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	175224	A. BUILDING _____ B. WING _____	03/16/2022

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F 000	INITIAL COMMENTS The following citations represent the fininds of a Health Resurvey and Complaint Investigation #169251. This 2567 was electronically sent to the facility on 03/18/2022.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility reported a census of 20 residents with 15 residents selected for the sample. Based on interview, observation, and record review, the facility failed to complete a significant change "Minimum Data Set" (MDS), for one Resident (R)#6 for initiation of hospice care services. Findings included: - Review of Resident (R)6's electronic medical record (EMR), under the "Med Diag" tab, included the following diagnoses: dementia (progressive mental disorder characterized by failing memory,	F 637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/18/2022

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confusion), hypertension (HTN) (elevated blood pressure) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness emptiness).

The significant change "Minimum Data Set" (MDS), dated 12/10/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She required extensive assistance of one staff for transfers, toilet use and ambulating in her room. The resident did not have a condition or chronic disease that would result in a life expectancy of less than six months and was not on hospice care.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 12/10/21, documented the resident was at risk for cognitive impairment related to dementia.

The care plan for Hospice, updated 12/29/22, instructed staff the resident received hospice services.

Review of the hospice "Plan of Care Report", dated 12/23/21, provided by the facility, included the resident began hospice care on 12/23/21, for diagnoses of frontotemporal dementia with co-morbidities (a disease or medical condition that is simultaneously present with another or others in a patient) of hypertension (elevated blood pressure), and depression.

On 03/14/22 at 11:06 AM, Certified Nurse Aide (CNA) entered the resident's room to get her up

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for lunch. Staff used extensive assistance of one to ambulate with the resident to the bathroom where she was continent of urine. The resident had no indication of pain or discomfort during cares.

On 03/15/22 at 09:02 AM, CNAs N and O, took the resident to her room to lie down in bed following breakfast. Staff used extensive assistance of one staff to transfer the resident from her wheelchair to the bed. The resident had no indication of pain or discomfort during cares.

On 03/14/22 at 11:06 AM, CNA N stated the resident required extensive assistance with cares. The resident was currently on hospice care.

On 03/14/22 at 02:07 PM, CNA O stated hospice came to see the resident twice weekly. Hospice supplied briefs, wipes, and creams for the resident.

On 03/15/22 at 02:19 PM, Licensed Nurse (LN) H stated the resident began hospice service on 12/23/21, due to her decline in activities of daily living (ADL) and her dementia.

On 03/16/22 at 08:50 AM, Administrative Nurse D stated, the resident was currently on hospice. A significant change MDS should have been done when the resident admitted to hospice services and was not as the facility staff failed to complete that.

The facility used the "Resident Assessment Instrument" (RAI) for guidance on when to complete MDSs.

The facility failed to complete a significant change

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F 637	Continued From page 3 MDS for this resident when she admitted to hospice care services.	F 637		
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 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	F 656		

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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:
The facility reported a census of 20 residents with 15 selected for review. Based on interview and record review, the facility failed to complete a comprehensive care plan for one resident (R)7 to ensure the development of goals, interventions, and treatments to meet the needs of this resident.

Findings included:

- Review of resident (R)7's "Physician Order Sheet," dated 01/24/22, revealed diagnoses of atrial fibrillation(rapid, irregular heart beat), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing,) Barrett's esophagus(a condition caused by inflammation and damage to the lining of the esophagus) chronic kidney disease, dysphagia (difficulty swallowing,) and pacemaker for heart failure.

The "Admission Minimum Data Set," (MDS), dated 12/27/21, assessed the resident with normal cognitive function, required extensive assistance of two persons for activities of daily living (ADL) and had impairment in functional range of motion in both lower extremities. The resident received scheduled and as needed pain medications with no non-medical interventions for pain. The resident rated her pain as constant with

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a score of nine on a scale of one to ten (most severe.)

