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F 000	INITIAL COMMENTS	F 000		
POC OK 7/13/22 SjS	Correction date: 08/05/2022 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints # 97182-C, # 98375-C, # 98822-C, # 100258-C, # 101472-C, # 102364-C, and facility-reported incident # 102590-I conducted May 16, 2022 to May 31, 2022. Complaints # 97182-C and # 98375-C were substantiated. Complaint # 102364-C was substantiated without deficiency. Complaints # 98822-C, # 100258-C, and # 101472-C were unsubstantiated. Facility-reported incident # 102590-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		

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

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possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, staff, resident and family member interviews, and Tenant Rights review, the facility did not ensure a homelike environment by failing to ensure staff provided a clean bed and clean bed linens and to consistently make the bed for 1 of 2 residents reviewed for incontinence (Resident # 65). The facility reported a census of 69 residents.

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F 584	Continued From page 2 Findings include: Resident #65's quarterly minimum data set (MDS) assessment dated 5/5/22 recorded a brief interview for mental status (BIMS) score of 14, indicating that she had intact memory and cognition. The MDS showed that Resident # 5 had frequent urinary incontinence, needed the limited assistance of 1 for dressing and personal hygiene, and the extensive assistance of 1 for toilet use. The MDS also showed Resident # 65's active diagnoses included Alzheimer's disease, Non-Alzheimer's dementia, depression, asthma, and respiratory failure. Resident # 65's care plan initiated on 5/9/22 documented she had a self care deficit as evidenced by requiring assistance with ADLs (activities of daily living), impaired balance during transitions which required assistance and/or walking, and incontinence. The care plan directed staff to assist Resident #65 with dressing, grooming/hygiene, toilet use, and bathing/showering. The care plan also indicated Resident # 65 with impaired cognition, impaired decision making, and an impaired ability to understand others related to dementia and Alzheimer's disease. The care plan goals included the ability to communicate basic needs and maintain dignity. The care plan further directed staff to allow time for task and responses, and to ask questions in order to determine the resident's needs. During observation on 5/16/22 at 12:55 PM, Resident # 65's room door sat open but Resident # 65 was not in the room. The room contained a pile of craft items and yarn on the floor in front of	F 584	F584 The plan for correction on this specific deficiency is as follows: 1.Corrective action for resident #65 was completed of by the Environmental Services Manager and Assistant Director of Nursing on 5/26/2022 by educating environmental and nursing staff to check resident #65 bedding while in the room for cleanliness throughout the day and change bedding immediately if needed. 2.Monitoring Plan as followed: 12 rooms audit on different halls will be monitored weekly by the Environmental Services Manager or designee for 3 months then monthly for 3 months and the findings will be turned into the Administrator or designee for review to ensure bedding is being changed promptly and rooms are cleaned appropriately. 3. A list of all the findings will be compiled monthly and presented to QAPI for review. Recommendation and outcome until QAPI committee reviews. 4. The person responsible for the implementation and compliance of this plan of correction will be the Administrator or designee. This corrective action will be fully implemented by 8/5/2022.	

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her chair. The resident's bed was unmade with rolled linens and clothes on top of bed, and the head of the bed was elevated at about a 45-degree angle.

During observation on 5/17/22 at 12:45 PM, Resident # 65 sat in her recliner chair while knitting. The bed was unmade and the room contained a slight urine odor. Resident # 65 was pleasant in mood and spoke in Spanish. At 12:47 PM, Family Member (FM) arrived to the resident's room, and said she visits Resident # 65 regularly because Resident # 65 spoke Spanish and had difficulty expressing her needs to staff members. With discussion about the unmade bed, the FM said this had always been a concern because when she visits, the bed was always wet and she has to change and make the bed all the time. She also stated the aides have told her they did not know her parent was incontinent. There were times when staff were told to make the bed, they came and used the pad and the top cover, no sheet, they left the rest of the sheets. The FM stated that one time, Resident # 65 reported sleeping on the cold plastic bed cover without a cloth sheet. The FM planned to visit the assistant director of nursing (ADON) on her way out to request them to make Resident # 65's bed.

Observations on 5/18/22, showed the following:
a. At 8:28 AM, Resident # 65 was not in room. Resident # 65's bed was unmade with the head of the bed cranked up to 45 degrees. A pile of clothes lay on top of the foot of the bed.
b. At 8:38 AM, Resident # 65 sat in her recliner. The bed remained unmade and knitting materials and craft books sat on the floor.
c. At 9:54 AM, Resident # 65's bed remained unmade.

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d. At 10:25 AM Resident # 65 sat in her in room watching TV, and knitting. The resident's bed remained unmade and a strong urine odor was present in the room.
e. At 11:14 AM, the resident's FM walked towards Resident # 65's room. The FM pointed at the bed and commented, see the bed is not made. The FM stated it was like that when she left yesterday and she told Staff N before she left the facility. The FM touched the bed covers in an attempt to make the bed and stated that it was wet. The bed covers were rolled on top of the bed, with a hospital gown also on top at the foot part of the bed, and clothes were lying on the floor. The room contained a strong odor of urine.
f. At 11:19 AM, when informed about the urine odor in Resident # 65's room, Staff O licensed practical nurse (LPN) said she was going to find somebody to help.
g. At 11:22 AM, Staff B certified medication aide (CMA) verified Resident # 65's bedding was wet and stated the bed was the source of the urine odor. Staff B proceeded to strip the bed, put the linens in the laundry basket, and then stated she planned to change the sheets. Housekeeping staff entered the room and sprayed the bed's plastic cover to clean it.

During observation on 5/24/22 at 1:34 PM, Resident # 65's bed was elevated at 45 degrees, unmade, with blankets rolled on top at the foot of the bed. Resident # 65 sat in her room, visiting in Spanish with Staff P, Housekeeping. Upon seeing surveyor, Resident # 65 said, "cama cama" pointing to the unmade bed and at the same time shaking her head. Resident # 65 continued to talk in Spanish, which Staff P interpreted saying that Resident # 65 wished for an ongoing survey so that staff would maintain a clean and organized

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F 584	Continued From page 5 bed. During interview on 5/26/22 at 1:30 PM, the Administrator stated staff should be making rounds to ensure that beds linens are clean and beds made. The facility's undated Tenant Rights Statement documented residents would be shown consideration and respect and be treated with dignity. The document indicated the facility's recognition of responsibilities to deliver quality services to residents in an individualized, safe, and homelike environment.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical and facility record review, and interviews, the facility failed to conduct a thorough investigation as directed by the abuse prevention policy following a family concern related to medications and medication administration for 1 of 3 residents reviewed for abuse prevention (Resident # 67). The facility reported a census of	F 607		

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F 607	Continued From page 6 69 residents. Findings include: Resident # 67's admission minimum data set (MDS) assessment dated 10/15/21 indicated severe cognitive impairment with a brief interview for mental status (BIMS) score of 0. The assessment documented the resident received antianxiety medication during one of the 7-day assessment period and received Hospice care while residing at the facility. The care plan listed Resident # 67's diagnoses including acute and chronic respiratory failure with hypoxia (lack of oxygen), pneumonia, insomnia, muscle weakness, aphasia (loss of ability to understand or express speech) following cerebral infarction, chronic atrial fibrillation, hypertension, Alzheimer's disease, anxiety disorder, depression, and vascular dementia without behavioral disturbance. The care plan initiated on 10/19/21 indicated that Resident # 67 admitted on Hospice level of care with a goal to maintain comfort through the end of life or next review date. The care plan initiated on 11/4/21 also indicated Resident # 67's insomnia diagnosis and on melatonin (medication that help promote sleep) as ordered. The care plan initiated on 11/4/21 further indicated Resident # 67 on anti-anxiety and antidepressant, and a potential for a mood deficit related to diagnosis of major depressive and anxiety disorder. The care plan directed staff to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of [SPECIFY: anti-depressant medication drugs being given] and to administer the medications as ordered.	F 607		

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The order summary report of 5/26/22 documented physician's orders for Resident # 67 that included buspirone hyrdochloride (Buspar) 7.5 mg tablet by mouth two times a day for anxiety and to discontinue the medication on 11/29/21, trazodone hydrochloride 50 mg tablet by mouth at bedtime related to insomnia, hydrocodone-acetaminophen solution (Norco) 7.5-325 mg/15 milliliters (ml) by mouth every 12 hours for pain, eliquis 2.5 mg tablet by mouth 2 times a day related to chronic atrial fibrillation, and remeron 15 mg tablet by mouth at bedtime for depression.

The medication administration record (MAR) for the month of 11/21 showed that on 11/4/21 Resident # 67's bedtime medications, except for Buspar 7.5 mg, were checked and initialed to indicate they were administered, as follows: senna plus 8.6-50 mg tablet, Norco 7.5-325 mg/ml 10 ml, eliquis 2.5 mg tablet, remeron 15 mg tablet and trazodone 25 mg tablet. The MAR also showed one-time orders for Norco 10 ml, Remeron 15 mg, Eliquis 2.5 mg, trazodone 25 mg, and Buspar 7.5 mg that were unsigned in the MAR.

The nurses' progress notes dated 11/4/21 at 11:57 PM revealed a duplicate administration of Resident # 67's 5 bedtime medications and showed a one-time order of the said medications were obtained and given, as follows: Norco 10ml, Remeron 15mg, Eliquis 2.5mg, trazodone 25mg, and Buspar 7.5mg." The notes also showed that these medications were crushed and administered to Resident # 67 who tolerated and swallowed with no concerns.

