STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415050	A. BUILDING _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DAWN HILL HOME FOR REHAB & HEALTHCARE	1 DAWN HILL BRISTOL, RI 02809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted at The Dawn Hill Home For Rehab & Healthcare from 08/10/2021 through 08/13/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. As a result of this survey, deficiencies were identified.	F 000	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. Completion date for optimal compliance with POC will be September 3, 2021.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, it has been determined that the facility has failed to ensure that services provided by the facility meet professional standards of quality for 2 of 2 residents reviewed with thrombo-embolus deterrent (TED) stockings, Resident ID #s 3 and 414, 1 of 1 resident reviewed for vital signs, Resident ID #414, 1 of 6 residents observed during med pass, Resident ID #6 and 4 of 4 sample residents reviewed for weekly skin assessments, Resident ID #'s 25, 62, 82, & 207. Findings are as follows: A. According to "Standards of Clinical Nursing Practice for Collaboration," published by the American Nurses Association, the "Nurse consults with health care providers for clients	F 658	IMR 8/31/21	

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

BRIAN D. BROWN, ADMINISTRATOR 8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 1 care as needed." 1. Record review for Resident ID #3 revealed that s/he was admitted to the facility in January of 2021 and has diagnoses including, but not limited to, dementia, history of fracture of left tibia and sacrum and osteoarthritis. Additionally, the resident has a pressure ulcer to the left heel. During a surveyor observation on 8/11/2021 at 10:51 AM and 1:28 PM and 8/12/2021 at 12:48 PM, the resident was wearing TED stockings on both legs. Further record review failed to reveal evidence of a physician's order for TED stockings. During a surveyor interview with the Nursing Assistant (NA) Staff A, on 8/12/2021 at 9:33 AM, she acknowledged that she put TED stockings on the resident's legs. During a surveyor interview with the Director of Nursing Services (DNS) on 8/13/2021 at 10:03 AM, she indicated that the resident should not be wearing TED stockings without a physician's order. 2. Record review for Resident ID #414 revealed that s/he was admitted to the facility in July of 2021 and has a diagnosis including, but not limited to, diabetes mellitius. Surveyor observation of Resident ID #414 on 8/10/2021 at 11:55 AM, 8/11/2021 at 11:06 AM, and 8/12/2021 at 11:38 AM, revealed the resident wearing TED stockings on both legs. Record review of a nursing progress note for	F 658	**As a POC for 658** Resident #3 remains in the building and has had no ill effects; she is no longer wearing ted stockings. Resident #414 has been discharged home successfully; she has had no adverse effect. Resident #6 remains in the facility and has had no adverse effect. Resident #25 remains in the facility and has had no adverse effect Resident #62 remains in the facility and has had no adverse effect Resident #82 remains in the facility and has had no adverse effect Resident #207 remains in the facility and has had no adverse effect All residents with medications and treatments are at risk for this alleged deficient practice. All nursing staff are being in serviced about the importance of giving medications and performing treatments as ordered. DON and unit managers will review MARs, TARs, and UDAs daily Monday through Friday as part of morning clinical meeting. DON or designee to spot check 10% of treatments daily Monday through Friday for completion. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved.	

MAR 8/31/21

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F 658	Continued From page 2 Resident ID #414 on 7/31/2021 at 2:11 PM states in part, "...pt [patient] wearing teds during day..." Further review revealed another progress note dated 8/6/2021 at 12:01 PM which states in part, "...teds on as ordered..." Record review with North Wing Nurse Staff F on 8/12/2021 at 12:12 PM, failed to reveal evidence of a physician order for TED stockings. During a surveyor interview at 8/12/2021 at approximately 12:15 PM with Staff F, she acknowledged that the resident was wearing TED stockings without a physician order. During a surveyor interview with the physician on 8/12/2021 at 2:10 PM, he indicated that he would expect staff to obtain a physician's order if they were putting TED stockings on the resident. B. Mosby's 4th Edition, Fundamentals of Nursing page 314 states "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients." Record review for Resident ID #414 revealed that s/he was admitted to the facility in July of 2021 and has diagnoses including, but not limited to, type 2 diabetes mellitus. Record review revealed an 8/4/2021 physician's order for "VS [vital signs] daily while skilled every day shift." Review of the August 2021 Medical Administration Record revealed this order was not documented as completed on 8/7/2021.	F 658	MR 8/31/21	

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F 658	Continued From page 3 During a surveyor interview on 8/13/2021 at 2:25 PM with the DNS, she acknowledged the above-mentioned order for Resident ID #414 was not completed on 8/7/2021. C. Review of the facility policy, titled, "Administration of Medication", revealed in part, "...Medications must be charted immediately following the administration by the person administering the drugs..." Observations made during a medication pass on South Wing on 8/13/2021 at approximately 10:00 AM, revealed Licensed Practical Nurse (LPN) Staff G did not have Lasix [diuretic (water pill) used to treat fluid retention and high blood pressure] in the medication cart for Resident ID #6, therefore the medication was not administered to him/her. During a review of the resident's record, it was revealed that the Lasix was documented as administered at 10:54 AM in the Medication Administration Record (MAR). During an interview with Staff G on 8/13/2021 at approximately noon, in the presence of the Director of Nursing, he acknowledged that the Lasix was not administered to the resident and was documented as given. The DNS stated her expectation is that staff sign off medications after they are administered, as stated in the policy. D. Review of the facilities policy titled "Skin Care Protocol "states in part; "Procedure: 4. The weekly skin observation will be done for every resident regardless of their "risk" score." 1. Record review for Resident ID #25 revealed	F 658	KLK 8/31/21	

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F 658	Continued From page 4 that s/he was admitted to the facility in December of 2016 and has diagnoses that include, but are not limited to, cerebral infarction (stroke) with left hemiplegia (paralysis of one side) and hemiparesis (partial weakenss on one side of the body). Record review revealed a physician's order, dated 4/30/2020, for weekly skin check to be documented in the skin observation tool under assessments every Wednesday. Further record review of the weekly skin observations on 8/13/2021 failed to reveal that a weekly body observation had been completed since 7/28/2021 (2 weeks). 2. Record review for Resident ID #62 revealed that s/he was admitted to the facility in January of 2016 and has a diagnosis that includes, but is not limited to, multiple sclerosis. Additionally, record review revealed the resident currently has two stage 4 pressure ulcers. Review of the weekly skin observations from 6/30/2021 to 8/11/2021 revealed that skin checks were not completed on 3 of the 7 weeks (7/7/2021, 7/28/2021, and 8/4/2021). 3. Record review for Resident ID # 82 revealed that s/he was admitted to the facility in June of 2021 and has diagnoses that include, but are not limited to, cerebral infarction, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side. Review of the weekly skin observations on 8/11/2021 revealed that a weekly skin check was not completed since 7/20/2021 (3 weeks).	F 658	MR 8/31/21	

