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F 000	INITIAL COMMENTS The Centers for Medicare and Medicaid Services (CMS) conducted a comparative Federal Monitoring Survey (FMS) 6/24-6/28/24. Refer to State Survey Agency (SSA) Event ID 0M7011. Census: 68. On 6/26/24 at 6:35 PM, an Immediate Jeopardy was identified for accidents related to the failures to prevent elopments. A removal plan was accepted, and the Immediate Jeopardy was removed on 6/27/24 at 5:00 PM.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 3 residents (R) reviewed for self-administration of medication were assessed appropriately to ensure it was safe to self-administer their own medication (R21, R51 and R63). This failure created the potential for residents to incorrectly administer their medication. Findings include: Review of facility policy, Self-Administration of Medications Policy, dated 2024, revealed in pertinent part, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically	F 554		

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

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appropriate and safe for the resident to do so;" and "1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident;" and "3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status;" and "6. For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken;" and "8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents;" and "Nursing staff reviews the self-administered medication record for each nursing shift, and transfers pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses were self-administered."

1. Review of R21's Admission Record, indicated the resident was admitted to the facility on 4/20/21. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure.

Review of R21's Quarterly Minimum Data Set (MDS - federally mandated assessment, with an assessment reference date (ARD) of 4/29/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact.

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Review of R21's Order Recap Report, indicated an order initially dated 1/12/22, for the resident to receive Albuterol Sulfate Aerosol Solution (a metered dose inhaled short acting bronchodilator administered to assist with breathing) two puffs orally/inhaled every six hours round the clock to treat COPD. The order report indicated an order for the resident to self-administer his own medication.

Review of R21's comprehensive Care Plan, dated 2/22/24, revealed no care plan related to the resident self-administering his own medications.

Review of R21's most recent Quarterly Medication Self-Administration Safety Screen, dated 8/26/23, indicated the resident was assessed, at that time, for the self-administration of a different respiratory medication, Stiolto Respimat (a long-acting inhaled bronchodilator). However, the assessment indicated the resident had been assessed to be "fully capable" of administering subcutaneous injections rather than inhalant medications and did not indicate R21 had been assessed for the self-administration of his Albuterol (short-acting bronchodilator).

Review of R21's Medication Administration Record (MAR), dated 4/01/24 through 6/27/24, indicated that R21 was self-administering all ordered doses of his Albuterol (routinely every six hours).

During a concurrent observation and interview on 6/24/24 at 2:11 PM, R21 was observed in his room and an unlabeled and undated albuterol inhaler was observed on the resident's bed/on his overbed table. R21 stated he thought he self-administered the inhaler once every two days

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or so when he needed it for rescue breathing (when he was having a hard time breathing).

During a concurrent observation and interview on 6/26/24 at 4:47 PM, R21 was observed, along with the Director of Nursing (DON), in his room. R21 had two unlabeled and undated albuterol inhalers on his overbed table. R21 stated he had thrown away the boxes the inhalers came in with the labels on them. R21 stated he administered the inhaler (albuterol) as needed for rescue, rather than routinely per physician's orders. R21 stated he did not document the administration of the albuterol anywhere and he did not tell nursing when he had administered the medication so it could be documented in his record.

During an interview on 6/26/24 at 4:50 PM, the DON stated her expectation was R21's inhaled medications should be labeled, and the administered doses were expected to be documented. She stated R21 was expected to have been appropriately assessed for the administration of his inhaled medication, and a care plan was expected to be in place to address self-administration for the resident.

2. Review of R51's Admission Record, indicated the resident was admitted to the facility on 1/10/23 with diagnoses including type 2 diabetes, malnutrition, and cognitive communication deficit.

Review of R51's Quarterly MDS, with an ARD of 4/5/24, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.

Review of R51's Order Recap Report, indicated orders for multiple oral medications, including

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acidophilus (a probiotic) give one capsule by mouth once daily, aspirin 81 milligrams (mg) once daily for heart health, atorvastatin (a medication used to control high cholesterol) 80 mg one time daily, famotidine (a medication used to control heart burn) 20 mg one time daily, fenofibrate (a medication used to control high cholesterol) 160 mg daily, iron 325 mg one time daily for low iron, glipizide (a medication used to control blood sugar) 5 mg daily, metoprolol extended release (a medication given to control blood pressure) 12.5 mg once daily, Senna (a medication to help soften bowel movements) 8.6 mg daily, sodium bicarbonate (a supplement) 650 mg twice daily to control stomach acid, gabapentin (a muscle relaxing medication) 300 mg by mouth three times daily and oxybutynin extended release (a medication used to control bladder spasms) 10 mg once daily. The order report did not indicate an order for the resident to self-administer his own medications.