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Interviews of staff who worked with Resident # 67 on 11/4/21, showed potential duplicate administration of Resident # 67's bedtime medication, as follows:

1. On 5/24/22 at 3:28 PM, Staff F certified nurse aide (CNA) stated that she worked with Resident # 67 in the evening of 11/4/21. Staff F said she was feeding Resident # 67 for supper at around 6:30 PM and was asked by the nurse on that hall if she could give the resident's medications because it was easier to do that when she was eating. Staff F also confirmed that Staff I registered nurse (RN) as the nurse on duty that time and who gave her 2 medication cups, one with crushed medications in apple sauce and another with pink liquid, which Staff F thought was cough syrup. Staff F also said that Resident # 67 took all that with the apple sauce and a little left with the pink liquid. Staff F said she took both cups (empty one and the one with left over pink liquid) to show Staff I what was left. After that, Staff F threw the cups in the trash per Staff I's instruction. Staff F reported she then stayed and fed Resident # 67 for about 10-15 minutes.

2. On 5/24/22 at 4:06 PM, Staff H (RN) said he worked as the nurse for the night shift 11/4/21, starting at 10 PM and the 2-10 PM nurse was Staff I. Staff H stated he was called into the resident's room and told by family that Resident # 67 did not receive night medications. Staff H said that Resident # 67's family claimed to have stayed in the room from 5 PM to 10 PM and nobody went to administer Resident # 67's bedtime medications. Staff H stated he did not ask Staff I about the concern since the latter already left for the night. Staff H stated he checked the bubble packs and the pills were not

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there and since he had to switch the sharps container anyway, he saw that there were pills in the sharps container. Staff H reported calling Staff G licensed practical nurse (LPN) to witness and they opened the sharps container, took out the pills, matched them with Resident # 67's medications, found that the pills were similar, and then concluded that the pills were Resident # 67's. Staff H said he contacted the nurse manager, who gave instructions for Staff H to write an incident report and to notify the doctor. Staff H stated he told family that he got new orders to give the medications. Staff H acknowledged giving the medications to Resident # 67, who took them without issues. Staff H stated that management did an investigation and Staff I did not come back after that.

3. On 5/24/22 at 4:15 PM, Staff G confirmed she worked with Staff H on the night shift of 11/4/21, and that during change of shift at about 10:15 PM, Resident # 67's family members complained that Resident # 67 did not receive night medications. Staff G that together with Staff H, they noted Resident # 67's night time medications were popped out but family claimed that no nurse ever went in the room. Staff G also said they looked in the garbage can and then had to open the sharps container because there was odor and that's how they found pills in it. Staff G denied that there were narcotics found and only the pills that resembled Resident # 67's night time medications. Staff G also denied having contacted Staff I about the medication concern, saying she was not assigned on Resident # 67's hall.

4. On 5/25/22 at 8:59 AM, during a follow-up interview, Staff F clarified that before dinner time

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on 11/4/21, she checked on her group of residents if they needed to be changed for dinner. Staff F said that there were family members in the resident's room, an older lady with daughter or grandchildren, but by the time the meal trays were there nobody was there. Staff F reiterated that during the time she fed Resident # 67, nobody else was in the room. Staff F stated the resident's light came on later in the room and when she entered, family members were there and told her the resident was ready for her meds (medications). Staff F reported she did not know what meds the family wanted to know about and if they were different from the ones she gave at supper time. Staff F said she told the family that Resident # 67 took medications at supper time.

5. On 5/25/22 at 10:03 AM, Staff E, registered nurse, who was then the interim director of nursing during the time of the incident on 11/4/21, confirmed participation in the investigation concerning family concern that Resident # 67 did not receive bedtime medications. Staff E said their investigation started in the morning of 11/5/21, where they found Staff I as the day nurse on 11/4/21, working from 6 AM to 10 PM, and Staff H worked as the overnight nurse from 10 PM to 6 AM, who found the pills in the sharps container on the same night. Staff E verified that the sharps container was attached to a medication cart being used for all residents in 2 halls. Staff E said they concluded that the pills found in the sharps container were those of Resident # 67 because when compared, the pills were the same as Resident # 67's and with the timing that the family said they did not see anybody give medications to Resident # 67. However, when asked if the pills in the sharps container could possibly be those scheduled for

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another date/evening or for another resident, Staff E acknowledged that it was possible. Staff E stated that Staff I reported to work the following morning or on 11/5/21, and during interrogation, Staff I was insistent that we call Staff F to ask if Staff I gave 2 cups of medications where one was with a pink liquid to Resident # 67 in the evening of 11/4/21. Staff E said that when Staff F was first interviewed before going home in the morning of 11/5/21, there was no inquiry or mention about pink liquid but during Staff F's second interview in the evening of 11/5/21, Staff F acknowledged giving pink liquid that Resident # 67 did not consume, and that Staff F took what was left to show Staff I. Staff E stated they did not let Staff I continue to work that day, sent her home and reported her to the the police. Staff E acknowledged the facility lacked thorough investigation regarding the concern about Resident # 67's night time medications as shown by the following: it lacked follow-up inquiry to ascertain the bedtime medications on 11/4/21 were not given before providing another dose of the same; assumption that the pills found in the night of 11/4/21 in a common sharps container were those belonging to Resident # 67's because they looked the same; it lacked consideration to follow-up on the statements provided by the ones involved (Staff F and Staff I); and lacked a deeper inquiry as to the timeline of family's presence in Resident # 67's room.

On 5/26/22 at 1:30 PM, the Administrator acknowledged the importance of facility management's thorough investigation and handling of cases regarding concerns or complaints. The Administrator said that this case should have been handled better.

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F 607	Continued From page 12 The facility's policy and procedure titled, Abuse Prevention, Identification, Investigation, and Reporting, with revision date of 4/20/22, indicates that employees are trained regarding facility's policies and procedures relating to abuse identification, and reporting requirements. The policy also indicates staff education on (a) activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (b) procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property; and (c) dementia management and resident abuse prevention. The policy defined abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The policy directs staff to investigate an allegation of abuse following the facility procedure.	F 607	F607 The plan for correction on this specific deficiency is as follows: Corrective action was completed of by the Administrator and The Director of Nursing on 4/20/2022 by re-educating staff about the investigation process. Resident #67 is no longer in facility no further action could be taken on this resident. Monitoring Plan as followed: 7/15/2022 in-service education for all staff by Social Worker on abuse, neglect and resident rights. Assistant Director of Nursing will re-education all staff on abuse policy including procedure for reporting abuse neglect and resident rights. Quarterly training will be conducted by Social Services or designee for staff on abuse, neglect and resident rights. Training for all staff on abuse, neglect and resident rights to include reporting of abuse and neglect for newly hired employees. Administrative or designee will complete resident interviews for abuse monitoring with interviewable residents weekly X4 weeks, then monthly X 3 months then quarterly thereafter, Administrative will complete resident observation for indicators of abuse for residents considered non-interviewable weekly X 4 weeks, then monthly X 3 months then quarterly thereafter. Resident interviews for abuse monitoring will be reviewed by the Administrator or designee weekly X 4 weeks, then monthly X 3 months then quarterly thereafter.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		

			The Administrator or designee will report all findings of resident interviews for abuse monitoring to the Quality Assurance and Performance Committee monthly for a minimum of 3 months. The Quality Assurance and Performance Committee will review interview findings to make recommendations to ensure compliance is sustained ongoing and determine the need for further monitoring. Date of substantial compliance: 8/5/2022	

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	165350	A. BUILDING _____ B. WING _____	05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND CARE CENTER	**1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265**

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F 623	Continued From page 13 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 623		

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F 623	Continued From page 14	F 623		

receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

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F 623	Continued From page 15	F 623		

well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews the facility failed to notify the Long Term Care (LTC) Ombudsman of discharge/transfer of residents to a hospital as required for three of six residents reviewed (Residents # 7, #15, and #49). The facility reported a census of 69 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment for Resident #15 dated 3/19/22 recorded diagnoses of heart failure and renal (kidney) failure. The assessment documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate impairment in memory and cognition.

Review of Resident #15's clinical record documented the resident admitted to the hospital 2/26/22 and returned to the facility 3/1//22.

During an interview on 5/18/22 at 1:15 PM, the Social Worker (SW) confirmed the Ombudsman was not notified when Resident #15 admitted to the hospital and was not on the list she sent to the Ombudsman every month on 2/22.