The "Pain Care Area Assessment" (CAA), dated 12/27/21, assessed the resident had a potential for pain related to chronic disease process which included heart disease, depression and anxiety. The resident required assistance with activities of daily living (ADL).

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential" CAA, dated 12/27/21, assess the resident had pain, history of falls, and recent discharge from acute care. The resident had a self-care deficit due to heart failure, weakness, poor coordination, gait, and balance. The resident's medications included Sertraline (an antidepressant,) Norco (a narcotic pain medication,) and Tramadol (a narcotic pain medication.)

The "Falls" CAA, dated 12/27/21, assessed the resident at risk for falls related to weakness, impaired balance and gait and multiple comorbidities that have the potential to increase fall risk.

The resident's medical record lacked evidence of the development of a comprehensive care plan as required.

A "Nurses' Note," dated 02/24/21 at 1:17 PM, revealed the resident transferred to acute care due to abdominal pain and nausea with vomiting.

Interview, on 03/16/22 at 10:30 AM, with Administrative Nurse revealed staff should develop the "Comprehensive Care Plan" as per facility policy (seven days after completion of the

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F 656	Continued From page 6 initial "Comprehensive MDS." The facility policy "Resident Centered Care Plan Process," updated 03/23/18, instructed staff to complete the "Comprehensive Care Plan" within seven days of completion of the initial "Comprehensive MDS. The facility failed to complete a "Comprehensive Care Plan" to ensure the development of goals, interventions and services to meet the needs of this resident as required.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The	F 661		

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post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 20 residents with 15 residents selected for review, including one resident reviewed for discharge. Based on interview and record review, the facility failed to complete a discharge summary for one Resident (R)22, following discharge from the facility.

Findings included:

- Review of the resident's electronic medical record (EMR) under the "Med Diag" tab, included the following diagnoses: spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities) and type II diabetes mellitus (DM--when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The admission "Minimum Data Set" (MDS), dated 12/28/21, documented the resident admitted to the facility on 12/22/21 from an acute care hospital. The resident expected to be discharged to the community.

The "Return to Community Referral Care Area Assessment" (CAA), dated 12/28/21, documented the resident was a short term resident with plans to return to the community.

The baseline care plan, dated 12/22/21, instructed staff the resident's goal was to return home.

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F 661	Continued From page 8 Review of the resident's EMR, under the "Misc" tab, dated 01/07/22, revealed a physician's order, which included to discharge the resident to home with a home health referral for therapy to evaluate and treat. Review of the resident's EMR, under the "Prog Notes" tab, dated 01/07/22, documented the resident discharged to home. On 03/15/22 at 02:19 PM, Licensed Nurse (LN) H stated, when a resident discharged from the facility, the nurse was to complete a discharge summary. On 03/16/22 at 08:50 AM, Administrative Nurse D stated, a discharge summary should be completed for every resident who discharged from the facility. A policy regarding discharge summaries was not provided. The facility failed to complete a discharge summary following this resident's discharge to home.	F 661		
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 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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F 684	Continued From page 9	F 684		

care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 20 residents with 15 selected for review. Based on observation, interview and record review, the facility failed to ensure dressing change to one resident (R)11 skin tear in a sanitary manner to promote healing and prevent infections.

Findings included:

- Review of resident (R) 11's "Physician Order Sheet," dated 02/01/22, revealed diagnoses included hypertension (elevated blood pressure,) , glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow) and falls.

The "Admission Minimum Data Set" (MDS), dated 01/07/22, assessed the resident had normal cognition. The resident had severely impaired vision. The resident had no impairment in functional range of motion in her upper and lower extremities.

The "Falls Care Area Assessment" (CAA), dated 01/07/22, assessed the resident had falls while living at home within the last two to six months, and was virtually blind in both eye due to glaucoma, which increased her risk for falls. The resident utilized a rolling walker and staff assistance for guidance and direction.

