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	165441	A. BUILDING _____ B. WING _____	09/30/2021

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SUNNY VIEW CARE CENTER	410 N W ASH DRIVE ANKENY, IA 50023

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F 000	INITIAL COMMENTS Correction date 10/29/21 The following deficiencies result from the facility's annual health survey and investigations conducted September 15-30, 2021. Investigation of complaints #89493-C and #90856-C did not result in deficiency. Complaint #93100-C, #93813-C, and facility-reported incidents #95229-I, #99746-I and #100074-I were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		

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

Mike Anderson Administrator 10/29/21

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

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medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to document an accurate code status for one out of 24 residents reviewed for advanced directives (Resident #63). The facility reported a census of 71 residents.

Findings include:

The Minimum Data Set (MDS) assessment tool dated 8/4/21, documented Resident #63 had diagnoses of coronary artery disease, hypertension, renal insufficiency (poor kidney function), diabetes, and cerebrovascular accident (CVA). The MDS documented 11/5/20 as the resident's admission date.

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The resident's care plan updated on 5/20/21 had no advanced directive listed.

The IPOST (Iowa Physician's Orders for Scope of Treatment) signed on 11/6/20 recorded a do not resuscitate (DNR) status requested in the event the resident's heart stopped beating or she stopped breathing.

The Medication Review Report revealed a physician's order for a full code since 3/3/21.

The electronic health record (EHR) revealed the resident's code status listed as full code.

During observation 9/22/21 at 2:50 PM, the name placard by the resident's room revealed no sticker by her name.

In an interview 9/20/21 at 2:47 PM, Staff C, Licensed Practical Nurse (LPN) reported she looked at the IPOST in the resident's paper chart for the advanced directive and code status. Staff C reported the nurses entered orders in the EHR whenever a physician order received.

In an interview 9/22/21 at 2:30 PM Staff D, LPN, reported he looked at the IPOST in the resident's chart to verify a resident's code status.

In an interview 9/22/21 at 2:40 PM, the facility's Corporate Nurse reported they checked the IPOST, EHR, and the purple dot system to know a person's code status. The purple dot sticker on a resident's name placard meant the resident was a full code. The Corporate Nurse reported the nurses entered orders into the EHR. At the time, the Corporate Nurse confirmed a discrepancy

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F 578	Continued From page 3 with Resident #63's IPOST signed 11/6/20, and the physician's order dated 8/2021. The IPOST revealed a DNR status, and the physician's order revealed a full code status. The Corporate Nurse reported she planned to update the order in the EHR. In the event the resident's advanced directive had changed, a new IPOST would've been obtained and signed by the resident/representative and physician.	F 578		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		

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Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on facility document review and staff interview, the facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices for one of three residents reviewed for liability and appeal notices (Resident #30). The facility identified a census of 71 residents.

Findings include:

Review of facility documentation for Resident #30 revealed the resident received the Medicare benefits for skilled services 6/22/21 through

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F 582	Continued From page 5 8/9/21. The facility provided the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice (CMS form 10055), to inform the resident of the potential liability if skilled services continued but failed to identify the selection of an option for continuation of services, the option for an appeal, or termination of services. In an interview 9/27/21 at 11:13 AM, Community Coordinator acknowledged no option marked on CMS form 10055 for Resident #30, but one of the boxes should have been marked by the resident or representative.	F 582		
F 656 SS=D	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 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	F 656		

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F 656	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to develop a care plan to address the resident need for oxygen and hospice care for one of 20 sampled residents reviewed for comprehensive care plans (Resident #10). The facility reported a census of 71 residents. Findings include: The Minimum Data Set (MDS) assessment dated 5/25/21 for Resident #10 recorded the resident had short-term memory problems and moderately impaired cognitive skills for daily decision-making. The resident had diagnoses that included atrial fibrillation, hypertension, chronic kidney disease and diabetes mellitus. The MDS documented the resident received hospice services and oxygen therapy while residing in the facility.	F 656		

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F 656	Continued From page 7 The resident's Order Summary Report dated 9/29/21 recorded an order initiated on 5/21/21 that directed Resident #10 receive 2 liters continuous oxygen via nasal cannula. The signed order dated 5/10/21 revealed Resident #10 received hospice services. Observations on 9/15/21 at 11:30 AM and 9/20/21 at 8:46 AM revealed Resident #10 in bed wearing oxygen running at 2 liters per nasal cannula. The resident's care plan revised on 6/9/21 failed to document coordination of care with hospice that reflected interventions required by both entities. The care plan also lacked documentation resident received oxygen until 9/21/21 when staff updated Resident #10's care plan to reflect his oxygen and hospice care. The hospice records revealed Resident #10's care plan reviewed in an Interdisciplinary Group Meeting dated 9/15/21 at 12:30 PM. The hospice care plan lacked documentation that reflected resident received oxygen and interventions required by both entities. In a joint interview on 9/21/21 at 12:00 PM with Staff H, Director of Clinical Services and the Administrator, Staff H, stated Resident #10 received hospice services and hospice staff maintained his oxygen tanks and tubing. She noted the facility wanted hospice to follow facility policy regarding oxygen use and acknowledged a need for education of hospice staff. On 9/21/21 at 1:30 PM, Staff J, MDS Coordinator stated that oxygen and hospice should be on	F 656		