Review of R51's comprehensive Care Plan dated 4/14/24, indicated no care plan related to the resident self-administering his own medications.

There was no evidence in R51's record that he had a Medication Self-Administration Safety Screen assessment to self-administer his medications.

Review of R51's MAR, dated 4/1/24 through 6/27/24, indicated that R51 was receiving his ordered medication, administered by nursing staff, as ordered by his physician.

During a concurrent observation and interview on 6/25/24 at 9:12 AM, revealed R51 in his room and six pills/oral medications were observed in a

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medication cup on the resident's overbed table. There was no nursing staff observed in the resident's room. R51 stated nursing staff generally left the medication with him in the morning and he took the medication one by one as he was able. He stated, "I'll take them right now. I take them one at a time. They leave them here. That's what I do." R51 was not able to verbalize what medication was in the medication cup.

During an interview on 6/26/24 at 3:21 PM with the DON and the Administrator, they both confirmed medication was not to be left unattended at any resident's bedside without a proper assessment, a care plan, and a physician's order to do so.

3. Review of R63's Care Plan revealed R63 was readmitted to the facility on 4/5/24. Diagnoses include infection, below the knee amputation of left leg and muscle weakness. The Quarterly MDS with an ARD of 4/8/24 revealed the resident had intact cognition with a BIMS score of 13 out of 15.

Review of R63's Care Plan dated 4/5/24, revealed no care area associated with R63 self-administering his own medication.

Review of R63's Electronic Medical Record (EMR) revealed that there was no physician's order, or an assessment performed to evaluate R63's ability to self-administer his medication.

During an observation on 6/24/24 at 12:17 PM, R63 was lying in bed, and a medication cup containing several pills was observed on his bedside table. R63 sat up on the side of the bed

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F 554	Continued From page 6 and stated "These are my morning medications" and took them. There was no nurse present in the room at the time of administration. During an interview on 6/25/24 at 1:43 PM, License Practical Nurse (LPN) 1 stated residents required an order to self-administer medication. LPN1 stated that two residents have orders to self-administer their inhalers, but "No resident should be self-administering pill medication." During an interview on 6/26/24 at 11:44 AM, Registered Nurse (RN) 4 stated that some residents are allowed to self-administer medication if they have been assessed and have an order. RN4 stated that nurses administer medications to residents who are not allowed to self-administer. During an interview on 6/27/24 at 10:52 AM, R63 stated that the nurses always leave his medication on the bedside table because he's asleep when they come to his room to administer it.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

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F 578	Continued From page 7 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's right to formulate an advance directive (R2), failed to obtain advance directive documentation to support the representative's authority to sign (R12), and failed to ensure the individual with advance directive authority signed documents for the resident (R30), for 3 of 31 residents reviewed for advance directives.	F 578		

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Findings include:

Review of facility policy, Advance Directives, last revised June 2024, revealed in pertinent part,
- "Advance Directive - a written instruction, such as a living will or durable power of attorney for health care..."
- "Legal Representative ... a person designated and authorized by an advance directive or state law to make treatment decisions for another person in the event the other person becomes unable to make necessary health care decisions."
- "Prior to or upon admission, the social service director or designee inquires ... about the existence of any written advance directives."
- "The resident or representative is provided with written information concerning the right ... to formulate an advance directive if he or she chooses to do so."
- "If the resident or the resident's representative has executed one or more advance directive(s) ... copies of these documents are obtained and maintained in the ... residents medical record."

1. Review of R12's Face Sheet revealed R12's relative was her responsible party.

Review of the Provider Order for Life-Sustaining Treatment (POLST) documented verbal consent per relative, dated 11/19/21. "No Advance Directive available" was selected on the form.

During a telephone interview on 6/24/24, starting at 3:53 PM, the relative stated that he had documentation that he was the power of attorney (POA) for R12.

During an interview on 6/25/24 at 10:16 AM, the

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Medical Records (MR) employee stated there was no POA paperwork for R12. The MR employee stated she had not called the relative to ask for the paperwork. "I can do that." The MR employee stated it was important to have the paperwork in the record to show who had the authority to make medical decisions on behalf of the resident.
2. Review of R30's Admission Record, indicated the resident was admitted to the facility on 1/8/2020. Diagnosis included history of traumatic brain injury, schizophrenia, and substance induced dementia. The Admission Record indicated R30 had a court ordered guardian in place to assist with all medically related decision-making.