During an interview on 5/18/22 at 1:36 PM, the Administrator (ADM) stated she expected notice to the Ombudsman with all resident transfers/discharges. On 5/25/22 at 1:16 PM, the ADM stated Ombudsman notification of resident transfers/discharges is a regulation and requirement, so the facility did not have a policy

F 623	Continued From page 16 for it. 2. Review of the MDS assessment dated 1/1/22 revealed Resident #7 re-admitted to the facility on 8/5/21 after an acute hospital stay. The MDS recorded the resident had diagnoses of respiratory failure, hypertension, ulcerative colitis, diabetes, Parkinson's disease, and malnutrition. Review of the Census List revealed Resident #7 had hospital leave on 6/2/21-6/3/21, and 8/1/21-8/5/21. Progress Notes revealed: a. On 6/2/21 at 9:25 PM, the resident went to the emergency department (ED) after she fell. b. On 6/3/21, the resident returned to the facility. c. On 8/1/2021 at 10:16 AM, the resident went to the ED for evaluation after a fall. d. On 8/5/21, the resident returned to the facility. In an interview 5/18/22 at 1:25 PM, the ADM reported she expected staff notified the LTC Ombudsman whenever residents transferred to the hospital or discharged from the facility. In an interview on 5/18/22 at 2:30 PM, the ADM confirmed Resident # 7 as not listed on the notice of transfer form submitted to the Ombudsman. The ADM reported the resident's name didn't pull onto the discharge report. 3. The MDS assessment dated 4/20/22 documented Resident #49 re-admitted to the facility on 4/6/22 after an acute hospital stay. The MDS recorded the resident had diagnoses of heart failure, Non-Alzheimer's dementia, seizure disorder and urinary tract infection. Review of the electronic health record (EHR)	F 623	F623- The plan for correction on this specific deficiency is as follows: Residents found to have been affect by deficient practice- Corrective action was completed of by the: Administrator and The Director of Admissions and Resident Services on 6/1/2022 by the discharges of resident's #7, #15, and #49 and reporting these to the Office of the Ombudsman. When sending a resident out to hospital, the charge nurse will have resident or POA sign bed hold policy prior to sending them out to the hospital and document in PCC. SSD will follow up the next day and send out in the mail or email which one is preferred for POA or resident. Document in PCC how it was sent to POA. End of every month send all discharges to ombudsman via email per request of ombudsman Correction plan: Education for all nursing staff that bed hold is given to resident at time of transfer with reason of transfer/discharge. Education for all nursing staff that progress note will be completed at time of transfer and Social Services will be notified of transfer. The change will be audited by DON on transfers/discharges. Audits will then be reviewed by QAPI team until such time substantial compliance has been determined by committee. Date of substantial compliance: 8/5/2022	

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F 623	Continued From page 17 census list revealed Resident #49 had hospital leave on 4/3/22-4/6/22. The progress notes dated 4/1-4/30/22 indicated Resident #49 transferred to the hospital ED for evaluation after he fell on 4/3/22 and re-admitted to the facility on 4/6/22. The notice of transfer form to the LTC Ombudsman 4/2022 lacked Resident #49's name when he transferred to the hospital on 4/3/22. In an interview 5/18/22 at 2:30 PM, the ADM confirmed Resident # 49 not listed on the notice of transfer form submitted to the LTC Ombudsman. The ADM reported the resident's name didn't pull onto the discharge report.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		

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F 625	Continued From page 18 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, facility staff failed to provide the resident/resident representative notice of the bed hold policy at the time of transfer for hospitalization for two of six residents reviewed (Residents #7 and #15). The facility reported a census of 69 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #15 dated 3/19/22 documented diagnoses of heart failure and renal (kidney) failure. A Brief Interview for Mental Status (BIMS) score of 11 indicated moderate memory and cognitive impairment. Review of Resident #15's clinical record documented the resident admitted to the hospital 2/26/22 and returned to the facility 3/1//22. Review of resident's clinical record lacked documentation of notice to the resident or the resident's representative regarding the bed-hold policy when she transferred to the hospital. Review of the facility's Resident Bed Hold policy,	F 625	F625- The plan for correction on this specific deficiency is as follows: Corrective action was completed for resident #7 and #15 by the Skilled Unit Manager by discussing the bed hold policy with the residents for their knowledge should they need to go out to the hospital again. The Administrator and The Director of Nursing on 4/22/2022 by reviewing the policy and procedure to ensure all bed holds are completed. The skilled unit manager will complete the bed hold with the family upon the resident's admission to the hospital. Identification of residents having the potential to be affected by the same deficient practice All residents have the potential to be affected Monitoring Plan as followed: Administrator, Director of Nursing, and Social Services or designee will update the policy and procedure regarding the Bed-Hold policy before/upon transfer to meet the current regulation regarding notification. Administrator, Director of Nursing, and Social Services or designee will educate the licensed nurses and social service staff regarding notifying the resident and/or resident representative in the event there is a resident being transferred from the facility including the form to be used, when it should be used, and documenting in the resident's chart when given, and who it was given to. The Social Services or designee will review all the medical record notes of residents who are transferred from the facility when the Social Services are not in the facility to ensure proper notice has been given. These reviews will be completed the next working day of the Social Services or designee will maintain audit on residents transferred from the facility and will submit the information to the facility's State Ombudsman as per regulations. The Social Services or designee will maintain the logs for a minimum of 2 years. The Social Services or designee will present the logs to the monthly QAPI committee meeting along with the chart notes and copies of the notices to indicate compliance of this requirement for their review and further recommendations. Any non-compliant staff will be re-educated by the Social Services or designee and documented in employee personal file. Date of substantial compliance: 8/5/2022	

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F 625	Continued From page 19 revised 6/21/21, revealed that all residents with a temporary absence from the facility will be notified as follows: At the time of the notification of the temporary absence, the facility designee will contact the resident or resident's legal representative and inquire if the legal representative would like to hold the bed. During an interview on 5/18/22 at 1:15 PM, the Social Worker (SW) stated she completes bed hold forms with new admissions only, not each time a resident goes out to the hospital. During an interview on 5/18/22 at 1:36 PM, the Administrator (ADM) stated the expectation for bed hold notices to be completed each time a resident is admitted to the hospital. 2. The MDS assessment dated 1/1/22 recorded Resident #7 re-admitted to the facility on 8/5/21 after an acute hospital stay. The MDS documented the resident had diagnoses of respiratory failure, hypertension, ulcerative colitis, diabetes, Parkinson's disease, and malnutrition. Review of the Census List revealed Resident #7 had hospital leave on 8/1/21-8/5/21. Progress Notes documented Resident #7 went to the emergency department for evaluation after a fall on 8/1/21. In an interview 5/18/22 at 1:20 PM, the ADM reported she expected bed hold information provided to the resident or resident representative whenever a resident transferred to the hospital. In an interview 5/18/22 at 1:33 PM, the Social Worker reported a bedhold form was completed whenever a resident admitted to the facility, but	F 625		

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F 625	Continued From page 20 not when a resident transferred to the hospital. The Social Worker stated the bedhold information was in the admission packet she provided residents and their representative during admission. In an interview 5/18/22 at 2:30 PM, the ADM reported the Assistant Director of Nursing (ADON) obtained a verbal bedhold from family and documented a bedhold request on the form, but this process just started 4/22. In an interview 5/25/22 at 2:21 PM, the Director of Nursing (DON) reported no bedhold form found for Resident #7 for 8/21. The facility's bed hold policy in the admission packet provided to the resident/resident representative revealed whenever a resident had a temporary absence from the facility for medical treatment, the facility asked the resident or legal representative if the resident wished for the facility to hold their bed open. Each resident and legal representative had the right to receive written information that explained the designated circumstances and relevant policies about bedhold before the resident transferred or left the facility.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to accurately complete	F 641		

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F 641	Continued From page 21 a Minimum Data Set assessment for one of nineteen residents reviewed in the sample (Resident #24). The facility reported a census of 69 residents. Findings include: Review of the annual minimum data set (MDS) assessment dated 1/1/22 revealed Resident #24 had diagnoses of anxiety disorder, depression, and bipolar disorder. The MDS indicated the resident was not considered by the state level II PASRR to have a serious mental illness. The MDS documented the resident took an antidepressant medication 7 of 7 days during the look-back period. The quarterly MDS assessment dated 4/1/22 recorded Resident #24 took an antidepressant medication 7 of 7 days during the look-back period. The resident's care plan initiated on 4/4/21 documented the resident had a potential for mood deficit and took psychotropic medications related to diagnoses of anxiety, depression, and bipolar disorder. The staff directives included to administer antianxiety and antidepressant medications and report side effects. A psychiatry evaluation dated 4/5/22 indicated the resident referred to a psychiatrist for evaluation of depression, anxiety, hallucinations, and bipolar disorder. The treatment plan included sertraline daily for her anxiety disorder and major depressive disorder. The order summary report and medication administration record dated 5/22 revealed the	F 641	F641- The plan for correction on this specific deficiency is as follows: 1. The MDS Coordinator reviewed the assessment for Resident #24 and the Assessment was modified to reflect the Section A, Level II change on 6/1/2022. The MDS coordinator audited assessments for all Level II residents on 6/1/2022 to ensure all assessments were completed correctly. Identification of residents having the potential to be affected by the same deficient practice All residents have the potential to be affected MDS coordinator completed in-service education for interdisciplinary team that are responsible for completing MDS assessments to include review of RAI manual with emphasis on MDS accuracy of assessments. This information will be included in the employee orientation program for newly hired IDT members, who will complete MDS assessments. The Social Services or designee will review Level II assessments and notify the MDS Coordinator for correction. The SSD, MDS, or designee will reporting findings of MDS validation audit to the Quality Assurance and Performance Improvement Committee monthly x 3 months to ensure compliance is sustained ongoing and determine the need for further monitoring. Date of substantial compliance: 8/5/2022	

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F 641	Continued From page 22 prescribed medications of risperdal (an antipsychotic) at bedtime daily for diagnosis of bipolar disorder, and zoloft (an antidepressant) every morning for anxiety disorder and major depressive disorder. During an interview 5/25/22 at 10:30 AM, the Care Plan Coordinator reported she completed Resident #24's MDS assessment since 2/22. The Coordinator stated the social worker filled out certain sections of the MDS, including section A1500 to A1510 regarding a resident's mental illness or condition. The Care Plan Coordinator reviewed Resident #24's record and reported she planned to modify her MDS assessment to include information in Section A regarding level II information. During an interview 5/31/22 at 10:36 AM, the Director of Nursing reported the facility had no policy for completion of MDS assessments. Staff followed the guidelines for completion of MDS assessments.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of	F 644		

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F 644	Continued From page 23	F 644		

care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) when a resident had a newly diagnosed mental disorder for one of three residents reviewed (Resident #24). The facility reported a census of 69 residents.