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F 656	Continued From page 8 resident care plans. In an interview on 9/27/21 at 9:21 AM, Staff E, Registered Nurse (RN), stated the facility followed directives in the RAI (Resident Assessment Instrument) to complete MDS assessments and that hospice and oxygen should be on resident care plans. The facility policy titled Care Planning, revised in 2018, directed the comprehensive care plan based on a thorough assessment that includes, but is not limited to the MDS. The resident's comprehensive care plan developed within 7 days of the completion of the resident's comprehensive assessment (MDS). Assessments of residents were ongoing and care plans revised as information about the resident and the resident's condition change. The MDS 3.0 RAI Manual v1.17.1_October 2019 accessed 9/23/21 at 1:13 PM documented if a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, facility policy review, and staff interviews, the facility failed to assess and document follow up skin assessments for one of three residents reviewed (Resident #24). The facility reported a census of 71 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 6/22/21 documented Resident #24 had diagnoses that included major depressive disorder, hemiplegia (weakness on one side of the body) and hemiparesis (paralysis) following unspecified cerebrovascular disease affecting left non-dominant side, long term (current) use of anticoagulants, and peripheral vascular disease. The MDS indicated the resident required extensive assistance of two staff for bed mobility and toilet use and the assistance of one staff for personal hygiene. The MDS revealed the resident had moisture associated skin damage and had a risk for pressure ulcers.

The resident's care plan, revised on 4/28/21, documented Resident #24 had a risk for skin breakdown related to impaired physical mobility and incontinence. The care plan directed application of anti-itch lotion to her extremities, gentle repositioning and cares, geri-sleeves to her arms, an air mattress, derma foam sleeves to her arms, encourage good nutrition and hydration, occupational therapy to evaluate

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electric wheelchair safety, seat cushion in electric wheelchair, treat skin tears per facility protocol, keep skin clean and dry, monitor and document the location, size, and treatment of the skin injury, and report abnormalities, signs/symptoms of infection or maceration, provide incontinence care, ensure proper removal of Hoyer sling and use a blanket as padding when transferring in the lift.

The Braden Scale (to predict pressure ulcer development) assessments of 9/20/20 and 12/16/20 revealed a score of 12 indicating Resident #24 at high risk for skin breakdown. The Braden Scale assessments dated 3/23/21 and 6/22/21 revealed a score of 13 indicating the moderate risk for skin breakdown.

The resident's Ulcer Documentation forms revealed daily skin assessments and measurement on 3 ulcers identified for Resident #24 dated 8/31/21, 9/1/21, 9/2/21, 9/3/21, 9/4/21, and 9/6/21. No assessments were noted on 9/5/21. The forms documented the following:
a. On 8/31/21, the resident had a 0.4 centimeter (cm) long (L) by 0.6 cm wide (W) by 0.1 cm deep (D) Stage II ulcer to her left buttock. It remained the same size on 9/1/21, 9/2/21, and 9/3. On 9/4/21 and 9/6/21 the measurement was 0.4 cm L by 0.5 cm W by 0.1 cm D. All assessments indicated the wound as pink, dry and with no exudate (drainage).
b. On 8/31/21, the resident had a 0.6 cm L by 0.4 cm W by 0.1 cm D ulcer to the left fifth toe. The ulcer remained the same size on 9/1/21, 9/2/2/21, and 9/3/21. On 9/4/21 and 9/6/21 the area measured 0.6 cm L by 0.5 cm W by 0.1 cm The daily assessments indicated the wound raised purple/red and irregular with no exudate.

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F 684	Continued From page 11 c. On 8/31/21, the resident had a 0.3 cm L by 0.3 cm W ulcer to the left second toe. The ulcer remained the same size on 9/1/21, 9/2/21 and 9/3/21. On 9/4/21 and 9/6/21 the area measured 0.2 cm L by 0.2 cm W. The daily assessments indicated the wound as brown, dry, irregular with no exudate. The Ulcer Documentation forms contained no measurement or assessments on all 3 pressure areas from 9/6/21 to 9/21/21. The resident's Ulcer Documentation forms dated 9/21/21 completed by the Corporate Nurse revealed the following information: a. The left buttock pressure area wound bed was pink, dry healing eschar tissue and the wound edges pink and intact. The wound measured 2.1 cm L by 1 cm W by 0.1 cm D. The type of wound had changed from a Stage II pressure ulcer to a shearing/moisture associated skin damage (MASD) wound. b. The left fifth toe pressure area wound bed assessed as open, red and the wound edges pink and smooth. The area had scant amount of sanguineous (clear reddish) drainage. The wound measured 0.8 cm L by 0.5 cm W by 0.1 cm D. The type of wound changed from a pressure ulcer to an arterial/peripheral vascular disease (PVD) wound. c. The left second toe pressure area wound bed showed a brown scab and pink and intact wound edges. The wound measured 0.4 cm L by 0.4 cm W and could not be staged. The type of wound changed from a pressure ulcer to an arterial/peripheral vascular disease (PVD) wound. Review of Resident #24's Progress Notes revealed the following information:	F 684		

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F 684	Continued From page 12 a. On 8/31/21, staff noted pressure areas on Resident #24's left buttock, the left second and pinky toes. Staff notified the resident's Power of Attorney (POA) and notified her ARNP (Advanced Registered Nurse Practitioner) via fax (facsimile). b. On 9/1/21, staff received new orders for Triad cream to the area on her buttocks and Betadine to the left foot; staff notified the resident's family. c. On 9/3/21, Resident #24 voiced no complaints and no adverse effects noted with treatment to her toes and buttock. The resident assisted with activities of daily living every two hours per staff. d. On 9/4/21, staff noted no adverse side effects from the treatments to her toes and buttock. e. On 9/7/21, staff documented Resident #24 had several open areas to her skin with treatment continuing. During observation on 9/21/21 at 9:10 AM, Resident #24 had a small reddened area on her upper left buttock covered with ointment. The resident also had scabbed areas on top of her left second toe and her left little toe with Betadine applied to the areas. In an interview 9/30/21 at 8:24 AM, the Director of Nursing (DON), reported she expected staff to notify the DON or Corporate Nurse whenever they identified a new resident skin issue or pressure area. The DON expected staff to initiate a skin sheet assessment, assess and measure the wound daily for seven days, and notify the family and physician. The DON or Unit Manager then completed the skin assessment after the initial seven days until the area healed. The DON stated staff notified the physician whenever a decline noted and treatment then changed as appropriate.	F 684		