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F 658	Continued From page 5 4. Record review for Resident ID #207 revealed that s/he was admitted to the facility in June of 2013, with a diagnosis including, but not limited to, traumatic brain injury. Review of the weekly skin observations on 8/11/2021 revealed that a weekly skin check was not complete since 8/1/2021 (1 week). During surveyor interview on 8/12/2021 at approximately 11:30 AM with Nurse Staff H, she was unable to produce evidence that the above skin checks were completed weekly as required by policy. During surveyor interview with the DNS on 8/13/2021 at 12:47 PM, she was unaware that the weekly skin checks were not completed for the above residents.	F 658	**F686** Resident #3 remains in the facility with no ill effects. She no longer has orders for an air mattress, her orders for soft boot state while out of bed as tolerated. Resident #51 remains in the facility and has had no adverse effect. Her treatment orders have been updated to include most recent VOHRA wound physician recommendations. Any resident with wounds has the potential to be affected by this alleged deficient practice. Nursing staff are being in serviced regarding the importance of following wound recommendations and keeping the plan of care related to wound treatments up to date. DON and unit managers will review wound recommendations and the orders and plans of care related to wounds daily Monday through Friday as part of morning clinical meeting for accuracy and completion. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		

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F 686	Continued From page 6 by: Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to ensure that residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 2 of 4 residents reviewed with pressure ulcers, Resident ID #'s 3 and #51. Findings are as follows: 1. Record review for Resident ID #3 revealed that s/he was admitted to the facility in January of 2021 and has diagnoses including, but not limited to, dementia, history of fracture of left tibia and sacrum, major depressive disorder, anxiety disorder, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 4/16/2021, revealed that the resident has severe cognitive impairment. Additionally, it revealed that the resident has a stage 4 pressure ulcer. Review of the wound consultant evaluation, dated 8/5/2021, revealed that the resident has a stage four pressure ulcer of the left, posterior heel. Review of the care plan intervention, revised on 4/7/2021, states "air mattress in place to prevent skin breakdown." Review of the physician's orders revealed the following: - 7/15/2021: wear a soft boot to the left foot while out of bed, every day and evening shift.	F 686	LMR 8/31/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 686	Continued From page 7 - 7/18/2021: check air mattress to current weight every shift for skin integrity Surveyor observations on the following dates and times revealed the resident out of bed with no soft boot on the left foot: - 8/11/2021 at 10:51 AM, 10:56 AM, and 1:28 PM - 8/12/2021 at 12:48 PM - 8/13/2021 at 9:07 AM Surveyor observations on the following dates and times revealed no air mattress on the resident's bed: - 8/11/2021 at 8:56 AM, 10:56 AM, and 1:28 PM - 8/12/2021 at 8:14 AM, 8:36 AM, 8:46 AM, 9:00 AM, 9:09 AM, and 12:48 PM During a surveyor interview with the Nursing Assistant (NA) Staff A, she revealed that she no longer puts the soft boot on the resident's foot while s/he is out of bed. During a surveyor interview with Nurse Staff I, she acknowledged that there was no air mattress on the resident's bed. During a surveyor interview with the Director of Nursing Services (DNS), she could not provide evidence that the physician's order to provide a soft boot to the resident's left foot was followed nor that the resident had an air mattress. 2. Record review for Resident ID #51 revealed	F 686 NWR 8/31/21		

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F 686	Continued From page 8 that s/he was admitted to the facility in February of 2019 and has diagnoses, including but not limited to, major depressive disorder, Alzheimer's disease, dementia, encephalopathy, diabetes mellitus, severe protein-calorie malnutrition, and Parkinson's disease. Review of the quarterly MDS assessment, dated 4/16/2021, revealed that the resident has severe cognitive impairment. Additionally, it indicates that the resident is at high risk of developing pressure ulcers. Review of the wound consultant documentation, dated 8/5/2021, reveals that the resident has the following wounds: - An unstageable deep tissue injury (DTI) of the left, lateral foot - An unstageable DTI to the left, distal, plantar, lateral foot - Wound of the left, medial, first toe Review of the wound consultant's recommendations, dated 8/5/2021, revealed to put skin prep on both DTIs on the left, lateral foot for 16 days. Additionally, the consultant recommended to put skin prep on the left, medial, first toe twice daily for 23 days. Review of the physician's orders on 8/13/2021 failed to reveal evidence of an order for the above treatments. During a surveyor interview with South Wing Nurse Staff I on 8/13/2021 at 9:22 AM, she acknowledged that there were no orders in place for skin prep to the above wounds. Additionally, she indicated that the doctor had approved the	F 686	KMR 8/19/21	

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F 686	Continued From page 9 wound consultant's above recommendations. During a surveyor interview with the DNS on 8/13/2021 at 10:12 AM, she indicated that an order should have been put into place for the wound consultant's above recommendations.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure a resident with limited range of motion receives appropriate treatment to prevent further decrease in range of motion for 1 of 2 residents reviewed for limited range of motion, Resident ID #3. Findings are as follows:	F 688	**F688** Resident #3 remains in the facility and has had no ill effects. Order for knee immobilizer has been discontinued as patient now has active range of motion to affected extremity. All residents at risk for decreasing mobility are potentially at risk for the alleged deficient practice. All nursing staff are being in serviced regarding the importance of administering all treatments as ordered. DON and unit managers will review TARs daily Monday through Friday as part of morning clinical meeting. DON or designee to spot check 10% of treatments daily Monday through Friday for completion. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved. MR 8/31/21	

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F 688	Continued From page 10 Record review for Resident ID #3 revealed that s/he was admitted to the facility in January of 2021 and has diagnoses including, but not limited to, dementia, history of fracture of left tibia and sacrum, major depressive disorder, anxiety disorder, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 4/16/2021, revealed that the resident has severe cognitive impairment. Additionally, it revealed that the resident has impairment to one side of the lower extremity. Record review revealed a physician's order, dated 3/16/2021, to apply the soft knee immobilizer to the left knee while in bed. Record review of the physical therapy discharge summary, dated 3/16/2021, revealed the resident should wear the knee immobilizer on the left lower extremity when in bed. Surveyor observations on the following dates and times revealed the resident in bed without the soft knee immobilizer on the left knee. The soft knee immobilizer was on the chair at the bedside: - 8/11/2021 at 8:58 AM - 8/12/2021 at 8:14 AM, 8:36 AM, 8:46 AM, 9:00 AM, and 9:09 AM During a surveyor interview with the Nursing Assistant (NA) Staff A on 8/12/2021 at 9:33 AM, she indicated that the resident no longer uses the knee immobilizer. During a surveyor interview with the Director of	F 688		