The "Care Plan," revised 03/12/22, instructed staff to ensure her call light remained within reach, to wear nonslip footwear for walking and transfers, and to keep frequently used items within reach. The care plan instructed staff to

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assist with toileting hourly from 7:30 PM through 6:00 AM if awake, while on antibiotic.

The "Physician's Order," dated 03/12/22 instructed staff to cleanse the skin tear to her right elbow with wound cleanser, apply Medihoney (a honey-based product used for treating wounds), four by four gauze pads and rolled gauze daily till healed.

Observation, on 03/16/22 at 9:45AM, revealed Licensed Nurse (LN) G, prepared to provide wound care to the resident's skin tear on the elbow. LN G did not sanitize the resident's over the bed table and placed several pairs of gloves and a bottle of wound cleanser and a tube of medihoney directly on the unsanitized table. LN G placed a Styrofoam plate containing the four by four gauze pads. LN G performed hand hygiene, donned gloves, removed the old dressing, removed gloves, performed hand hygiene donned gloved cleansed the wound with wound cleanser, removed gloves, performed hand hygiene, donned gloves (which laid directly on the unsanitized bedside table) and with a gloved finger obtained Medihoney and applied it to the wound bed. The wound bed revealed an area of approximately 1.5 centimeter in diameter of yellow-white tissue. LN G removed the glove and obtained another glove from his/her pocket and donned this glove, then wrapped the wound with the rolled gauze.

Interview, on 03/16/22 at 09:55 AM, with LN G, revealed he/she provided a clean dressing change, but did not sanitize the surface of the resident's table prior to putting the gloves, wound cleanser and medihoney containers on the surface, furthermore, gloves obtained from his

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F 684	Continued From page 11 pocket would not be considered clean for a dressing change. Interview on 03/16/22 at 10:15 AM, with Administrative Nurse D, revealed she would expect staff to provide a clean surface to place supplies, and the Styrofoam plate provided a clean surface for the four by fours, but the surface of the resident's bedside table would not be considered clean unless staff sanitized it. The facility policy "Non-Sterile Dressing Changes," undated, instructed to staff to assemble dressing supplies and place on clean paper plates, then open dressing supplies and place on a clean surface. The facility failed to ensure a sanitary dressing change for this resident's skin tear to prevent the spread of infection.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 12 §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: The facility reported a census of 20 residents. Based on observation and interview, the facility failed to ensure a two-inch air gap existed between the two water drainage pipes on the ice machine and the sewer drain to prevent the backflow of contaminated drain water up into the ice machine to prevent the spread of food borne illness to the residents. Findings included: - Observation, on 03/15/22 at 2:00 PM, environmental tour of the kitchen areas revealed an ice machine with two drainage pipes. The end of the upper most drainage pipe elbowed into a cylinder shaped attachment and to the sewer pipe. The lower ice machine drainage pipe was positioned in the large opening of the sewer pipe. Interview, on 03/15/22 at 2:15 PM, with maintenance staff U, stated the ice machine was installed last year. Maintenance staff U stated he thought the sewer water would not back flow into the machine as the pressure from the sewer would not exceed the pressure from the pipes leading from the ice machine. Maintenance staff U confirmed the drainage pipes from the ice machine could be exposed to bacteria from the sewer if the sewer flooded without a required two-inch air gap between the two. Interview, on 03/15/22 at 4:40 PM, with Administrative Nurse D, revealed the ice machine	F 812		

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F 812	Continued From page 13 was installed last year by professional installers and Nurse D did not know the two-inch air gap was not established byt he installation company. The facility did not have a policy for the two-inch air gap to prevent the blackfow of contaiminated water into the ice machine. The facility failed to ensure a two-inch air gap between the two ice machine drainage pipes and the floor sewer drainage pipe to prevent the potential backflow of contaminated water into the ice machine to prevent the spread of food borne illness to the residents of the facility.	F 812		