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F 684	Continued From page 13 A facility policy titled Skin Assessments, dated 2016, documented the purpose to ensure residents received proper assessment of their skin, maintain skin integrity, and steps are taken to ensure proper treatment and follow-up taken for skin concerns. Whenever staff identified a skin concern, staff direction included documentation on a skin condition report, a new entry in the nurse's notes, necessary notifications made and placement in the "Hot Charts". The policy directed to continue documentation in the nurse notes for seven consecutive shifts. Following the seventh entry, remove from "Hot Charts" and follow the weekly skin assessment protocol. Complete resident treatments until wound is healed. The Unit Manager responsibilities included conducting weekly assessments on all pressure sores and/or surgical sites. The Unit Manager is responsible for all notifications and interventions, to communicate any and all changes to the resident(s) plan of care to the charge nurse and participate in a weekly skin meeting.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and facility policy review, the	F 689		

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facility failed to provide adequate supervision to prevent falls and provide a safe environment for two of five residents (Residents #40 and #79) reviewed for falls. The facility reported a census of 71 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 3/30/21 for Resident #79 recorded diagnoses that included arthritis, Non-Alzheimer's dementia, anxiety disorder and a history of COVID 19. The MDS documented the resident had severely impaired memory and cognition and was totally dependent on two staff for bed mobility and transfers. The MDS also recorded she fell twice and sustained non-major injuries since the prior assessment. Resident #79 received antianxiety medication one day out of seven and an opioid medication two days out of seven during the look back period

Review of the resident's Care Plan, initiated on 6/3/13, revealed she had a risk for falls related to confusion, unawareness of safety needs and being very unsteady at times. The Care Plan directed staff to keep her bed in the lowest position with the left side rail in place, place a padded side rail for safety, use a low bed, and place a mattress by the bed. Care Plan interventions added on 5/5/21 included a sign in the room to leave her bed in the lowest position before staff left the room and removal of a table from the room to allow staff room to prevent injuries from falls.

The Bio Sheet (pocket care plan for staff) revealed Resident #79 needed bilateral side rails, but lacked other fall interventions prior to

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resident's fall. The Bio Sheet dated 5/5/21 at 9:00 AM documented Resident #79 as at high risk for falls. Staff directives included to ensure the bed was in its lowest position, placement of a floor mat next to the bed while in bed, and bilateral side rails up.

The Side Rail assessment dated 6/19/20 revealed resident had a left side rail to promote her safety and independence.

The Morse Fall Scale assessment dated 12/24/20 revealed the resident had a high risk for falls and a history of falls.

In a communication to the physician on 4/16/21, staff documented Resident #79 found lying on her abdomen next to the bed on the floor. Staff initiated fall follow up with neurological (neuro) checks.

Communication to the physician on 5/4/21 recorded Resident #79 had unwitnessed fall out of bed. The resident's left knee and leg appeared more rotated than usual and she screamed out with touch to her left knee and left hip. Staff obtained an order to send Resident #79 to the emergency room for evaluation.

The resident's Nurse's Notes revealed the following information:

a. On 3/27/21 at 10:21 AM, staff found Resident #79 on the floor at 6:15 AM sitting up with her back against the end of the bed. Assessment revealed red/purple discoloration. Nobody witnessed the fall and staff initiated neuro checks.
b. On 4/16/21 at 4:30 AM, a Certified Nursing Assistant (CNA) found the resident lying on floor

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F 689	Continued From page 16 on her stomach next to the bed. A CNA saw the resident approximately 1/2 hour before. Assessment revealed a skin tear and bruising to her left arm by the elbow. Staff completed an incident report and obtained witness statements. Staff initiated fall follow up and neuro checks. c. On 4/30/21 at 9:50 PM, staff found Resident #79 on the floor around 9:15 PM. Assessment revealed no injuries and staff would continue to monitor. d. On 5/4/2021 at 8:34 PM, Resident #79 had an unwitnessed fall out of bed and a CNA found her upon passing the room. Resident #79 lay with her head toward the door and her left leg bent at a 90 degree angle next to end table. The resident's knee appeared rotated further inward and resident yelled out in pain when her knee and left hip were touched. The resident's left knee appeared dislocated with a possible left hip injury. Her vital signs measured BP (blood pressure) 159/67, P (pulse) 65 and R (respirations) 20. Another nurse assessed the resident's leg and believed an injury occurred. Staff notified family members and Resident #79 transferred to the hospital for evaluation. e. On 5/5/21 Hospital staff informed facility staff Resident #79 fractured both femurs and had a urinary tract infection. f. On 5/5/21 at 6:14 PM, Resident #79 returned to facility via ambulance at approximately 5:45 pm. The resident had bilateral femur breaks and immobilizers on her legs to be worn at all times. The resident returned with orders for morphine every 2 hours as needed for pain, Ativan every 4 hours as needed for anxiety, and Levaquin (antibiotic) daily for five days. Resident #79 yelled out in pain when rolled onto her side. Staff positioned her bed in the lowest position and placed a floor mat. Resident #79 was extremely	F 689		