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F 688	Continued From page 11 Rehab on 8/13/2021 at 8:58 AM, she revealed that the resident should wear the left knee immobilizer when in bed to prevent contracture.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status and failed to follow the policy related to weight monitoring for 2 of 9 sample residents reviewed for nutrition, Resident ID #s 24 and 51. Findings are as follows:	F 692	**F692** Resident #24 remains in the facility and her weight is up to date. Resident #51 remains in the facility and her weight is up to date. All nurses and CNAs are being in serviced regarding obtaining and documenting weights as ordered. DON and unit managers will review weights daily Monday through Friday as part of morning clinical meeting to ensure that they are obtained and documented Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved. MR 8/31/21	

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F 692	Continued From page 12 Review of the facility's policy titled, "Weight Policy," states in part, "All residents will be weighed once a month." 1. Record review for Resident ID #24 revealed that the s/he was admitted to the facility in November of 2018 and has diagnoses including, but not limited to, dementia and major depressive disorder. Review of the care plan, revised on 6/4/2021, reveals that the resident is at nutritional risk due to requiring assistance with eating, a history of weight fluctuations, and dysphagia (difficulty swallowing). Record review of the resident's weights revealed a weight of 144.2 pounds on 6/9/2021. The record failed to reveal evidence of a monthly weight in July or August. Further record review revealed a weight of 140.0 pounds, indicating a 4 pound weight loss, on 8/12/2021 after it was brought to the attention of the facility by the surveyor. During a surveyor interview with the Director of Nursing Services (DNS) on 8/12/2021 at 12:04 PM, she revealed that all residents should be weighed monthly, unless otherwise specified. 2. Record review for Resident ID #51 revealed that s/he was admitted to the facility in February of 2019 and has diagnoses, including but not limited to, major depressive disorder, Alzheimer's disease, dementia, encephalopathy, diabetes mellitus, severe protein-calorie malnutrition, and Parkinson's disease. Review of the care plan, revised on 7/14/2021,	F 692	KMR 8/31/21	

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F 692	Continued From page 13 revealed that the resident is experiencing weight loss. Additionally, an intervention, revised 4/7/2021, states, "monitor weights monthly or per MD [Medical Doctor] order." Review of the physician's order, dated 6/1/2021 (to start on 6/8/2021), states, "weekly weight every evening shift every Tue [Tuesday]." Record review of the resident's weights from 6/8/2021 to 8/10/2021 revealed 6 out of 10 opportunities in which a weekly weight was not obtained. The resident lost 10.4 pounds from 6/4/2021 (143.4 pounds) to 8/10/2021 (133.0 pounds), indicating a 7.3% weight loss in 2 months. During a surveyor interview with the DNS on 8/12/2021 at 12:04 PM, she could not provide evidence that this resident was weighed weekly, per the physician's order.	F 692	**F725** The facility continues to work on recruitment of new staff and retention of current employees. Recruitment efforts include but are not limited to: working with nursing schools such as Lincoln Tech to recruit new graduate nurses, and CNA programs to hire new CNAs as well as hosting a CNA class through Greentree Healthcare. The facility offers sign on and referral bonuses to incentivize new staff to onboard with the facility. The facility is hosting ads on hiring sites such as Indeed to recruit staff as well as contracting with several staffing agencies. Also, the facility strives to maintain current employees through wage and shift differential increases, perfect attendance bonuses, instituting an employee of the month program, pick up bonuses and conducting exit interviews with staff who leave the facility's employment.	
F 725 SS=E	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 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725	All staff will be in serviced regarding call light times and the importance of addressing call lights timely. Administrator or designee will conduct call light response audits on a weekly basis to ensure compliance with answering call lights. Administrator, DON or designee will meet with the residents identified as not getting out of bed, weekly to ensure that they are assisted out of bed as appropriate. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved MR 8/31/21	

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F 725	Continued From page 14 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 surveyor observation, record review, staff and resident interview, it has been determined that the facility failed to provide sufficient nursing staff to ensure resident safety and attain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care relative to activities of daily living (ADL) for 3 of 3 sample units, East, South & North Units. Findings are as follows: A. Review of the "2021 Annual Facility's Assessment" revealed the facility is licensed to provide care for 133 residents. The average daily census is 105-110 residents. The facility has 3 units; East Wing (47 beds, Long-Term Care Unit), South Wing (43 beds, Dementia Care Unit) and North Wing (43 beds, Short-Term Care/Rehabilitation and Long-Term Care Unit). Review of the assessment under "Example 3: Assistance with Activities of Daily Living" revealed	F 725	LR 8/31/21	

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F 725	Continued From page 15 the following: -zero residents who are independent with dressing, bathing and mobility -approximately 80 residents who require assistance of 1-2 staff with dressing, bathing, transfer and toileting. -45 residents require assist of 1-2 staff for eating -48 residents require assistive devices to ambulate -73 residents are in his/her chair most of the time and are dependent with mobility -17 residents are "dependent" with dressing -25 residents are "dependent" with bathing -20 residents are "dependent" with transfer -21 residents are "dependent" with toileting During an interview with the Administrator on 8/13/2021 at 11:02 AM, he revealed that their plan relative to the staffing ratio is 1 Nursing Assistant (NA) to 10 residents for the first and second shifts, and 1 NA to 20 residents for the third shift or 2 NA(s) on each unit and at least 1 nurse on each unit. He stated that the facility has 133 beds and that the resident census has been 105-110 on average. Three community reported complaints were investigated during the survey, all of which involved concerns that the facility is unable to meet the needs of the residents relative to a lack of sufficient nursing staff causing unsafe conditions. During the resident council meeting on 8/12/2021, five residents indicated there was short staffing in this facility, mostly on second and third shifts and all weekend days.	F 725	MR 8/3/21	

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F 725	Continued From page 16 1. East Wing (47 bed long term care unit) 1. During a surveyor interview with the staffing scheduler on 8/12/2021 at 11:30 AM, she stated that the East unit is supposed to have 2 nurses, 1 CMT (certified medication technician), and 4 NAs on the first and second shift (7 total staff on unit) and 1 nurse and 2 NAs on third shift (3 total staff on unit). Review of the staff schedule dated 8/4/2021 thru 8/10/2021 revealed the following staffing on the East unit: First shift (7 AM - 3 PM) -8/4/2021: 4 NA(s), 1 LPN, 1 CMT; (census = 46 residents) -8/5/2021: 4 NA(s), 2 RN, 1 CMT; (census = 46 residents) -8/6/2021: 5 NA(s), 2 nurses, 1 CMT; (census = 46 residents) -8/7/2021: 2 NA(s), 2 nurses (one is the unit manager), 1 CMT working 4 hours (7 - 11 AM); (census = 46 residents) -8/8/2021: 3 NA(s), 1 LPN & 1 nurse manager, 1 CMT; (census = 46 residents) -8/9/2021: 5 NA(s), 2 nurses, 1 CMT; (census = 46 residents) -8/10/2021: 4 NA(s), 1 RN (who is the unit manager), 1 CMT; (census = 46 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 4 out of 7 opportunities. Second Shift (3 - 11 PM) -8/4/2021: 3 NA(s), 1 LPN, 1 CMT; (census = 46	F 725	MR 8/31/21	