Review of R30's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 4/3/24, revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was not able to be interviewed due to his poor cognition. The assessment indicated the resident had both short and long-term memory impairment.

Review of R30's Cognitive Loss/Dementia Care Plan, dated 4/7/24, indicated the resident had impaired cognitive function related to his diagnoses of dementia and head injury. The care plan indicated R30's ability to make decisions for himself was impaired. The care plan also indicated R30's capabilities, needs, nursing home placement, and disease process were to be discussed with the resident's family/caregivers.

Review of R30's Office of Public Guardian Document, dated 4/26/24 and provided directly to

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the survey team, indicated the court resident had appointed a guardian for the resident initially on 2/14/22 and the guardianship was to be continued since the resident was not able to make his own decisions related to care and he had only one family member who was not involved in the resident's life.

Review of R30's POLST, dated 2/21/24, authorized the resident's code status to be DNR (Do Not Resuscitate) in the event he was found without a pulse and not breathing. It was signed by the resident and not the court appointed guardian.

During an interview on 6/25/24 at 10:17 AM, the MR employee confirmed she was responsible for obtaining signatures/consents from residents and/or their responsible parties at the time of admission to the facility. She stated she was responsible for obtaining signatures related to the admission process, such as signed smoking policies and the admission agreement. She stated nursing was responsible for reviewing and obtaining consent for things like code status and consent for immunizations. The MR employee confirmed R30 was not able to make his own decisions related to his medical care and indicated the resident had a court appointed guardian at the time of his admission to the facility. She stated she thought most of the R30's consents and signed documentation had been in place prior to her beginning her job with the facility in 2021.

During a follow up interview with the MR employee on 6/25/24 at 10:59 AM, she confirmed the name of R30's court appointed guardian and stated the resident's guardian should have been

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reviewing and signing all his documents. She stated she had not been able to find anything in R30's record to show anyone from the facility had attempted to reach R30's guardian to review and sign consents and other documentation.

During an interview on 6/26/24 at 3:01 PM, with the Resident Advocate (RA) and the Corporate Licensed Clinical Social Worker (LCSW), the RA stated nursing was responsible for having residents sign documentation such as the POLST and immunization consents, admissions was responsible for obtaining signatures related to the admission process, and she was responsible for reviewing the smoking policy with residents or their guardians and having them sign to indicate they understood the documentation. She stated, "I should have reached out to his guardian." The Corporate LCSW stated it was her expectation that when a resident had a court appointed guardian, the guardian was to review and sign all medically related documentation.

During an interview on 6/26/24 at 3:32 PM, the Director of Nursing (DON) stated R30's guardian had been difficult to reach, however her expectation was that all attempts should have been made to reach the resident's guardian to review and sign documentation related to his care at the facility.

3. Review of the Admission MDS assessment for R2, dated of 2/11/24, identified the resident was admitted to the facility on 2/5/24. The MDS included a BIMS score of 9, which indicated moderately impaired cognition. The MDS identified inattention and disorganized thinking as present but fluctuated. The MDS listed diagnoses of hypertension, non-Alzheimer's dementia, traumatic brain injury, schizophrenia, and

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obsessive-compulsive disorder.

The POLST for R2, signed by the resident on 2/5/24 and signed by the resident's primary care provider on 2/12/24, identified the resident requested DNR. The POLST lacked documentation, completion, under the Advanced Directives and Resident Preferences.

The review of R2's Electronic Medical Record (EMR) lacked documentation that R2 had been provided the facilities Admission Agreement on admission to the facility 2/5/24. R2's EMR lacked documentation that the facility staff had reviewed the facilities Admission Agreement with the resident and/or documentation that the resident refused to sign.

A copy of the facilities Admission Agreement revised 5/24/23, included a section for Advanced Directives: the resident /resident representative acknowledges being informed, orally and in writing, of the facilities policy on advanced directives and medical treatment decisions.

Review of R2's EMR included facility documents the resident had signed and dated on admission, 2/5/24, including Antipsychotic Medication Informed Consent, Consent to Treat and Assignment of Benefits, Immunization Consent, Private Room Acknowledgement, and Smoking Policy.