Findings include:

Review of the annual minimum data set (MDS) assessment dated 1/1/22 revealed Resident #24 had diagnoses of anxiety disorder, depression, and bipolar disorder. The MDS indicated the resident was not considered by the state level II PASRR to have a serious mental illness. The MDS documented the resident took an antidepressant medication 7 of 7 days during the look-back period.

The quarterly MDS assessment dated 4/1/22 recorded Resident #24 took an antidepressant medication 7 of 7 days during the look-back period.

The resident's care plan initiated on 4/4/21 documented the resident had a potential for mood deficit and took psychotropic medications related to diagnoses of anxiety, depression, and bipolar disorder. The staff directives included to

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F 644	Continued From page 24 administer antianxiety and antidepressant medications and report side effects. A psychiatry evaluation dated 4/5/22 indicated the resident referred to a psychiatrist for evaluation of depression, anxiety, hallucinations, and bipolar disorder. The treatment plan included sertraline daily for her anxiety disorder and major depressive disorder. The order summary report and medication administration record dated 5/22 revealed the prescribed medications of risperdal (an antipsychotic) at bedtime daily for diagnosis of bipolar disorder, and zoloft (an antidepressant) every morning for anxiety disorder and major depressive disorder. Review of the preadmission assessment and resident review (PASRR) notice for nursing facility approval dated 10/1/19 revealed the resident had mental illness diagnoses of bipolar disorder and anxiety disorder. The PASRR directed facility staff to submit a status change if the resident had a change in symptoms, behavior, or diagnoses. The electronic health record (EHR) diagnoses report revealed the diagnoses of anxiety disorder (added 4/13/22), bipolar disorder (added 4/13/22), and major depressive disorder (added 1/27/20). A psychiatry evaluation dated 4/5/22 revealed Resident #24 referred for evaluation of depression, anxiety, hallucinations, and bipolar disorder. During an interview 5/25/22 at 9:20 AM, Staff C, Social Worker (SW) reported she ensured	F 644	F644- The plan for correction on this specific deficiency is as follows: The Resident and Family Services Director submitted a request to Ascend for a new PASSR with updated diagnosis and medication information for resident #24. MDS Coordinator will update the assessment as soon as it is received. Identification of residents having the potential to be affected by the same deficient practice All residents have the potential to be affected The Resident and Family Services Director will inform the MDS Coordinator of all PASSR changes and report to the Administrator of any discrepancies. SSD was provided the PASRR manual with forms. The Administrator will complete an in-service for the SSD related to PASRR level II screenings completion for any Level I which are positive for Mental Disorders, Intellectual disabilities and related conditions. SSD will review and audit all Level I PASSR upon admission, monthly and with any new related diagnosis. Level II screening will be submitted accordingly and timely. The SSD will complete a audit of Level I or II PASRR upon admission, monthly and as needed with any new MD or ID or related condition. The SSD will report her audit to the Administrator and QAPI Committee monthly 3 x months for compliance. SSD will continue regular and consistent audits of PASSR levels at least monthly thereafter. The person responsible for the implementation and compliance of this plan of correction will be the Administrator, the MDS Coordinator and the SSD. Substantial compliance will be attained by 8/5/2022	

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F 644	Continued From page 25 PASRR's were completed. Staff C stated that whenever a resident admitted to the facility she looked at the PASRR and ensured the resident's mental health diagnoses were listed on the PASRR. Staff C stated she submitted a request for PASRR re-evaluation whenever a resident had change in mental health diagnosis. Staff C stated she checked the orders screen on the EHR for any new medications and diagnoses or the reason for a medication, rather than looking under the diagnoses list on the EHR to determine if a resident had a new mental health diagnoses or condition. Staff C confirmed Resident #24's most current PASRR was completed 10/1/19, and she had diagnoses of bipolar disorder and anxiety disorder. During an interview 5/26/22 at 10:30 AM, the Administrator reported a PASRR are completed whenever a resident admitted to the facility, and again whenever a resident had a significant change in mental health diagnosis. The Administrator reported the SW completed a request for PASRR evaluation. The Administrator stated the facility had no policy for PASRR, they followed the regulation guideline for PASRR.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		

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F 655	Continued From page 26 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record, facility policy review, and staff interview, facility staff failed to develop and implement a baseline care plan within 48 hours for one of three residents reviewed	F 655		

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F 655	Continued From page 27 (Resident #68). The facility reported a census of 69 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/24/22 for Resident #68, documented resident admitted to the facility on 4/20/21 with diagnoses that included ankylosing spondylitis (arthritis of spine), and diabetes mellitus. The MDS identified the resident required the limited assistance of one staff for personal hygiene and toilet use and the extensive assistance of one staff for bed mobility, transfers, and walking. A Brief Interview for Mental Status (BIMS) score of 10 indicated moderate cognitive and memory impairment. Resident #68's baseline care plan admission assessment, dated 4/20/22, lacked any documentation. Review of facility's policy on Comprehensive Person-Centered Care Planning, reviewed 9/7/21, revealed the baseline care plan will be developed with 48 hours of a resident's admission and will include the minimum healthcare information necessary to properly care for the resident. During an interview on 5/25/22 at 3:22 PM, the MDS Coordinator confirmed resident's baseline care plan had not been completed and the expectation for it to be completed within 48 hours of admission.	F655 F 655	The plan for correction on this specific deficiency is as follows: The MDS Coordinator reviewed the baseline comprehensive plan of care for resident #68 and corrected to include all information for completion on 6/1/2022. Resident #68 is no longer in the facility as of 6/6/2021. The MDS Coordinator reviewed all baseline care plans for all new admissions from 5/1/2021 to ensure completion and correct information on 6/1/2022. The Skilled Unit Manager will do an audit of all Baseline Care Plans weekly for all new admissions to ensure that all are completed within 48 hours of admission and has developed an audit tool to ensure completion beginning 6/1/2022. The Skilled Unit Manager and the Director of Nursing are responsible for this plan of correction. This plan of correction has been fully implemented.
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656	

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F 656	Continued From page 28 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 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.	F 656		

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F 656	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff interviews, facility failed to develop resident specific care plans to address the use of psychotropic medications and pain management medications for 3 of 4 residents reviewed for unnecessary medications (Residents # 39, # 44, # 24, and # 55). The facility reported a census of 69 residents. Findings include: 1. Resident # 39's admission minimum data set (MDS) dated 4/16/22, indicated he had intact cognition with a brief interview for mental status (BIMS) score of 15. The MDS identified Resident # 39's diagnoses included fracture of the right tibia, diabetes mellitus, chronic pain, anxiety disorder, and depression. The MDS also indicated Resident # 39 received daily anticoagulant, antidepressant, diuretic, and diabetic medications and an opioid medication during one of seven days. The resident's Order Summary Report dated 5/26/22 documented prescribed medications included Insulin Lispro (1 Unit Dial) Solution Pen-injector 100 unit/ml (milliliter) inject as per sliding scale; Furosemide (a diuretic) 80 mg (milligram) tablet by mouth two times a day for diuretic; Eliquis (anticoagulant) 2.5 mg tablet by mouth two times a day; Trazodone (antidepressant) Hydrochloride 100 mg tablet by mouth at bedtime; and Oxycodone HCl 5 mg tablet by mouth every 4 hours as needed for pain. The orders directed staff to monitor side effects of diuretics, anticoagulants, and side effects and behaviors for the use of antidepressants.	F 656		

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F 656	Continued From page 30 The resident's care plan initiated on 3/28/22 lacked specific directions on how staff would manage Resident # 39's use of the above-noted medications. 2. Resident # 44's quarterly MDS assessment dated 4/19/22 showed moderate cognitive impairment with a BIMS score of 9. The MDS recorded her diagnoses included hypertension, urinary tract infection, hyperlipidemia, Non-Alzheimer's dementia, anxiety disorder, depression, and asthma. The MDS further showed that Resident # 44 received daily antipsychotic and antidepressant medications during the assessment period. The resident's Order Summary Report dated 5/26/22 documented prescribed medications that included aripiprazole (antipsychotic) 20 mg tablet by mouth in the morning, venfaxine hydrochloride (antidepressant) extended release 37.5 mg tablet by mouth in the morning; and sertraline hydrochloride (antidepressant) 100 mg 2 tablets by mouth in the morning. The orders directed staff to monitor the resident's behavior/mood/cognition changes; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; no voiding; constipation, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting/diarrhea, dry mouth, dry eyes; and to document if observed. Resident # 44's care plan initiated on 12/3/21 lacked specific directions on how to manage the use of the psychotropic medications. Observation on 5/18/22 from 9:55 to 10:03 AM,	F 656		