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F 725	Continued From page 17 residents) -8/5/2021: 4 NA(s), 1 LPN, 1 CMT; (census = 46 residents) -8/6/2021: 3 NA(s) - one in which only worked 3 hours (3 -6 PM), 1 RN, 1 CMT; (census = 46 residents) -8/7/2021: 4 NA(s) - one in which only worked 6 hours (3 -9 PM), 1 RN, 1 CMT; (census = 46 residents) -8/8/2021: 4 NA (s), 1 RN, 1 CMT; (census = 46 residents) -8/9/2021: 4 NA(s) - one in which only worked 6 hours (3 -9 PM) & one in which only worked 7 hours (3 -10 PM), no nurse working for 2 hours (3 -5 PM),1 RN only worked 6 hours (5 -11PM), 1 CMT; (census = 46 residents) -8/10/2021: 4 NA(s), 2 RN, 1 CMT; (census = 46 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 6 out of 7 opportunities. Third Shift (11 PM - 7 AM) -8/4/2021: 2 NA(s) - one in which only worked 6 hours (11- 5 AM), 1 RN; (census = 46 residents) -8/5/2021: 1 NA(s), 1 RN; (census = 46 residents) -8/6/2021: 1 NA(s), 1 LPN; (census = 46 residents) -8/7/2021: 1 NA(s), 1 RN; (census = 46 residents) -8/8/2021: 2 NA(s) - one in which only worked 6 hours (11- 5 AM), 1 LPN; (census = 46 residents) -8/9/2021: 2 NA (s), 1 LPN; (census = 46 residents) -8/10/2021: 2NA(s), 1 LPN; (census = 46 residents) Review of the above staffing revealed that the	F 725	MR 8/31/21	

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F 725	Continued From page 18 facility did not meet their staffing goals for 3 out of 7 opportunities. During a surveyor interview with the staffing scheduler(who provided the surveyor the above staffing information) on 8/12/2021 at 11:30 AM, she stated that she has been at the facility for several years and that she used to do the staffing a week at a time, but now she has to staff on a shift to shift basis due to all of the open positions. She informed the surveyor that currently there are 5 nurse positions vacant (between 24-40 hour positions) and 2 weekend positions, totaling 104 RN hours and 96 LPN hours (total of 200 hours per week). Additionally, she indicated there are 11 NA positions vacant (between 16 & 40 hours) and 5 weekend positions (total of 352 hours per week). Lastly, there is one 8 hour weekend CMT vacant position. Additionally, the scheduler showed the surveyor the book that she keeps in her office, which has all the open shifts for each day. Record review for Saturday (8/14/2021) revealed the following open shifts: 5 NA shifts for 7-3 PM, 7 NA shifts for 3-11 PM, and 3 NA shifts for 11-7AM; 3 nurse shifts for 7-3 PM, 2 nurse shifts for 3-11 PM, and 3 nurse shifts for 11-7AM. 2. During the inital tour of the East unit on 8/10/2021, the surveyor received multiple complaints from residents relative to the facility being short staffed, especially on the previous weekend of 8/7/2021 & 8/8/2021. - Resident ID #30 informed the surveyor that the facility is very short on staff and that you have to wait a long time for them to come and assist you	F 725		

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F 725	Continued From page 19 with getting in or out of bed. S/he said that on the weekend (8/7 & 8/8/2021) they only had 2 nursing assistants on the unit for 46 residents. S/he said all they do is run, and can't keep up. - Resident ID #25, who has been at the facility for several years and is dependent on 2 staff for assistance with transfers, told the surveyor that it is getting worse. S/he indicated that an NA will answer the call light, state they need another NA to assist with transferring him/her to the toilet, and not return until after multiple requests are made for assitance. S/he further stated it is the same issue when requesting to transfer off of the toilet, indicating a wait time of up to 2 hours. Additionally, the resident said that the staff are tired and are getting "short" (tempered) with the residents. - Resident ID #7 was tearful when speaking with the surveyor. The resident stated that s/he was leaving the next day because his/her daughter was moving him/her to another facility due to the short staffing. The resident said that s/he likes the "girls" (staff) very much and hates to leave the facility. Further, the resident stated that they are always short staffed and the girls keep running, but that you have to wait for help and that some days are worse that others. (This resident was discharged to another nursing facility on 8/11/2021). - Resident ID #85 told the surveyor that s/he has a foley and stated that it is supposed to be irrigated daily and that it does not get done. The resident stated that s/he has to ask and sometimes it still does not get done. The resident stated that if it is getting done once or twice a week that is good. The staff are so short of help,	F 725	KLR 8/31/21	

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F 725	Continued From page 20 s/he stated it is a big problem. The resident said s/he is very upset with the long wait times for staff to answer call lights and having to ask staff to do things that they are supposed to be doing. The resident stated that sometimes s/he cannot get out of bed because they need two staff to transfer him/her. The resident stated that they have a lot of agency staff who don't know the residents, stating, "one was here the other day and told him/her that she would never come back." - During a surveyor interview with Nursing Assistant (NA) Staff C on 8/11/2021 at approximately 10:00 AM, she stated that she has been working at the facility for over 20 years and they previously never had 2 NAs for 46 residents. She stated that the residents get upset because they have to wait for assistance; however, many of them require 2 staff to assist so that they end up waiting a long time. She also indicated that sometimes they just give the residents a small bath (face, hands and bottoms) if they don't have enough help. - During a surveyor interview with (NA Staff B on 08/11/2021 at 9:30 AM, she told the surveyor that she has worked at the facility for over 20 years and stated she has never seen the staffing like this. She stated that on Saturday 8/7/2021 there were only 2 NAs for the 46 residents on the unit. Further she revealed that she was unable to give personal care to everyone, stating some residents just had hands, face and bottoms washed as that was the best they could do. Additionally, she stated that they used to have 6 NAs on the unit, then it was 5, and now it is supposed to be 4, but they are always short. The NA stated that Saturday, 8/7/2021, they had 23 residents each for 2 NAs and many of the	F 725	NLR 8/31/21	