During an interview on 6/25/24 at 11:14 AM, the Admission Coordinator and the Resident Advocate stated R2 refused to sign paperwork and/or documents. The Resident Advocate requested a review of R2's PASRR (Pre-admission Screening for Resident Review,

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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 578	Continued From page 13 in-depth federal assessment completed by a mental health professional) Level II related to the residents history with mental health issues. The Resident Advocate again stated the resident refused to sign any paperwork from the facility. During an interview on 6/26/24 at 4:38 PM, the Resident Advocate stated the Admission Coordinator completed the facilities Admission Agreement with the residents on admission. The Resident Advocate stated when R2 was admitted to the facility on 2/5/24, he refused to sign any paperwork. The Resident Advocate stated she had not followed up on the facilities Admission Agreement to see if the resident had signed it. The Resident Advocate confirmed R2 did not have an Admission Agreement in his EMR. The Resident Advocate stated she had gone with the MDS Coordinator after R2's Medicare stay, in an attempt for him to sign paperwork on 2/16/24 and 2/19/24, and the resident refused. The Resident Advocate stated the Medicare paperwork had documentation that R2 had refused to sign, and two-facility staff had signed the documentation noting R2 the refusal to sign. During an interview on 6/27/24 at 11:30 AM, the Administrator stated R2 refused to sign paperwork on admission to the facility. The Administrator stated the facility did not have documentation that R2 refused to sign the Admission Agreement.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		

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	465006	A. BUILDING _____ B. WING _____	06/28/2024

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neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure 1 of 10 residents (R) reviewed for abuse (R27) was free from physical abuse by another resident (R128).

Findings include:

Review of facility policy, Abuse, Neglect, Exploitation, and Misappropriation Prevention Policy, dated April 2024, read in pertinent part, "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms."

Review of R27's Admission Record, indicated the resident was admitted to the facility on 3/28/19 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, and mild cognitive impairment.

Review of R27's Admission Minimum Data Set

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(MDS - federally mandated assessment, with an Assessment Reference Date (ARD) of 6/8/23, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating he was cognitively intact.

Review of R27's Progress Note, dated 5/29/23 at 8:00 PM read, "At 1930 [7:30 PM], this nurse heard loud verbal arguing coming from lobby area of SNF [Skilled Nursing Facility]. Situation assessed and pt [R27] was seen in the doors to lobby yelling at other resident [R128] who was sitting outside farther away. This nurse was unable to hear what other resident was saying but was noted to make pt angrier and instigating escalation. [R27] encouraged to leave situation and calm down and head back to unit. [R27] starting [sic] moving w/c [wheelchair] toward this nurse away from doors and other resident [R128] left the area but remained outside. [R27] stated other res [R128] was being disrespectful. this nurse then call[ed] RA [Resident Advocate] and reported situation. When this nurse returned to nursing station more/louder yelling was heard and other resident [R128] was heading down hallway ahead of [R27] and CNA [Certified Nursing Assistant]. CNA reports other resident [R128] intentionally drove power chair into legs of [R27] causing superficial abrasion to L [left] shin area. Both [residents] told to separate and avoid each other. [R27] reports other resident [R128] said multiple racial slurs at him, CNA reports having witnessed the 2nd altercation between them. RA/LCSW/ADON [Resident Advocate/Licensed Clinical Social Worker/Assistant Director of Nursing] notified of res v res [resident versus resident] altercation. UPD [Police Department] notified by RA to aid in situation resolution, NP [Nurse Practitioner] notified of new skin

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impairment to L shin area, no bleeding/drainage at time of event from new wound, increased supervision put into place to prevent further altercation."

Review of R27's Progress Note, dated 5/30/23at 5:14 PM, read "Reassessed [R27's] Left shin abrasion and noted superficial scab stable 4 cm x [centimeters by] 1 cm x 0 cm, no s/s [signs or symptoms] of infection, denies pain, no sewlling [sic] noted, able to lower extremities without difficulty."

Review of R27's Quarterly MDS with an ARD of 4/4/24, BIMS score was now an 11 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident exhibited verbal and physical behaviors toward others on one to three days of the assessment reference period.

Review of R27's Behavioral Symptoms Care Plan, dated 5/20/24, indicated R27 exhibited behavioral symptoms toward others related to his paranoia. The care plan indicated staff were to intervene as necessary to protect the rights and safety of R27 and others in the facility.

Review of R128's Admission Record, indicated the resident was admitted to the facility on 3/3/22 with diagnoses including Post Traumatic Stress Disorder (PTSD) and depression. R128 was discharged from the facility on 8/4/23.