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agitated and yelled out in pain when the nurse attempted to look at her legs; unable to assess the areas due to resident distress.
g. On 5/12/21 at 4:15 AM, staff documented administration of Ativan and morphine at 10:30 PM and 2:30 AM for restlessness and pain. The resident's left above the knee area had a hole about .5 cm (centimeter) round with drainage. Staff applied an ABD (dressing), but the resident removed the dressing and the area now measured one cm by .4 cm with bone seen in the hole. The nurse re-arranged the immobilizer to straighten the resident's leg and keep her bone from rubbing on the hole. The nursed notified Hospice notified and applied a new dressing.
h. On 5/22/21 at 7:50 PM, staff changed the dressing to her left knee due to saturation through the gauze dressing and noted the bone appeared to be protruding more than usual.
i. On 5/24/21 at 11:49 AM, staff summoned the nurse to the resident's room at 8:40 AM. Resident #79 had no respirations or heart rate.

The Quality Assurance Condition Report dated 5/4/21 at 8:25 PM revealed Resident #79 as found by a CNA. The nurse evaluated the resident; her left leg bent at a 90 degree angle next to the end table and her left knee appeared rotated with pain to the left hip. The nurse called 911. The author added an intervention to the Bio Sheet/care plan for the resident's bed to be in its lowest position and a floor mat by the bed. Both interventions were not on the Bio sheet/care plan and education provided to CNAs.

A Witness Statement dated 5/4/21 at 8:25 PM Staff O, CNA documented she last visualized the resident after supper when she laid her down and changed her. Staff O wrote the Bio sheet

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indicated Resident #79 needed to be on her side because of a wound on her coccyx but didn't say anything about her bed being in the lowest position or a mat on the floor and no signs detailing either of these interventions. Staff O heard the resident yelling for help and found her on the ground. Staff O got help and staff moved her into a lying position; the resident's leg looked wrong and she complained of pain.

The Emergency Department physician's note dated 5/4/21 revealed resident fell out of bed and complained of bilateral leg and hip pain. X-ray of left and right knee revealed distal femur fractures.

The Internal Medicine History and Physical dated 5/5/21 documented Resident #79 fell out of bed on 5/4/21. The resident complained of bilateral hip and leg pain. Per family, the resident had a low bed at nursing facility, pads on the floor and bed rails to prevent her from falling out. Somehow, the resident was found down on the ground by staff and were concerned about her lower extremity injuries. The physician documented the resident had acute bilateral distal femur fractures and consulted Orthopedics.

The Orthopedic Consult note dated 5/5/21 documented the resident had closed bilateral periprosthetic distal femur fractures, left worse than right. Resident #79 was not a surgical candidate given her history.

An Employee Warning Notice dated 5/4/21 recorded that Staff M, former Director of Nursing (DON) provided coaching to Staff O, CNA regarding leaving resident bed in the highest position. Resident crawled out of bed which resulted in injury.

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An Employee Warning Notice dated 5/5/21 documented Staff M provided coaching to Staff P, Licensed Practical Nurse (LPN) regarding failure to place an intervention on the Bio sheet and as a result the aides did not follow the intervention and Resident #79 fell. Staff M instructed that Staff P immediately will put all interventions on the Bio sheet.

The resident's Skin Condition Report dated 5/12/21 revealed she had open area with red drainage and bone tip showing to her left leg above the knee. The resident wore an immobilizer to the knee area.

In an interview on 9/23/21 at 9:45 AM, Staff M, Registered Nurse (RN), stated she worked as a RN since 2008 and worked at the facility since 2016. Staff M was familiar with residents and the care they required. Staff M used the pocket care plan for each individual to guide care; the pocket care plan provided knowledge of assistance needed and interventions. She referred to the pocket care plans as mini care plans set up for each resident and fall interventions are incorporated. Nurses complete follow up after falls that included vital signs and assessment (possibly neurological) every shift for 72 hours. She reported the facility completed huddles on each shift that updated nurses on changes. The Managers updated the pocket care plans, placed them on a drive, and printed them each morning. The pocket guides were placed in a binder for all staff to review. Staff M said changes made throughout the day were put on the master copy and entered in the system the next day. Licensed staff initiated fall interventions immediately after a fall. If management did not agree with the

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implemented intervention, they changed it back or initiated a different intervention and then updated the pocket care plan. Staff M reported the facility rarely used alarms and used alarms as a last resort. Staff M could not recall that any residents currently utilized alarms. She remembered Resident #79 and believed that she had an infrequent fall history. Staff M stated that Resident #79 came on and off Hospice. Staff M remembered the fall on 5/4/21 in which Resident #79 fell from her bed and fractured her femurs. The resident went to the hospital and returned on 5/5/21. On the evening of the fall in question, she thought Resident #79's bed was left in the high position and the side rails were up. She thought maybe Resident #79 climbed over the top of the side rails. Staff M did not know for sure if Resident #79 used a regular bed or a low bed; she received hospice services at the time of the fall. Staff M did not know whether or not the pocket care plan contained fall interventions that staff did not use at the time of the fall. Staff M reported she was the DON at the time of the incident and did not recall concerns with the fall or how staff handled the fall. Staff M stated Resident #79 had no alarm at the time of the fall. Staff M did not recall intervention put into place after the fall, but stated staff put interventions in place after every fall. The management team reviewed falls daily, planned interventions, and assisted with implementation. Staff M considered residents at risk for falls with any medication changes, anxiety, agitation, confusion, and behavior out of the norm, room changes or new admissions. Residents are assessed for fall risk upon admission and quarterly thereafter or with any physical or behavioral changes. Staff documented the assessments on the admission paperwork and in the electronic health record

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(EHR) or in the paper chart. Staff documented fall assessments in the progress notes. Staff M reported she monitored staff to ensure interventions were implemented and placed on Bio sheets. The management team reminded staff to sign off on changes made and discussion at shift report.