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F 725	Continued From page 21 residents need 2 staff to assist with turning, personal care, etc. She also stated that some residents were not able to get out of bed, due to only having 2 NAs on the unit and she was unable to chart on any of the residents for the day. Review of the NA documentation for ADL's, in the presence of NA Staff B, failed to reveal any NA documentation for 8/7/2021 by any NA on the East unit. During a surveyor interview with the Director of Nursing Services (DNS) on 8/11/2021 at approximately 1:30 PM, she stated that she was unaware that the NAs did not document on any residents on 8/7/2021. 2. South Unit (43 bed Dementia secured unit) During a surveyor interview with the staffing scheduler on 8/12/2021 at 11:30 AM, she stated that the South unit is supposed to have 1 nurse, 1 CMT, and 4 NAs on first and second shift (6 total staff on unit) and 1 nurse and 2 NAs on third shift (3 total staff on unit). Review of the staff schedule dated 8/4/2021 thru 8/10/2021 revealed the following staffing on the South unit: First shift (7 AM - 3 PM) -8/4/2021: 3 NA(s) - one in which only worked 7 hours (7 - 2 PM), 1 LPN, 1 CMT; (census = 42 residents) -8/5/2021: 4 NA(s) - two in which only worked 7 hours (7 - 2 PM), 1 RN, 1 CMT; (census = 42 residents)	F 725	MR 8/31/21	

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F 725	Continued From page 22 -8/6/2021:4 NA(s) - one in which only worked 7 hours (8 - 3 PM), 1 LPN, 1 CMT; (census = 42 residents) -8/7/2021: 2 NA(s), 1 LPN, 1 CMT; (census = 42 residents) -8/8/2021: 3 NA(s) - one in which only worked 3 hours (12 - 3 PM), 1 LPN; (census = 42 residents) -8/9/2021: 4 NA(s) - one in which only worked 5 hours (7 - 12 PM) & one in which only worked 7 hours (8 - 3 PM), 1 LPN, 1 CMT, (census = 42 residents) -8/10/2021: 4 NA(s), 1 LPN, 1 CMT; (census = 41 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 3 out of 7 opportunities above. Second Shift (3 - 11 PM) -8/4/2021: 3 NA(s),1 RN, 1 CMT who worked only 6 hours (3 - 9 PM); (census = 42 residents) -8/5/2021: 4 NA (s) - one in which only worked 5 hours(4 - 9 PM) & one in which only worked 4 hours (5 - 9PM), 1 nurse, 1 CMTs; (census = 42 residents) -8/6/2021: 3 NA (s) - one in which only worked 4 hours (2 - 6 PM) & onein which only worked 6 hours (3 - 9 PM), 1 LPN, 1 CMT; (census = 42 residents) -8/7/2021: 2 NA (s), 1 LPN, 1 CMT; (census = 42 residents) -8/8/2021: 3 NA (s), 1 LPN, 1 CMT who worked only 6 hours (3 - 9 PM); (census = 42 residents) -8/9/2021: 4 NA(s) - two of which only worked 6 hours (3 - 9 PM), 1 LPN, 1 CMT who only worked 6 hours (3-9 PM); census = 42 residents) -8/10/2021: 3 NA(s), 1 RN, 1 CMT; (census = 41	F 725	MR 8/31/21	

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F 725	Continued From page 23 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 5 out of 7 opportunities. Third shift (11 PM - 7 AM) -8/4/2021: 2 NA(s), 1 RN covering both north and South units; (census = 42 residents) -8/5/2021: 2 NA(s), 1 LPN; (census = 42 residents) -8/6/2021: 1 NA(s), 2 RN; (census = 42 residents) -8/7/2021: 2 NA(s), 1 RN; (census = 42 residents) -8/8/2021: 2 NA(s), 1 RN; (census = 42 residents) -8/9/2021: 2 NA(s), 1 nurse; (census = 42 residents) -8/10/2021: 2 NA(s), 1 RN; (census = 41 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 1 of 7 opportunities. Record review for Resident ID #90 revealed that the resident was admitted to the facility in April of 2016 and has diagnoses including, but not limited to, Alzheimer's disease, dementia, anxiety disorder, and stroke. Record review of the significant change Minimum Data Set assessment, dated 7/2/2021, reveals that the resident has severe cognitive impairment. Additionally, it indicates that the resident requires extensive assistance of two staff for transfers. Record review revealed a care plan intervention, initiated on 8/11/2021, for "mechanical lift for all	F 725		

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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 725	Continued From page 24 transfers with two staff members." During a surveyor interview with Resident ID #90's family member on 8/10/2021 at 12:10 PM, she reported that on Saturday, 8/7/2021, the resident did not get up out of bed due to staffing. Furthermore, she stated that the resident enjoys getting out of bed daily, but requires the use of two staff via mechanical lift for transfers. Additionally, she stated that staff told her that they did not have enough staff working on the unit to assist the resident out of bed. She further indicated that there were only two nursing assistants working on the South unit this day. Review of the staffing schedule for the South unit on 8/7/2021 revealed that there were only two nursing assistants working the 7 AM - 3 PM shift and again on the 3-11 PM shift. The resident census on the unit on this date was 42 residents, indicating a 21 to 1 resident to staff ratio. During a surveyor interview with the Staffing Coordinator on 8/13/2021 at 8:25 AM, she confirmed the above staffing on 8/7/2021. Review of the nursing assistant documentation from 8/7/2021 failed to reveal documentation of transfers on 8/7/2021 during the 7 AM - 3 PM shift. Further review revealed that transfers were documented as not applicable at 10:18 PM. During a surveyor interview with NA Staff D (who worked 3-11 PM on 8/7/2021), she indicated that if not applicable is documented under transfers, it means that the resident was not transferred that shift. During a surveyor interview on 8/12/2021 at 9:23	F 725	MR 8/31/21	

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F 725	Continued From page 25 AM with NA Staff E, she revealed that they cannot always get care done for residents if they are short-staffed (2 or 3 nursing assistants). Additionally, she revealed that there are times (approximately twice a week) when they cannot get a resident up for the day due to staffing (especially for residents who are a 2-person assist). During a surveyor interview on 8/12/2021 at 9:33 AM with Certified Nursing Assistant (NA) Staff A, she stated that it is almost impossible to get care done when there are only two nursing assistants working. Additionally, she revealed that at times she feels as if it is neglectful. 3. North Wing (43 bed short term rehab unit) During a surveyor interview with the staffing scheduler on 8/12/2021 at 11:30 AM, she stated that the North unit is supposed to have 2 nurses, 1 CMT, and 4 NAs on the first and second shift (7 total staff on unit) and 1 nurse and 2 NAs on third shift (3 total staff on unit). Review of the staff schedule dated 8/4/2021 thru 8/10/2021 revealed the following staffing on the North unit: First shift (7 AM - 3 PM) -8/4/2021: 2 NA(s), 1 nurse (LPN), 1 CMT; (census = 29 residents) -8/5/2021: 3 NA(s) - one of which only worked 6 hours (8 AM - 2 PM), 1 licensed practical nurse (LPN), 1 CMT; (census = 29 residents) -8/6/2021: 3 NA(s) - one of which only worked 7 hours (7 AM - 2 PM), 3 LPNs (2 from agencies); (census = 29 residents)	F 725	MR 8/31/21	