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F 656	Continued From page 31 revealed Resident # 44 in her room, sitting in a wheelchair and reading a book. Resident # 44 refused an invitation by the activities staff for a group bible study. During interview on 5/19/22 at 10:42 AM, Staff D assistant director of nursing (ADON) stated that target behaviors as well as the side effects of psychotropic are in the medication administration record (MAR). Staff D verified that not all side effects of the medications for Resident # 44's psychotropic medications were monitored such as falls. Staff D stated the expectation for accurate documentation for monitoring side effects and target behaviors. 3. Resident #24's MDS assessment dated 1/1/22 recorded diagnoses of anxiety disorder, depression, and bipolar disorder. The MDS documented the resident felt down, depressed, or hopeless 7-11 days and wandered 1-3 days during the look-back period. The MDS documented she took an antidepressant medication 7 of 7 days and had no psychiatry therapy during the look-back period. The MDS assessment dated 4/1/22 recorded the resident had diagnoses of anxiety disorder, depression, and bipolar disorder. The resident had behavioral symptoms such as hitting or scratching herself, and pacing, and/or verbal symptoms such as screaming and disruptive sounds not directed toward others. The MDS indicated the resident took an antidepressant medication 7 of 7 days and had no psychiatry therapy during the look-back period. The resident's care plan initiated 4/4/21 revealed the resident had the potential for a mood deficit	F 656		

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F 656	Continued From page 32 and took psychotropic medications related to diagnoses of anxiety, depression, and bipolar disorder. The staff directives included to administer antianxiety and antidepressant medications and report side effects, and a pharmacy review of medications monthly. The preadmission assessment and resident review (PASRR) notice for nursing facility approval dated 10/1/19, revealed the resident had mental illness diagnoses of bipolar disorder and anxiety disorder. The PASRR recommended ongoing psychiatric services by a psychiatrist to evaluate the response and effectiveness of medications on targeted symptoms, obtain archived psychiatric records, and complete an ongoing medication evaluation. During an interview 5/25/22 at 10:30 AM, the Care Plan Coordinator reported she developed a comprehensive care plan for each resident at the facility. The Coordinator reported PASRR information should be on the care plan, but the previous social worker deleted some PASRR's when she left. During an interview 5/26/22 at 10:30 AM, the Administrator reported information from the PASRR and about psychiatric service should be on the care plan. The Administrator stated the previous Director of Nursing (DON) ripped the care plans apart and removed a lot of information from the care plans because she thought the care plans were too lengthy and difficult to maintain. The Administrator stated they were in the process of rebuilding care plans and had identified the care plans as an area for improvement. During an interview 5/31/22 at 10:36 AM, the	F 656	F656 The plan for correction on this specific deficiency is as follows: A review of resident #39, #44, #24,and #55 was performed on 6/12/2022 to confirm a comprehensive plan of care was implemented with all required elements of the individual patient needs. The resident's care plans were updated and completed appropriately. This was completed by the MDS Coordinator. A process to ensure implementation of a comprehensive plan of care for newly admitted residents was implemented on 6/12/2022. Education was completed regarding the definition, importance, and process for the comprehensive plan of care for residents was completed with the MDS Coordinator on 6/12/2022. All new resident care plans will be placed on monitoring for the next 90 days to ensure timely completion, and individualization of resident needs. Random monitoring occurring thereafter on an ongoing basis. The Care Plan process will be added to the QAPI monitoring plan with data presented at least quarterly to the QAPI team. The MDS Coordinator and the Administrator will be responsible for this plan of correction, and it has been fully implemented.	

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F 656	Continued From page 33 DON reported the facility had no policy for care plans. They followed the guidelines for completion of the care plans. 4. A MDS assessment dated 4/27/22 for Resident #55 documented diagnoses that included fracture of right femur (leg), anxiety, depression, and osteoporosis (thinning/weakening of bones). The MDS documented Resident #55 received opioid (narcotic) and antidepressant medications daily. A BIMS score of 7 indicated she had moderate cognitive and memory impairment. Resident #55's Medication Review Report (admission orders) dated 11/23/21 revealed the following medication orders: a. Zoloft Tablet 50 milligrams (MG) - give 50 mg by mouth in the morning related to major depressive disorder. b. Fentanyl Patch 72 Hour 25 microgram (mcg)/hour (hr) - apply 1 patch transdermal (via skin) every 72 hours related to chronic pain syndrome. c. Diclofenac Sodium Gel 1 % - Apply to back and hips topically every 12 hours as needed for pain related to chronic pain syndrome - apply 2 grams to the affected area two times a day as needed. d. Gabapentin Capsule 300 MG - give 300 mg by mouth three times a day related to chronic pain syndrome. Resident #55's care plan, initiated on 11/23/21, lacked documentation of any problem or interventions for pain and pain medication or her psychiatric diagnoses and medication. Interview on 5/24/22 at 10:00 AM, the MDS Coordinator revealed the expectation for pain/pain medication and psychiatric	F 656		

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F 656	Continued From page 34 diagnoses/medication to be included in a resident's care plan.	F 656		
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 clinical record review and staff interview, the facility failed to update and revise the comprehensive care plans when indicated for two of nineteen residents reviewed (Residents	F 657		

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F 657	Continued From page 35 #40 and #58). The facility reported a census of 69 residents. Findings include: 1. The minimum data set (MDS) assessment dated 4/18/22 documented Resident #40 had diagnoses that included chronic obstructive pulmonary disease, septicemia, urinary tract infection, Non-Alzheimer's dementia, and malnutrition. The MDS indicated the resident received Hospice care and had a life expectancy of less than six months. The resident's care plan revised on 4/20/22 revealed she had a likely nutritional decline, as she had admitted to Hospice on 4/18/22. The care plan lacked information about the Hospice service or treatment plan interventions related to Hospice care. Observations on 5/16/22 at 1:04 PM revealed Resident #40 lying in bed and a small blue mat on the floor by her bed. The resident reported she broke her back and had pain, and received Hospice care. The electronic health record (EHR) revealed the resident admitted to Hospice on 4/18/22 In an interview 5/25/22 at 10:30 AM, the Care Plan Coordinator reported she'd worked at the facility since 2/22. The Coordinator stated she developed the comprehensive care plan for each resident at the facility, and had a list of focus areas she included on the care plan. The Care Plan Coordinator reported she expected Hospice information and it's plan of care on the resident's care plan if a resident was on Hospice.	F 657		

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F 657	Continued From page 36 During an interview 5/31/22 at 10:36 AM, the Director of Nursing (DON) reported the facility had no policy for completion of care plans. The DON stated staff followed the guidelines for completion of care plans. 2. The MDS assessment dated 4/29/22 for Resident #58 recorded diagnoses that included Alzheimer's disease, depression, diabetes mellitus and hip fracture. The MDS documented a significant change in status assessment, placement on Hospice, and identified the resident required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Brief Interview for Mental Status (BIMS) was not completed, as resident rarely/never understood communication. During an observation on 5/19/22 at 8:27 AM, Resident #58 transferred from wheelchair to bed with gait belt and the assistance of two staff. Resident #58's care plan initiated on 4/13/22 documented she transferred with the assistance of one person with a front wheeled walker and lacked focus/interventions for Hospice care. During an interview on 5/24/22 at 10:00 AM, the MDS Coordinator stated the expectation for Hospice care to be addressed on the care plan.	F 657	F657 The plan for correction on this specific deficiency is as follows: A review of resident # 40 and #58 was performed on 6/12/2022 to confirm a comprehensive plan of care was implemented with all required elements of the individual patient needs for resident #40. Resident #58 no longer resides in the facility as of 6/5/2022. A process to ensure implementation of a comprehensive plan of care for newly admitted residents was implemented on 6/12/2022. A staff education plan regarding the definition, importance, and process for the comprehensive plan of care for residents was completed with the MDS coordinator on 6/12/2022. All new resident care plans will be placed on monitoring for the next 90 days to ensure timely completion, and individualization of resident needs. Random monitoring occurring thereafter on an ongoing basis by the MDS Coordinator to ensure timely completion. The Care Plan process will be added to the QAPI monitoring plan with data presented at least quarterly to the QAPI team.	
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-	F 658	The MDS Coordinator and the Administrator will be responsible for this plan of correction, and it has been fully implemented.	