In an interview on 9/23/21 at 11:40 AM, Staff O, CNA, stated she worked at the facility for three years and became familiar with the residents, cares needed, and how much assistance they needed by referring to the Bio sheets which had information about each resident. Staff O, stated fall interventions are located on the back of the Bio sheets (for example fall mats, low bed, wheelchair by bed), and the front of the Bio sheets indicated how much assistance each resident needed. Staff O stated the facility no longer utilized bed alarms. Resident #79 fell on 5/4/21 and Staff O reported she put the resident to bed that evening. Staff O reported she had not worked at the facility in a while, and did not know of the resident's change in cognition, her crawling out of bed, and recent fall. Staff O reported she had reviewed the Bio sheet prior to assisting Resident #79, and noted she had a body pillow on her bed but unsure of the reason. Staff O stated the Bio sheet lacked interventions related to falls. She received report but because she hadn't worked in a while, pertinent information related to Resident #79 was not shared. Staff O assisted the resident to bed and placed a body pillow and padded side rail. A couple of hours later she heard the resident yelling. Staff O found Resident #79 on the floor and noted an injury as her leg was crooked and she appeared in pain. Staff O notified the nurse for assistance. Staff O stated that after the fall, staff put interventions in

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place. Physical Therapy marked all the residents' walls at the level where the bed should be left after the incident.

In an interview on 9/27/21 at 08:40 AM, Staff A, CNA, stated she had worked at the facility since 9/2020, and was familiar with the residents who resided in the front halls. Staff A reported she utilized the care plans or Bio sheets to know what cares the residents needed. The Bio sheets are located at the nurse's station and then they are printed daily for the staff to review. Staff A stated fall interventions are located next to the resident's name on the Bio sheet. The Bio sheet tells staff what type of supervision or assistance the resident needed. The CNAs and nurses provided information to management whenever new interventions were needed for a resident and placed these on the Bio sheet. Staff A reported Resident #79 had a history of falls. Staff A worked the evening of 5/4/21 when Resident #79 fell from her bed. Staff A and Staff O transferred Resident #79 into bed on 5/4/21. Staff A stated she believed the Bio sheet directed to have her side rails down but she could not state if other interventions were on the Bio sheet at that time. Staff A thought the resident had padded side rails at one point.

In an interview on 9/27/21 at 11:26 AM, Staff R, Certified Medication Assistant (CMA), reported she had worked at the facility for four years and was familiar with Resident #79's cares. Staff R reported the resident used a 1/2 side rail on her bed, on the opposite side of the wall, and a body pillow against the side rail. Staff used the side rail anytime Resident #79 lay in bed. Staff R reported she knew to use the side rail by reviewing the Bio sheet. She also stated the side rails were used

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F 689	Continued From page 23 until the resident passed away. In an interview on 9/27/21 at 11:32 AM, Staff B reported she worked at the facility for one year and cared for Resident #79. Staff B recalled the resident used a side rail located in the middle of the bed and the pad placed against the side rail was longer than the side rail. She stated she knew to use the side rails per the Bio sheet. She stated Resident #79 utilized the side rails until the time of her death. In an interview on 9/27/21 at 11:38 AM, Staff Q, CNA, reported she worked at the facility for four years. Staff Q reported Resident #79 utilized side rails while in bed, a fall mat on the floor opposite the wall, and her bed in its lowest position. Staff Q reported the Bio sheets listed the interventions. In an interview on 9/30/21 at 10:53 AM, Staff H, Corporate Nurse, reported the facility had no policy related to falls besides the Resident Safety Policy. At 11:21 AM, Staff H reported there are no other fall policies utilized at the facility. Review of the Resident Safety Policy, dated 2016, revealed following a resident fall, section 2.k. directed staff to document any corrective action taken and section 2.l. directed to documented follow-up information. The policy contained no specific instruction to update resident Care Plans. 2. The admission MDS assessment dated 4/6/21 documented Resident #40 entered the facility on 5/31/18. The resident had diagnoses of a right above the knee amputation, traumatic brain injury	F 689		

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(TBI), depression, osteoporosis and arthritis. The MDS recorded the resident had a brief interview for mental status (BIMS) score of 13, which indicated intact memory and cognition. The MDS documented Resident #40 required the extensive assistance of two for bed mobility and toilet use, total dependence on two for transfers, and partial/moderate assistance to roll left and right. The MDS documented Resident #40 fell once without injury since her prior assessment.

The facility Quality Assurance Condition Report dated 6/23/21 at 6:00 AM documented Staff K, CNA stated Resident #40 rolled out of bed and hit the back of her head on the bedside table while Staff K completed a linen change. Resident #40 reported her right stump was sore and slightly red. No side rails were in use at the time of the incident. Staff L, LPN completed the report, documented environmental concerns, and wrote resident needed side rails. Initiated interventions included counseling of Staff K and the resident.

The witness statement report dated 6/23/21 documented during the process of changing the resident, Staff K, CNA told the resident to roll. As Staff K removed wipes and a bedpan from area, Resident # 40 rolled out of bed onto the floor. On 6/28/21 Staff L, LPN added to the report that staff were educated on Resident # 40's fall and instructed to take all items needed to the bedside when changing Resident #40. Staff K, CNA added she had everything next to her. She stepped back an inch and removed the package of wipes out of her way. During that moment, the resident rolled out of bed. She also noted Resident #40 rolled by herself and Staff K just cued her.