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F 725	Continued From page 26 -8/7/2021: 2 NA(s), 1 RN, & 1 additional RN worked 1 hour (in at 2 PM); no CMT; (census = 28 residents) -8/8/2021: 2 NA(s), DNS covering for nurse, & 1 RN in at 1 PM, no CMT (census = 28 residents) -8/9/2021: 3 NA(s) - one of which only worked 5 hours (7 AM - 12 PM), 1 LPN, & 1 CMT; (census = 30 residents) -8/10/2021: 3NA(s), 1 LPN, 1CMT; (census = 30 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 7 out of 7 opportunities. Second shift (3 - 11 PM) -8/4/2021: 3 NA(s) - one of which only worked 4 hours (5 - 9PM) , 1 LPN, 1 CMT; (census = 29 residents) -8/5/2021: 3 NA(s), 1 RN (agency), 1 CMT; (census = 29 residents) -8/6/2021: 2 NA(s) 1 RN, 2 LPN; (census = 28 residents) -8/7/2021: 2 NA(s), 1 RN, 1 LPN, 1 CMT; (census = 28 residents) -8/8/2021: 3 NA(s) - one of which only worked 4 hours (5 - 9PM), 1 RN, 1 LPN; (census = 28 residents) -8/9/2021: 3 NA(s) - one of which only worked 6 hours (3 - 9 PM), 1 RN, 1 LPN, 1 CMT (census = 30 residents) -8/10/2021: 2NA(s), 1 RN, 1 LPN, 1 CMT; (census = 30 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 7 out of 7 opportunities.	F 725 MR 8/31/21		

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F 725	Continued From page 27 Third shift (11 PM - 7 AM) -8/4/2021: 2 NA(s), 1 RN who is also covering South unit; (census = 29 residents) -8/5/2021: 2 NA(s), 1 RN 11PM-3AM & DNS 3AM - 7AM; (census = 29 residents) -8/6/2021: 1 NA(s), 1 RN; (census = 28 residents) -8/7/2021: 1 NA(s), 1 RN; (census = 28 residents) -8/8/2021: 2 NA(s), 1 RN (census = 28 residents) -8/9/2021: 2 NA(s), 1 RN (agency); (census = 30 residents) -8/10/2021: 2 NA(s), 1 RN; (census = 30 residents) Review of the above staffing revealed that the facility did not meet their staffing goals for 3 out of 7 opportunities. During a surveyor interview on 8/11/2021 at 10:33 AM with a family member of Resident ID #8, it was stated, "the facility is short staffed. I get the sense they are very busy." During a surveyor interview on 08/11/2021 at 10:46 AM with Resident ID #365, it was stated that s/he waited for an hour for staff to answer the call light. Furthermore, s/he indicated that this occurred on all shifts. During the exit conference with the Administrator and DNS on 8/13/2021 at approximately 4:00 PM, they were unable to provide evidence that the facility was meeting their staffing goals.	F 725	NR 8/19/21	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		

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F 760	Continued From page 28 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure its residents are free of significant medication errors for 1 of 5 residents selected for medication regimen review, Resident ID #414. Findings are as follows: Record review revealed the resident was admitted to the facility in July of 2021 with diagnoses including type 2 diabetes mellitus [a condition resulting from insufficient production of insulin]. Record review revealed a 7/29/2021 physician's order which states in part, "Basaglar KwikPen Solution...(Insulin Glargine) [medication used to lower high blood sugar levels] Inject 120 units subcutaneously [under the skin] at bedtime..." Review of a 6/3/2021 care plan for diabetes mellitus revealed interventions including: "...Diabetes medication as ordered by doctor..." Record review of physician progress notes on 7/30/2021, 8/2/2021, and 8/5/2021 state in part, "...DM [diabetes mellitus]: c/w [continue with] insulin..." Record review revealed the following nursing progress notes: - 7/29/2021 at 9:16 PM, "...Resident requested only give [him/her] 80 units r/t [related to] receiving insulin while at hospital."	F 760	**F760** Resident #414 has been discharged home successfully, she has had no adverse effect Any resident receiving sliding scale insulin is at risk for this alleged deficient practice. Nursing staff have been in serviced regarding the importance of obtaining and documenting blood sugars as ordered and administering insulin per MD order as well as notification of MD if insulin is not administered as ordered. DON/designee will review a random sample of residents with blood sugar and/or insulin orders weekly Monday through Friday to insure blood sugars are obtained and documented and that insulin is administered as per MD order and confirm MD notification as appropriate. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved.	

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F 760	Continued From page 29 - 8/2/2021 at 9:27 PM, "...pt [patient] fsbs [fasting blood sugar] 160, [s/he] stated [s/he] did not want to take 120 units, so [s/he] agreed to take 80 units..." - 8/3/2021 at 8:51 PM, "...resident requested only 80 units be given." - 8/4/2021 9:51 PM, "...Resident requested only 80 units be given r/t BS [blood sugar] at 160." - 8/6/2021 at 12:20 AM, "...Resident was concerned about the amount of insulin that [s/he] was taking. [S/he] requested that [s/he] be given less than the ordered dose..." - 8/8/2021 at 9:07 PM, "...pt only took 80 units." - 8/9/2021 2:50 PM, "...patient had more complaints at end of the shift as to why a doctor hasn't seen [him/her] and wanting insulin reviewed with [him/her]..." - 8/10/2021 at 8:37 PM, "...due to BS being 176 resident requested only 100 units be administered..." - 8/11/2021 at 10:24 PM, "...Patient would only take 100 units of 120." During a surveyor interview on 8/12/2021 at 12:26 PM with the Director of Nursing Services, she was unable to provide evidence that the 120 units of insulin at bedtime was administered as ordered on 7/29/2021, 8/2/2021 through 8/4/2021, 8/6/2021, and 8/8/2021 through 8/11/2021. During a surveyor interview on 8/12/2021 at 2:10	F 760	NLR 8/31/21	

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F 760	Continued From page 30 PM with the Physician, he indicated he was not aware that the resident was receiving less than the ordered 120 units of insulin at bedtime. He indicated he expects staff to administer the 120 units of insulin as ordered.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interviews, it has been determined that the facility failed to ensure that medications and vaccines	F 761	F761 Expired Lorazepam Intensol Solution and Pneumovax23 have been discarded. The bottle of Morphine Sulfate in question has also been disposed of. No evidence has been noted of any adverse effect to any resident from incident. Any resident receiving a liquid medication or vaccination is potentially at risk from the alleged deficient practice. All nursing staff have been in serviced regarding labelling liquid medications and vaccinations with expiration date and removing them from use as appropriate as well as narcotic count procedure and the importance of maintaining a temperature log for the medication refrigerator. Unit Managers will audit all medication carts and medication refrigerators to ensure that dates are evident when medications are opened, medications are discarded when expired or past the date of efficacy Monday through Friday. Unit Managers will review refrigerator logs daily Monday through Friday for completion. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved.	