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F 658	Continued From page 37 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clincial and facility record review, and interviews, the facility failed to ensure medication administration by licensed staff only, proper documentation of medications given, and proper disposal of refused medications for one of six residents reviewed (# 67) for medication administration. The facility reported a census of 69 residents. Findings include: Resident # 67's admission minimum data set (MDS) assessment dated 10/15/21 indicated severe cognitive impairment with a brief interview for mental status (BIMS) score of 0. The assessment documented the resident received antianxiety medication during one of the 7-day assessment period and received Hospice care while residing at the facility. The care plan listed Resident # 67's diagnoses including acute and chronic respiratory failure with hypoxia (lack of oxygen), pneumonia, insomnia, muscle weakness, aphasia (loss of ability to understand or express speech) following cerebral infarction, chronic atrial fibrillation, hypertension, Alzheimer's disease, anxiety disorder, depression, and vascular dementia without behavioral disturbance. The care plan initiated on 10/19/21 indicated that Resident # 67 admitted on Hospice level of care with a goal to maintain comfort through the end of life or next review date. The care plan initiated on 11/4/21 also indicated Resident # 67's insomnia diagnosis and on melatonin (medication that help promote sleep) as ordered. The care plan initiated on	F 658		

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F 658	Continued From page 38 11/4/21 further indicated Resident # 67 on anti-anxiety and antidepressant, and a potential for a mood deficit related to diagnosis of major depressive and anxiety disorder. The care plan directed staff to educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of [SPECIFY: anti-depressant medication drugs being given] and to administer the medications as ordered. The order summary report of 5/26/22 documented physician's orders for Resident # 67 that included buspirone hyrdochloride (Buspar) 7.5 mg (milligrams) tablet by mouth two times a day for anxiety and to discontinue the medication on 11/29/21, trazodone hydrochloride 50 mg tablet by mouth at bedtime related to insomnia, hydrocodone-acetaminophen solution (Norco) 7.5-325 mg/15 milliliters (ml) by mouth every 12 hours for pain, eliquis 2.5 mg tablet by mouth 2 times a day related to chronic atrial fibrillation, and remeron 15 mg tablet by mouth at bedtime for depression. The medication administration record (MAR) for the month of 11/21 showed that on 11/4/21, Resident # 67 received bedtime medications including senna plus 8.6-50 mg tablet, Norco 7.5-325 mg/ml 10 ml, eliquis 2.5 mg tablet, remeron 15 mg tablet and trazodone 25 mg tablet. However, the MAR also showed that Buspar 7.5 mg and the one-time orders for Norco 10 ml, Remeron 15 mg, Eliquis 2.5 mg, trazodone 25 mg, and Buspar 7.5 mg remained unsigned in the MAR for 11/4/21. The progress notes also showed that a one-time order for Norco 10 ml, Remeron 15 mg, Eliquis	F 658		

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F 658	Continued From page 39 2.5 mg, trazodone 25 mg, and Buspar 7.5 mg were administered to Resident # 67 on 11/4/21 at approximately 11:45 PM, which indicated a duplicate dose from those administered at bedtime as documented in the MAR. Staff interviews related to Resident # 67's bed time medications on 11/4/21 revealed the following information: 1. On 5/24/22 at 3:28 PM, Staff F certified nurse aide (CNA) stated that she worked with Resident # 67 in the evening of 11/4/21. Staff F said she was feeding Resident # 67 for supper at around 6:30 PM and was asked by the nurse on that hall if she could give the resident's medications because it was easier to do that when she was eating. Staff F also confirmed that Staff I registered nurse (RN) as the nurse on duty that time and who gave her 2 medication cups, one with crushed medications in apple sauce and another with pink liquid, which Staff F thought was cough syrup. Staff F also said that Resident # 67 took all that with the apple sauce and a little left with the pink liquid. Staff F said she took both cups (empty one and the one with left over pink liquid) to show Staff I what was left. After that, Staff F threw the cups in the trash per Staff I's instruction. Staff F reported not knowing what the pink liquid was but that she thought it was cough medication. Staff F stated she did not understand why they're making such a big deal with this when it was not the first time that nurses gave her medications to give when feeding residents. 2. On 5/24/22 at 4:06 PM, Staff H, registered nurse (RN) said he worked as the nurse for the overnight shift on 11/4/21, starting at 10 PM. Family members informed him the resident did	F 658		

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F 658	Continued From page 40 not receive her night medications. Resident # 67's family claimed they had been in the room from 5 PM to 10 PM and nobody went to administer her bedtime medications. Staff H stated he checked the bubble packs and the pills were not there. Staff H also said that since the sharps container was to be changed, Staff H looked inside and saw pills that looked similar to Resident # 67's pills. Staff H stated he contacted the nurse manager, who gave instructions to notify the doctor. Staff H then told family members he got new orders to give the medications. 3. On 5/25/22 at 8:59 AM, during a follow-up interview, Staff F stated the resident's light came on later in the room and when she entered, family members were there and told her the resident was ready for her meds (medications). Staff F reported she did not know what meds the family wanted to know about and if they were different from the ones she gave at supper time. Staff F said she told the family that Resident # 67 took medications at supper time. Staff F said since she was not a medication aide, she did not know what was already given to the resident at supper or bedtime medications. Staff F also said she did not know what the pink liquid that she was asked to give Resident # 67, and did not know procedure for disposal of narcotic medications. 4. On 5/25/22 at 10:03 AM, Staff E, who was then the interim director of nursing at the time of the incident on 11/4/21 confirmed participation in the investigation about Resident # 67's medications. Staff E said their findings showed that Staff I worked from 6 AM to 10 PM on 11/4/21 as the nurse when family members complained that Resident # 67 did not receive bedtime	F 658		

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F 658	Continued From page 41 medications. Staff E said that Staff H was the nurse working from 10 PM to 6 AM, and who found the pills in the sharps container that night. Staff E said during their interview in the morning of 11/5/21, Staff I told them that she gave Resident # 67's bedtime medications in two medication cups to Staff F, a CNA for administration. Staff E also said that Staff F confirmed during inquiries (morning and evening of 11/5/21) that she did give medications to Resident # 67 during supper time at 6:30 PM, including a pink liquid that Resident # 67 did not consume but that she discarded in the trash per Staff I's instructions. Staff E also said that Staff H replaced the sharps container in the night of 11/4/21. However, the following day or on 11/5/21 when Staff I was working, Staff E and former QA (Quality Assurance) nurse found new pills in the sharps container. The pills found were compared to be the same as Resident # 67's morning medications. Staff E said Staff I confirmed during inquiry that those were Resident # 67's refused morning medications. Staff I reportedly attempted to administer the liquid Norco but that Resident # 67 spit it out and so Staff I said to have have attempted giving the other medications, instead, put them in the sharps container. Staff E also verified the duplicate doses of the bedtime medications given to Resident # 67 on 11/4/21 as documented in the MAR and the progress notes. 5. On 5/26/22 at 1:30 PM, the Administrator stated the expectation that staff should follow facility policies and procedures regarding medications, including medication administration by licensed staff only, and proper documentation and disposal of unused medications. The facility's in-service training documentation of	F 658	F658 The plan for correction on this specific deficiency is as follows: The Director of nursing reviewed the MAR/TAR for Resident #67 to ensure that the correct information was listed. Resident #67 no longer resides at the facility as of 11/19/2021. Any resident(s) admitted since the original report, have reviewed to ensure that medications were transcribed to the medication administration record (MAR), medications were received from the pharmacy, and administered as ordered. No discrepancies found. Education was provided with staff that only licensed nurses or medication aides are to administer medications to residents on 12/23/2021. . Staff Education was completed by the Director of Nursing on 12/23/2021, which included the medication administration policy. New employees will be educated during their new-hire orientation. New order(s) audits will be completed by the Director of Nursing or a designated nurse manager weekly to include any new admission or readmission resident orders are properly faxed to the pharmacy, entered correctly into the facility electronic medical record, received as ordered and administered as ordered. The Director of Nursing is responsible for the Implementation of the Plan of Correction and the Administrator is responsible is for sustained compliance. This plan of correction has been implemented.	

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F 658	Continued From page 42 11/8/21 indicated instructions for staff members to not give medications to CNAs to administer, to not sign off medications until a resident has taken them, to discard medications in drug buster, for two nurses to destroy narcotics and sign. The training documentation lacked instructions for thorough investigation of questions regarding medication administration in order to avoid double dosing. The facility's policy and procedure titled, Medication Disposal, with revision date of 3/31/21, instructed staff to dispose of medications refused by residents using the drug buster. The facility's policy and procedure titled, Medication Administration, date 7/27/20, directed staff to properly discard any medications not administered to the resident, for two nurses to sign for wasting any/all narcotics, for licensed nurse or other individuals administering medication to be aware of the side effects of each drug given, and the reason/diaganosis for each of the drug given and for staff to initial each medication on the MAR as it is administered to the resident.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		

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F 676	Continued From page 43 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and resident, family and staff interview, the facility failed to provide restorative activities for one of six sampled residents in order to maintain a functional range of motion and prevent a decline in activities of daily living (Residents #10). The facility reported a census of 69 residents. Findings include:	F 676	F676 The plan for correction on this specific deficiency is as follows: Restorative program deficiency was discovered 3/2022, with resident #10, due to staffing shortage. The Therapy department was directed to begin working with the residents already designated for the program in the walk to dine program on 3/20/2022. Therapy department will audit of all residents that were offered or would benefit from restorative program by 7/15/2022. Designated staff to perform RA have been hired for these positions as of 7/15/2022. Restorative program will be in effect with updated care plans by 7/20/2022. The MDS Coordinator and the DON will audit the restorative program to ensure that it is being compliant with the designated care plan 1x per week for 3 months. The MDS Coordinator and the DON are responsible for ensuring this plan of correction is implemented with the Administrator ensuring compliance by 7/30/2022.	