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In an interview on 9/15/21 at 3:15 PM Resident #40 reported while staff assisted her with incontinence care, an aide told her to roll over. The side rail on the bed was down and she rolled off the bed onto the floor causing broken ribs and a punctured lung. In a follow up interview on 9/20/21 at 3:15 PM, Resident #40 stated she fell out of bed while staff assisted her with incontinence care. She stated staff told her to roll to one side of the bed and then roll back toward them. When she rolled back to staff, no one was there and Resident #40 fell off the bed. Resident #40 blamed staff for the fall out of the bed. She stated there was only one staff member in the room. During this interview, Resident #40 reported her only injury was bruising to the stump of her amputated leg. She further stated she had a different fall where she broke her ribs a very long time ago.

In a joint interview on 9/21/21 at 12:11 PM, the Administrator and Staff H, Director of Clinical Services reported that Staff K received counseling for Resident #40's fall. Education completed regarding turning and having resident turn into your body.

In an interview on 9/22/21 at 2:30 PM, Staff K reported she was assisting Resident #40 to change depends (incontinence briefs) and asked the resident to roll towards her. Staff K stated she stepped back maybe one inch to grab a wipe and Resident #40 rolled onto floor. Staff K denied stepping several feet away from the resident.

In an interview on 9/22/21 at 2:48 PM, Staff L, LPN stated Staff K reported she turned Resident #40 and asked Resident #40 to roll towards her.

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F 689	Continued From page 26 When Resident #40 rolled, the CNA thought Resident #40 had stopped rolling and she turned to grab a wipe. Resident #40 continued to roll and rolled onto the floor. Staff L thought the fall was preventable, but she did not witness the fall. Staff L felt the CNA needed to make sure Resident #40 was stable before she grabbed the wipes. At the request of the DON, Resident #40 re-interviewed on 9/29/21 at 9:39 AM regarding her fall on 6/23/21. Resident #40 stated she felt the CNA was at fault for her fall. Resident #40 reported the CNA had Resident #40 turn to the wall. The CNA removed her brief and then told Resident #40 to roll back toward her. Resident #40 said when she rolled back toward the CNA, she rolled onto the floor because the CNA was over by the door to the room. Resident #40 said the trash can held the door open and the CNA went to throw away her brief. Resident #40 reported a minor injury of bruising to her right above the knee amputation stump. The resident's Care Plan, updated 4/23/21, reflected Resident #40 at a moderate risk for falls and had activities of daily living (ADL) self-care performance deficit related to amputation above the right knee. The resident required assistance of two for bed mobility when repositioning the head of the bed, otherwise the assistance of one for turning. The Care Plan identified Resident # 40 used a bedpan, and usually had incontinence episodes daily.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails.	F 700		

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F 700	Continued From page 27 The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation staff interview, and facility policy review, the facility failed to complete ongoing monitoring, assessment, and consent for bed rails for one of four residents reviewed (Resident #40). The facility reported a census of 71 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated 4/6/21 documented Resident #40 entered the facility on 5/31/18. The resident had diagnoses of a right above the knee amputation, traumatic brain injury (TBI), depression, osteoporosis and arthritis. The MDS recorded the resident had a Brief Interview for	F 700		

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Mental Status (BIMS) score of 13, which indicated intact memory and cognition. The MDS documented Resident #40 required the extensive assistance of two for bed mobility and toilet use, displayed total dependence on two for transfers and needed partial/moderate assistance to roll left and right. The MDS recorded Resident #40 fell once without injury since the prior assessment.

The resident's Care Plan, updated 4/23/21, reflected Resident #40 as at a moderate risk for falls and had an activities of daily living (ADL) self-care performance deficit related to amputation above the right knee. The resident required assist of two for bed mobility when repositioning the head of the bed, otherwise the assistance of one for turning. The Care Plan identified Resident # 40 used a bedpan, and usually had incontinence episodes daily. The Care Plan lacked documentation of side rail usage.

The facility provided an informed consent for Resident #40 to use of side rails and a side rail assessment dated 11/13/19. The facility could not provide any additional side rail consents or assessments for Resident #40.

The facility Quality Assurance Condition Report dated 6/23/21 at 6:00 AM documented Staff K, Certified Nursing Assistant (CNA) stated Resident #40 rolled out of bed and hit the back of her head on the bedside table while Staff completed a linen change. Resident #40 reported her right stump was sore and slightly red. No side rails were in use at the time of the incident. Staff L, Licensed Practical Nurse (LPN) completed the report, documented environmental concerns, and wrote

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F 700	Continued From page 29 that Resident #40 needed side rails. Interventions initiated included counseling of Staff K and resident. Observation on 9/15/21 at 3:15 PM revealed ½ side rails on Resident #40's bed. Observation on 9/20/21 at 3:15 PM revealed ½ side rails on Resident #40's bed. The resident stated she liked having side rails to help turn in bed when staff provided cares and said the side rails made her feel safe while in bed. On 9/21/21 at 12:11 PM, in a joint interview with the Administrator present: a. Staff J, Registered Nurse, RN, MDS Coordinator stated in March of 2021 the previous Director of Nursing (DON) and Assistant DON (ADON) reviewed resident charts and determined which residents continued to need side rails. Staff J received a written note that it was determined Resident #40 no longer needed side rails and the facility removed her side rails. Staff removed the side rails from the resident's care plan at that time per DON and ADON instruction. Staff J acknowledged Resident #40's medical record lacked documentation of these events and said she did not know what happened to the note. b. Staff J reported Resident #40 rolled out of bed on 6/23/21. Staff L, LPN completed the incident report and identified Resident #40 needed side rails. Staff J acknowledged the facility did not complete a new assessment for side rails or obtain a new consent for side rails at that time. Staff J said Resident #40's side rail usage was not reported to her as the MDS Coordinator and therefore no side rails were added to the Care Plan after she fell. c. The Administrator and Staff H, Director of	F 700		