MR
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F 761	Continued From page 31 were discarded per the manufacturer's instructions when expired, temperatures were documented for a refrigerator storing medications, and accurate count of controlled substances were maintained in the narcotic log, for 1 of 2 medication storage rooms and 2 of 4 medication carts observed. Findings are as follows: Review of the facility policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles," revealed in part: "...once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications..." 1. Surveyor observation of the Certified Medication Technician (CMT) medication cart on South wing in the presence of CMT Staff J, on 8/12/2021 at approximately 8:43 AM, revealed 1 open bottle of Lorazepam Intensol Solution [a medication that is used to treat anxiety], with an expiration date of 8/2/2021. Manufacturer's instructions written on the box state, "discard opened bottle after 90 days". During an interview conducted with Staff J immediately following the observation, she acknowledged the medication had expired and stated the medication has been administered to Resident ID #13. Record review of his/her August 2021 Medication Administration Record revealed that from 8/3/2021 through 8/11/2021, s/he received 9 doses of the expired medication.	F 761	MR 8/31/21	

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F 761	Continued From page 32 2. Observations made of the nurse's cart in the presence of Licensed Practical Nurse (LPN) Staff K, on 8/12/2021 at approximately 9:00 AM, revealed 1 open bottle of Morphine Sulfate [an opioid medication used to treat pain] for Resident ID #12 with less than 4.25 milliliters remaining in the bottle. Review of the controlled substance log revealed that on 8/11/2021 the "AMOUNT LEFT" column revealed the amount in the bottle was 4.25 mL(milliliters). Surveyor observations of the bottle failed to reveal 4.25 mL of the Morphine. Surveyor observation of South Wing Nurse Staff I, utilizing a syringe to extract the Morphine from the bottle in the presence of the DNS, revealed 1.8 mL with a scant amount of residual medication remaining, indicating approximately 2.45 mL of the medication was not accounted for in the log. During an interview on 8/12/2021 at approximately 10:00 AM, with the Director of Nursing (DNS), she could not explain why the Lorazepam was administered after the expiration date and not discarded as specified. Additionally, she could not explain the discrepancy with the controlled substance log documentation and the amount of medication in the Morphine bottle. 3. Surveyor observation of the vaccine fridge in the medication room on North wing in the presence of Nurse Staff L and the Infection Preventionist (IP) on 8/12/2021 at 9:26 AM, revealed an expired box of PNEUMOVAX23 containing 9 of 9 vials of the pneumococcal vaccine, with an expiration date of 6/12/2021. Additional observations of a medication storage refrigerator revealed two documents titled,	F 761	8/31/21 KR	

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F 761	Continued From page 33 "Morrison Senior Dining Equipment Temperature Log...July 2021...Aug [August] 2021..." Review of these documents failed to reveal evidence of temperatures documented for 49 of 62 opportunities in July and for 17 of 23 opportunities in August. During surveyor interview, on 8/12/2021 at approximately 10:00 AM, with the Nurse Staff L and the IP, they acknowledged that the vaccine was expired. The IP further stated her expectation is that expired medication would be removed from the refrigerator and temperatures would be checked and documented as indicated on the form.	F 761		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	**F842** Residents # 3, 25,62 and 82 remain in the facility with no adverse effects noted. Resident #207 has been discharged from the facility. All residents have the potential to be affected by the alleged deficient practice. MR 8/31/21 All nurses and CNAs have been in service about the importance of accurate and complete documentation. DON and unit managers will review TARs daily Monday through Friday as part of morning clinical meeting. DON or designee to spot check 10% of treatments and CNA documentation daily Monday through Friday for completion. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved.	

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F 842	Continued From page 34 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842	MR 8/31/21	

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F 842	Continued From page 35 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records on each resident that are complete and accurately documented, in accordance with accepted professional standards and practices, for 5 of 23 sample residents reviewed, Resident ID #'s 3, 25, 62, 82 and 207. Findings are as follows: 1. Review of Resident ID #3's record revealed a physician orders dated 7/15/2021 to "Wear soft boot while out of bed to (L) foot every day and evening shift." Surveyor observations on the following dates and times revealed the resident out of bed with no soft boot on the left foot: - 8/11/2021 at 10:51 AM, 10:56 AM, and 1:28 PM - 8/12/2021 at 12:48 PM - 8/13/2021 at 9:07 AM Review of the August Treatment Administration Record (TAR) revealed that the order was inaccurately documented as complete on 8/11/2021, 8/12/2021, and 8/13/2021. Further record review revealed a physician's	F 842	MK 8/20/21	

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F 842	Continued From page 36 order dated 7/18/2021 to "check air mattress to current weight." Surveyor observations on the following dates and times revealed no air mattress on the resident's bed: - 8/11/2021 at 8:56 AM, 10:56 AM, and 1:28 PM - 8/12/2021 at 8:14 AM, 8:36 AM, 8:46 AM, 9:00 AM, 9:09 AM, and 12:48 PM Review of the August TAR revealed that the order was inaccurately documented as complete on 8/11/2021 and 8/12/2021. Record review revealed a physician's order dated 3/16/2021 to "Apply soft knee immobilizer to left knee while in bed." Surveyor observations on the following dates and times revealed the resident in bed without the soft knee immobilizer on the left knee: - 8/11/2021 at 8:58 AM - 8/12/2021 at 8:14 AM, 8:36 AM, 8:46 AM, 9:00 AM, and 9:09 AM Review of the August TAR revealed that the order was inaccurately documented as complete on 8/11/2021 and 8/12/2021. During a surveyor interview with the Director of Nursing Services on 8/13/2021 at 10:03 AM, she indicated that staff should not be signing off on the TAR unless the order was complete. 2. Record review for Resident ID #s 25, 62, 82,	F 842	MK 8/31/21	