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F 676	Continued From page 44 1. The Minimum Data Set (MDS) assessment dated 12/31/21 recorded Resident #10 had diagnoses that included intracerebral hemorrhage (bleeding into the brain causing a stroke), pulmonary embolism, aphasia, and chronic pain. The MDS documented he required one person assistance for bed mobility, transfers, dressing, toilet use and hygiene, and walked independently. The MDS documented the resident had impaired range of motion (ROM) to the upper and lower extremities on one side. The MDS documented the resident had occupational therapy (OT) services from 10/1/21 - 12/17/21, physical therapy (PT) services 9/30/21- 12/17/21, and no restorative nursing program (RNP) days during the look-back period. The MDS assessment dated 3/16/22 recorded Resident #10 required the limited assistance of one for transfers and dressing, and limited assistance of one staff to walk in his room and the corridor, The MDS documented the resident had impaired ROM to the upper and lower extremities on one side. Resident #10 had OT services 1/24/22-3/7/22, PT services 1/21/22 - 3/8/22, and no RNP days during the look-back period. The resident's care plan, initiated 8/11/21, documented a self-care deficit related to a stroke, weakness, and chronic pain, and falls related to poor balance. The staff directives included to use a walker and the assistance of one staff for transfers, assistance of one staff for toilet use and dressing, and a PT evaluation as needed (PRN). The care plan documented Resident #10 could self propel his wheelchair. The resident's progress notes revealed the	F 676		

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F 676	Continued From page 45 following information: a. On 7/21/21, resident admitted to the facility. b. On 7/22/21 at 6:56 AM, a therapy note documented the resident required the assistance of one staff using a front wheeled walker (FWW), and directed staff to stand on the resident's right side as his right knee tended to buckle. Resident #10 could walk to and from the bathroom as tolerated using a FWW and assistance of one. c. On 10/20/21 at 8:34 AM, a therapy note documented a planned 72-hour independent trial. The resident could transfer from the bed to/from his wheelchair and wheelchair to/from toilet. Resident #10 was deemed independent in room from the wheelchair level if no safety concerns were reported or noted by staff/nursing or therapy during 72-hour trial period. d. On 10/23/21 at 2:36 PM, Resident #10 displayed independence in his room and hallway, and propelled himself in the wheelchair without difficulty. Resident #10 transferred himself to and from his wheelchair and bed. e. On 12/17/21 at 12:37 PM, therapy recommended restorative activity 3-6 times a week, which included bilateral upper extremity and lower extremity active ROM for 10-20 repetitions, to use 2-3 pound ankle weights for both lower extremities, and 3 pound doll rod for upper extremities for 10-20 repetitions, a Nu Step (bicycle) for 15 minutes, and walk to dine using FWW and the assistance of one staff. f. On 1/18/22 at 2:15 PM, staff requested PT orders due to the resident had a functional decline. g. On 3/8/22, a restorative program note recommended ROM to upper and lower extremities for 20 repetitions, strengthening exercises using a 3 pound ankle weights and a 3 pound doll rod to upper extremities for 20	F 676		

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F 676	Continued From page 46 repetitions, a Nu Step for 15 minutes, and walking in the hallway with assistance of one staff and a FWW to be conducted 3-6 times a week. h. On 4/12/22 at 10:21 AM staff received an order for PT/OT therapy. The PT Progress Note and Discharge Summary dated 12/17/21 documented Resident #10 discharged to a restorative nursing program. The resident walked with a FWW and contact guard assist for approximately 300-350 feet. The resident had improved muscle strength and activity tolerance. The PT Plan of care dated 4/14/22 recorded Resident #10 demonstrated a knee wobble and shuffled gait. The documentation survey report 12/2021 - 5/2022 revealed the following information: 1. For nursing rehab active range of motion for 15 minutes for 3-6 days a week: a. 12/21 - none listed on report b. 1/22 - completed 2 times c. 2/22 - 0 completed d. 3/22 - 0 completed e. 4/22 - none listed on report f. 5/22 - none listed on report 2. For walk to dine with assistance of one and front wheeled walker a. 12/21 - none listed on report b. 1/22 - completed 16 times out of 69 opportunities c. 2/22 - completed 27 times out of 84 opportunities d. 3/22 - completed 3 times out of 25 opportunities	F 676		

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F 676	Continued From page 47 e. 4/22 - none listed on report f. 5/22 - none listed on report The electronic health record (EHR) tasks included the nursing rehab walk to dine added on 1/9/22 and revised 3/9/22, active ROM for 15 minutes 3-6 times a week added on 1/9/22 and revised on 3/18/22, and group exercise added on 1/9/22 and updated on 3/18/22. Observations revealed the following: a. On 5/19/22 at 9:55 AM, Resident #10 sat in a wheelchair in his room eating a glazed donut. b. On 5/19/22 at 11:10 AM, the resident sat in a wheelchair and self-propelled his wheelchair down the hall to the dining room. c. On 5/19/22 at 1:10 PM, Staff J, PT, placed a gait belt around the resident's waist, and assisted the resident to walk down the hall, using a walker. Staff J told the resident he had weakness in his right hand and he needed to grip his walker and guide the walker as he walked to prevent him from kicking his walker with his right leg. The resident verbalized understanding. d. On 5/24/22 at 7:40 AM, the resident sat in his wheelchair and propelled the wheelchair using his legs. During an interview 5/17/22 at 11:05 AM, a family member reported Resident #10 had therapy and facility staff were supposed to walk him to the dining room a couple times a day but staff had not walked him to the dining room for the past month. The resident reported he wanted to walk so he could go home and go on outings. The family member stated the resident had therapy, discharged from therapy, but then started on therapy again.	F 676		

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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 676	Continued From page 48 During an interview 5/19/22 at 2:00 PM, Staff J, PT reported she wrote a plan for restorative activities for Resident #10 when he discharged from therapy 12/2021. Staff J stated when she saw the resident always sitting in his wheelchair and not walking, she re-assessed the resident and placed him back on therapy due to his decline in function and ambulation. Staff J reported the resident had a stroke and could decline quickly if not doing his exercise activities. Staff J stated the facility did not have a designated restorative person, but some CNAs (certified nursing assistants) helped with restorative activity. During an interview 5/24/22 at 11:40 AM, the Director of Nursing (DON) reported staff documented restorative activity under tasks in the EHR since early 2021. The DON stated no restorative activities were documented on paper. The DON stated a restorative aide started working full time in 5/22, but before that time, the assigned restorative aide worked as a CNA and helped cover staffing needs. During COVID, the restorative aide worked as a CNA, so they didn't have restorative activity for awhile. The DON agreed when residents didn't get restorative exercises, the resident had potential for a decline in ADLs and ambulation (walking), and then had therapy re-evaluate the resident. During an interview 5/25/22 at 10:00 AM, Staff A, Licensed Practical Nurse (LPN) stated she had worked at the the facility for 2 1/2 years. Staff A reported Staff B, certified medication aide, just started doing restorative activity with the residents. Prior to this date, a few CNAs helped do restorative activity but it depended on staffing.	F 676		

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	165350	A. BUILDING _____ B. WING _____	05/31/2022

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F 676	Continued From page 49 During an interview 5/25/22 at 10:15 AM, Staff B, certified medication aide (CMA), reported she had worked at the facility since 12/21, and just began doing restorative activity the past 3 weeks (since the beginning of 5/22). Staff B stated when she started to work at the facility, they had no restorative aide for quite awhile. Staff B reported residents who received a restorative program and the type of restorative activity to perform with each resident would be listed on point of care in the EHR. During an interview 5/26/22 at 10:30 AM, the Administrator reported they had a restorative program in the works, and planned to hire and fill restorative aide positions. The Administrator reported when she started in the Administrator role in 12/21, the restorative program for residents was hit and miss, and non-existent at times because of staffing needs. The restorative aide worked as a CNA whenever needed due to short staffing. At 12:35 PM, the Administrator reported being unable to find a policy on the restorative program. The Administrator stated a plan to institute a policy by 7/1/22.	F 676		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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	F 725		

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F 725	Continued From page 50 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and resident and staff interviews, the facility failed to ensure staff provided timely assistance for one of 24 residents (Resident # 39) sampled for review. The facility reported a census of 69 residents at the time of the survey. Findings include: Resident # 39's admission minimum data set (MDS) dated 4/16/22, indicated intact cognition with a brief interview for mental status (BIMS) score of 15. The MDS identified Resident # 39's diagnoses included fracture of his right tibia, diabetes mellitus, chronic pain, anxiety disorder, and depression. The MDS also indicated recent orthopedic surgery requiring active skilled nursing facility care. The resident's physical therapy plan of care dated	F 725	F725 The plan for correction on this specific deficiency is as follows: Resident # 39 is a 2 person assist and staff must wait for another staff to assist before moving resident. Staff were re-educated to assist resident out of bed upon resident's request. Should the resident choose to not get up staff are to document this in the resident's electronic chart. The Administrator conducted an interview with five residents on 5/27/22 concerning their care and staffing no complaints were made. Corrective action has been taken to help to enhance staffing and to ensure the deficient practice does not recur as of 6/3/22 the Administrator has hired nurses and certified nursing assistants for all three shifts. In addition, to ensure the deficient practice does not recur and residents are gotten out of their beds upon request, CNA's will go in teams to the resident's rooms that are 2 person assists so they are able to help the residents in a timely manner. The Administrator and Director of Family and Resident Services are checking periodically throughout shifts to ensure call lights are being answered timely and will complete call light audits weekly on all shifts. The Administrator and the Director of Resident and Family Services are responsible for compliance with this plan of correction. This plan of correction has been implemented.	