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Clinical Services acknowledged per policy, the facility needed a new assessment and consent to re-initiate side rails use. They stated that side rails need to be added to care plan if they are in use for a resident.
d. Staff H stated after the resident's fall, the team reviewed the fall and determined side rails was not the intervention they wanted to use and they discontinued side rails for Resident #40 at that time.
e. The Administrator, Staff J, and Staff H acknowledged observations of current side rail use for Resident #40. Staff J stated the resident liked side rails to help reposition herself and assist with turning in bed. Staff J planned to obtain a new assessment and consent. The facility provided a new side rail assessment and consent dated 9/21/21 and review of the Care Plan showed the addition of side rails on 9/21/21.

The facility policy titled Side-Rail Usage, dated 2017, directed residents' beds will not have side rails unless it is medically indicated, specifically requested by the resident, representative, and/or physician, the assessment is complete and the informed consent signed. The policy directed side rail assessments at the following intervals: admission, re-admission-if in use, quarterly-if in use, yearly-if in use, and significant change-if in use. If a resident required side rails, the following steps needed completed:
a. Completion of side rail assessment
b. Obtain a physician order for the use of side rails
c. Obtain a signed informed consent from the resident or representative
d. Installation of rail per manufacturer guidelines
e. Update the plan of care to reflect use, type, and purpose of side rails

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F 700	Continued From page 31 f. Conduct side rail assessment and care plan updates as specified above Residents that have alternatives to side rails as part of their care plan will have the following completed: a. Completion of side rail assessment b. Install and/or implementation of specified alternatives c. Update the plan of care to reflect the use, type and purpose of specified alternatives d. Conduct side rail assessment and care plan updates as specified in the above schedule	F 700		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 32 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 33 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review observation, facility policy review, review of the Centers for Disease Control (CDC) website, and staff interview, facility staff failed to perform COVID-19 specimen collection in a manner consistent with current standards of practice for conducting COVID-19 tests to properly disinfect the area used for staff testing, and failed to implement infection control standards of practice by failing to label and document oxygen tubing for two of five residents reviewed for oxygen use (Residents #10 & #16). The facility reported a census of 71 residents. Findings include: 1. During observation 9/22/21 at 10:54 AM, Staff E, Registered Nurse (RN), stood at the nurse's station near a laptop computer and cabinets which contained resident charts. Staff E had a white gown, gloves, N95 mask, and goggles on. Staff E swabbed Staff F's (laundry) nasal passage. After Staff E removed the swab, Staff F sneezed and then pulled her N95 mask up over her mouth and nose. Staff E placed the swab inside a COVID antigen test card, removed her gloves and sanitized her hands. Staff failed to disinfect the area after the she obtained the nasal swab specimen and Staff F had sneezed without her mask over her mouth. At 11:30 AM, a COVID antigen test card labeled for Staff F sat on the nurse's station desk with a swab inside. A COVID-19 Response Plan for testing and reporting revised 4/30/21 instructed testing must	F 880		

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be conducted according to nationally recognized guidelines outlined by the Centers for Disease Control and Prevention (CDC) and the Point of Care (POC) testing. Infection control is maintained during specimen collection including full personal protective equipment (PPE) gown, gloves, goggles/faceshield and N95 mask.

The CDC COVID-19 guidance for specimen collection and handling of Point-of-Care and Rapid Tests (https://www.cdc.gov/coronavirus/2019-ncov/lab/point-of-care-testing.html#anchor_1615507063966) updated 7/8/21 revealed personnel collecting specimens or who worked within six feet of persons suspected to be infected with SARS-CoV-2, must maintain proper infection control and use recommended personal protective equipment (PPE), which included an N95 or higher-level respirator, eye protection, gloves, and a lab coat or gown. The CDC recommended surfaces to be disinfected within six feet of specimen collection and handling area before, during, and after testing including between each specimen collection and when the area visibly soiled.

In an interview 9/29/21 at 9:15 AM, the Infection Preventionist reported staff used droplet and contact precautions whenever a person was suspected of COVID-19. The facility performed COVID-19 specimen collection on staff routinely on vaccinated staff without symptoms during an outbreak one to two times a week. During testing, they relied upon the charge nurses to perform the test, and often times the nasal swab specimen collection and test would be performed at the nurse's station, but ideally they expected testing performed upon staff entrance to the

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F 880	Continued From page 35 facility. The Infection Preventionist reported she expected use of Clorox bleach wipes for disinfection of high touch surfaces and for sanitation of the testing area. 2. The Minimum Data Set (MDS) assessment dated 5/25/21 for Resident #10 recorded the resident had short-term memory problems and moderately impaired cognitive skills for daily decision-making. The resident had diagnoses that included atrial fibrillation, hypertension, chronic kidney disease and diabetes mellitus. The MDS documented the resident received hospice services and oxygen therapy while residing in the facility. The Order Summary Report dated 9/29/21 documented Resident #10 required two liters of oxygen via nasal cannula. Observation on 9/15/21 at 11:30 AM revealed the resident in bed with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing. Observation on 9/20/21 at 8:46 AM revealed the resident in bed with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing. Observation on 9/22/21 at 12:47 PM revealed oxygen tubing labeled and dated 9/20/21 In an interview on 9/20/21 at 2:17 PM, Staff C, Licensed Practical Nurse (LPN), stated night shift changed oxygen tubing weekly. She stated facility policy directed oxygen tubing to be labeled and dated.	F 880		

