/21 10:56 AM, EI #8, a LPN, stated that on 03/01/21, RI #47 was prescribed Haldol every four hours, to be administered PRN. EI #8 reviewed the Physician's Order dated 03/01/21 and verified there was no stop date for the medication and the order remained current on 04/22/21, the date of the interview. EI #8 stated she was aware of the requirement for PRN antipsychotic medications to be ordered for no more than 14 days and requirement for physician evaluation and a new order to continue the medication. She stated the resident had been exhibiting exit seeking behaviors and was very tearful at times. The resident called his/her children, stated he/she was in jail and wanted them to come and get him/her. EI #8 reviewed the record and verified that the physician had not been into the facility or reassessed the resident since the most recent visit on 03/23/21 During an interview on 04/22/21 at approximately 9:30 AM, EI #22, the Pharmacist, stated the maximum timeframe for use of PRN antipsychotic medications was 14 days before requiring re-evaluation by the physician before reordering for an additional 14 days. EI #22 stated if he saw an order without a stop date, he wrote a recommendation to the physician to address this. EI #22 stated, for RI #47, the April 2021 drug regimen review had not been completed as of 04/22/21.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to keep medications under safe and secure storage with limited access and under direct observation of authorized staff for one of six medication carts observed. In addition, the facility failed to ensure insulin vials and pens were dated when opened for four of six medication carts observed which affected six of 21 residents identified by the facility as having used insulin. Findings include: 1. Review of an undated facility policy titled, Administration of Medications, revealed .Medication carts shall be kept in sight or locked whenever back is turned or away from the cart .No one shall have access to drugs in the medication carts except the licensed nurses for that specific unit . On 04/19/21 at 12:45 PM, an observation of the medication cart on Hall Two Long-Term Care (LTC) was observed unlocked. The licensed nurse was away from the cart and there was no licensed nurse on the hall. During a continuous observation of the medication cart from 12:45 PM to 1:16 PM, the medication cart remained unlocked. During an observation and interview on 04/19/21 at 1:16 PM, Employee Identifier (EI) #3, Registered Nurse RN, returned to the cart, immediately locked the cart, and proceeded to remove the cart from the hallway. EI #3 was asked if medication carts were to be locked when away from them. EI#3 stated, Yes, it should be locked but I was working and got busy. During an interview on 04/19/21 at 1:37 PM, EI #1, Director of Nursing, confirmed that medication carts should be always locked. 2. Review of a facility policy titled, Vials and Ampules of Injectable Medications, dated August 2018, revealed, .EXPIRATION DATES: Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on multidose vials . Review of the Patient Information guide for Lantus Insulin (a long-acting insulin), revised November 2019, revealed .The LANTUS vials you are using should be thrown away after 28 days, even if it still has insulin left in it . Review of an undated Patient Information guide for Levemir Insulin (long-acting insulin), revealed, .Unrefrigerated LEVEMIR should be discarded 42 days after it is first kept out of the refrigerator, even if the FlexTouch Pen or vial still contains insulin . Review of the Patient Information guide for Humalog Insulin (a short-acting insulin), dated 04/2020, revealed, .Do not use HUMALOG past the expiration date printed on the label or 28 days after you first use it . Review of the undated Patient Information guide for Tresiba Flex Pen Insulin (long-acting insulin), revealed that Tresiba insulin pens IN-USE TIME (expiration date once opened) was six weeks. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Patient Information guide for Humulin R insulin (short-acting insulin), dated November 2019, revealed , .Unopened vials should be thrown away after 31 days if they are stored at room temperature . Observation of the Hall Two Rehab Cart on 04/20/21 at 10:50 AM, revealed Resident Identifier (RI) #282 had an opened, used vial of Lantus insulin which did not contain an open date. EI #3 Registered Nurse (RN), observed the vial and verified there was no date on the vial. During an observation of Hall Three Large Cart on 04/20/21 at 11:00 AM, EI #10, Licensed Practical Nurse (LPN) opened the top drawer of the medication cart which contained individually packaged insulin vials for the residents on the hall. RI #48's vial of Lantus Insulin was observed to be opened and undated. In addition, RI #66's vial of Levemir Insulin was also observed to be open and undated. EI #10 confirmed that insulin vials should be dated when they are opened. During an observation of the Hall One Cart on 04/20/21 at 11:05 AM, with EI #12, LPN, an open, undated vial of Humalog insulin for RI #72 was observed. EI#12 confirmed that insulin should be dated after being opened. During an observation of Hall Two LTC medication cart on 04/20/21 at 11:16 AM with EI#3, the top drawer of the cart contained a Tresiba Insulin Flex Pen for RI #22 which had been used. There was no date on the flex pen to indicate when it was opened. In addition, RI #7 had an opened, undated vial of Humulin R insulin which had been used and undated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure three of three residents (Resident Identifier (RI) #28, RI #50 and RI #282) reviewed for oxygen (O2) therapy in a sample of 23 residents received O2 therapy with equipment that was cleaned and stored in a way to prevent possible contamination. The concentrators had dusty filters and the nasal cannulas were not dated to indicated when the tubing had been changed and the nasal cannulas were not placed in a bag when not in use. This deficient practice had the potential to allow residents to receive therapy with equipment that was not stored properly between uses and increased their risk of infection and/or illness. Findings include: Review of undated maintenance instructions revealed on page 25, under 7.3 Cleaning the Cabinet Filter .1. Remove the filter and clean as needed. Environmental conditions that may require more frequent inspection and cleaning of the filter include but are not limited to high dust, air pollutions, etc. 2. Clean the cabinet filter with a vacuum cleaner or wash with a mild liquid dish detergent .and water. Rinse thoroughly. 3. Thoroughly dry the filter and inspect for fraying, crumbling, tears, and holes. Replace filter if any change is found . Review of the facility policy titled, Oxygen Therapy Policy, revised 10/24/2017, revealed:. 2. Oxygen tubing and humidifier bottles shall be changed weekly, on the 7P-7A shift on Friday . 1. On 04/19/21 at 9:43 AM, an O2 concentrator was observed in the room of RI #50. The concentrator had two filters on each side of the machine. Both filters appeared to have dust and lint on them. The undated nasal cannula was draped across the top of the concentrator. The uncovered nose prongs hung down toward the floor. On 04/21/21 at 8:34 AM, an O2 concentrator was observed in the room of RI #50. The concentrator had two filters on each side of the machine. Both filters appeared to have dust and lint on them. The undated nasal cannula was draped across the top of the concentrator. The uncovered nose prongs hung down toward the floor. Review of RI #50's paper medical record revealed an undated Face Sheet with an original admission date of 08/09/19 and a readmission date of 06/18/20 with diagnoses which included acute respiratory failure with hypoxia (low oxygen levels). Review of RI #50's paper medical record Physician Orders for the month of April 2021 revealed an order, dated 06/18/20, for O2 AT 2LITERS PRN (as needed) SOB (shortness of breath). 2. On 04/19/21 at 8:40 AM, an O2 concentrator was observed in the room of RI #28. The concentrator had two filters on each side of the machine. Both filters appeared to have dust and lint on them. The undated nasal cannula was draped across the top of the concentrator. The uncovered nose prongs hung down toward the floor. On 04/19/21 at 10:00 AM, an O2 concentrator was observed in the room of RI #28. The concentrator had two filters on each side of the machine. Both filters appeared to have dust and lint on them. The undated nasal cannula was draped across the top of the concentrator. The uncovered nose prongs hung down toward the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of RI #28's paper medical record revealed an undated Face Sheet with an original admission date of 12/18/18 and a readmission of 06/15/20 with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of RI #28's paper medical record revealed a physician orders sheet with an order, dated 03/10/21, for O2 at 2L/min PRN for O2 sats [levels] below 92% dx [diagnosis] COPD. 3. On 04/19/21 at 12:01 PM, an O2 concentrator was observed in the room of RI #282. The filter in the back had lint and the filter was torn on the bottom corner. The tubing hung loosely on the concentrator and the prongs were not covered. On 04/19/21 at 4:45 PM, an O2 concentrator was observed in the room of RI #282. The filter in the back had minor lint and the filter was torn on the bottom corner. The tubing hung loosely on the concentrator and the prongs were not covered. During review of RI #282's paper medical record revealed an undated Face Sheet with an admission date of 04/08/21. Review of RI #282's paper medical record under physicians orders for April 2021 revealed an order, dated 04/08/21, for O2 at 2LPM (Liters per minute) via NC (nasal cannula) q (every) shift PRN SOB. During an interview on 04/21/21 at 3:32 PM, Employee Identifier (EI) #5, Registered Nurse (RN), Quality Assurance Nurse and Infection Preventionist (IP), was shown the concentrator in RI #50's room. EI #5 verified there was no date on the tubing. EI #5 stated, The tubing is changed every Friday and should be dated at the time of change. EI #5 also stated, The nasal cannula should be bagged when not in use and not hanging toward the floor. When EI #5 was shown the filters on the concentrator, EI #5 stated, The filters are dusty and should not look like that. The filters should be cleaned by the housekeeping staff routinely. During an interview on 04/22/21 at 8:40 AM, EI #13 Housekeeper (HK) was asked if housekeeping cleaned the concentrators and filters. EI #13 stated, I've never cleaned the filters, but I wipe the concentrators off. I've never been told I need to clean the filters. During an interview on 04/22/21 at 8:45 AM, EI #14 Housekeeping Supervisor (HKS) was asked about cleaning the filters and the concentrators. EI #14 stated, Housekeeping staff have never been told to clean the filters or the concentrators. Housekeeping use to do it about 15 years ago but we were told it was a nursing duty. During an interview on 04/22/21 at 9:50 AM, EI #23, a Licensed Nurse Practitioner (LPN) was asked about nursing cleaning the concentrator filters. EI #23 stated, We have not been told we have to clean them.