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F 725	Continued From page 51 4/21/22, showed long term goals for Resident # 39 to complete bed mobility tasks safely with modified independence (assistive device or extra time needed) with trained nursing/CNA (certified nurse aide) in order to improve functional mobility at home, and for Resident # 39 to transfer with minimal assistance (1-25% assist) from trained nursing/CNA in order to improve functional mobility at home. The occupational therapy plan of care dated 5/16/22 also showed Resident # 39's transfer goal to complete all functional transfers safely with supervision (needs verbal cueing but no physical assist) in order to return to PLOF (prior level of function). Observations/interviews pertaining to Resident # 39's call/need for assistance showed the following: 1. On 5/18/22: a. At 8:33 AM, Resident # 39 was in his room lying in bed, Staff B certified medication aide (CMA) entered and came out from room with a breakfast tray. b. At 9:33 AM, Resident # 39 lay in bed and responded to knock on door. Resident # 39 reported he ate breakfast in bed but waited for staff to get him up. c. At 10:12 AM, Resident # 39 was still lying in bed. d. At 4:10 PM, Resident # 39 was still lying in bed awake. Resident # 39 said thinking surveyor was a staff member in the room to help when he asked 'what is going on?' When asked what he meant, the resident replied that he had been in bed all morning. Resident # 39 said he told somebody right after eating that he wanted to get up and sit in the chair but the staff didn't come back. Resident # 39 reported this was not the first	F 725		

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F 725	Continued From page 52 time that happened, that staff will say to come back and never do. Resident # 39 said he had been waiting for help since morning. e. At 4:12 PM, Staff B entered Resident # 39's room and told Resident # 39 that somebody would come get him up. f. At 4:24 PM, Resident # 39 lay awake in bed. g. At 4:28 PM, 2 staff members entered the room with a Hoyer (mechanical) lift to help Resident # 39. 2. On 5/19/22: a. At 8:20 AM, the call light was on at Resident # 39's room. b. At 8:24 AM, Staff B entered the room and Resident # 39 asked Staff B about getting up. Staff B told Resident # 39 that staff would come get him up to the chair. Staff B then exited the room with a meal tray. c. At 9:29 AM, Staff K licensed practical nurse (LPN) entered Resident # 39 and asked about doing wound treatments on his right ankle; Resident # 39 was still sitting in bed. d. At 9:34 AM Resident # 39 said that he had been asking to get up since this morning. Resident # 39 reported that the therapist wanted him to be up and to sit in that chair [pointing at chair] every day. Resident # 39 said that therapy recommendation was not being done because just like today, nobody came in to help yet. When asked if he put call light to ask for help, Resident # 39 stated staff had just been in the room. Resident # 39 also said that had always been the case that they would come to answer call light, say they will come back but do not. e. At 9:45 AM, Staff K and and Staff D assistant director of nursing (ADON) entered Resident # 39's room to complete wound treatment. f. At 9:50 AM, Resident # 39 also told Staff D	F 725		

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F 725	Continued From page 53 about wanting to get up and sit on the chair. Resident # 39 repeated to Staff D that he asked since breakfast to get up from bed and sit in the chair but nobody helped. g. At 9:58 AM, Staff L (CNA) and Staff M (CNA) entered the room with a Hoyer to assist Resident # 39 up. h. At 10:14 AM, Resident # 39 sat up in a chair and reported he felt better sitting in the chair. Resident # 39 stated he wanted to work with therapy recommendations because he wants to go home. 3. On 5/26/22: a. At 9:43 AM, Resident # 39 sat in bed awake with meal table/side table over the bed in front of him with glasses of liquids/drinks. Resident # 39 stated that therapy was going to get him up and then he would sit in the chair. Resident # 39 also stated that now they want him to sit up in the chair to eat, so he was working on that. b. At 11:16 AM, Resident # 39 was still sitting in bed. On 5/26/22 at 11:43 AM, Staff J physical therapy (PT) stated Resident # 39's therapy recommendation was to get up from his bed and sit in the recliner or chair for meals. Staff J stated Resident # 39 has a motorized scooter at home with goal to be able to transfer and go home. Staff J stated the expectation that staff follow Resident # 39's care plan. On 5/26/22 at 1:43 PM, the Administrator stated the expectation for staff to follow therapy recommendations and assist to follow up on residents' requests for help.	F 725		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 54 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 observations and staff interview, dietary staff failed to maintain clean and sanitary conditions in the kitchen in order to reduce the risk of contamination and food-borne illness. The facility identified a census of 69 residents. Findings include: I. Observations during the initial kitchen environment tour on 5/16/22, beginning at 11:05 AM, identified the following concerns: a. The kitchen floor was sticky with dried food particles throughout the kitchen area. b. The stove top had a large amount of black	F 812	F812 The plan for correction on this specific deficiency is as follows: On May 27, 2022, the Administrator inspected the kitchen for cleanliness and educated the dietary manager of all deficiencies. The Dietary Manager and Administrator in-serviced all dietary staff regarding the requirements and responsibilities of the cleanliness of the kitchen. The Administrator had the floors cleaned with professional products on 5/28/2022. On 5/31/2022, administrator approved overtime for dietary department to deep clean stove, grill, microwave, and steam table. The Dietary Manager, Administrator, and/or Director of Nursing will audit the daily cleaning task list, 3x weekly for 12 weeks. This will be documented on the kitchen audits. The Dietary Manager or Cook will report any cleanliness issues or daily task not being completed immediately to the Administrator thereafter. The Administrator and the Dietary Manager are responsible for ensuring that this plan of correct is complete. Substantial compliance will be attained by 8/5/2022	

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F 812	Continued From page 55 carbon build-up with areas of carbon flaking off and loose burnt food debris scattered across the top. There were dried food streaks/drippings down the oven door fronts and the knobs, and the areas around the knobs were soiled. c. The flat grill showed dried food particles on the grill and dried food drippings down the front of the grill. d. The inside of the microwave had dried food splatter on the tray, top, door and all sides. e. The bottom shelf of the steam table contained dried food splatter. f. The bottom shelf of the prep table was covered with a powdered substance and dried food debris. During an interview on 5/16/22 at 11:25 AM, the Dietary Manager (DM) observed and confirmed the cleaning concerns identified. The DM stated the expectation that the areas should be clean.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		

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F 883	Continued From page 56 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 57 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility policy review the facility did not ensure administration of influenza vaccine to 1 of 5 residents (#53) reviewed for immunizations. The facility reported a census of 69 residents. Findings include: The progress notes indicated Resident # 53's admission date as 4/18/22 for skilled nursing facility level of care s/p (status post) a fall with right shoulder dislocation. The progress notes recorded Resident # 53's admitted to the hospital on 5/2/22 related to skin sores with oozing pus. Resident # 53 returned to the facility on 5/6/22 after hospitalization for bullous pemphigoid (a rare skin condition that causes large, fluid-filled blisters) and infection. Resident # 53's 5-day minimum data set (MDS) assessment dated 5/10/22 documented she had intact memory and cognition with a brief interview for mental status (BIMS) score of 15. The MDS listed Resident # 53's active diagnoses included dislocation of his right shoulder joint, bullous pemphigoid and methicillin staphylococcus infection (MRSA, an antibiotic resistant infection). During initial admission on 4/18/22, Resident # 53 signed a document titled, "Flu Vaccine Consent Authorization - Nursing Facility" that indicated his consent for the facility to administer the influenza vaccine to him. However, review of Resident # 53's immunization record on 5/18/22 showed no documentation that he received the influenza	F 883	F883 Corrective action for resident(s) affected by the alleged deficient practice: Resident #53 is still not at baseline, and it is not safe to administer the vaccine currently. Resident #53 will be reevaluated after discharge from infection disease. The Director of Nurses/Unit Managers completed a audit of all pneumococcal and influenza vaccines to assess any residents who were eligible and didn't receive the pneumococcal and influenza vaccine. Any residents who were not vaccinated were assessed and offered the pneumococcal and influenza vaccine according to facility policy. The Director of Nurses/Unit Managers followed up with the residents and any family representatives for any residents who were identified as not receiving the pneumococcal and influenza vaccine during this audit to provide education for the vaccine. The Director of Nurses and the Nurse Management team will re-educated on the immunization policy and procedures The education will include the following topics: • Education to the resident or resident's representative of the benefits and potential adverse side effects of the vaccinations. • Obtaining of consent for administration of the vaccinations. • Uploading the consent or declination in Point Click Care (PCC). • Obtaining a physician's order to administer the vaccinations. • Administration of the vaccines. • Documentation of the vaccinations in the resident's immunization record in PCC. • Utilizing the Immunization Check list for pneumococcal and influenza vaccines Director of Nurses/Nurse Management team will begin education of all full time, part time and as needed nurses and agency nurses on the Pneumococcal and Influenza administration process. The Director of Nurses/Unit Managers will monitor the immunization process for pneumococcal and influenza vaccines by observing 5 residents utilizing the Immunization Audit Tool during the Daily Clinical Meeting Monday through Friday for compliance of the facility policy. This audit will be completed weekly for a period of 4 weeks and then monthly for a period of 3 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Substantial compliance will be attained by 8/5/2022	

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F 883	Continued From page 58 vaccine. On 5/18/22 at 12:08 PM, Staff D (Assistant Director of Nursing) verified that Resident # 53 consented for influenza immunization during admission on 4/18/22 but did not receive the said immunization as of this date. Staff D stated that it was his nursing judgment to not administer the vaccine because Resident # 53 was then hospitalized for skin infections. Staff D verified the resident's record lacked evidence to show communication to the physician and Resident # 53 regarding the decision to hold the immunization. The facility's Vaccine Policy, revised 3/22/22, documented the purpose to maintain a safe environment for residents, employees, visitors, vendors and other essential persons with whom you may encounter. The policy also indicated a goal to to prevent the occurrence of influenza. The policy further indicated that documentation regarding administration will be completed in the EMAR (electronic medication record).	F 883		