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F 842	Continued From page 37 and 207 failed to reveal evidence of nursing assistant documentation on 8/7/2021. During a surveyor interview with the Nursing Assistant (NA) Staff B on 8/11/2021 at 9:30 AM, she indicated that the nursing assistants were unable to document on any of the residents the East unit, on 8/7/2021 due to short-staffing, of only 2 NA's for 46 residents .	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to	F 849	**F849** Residents # 62, 82 and 90 remain in the facility with no ill effects noted. Orders to admit to hospice were placed as a onetime order to screen and admit if appropriate. Residents now have orders stating, "resident is on hospice services". DON has spoken with hospice providers to insure they are aware that hospice care plans, orders and MD re certifications must be evident in the residents' charts or in a hospice folder on the unit. All nurses to be educated about hospice documents (orders, MD certification and hospice plan of care) and the importance of having them included in the facility's medical record. Social services will continue to conduct routine audits on residents who receive hospice services to ensure all necessary documentation is evident in the medical record. Results of these reviews will be audited and brought to monthly IDT QAPI meetings for 3 months or until substantial compliance is achieved MR 8/31/21	

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F 849	Continued From page 38 any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and	F 849	MR 8/31/21	

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F 849	Continued From page 39 bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone	F 849	LMR 8/31/21	

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F 849	Continued From page 40 that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms,	F 849	MR 8/31/24	

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F 849	Continued From page 41 and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to ensure that hospice services meet professional standards and principles that apply to individuals providing services in the facility for 3 of 4 residents reviewed for hospice, Resident ID #s 62, 82 and 90. Findings are as follows: 1. Record review for Resident ID #62 revealed that the resident was admitted to the facility in January of 2016 and has a diagnosis including, but not limited to multiple sclerosis. Record review revealed that the resident was admitted to hospice services on 10/8/2019. Further record review failed to reveal a physician's order for hospice services, or evidence of a hospice plan of care or physician certification. During surveyor interview with the nurse manager on the east unit on 8/11/2021 at 2:03 PM, she was unable to produce evidence of a hospice	F 849	KMR 8/31/21	

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F 849	Continued From page 42 plan of care, physician's certification, or order for hospice services. 2. Record review for Resident ID #82, revealed that the resident was admitted to the facility in June of 2021 with a diagnosis including, but not limited to, cerebral infarction (stroke) due to embolism of basilar artery. Record review lacked evidence of a physician's order for hospice services. Additional review of the record revealed that the resident has been receiving hospice services since s/he was admitted to the facility in June 2021. During surveyor interview with the nurse manager on the east unit on 8/11/2021 at approximately 2:10 PM, she was unable to produce evidence of a physician's order for hospice services. 3. Record review for Resident ID #90 revealed that the resident was admitted to the facility in April of 2016 and has diagnoses including, but not limited to, Alzheimer's disease, dementia, anxiety disorder, and stroke. Review of the resident's care plan, revised on 8/3/2021, revealed that the resident was admitted to Hospice services on 6/25/2021. Further record review failed to reveal a physician's order for hospice services. During a surveyor interview with the Director of Nursing Services on 8/13/2021 at 9:58 AM, she could not provide evidence of an order for hospice services.	F 849	MR 8/31/21	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	MR 8/31/21	

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F 880	Continued From page 44 (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. 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 surveyor observation and staff interview, it has been determined that the facility failed to maintain a sanitary environment relative to hand hygiene and a contact precaution room, Resident ID #'s 6, 12, 61, 103 and 362. 1. According to the Center for Disease Control (CDC) guidance titled, "Hand Hygiene in Healthcare Settings", states in part, "...Multiple opportunities for hand hygiene may	F 880 MR 8/31/21	In accordance with Federal regulations at 42 CFR §488.424, a DPOC is imposed on the facility. The DPOC is as follows: Starting immediately upon receipt of this enforcement letter, The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following: - Conduct a root cause analysis ("RCA")	

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F 880	Continued From page 45 occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based sanitizer...Immediately before touching a resident...After touching a patient or the patient's immediate environment... Immediately after glove removal..." Observations made of the medication pass on South Unit with Licensed Practical Nurse (LPN) Staff G, on 8/13/2021 beginning at 9:09 AM until approximately 11:00 AM, revealed that he failed to perform hand hygiene prior to and after contact with 4 residents. Additionally, observations made during the medication pass of eye drop medications administered to Resident ID #103, revealed Staff G failed to perform hand hygiene after removing the gloves and before continuing the medication pass. During an interview with Staff G immediately following the observations, he could not explain why he failed to perform hand hygiene throughout the medication pass. During an interview with South Wing Nurse Manager Staff I, on 8/13/2021 at approximately 12:00 PM, she stated her expectation is that hand hygiene is performed between resident contact and when removing gloves. 2. Observations made on 8/11/2021 at approximately 10:00 AM of a contact precaution sign posted outside the door of this room revealed, in part, "...wear gown if in contact with patient or linen or environment..." Additional observations made from outside the	F 880 KLR 8/31/21	by the ICP, QAPI Committee, and Governing Body. Detailed documentation of the RCA will be completed. Please note an acceptable and effective RCA will include the following elements: Identify the root cause resulting in the facility's failure. This includes asking the Who, What, Where, When, and Why questions which can be done by conducting internal investigations; Develop solutions and systemic changes that need to be taken to address the root cause; and Implement the solution. The RCA should be completed by 8/26/2021. - The Medical Director, Administrator, Director of Nursing and the facility's ICP, will review and revise all infection control policies, procedures, and protocols to ensure they correlate to the current United States Centers for Disease Control and Prevention's (CDC) guidelines and recommendations. This shall be completed immediately and then AT LEAST every two weeks for the next six months. All staff and contracted direct care staff will be in-serviced on all revisions to infection control policies, procedures, and protocols within five calendar (5) day of the revisions. - An in-service concentrating on the proper use of personal protective equipment (PPE) and hand hygiene is required. In-services to be completed by 9/2/2021. - A QAPI regarding infection control	

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F 880	Continued From page 46 room of Resident ID #362 on 8/11/2021 at 10:06 AM revealed LPN Staff M failed to don a gown while assisting him/her with transferring out of the wheelchair and into bed. During an interview at 10:21 on 8/11/2021, with LPN Staff M following the observations, she acknowledged that she should have worn the gown in the contact precaution room. During an interview with the Director of Nursing (DNS) on 8/11/2021 at 12:54 PM, she indicated that her expectation is that staff wear the correct PPE in a contact precaution room, as posted outside of the resident's room.	F 880	issues related to proper use of PPE and hand hygiene is required. This shall be completed by 8/26/2021. MK 8/31/21	