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F 880	Continued From page 36 In a joint interview with Staff H, Director of Clinical Services and the Administrator on 9/21/21 at 12:00 PM, Staff H, stated Resident #10 received hospice and hospice maintained oxygen tanks and tubing. She reported the facility would like hospice to follow the facility policy regarding changing oxygen tubing and acknowledged they needed to do some education with hospice staff. In an interview on 9/21/21 at 1:30 PM, Staff J MDS Coordinator, she stated she expected oxygen tubing labeled and dated per policy. The undated facility policy titled Oxygen Tubing Replacement and Storage Policy/Proper Use of Oxygen Therapy directed that tubing be inspected and changed on a weekly basis and as needed by a charge person in the nursing department. 3. The MDS assessment dated 6/8/21 for Resident #16 identified a BIMS score of 15, indicating intact memory and cognition. The resident had diagnoses that included atrial fibrillation, heart failure, hypertension, and seizure disorder. The MDS documented the resident received hospice services and oxygen therapy. The order summary report dated 9/22/21 documented Resident #16 resident received two liters of oxygen via nasal cannula. Observation on 9/15/21 at 1:59 PM revealed the resident in chair with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing. Observation on 9/16/21 at 9:00 AM showed the	F 880		

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F 880	Continued From page 37 resident in chair with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing. Resident #16 reported the tubing felt nasty and she did not know how often staff changed it. The nasal cannula of the tubing appeared yellowed. Observation on 9/20/21 at 2:24 PM showed the resident in bed with oxygen administered per nasal cannula. The oxygen tubing did not contain a date to identify when staff last changed the tubing. Observation on 9/21/21 at 12:56 PM revealed oxygen tubing labeled and dated 9/21/21.	F 880		

The below Plan of Correction is submitted by the facility and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The facility denies that the alleged facts set forth constitute a deficiency under the interpretation of federal and State law. The preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared was executed solely because the provision of State and Federal law required it.

F 578 D

The Nursing Leadership Team will audit care plans for resident #63 and all similarly situated residents and document confirmation of proper code states; any needed updates will be added at that time.

Advanced directives will be processed through pcc and fully incorporated into the triple check system. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.

The DON or designee will update the purple dot relating to resident #63.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

Audit of purple dots to be performed monthly to ensure compliance. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.

F 582 B

The SSD or designee will note which option was chosen.

The SSD or designee will perform an audit of all ABN's for the past 3 months correct any similar issues found.

The ABN's will be reviewed weekly at Medicare Meeting to ensure compliance. Appropriate staff will be educated on the change in process.

The Administrator or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.

F 656 D

MDS Coordinator or designee will review hospice care plans for resident #10 and all similarly situated residents. In addition, they will ensure care plans reflect the most current information, including the coordination of care with Hospice providers and the use of oxygen.

DON or designee will review care plans monthly and recommends to MDS Coordinator any changes. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.

F 684 D

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

Skin assessments to be scheduled in PCC per facility policy. Appropriate staff to be educated on the changes in process and will be audited for compliance by the Nursing Facility Leadership team on a routine basis, not less than weekly.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

DON or designee to ensure any needed medical interventions are put in place and followed.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

F 689 G

MDS Coordinator or designee will ensure that related biosheet and careplan is up to date with the most current information.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

Biosheets to be reviewed weekly by DON or Designee and MDS Coordinator or designee to address issues found. Appropriate staff to be educated on the changes in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

DON or designee to ensure any needed medical interventions are put in place and followed.

Audit of all relevant staff performed by nursing leadership team concerning relevant cares.

All new relevant staff members will have relevant skill assessed upon hire and annually.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

F 700 D

DON or designee to obtain all necessary consents and other documentation needed to ensure careplan interventions are in place and appropriate.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will perform side rail audit monthly to ensure compliance. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

DON or designee to obtain all necessary documentation needed to ensure careplan interventions are in place and appropriate.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will perform side rail audit monthly to ensure compliance. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 12 months and ongoing as needed.

DON or designee to ensure careplan interventions are in place and appropriate.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will deliver instructions for all required interventions to Plant Manager or designee daily to ensure timely implementation of all needed interventions. Administrator to review weekly that all interventions are in place. Appropriate staff will be educated on the changes in process.

QAPI Committee to review system quarterly for 6 months to ensure compliance and ongoing as needed.

F 880 E

DON or designee will clean relevant area.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will set up clean area for testing, review testing process and ensure needed changes are put in place and communicated to all staff. QAPI team will perform a root cause analysis and incorporate any identified changes into facility practices. All facility staff to review the following infection control training videos: https://www.youtube.com/watch?v=t7OH8ORr5lg
https://www.youtube.com/watch?v=xmYMUly7qiE
https://www.youtube.com/watch?v=1ZbT1Njv6xA
https://www.youtube.com/watch?v=7srwrF9MGdw
https://www.youtube.com/watch?v=YYTATw9yav4

QAPI to provide ongoing oversight for all facility testing related to COVID-19

The DON or designee will ensure that appropriate tubing is put in place and marked accordingly.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will perform oxygen audit monthly to ensure compliance. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.

MDS Coordinator or designee will review appropriate care plan and ensure it reflects the most current information.

The Nursing Leadership Team will perform a facility wide audit and correct any similar issues found.

DON or designee will perform oxygen audit monthly to ensure compliance. Appropriate staff will be educated on the change in process.

The DON or designee will perform audits to ensure compliance monthly for the first 3 months. QAPI committee will follow compliance with this system for 6 months and ongoing as needed.