Review of R128's Annual MDS, with an ARD of 3/6/23, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident did not exhibit behaviors during the assessment

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F 600	Continued From page 17 reference period. Review of R128's undated Behavioral Symptoms Care Plan, indicated R128 had the potential to exhibit aggression toward others related to his mental health diagnoses. The care plan indicated staff was to assist the resident with coping skills and support to de-escalate behaviors when they occurred. Review of the facility's investigation provided by the facility of the incident between R27 and R128 that occurred on 5/29/23 revealed the potential abuse was reported timely to pertinent entities including the State Health Department, and a thorough investigation was conducted into the incident. The investigation revealed resident to resident abuse perpetrated by R128 against R27 was substantiated. During an interview with R27 on 6/24/24 at 2:54 PM, he indicated he remembered the incident between himself and R128 on 5/29/23 and confirmed he was run into by the other resident with his wheelchair causing an injury to his leg. He stated R128 had been discharged from the facility and he currently felt safe in the facility and did not feel he had been recently abused by anyone. During an interview with the Director of Nursing (DON) on 6/27/24 at 10:25 AM, she stated her expectation was all residents were to remain free from abuse.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		

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F 623	Continued From page 18 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the State Long Term Care Ombudsman of the transfer and/or discharge for 3 of 12 residents reviewed for hospitalization and discharge (R4, R46, and R121).

Findings Include:

Review of the facility policy, Transfer or Discharge Notice, last revised June 2024, revealed in pertinent part, transfer and discharge included movement of a resident from a certified bed in the facility to a non-certified bed outside of the facility. Transfer referred to movement of a resident to a bed in one certified facility to a bed in another certified facility when the resident expected to return to the original facility. Discharge referred to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. A copy of the discharge notice would be sent to the Office of the State

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Long-Term Care Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative.

1. Review of R4's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 6/2/24, identified a most reentry to the facility of 2/27/24, from acute hospital. The MDS identified a Brief Interview of Mental Status (BIMS) score of 14 which indicated no cognitive impairment. The MDS documented diagnoses of hypertension, diabetes, Parkinson's, traumatic brain injury, and schizophrenia.

The Discharge tracking MDS assessment, with an ARD of 2/25/34, identified the resident had an unplanned discharged with return anticipated to the hospital on 2/25/24.

The Entry tracking MDS assessment, with an ARD of 2/27/24, identified the resident returned from the hospital on 2/27/24.

During an interview on 6/24/24 at 1:48 PM, during the initial tour of the facility, R4 stated she had been hospitalized two or three months ago.

The Progress notes for R4 revealed on:
- 2/25/24 at 4:01 AM, nurse note stated the resident called the paramedics at 3:30 AM, for the third time. When the paramedics arrived, the resident reported chest pain and for that reason, the paramedics were required to transport.
- 2/25/24 at 9:08 AM, order administration note stated the resident was in the hospital.
- 2/26/24 at 8:30 AM, order administration note stated the resident was in the hospital.
- 2/27/24 at 10:39 AM, order administration note

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stated the resident was in the hospital.
- 2/27/24 at 11:23 AM, nurse note stated the resident had stitches above right eye related to cancer diagnosis and recent surgery by dermatology.

During a concurrent interview and record review on 6/26/24 at 4:38 PM, the Resident Advocate (RA) stated she had only previously sent notifications to the State Long Term Care Ombudsman when resident's left the facility against medical advice and/or when the discharge was facility initiated. The RA stated she was not aware that all facility transfers and/or discharges were to be sent to the Ombudsman. The RA stated she just recently started notifying the Ombudsman of all transfers and/or discharges and showed the Ombudsman notifications for the transfers and/or discharges for the months of April and May 2024.
2. Review of R46's Admission Record, revealed the resident was admitted to the facility on 1/28/22. Diagnoses included a history of stroke, type 2 diabetes, epilepsy, and dementia. The record indicated the resident was his own responsible party (RP) and that he had a brother who was listed as an emergency contact.

Review of R46's Quarterly MDS with an ARD of 3/29/24, revealed R46 had a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired.

Review of R46's Census Records, indicated the resident was out of the facility between 12/2/23 and 12/9/23 and again between 3/23/24 and 3/26/24.

Review of R46's Progress Notes on:

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- 12/2/23 indicated the resident was sent to the local hospital on that date related to seizure activity and decreased level of consciousness.
- 3/23/24 indicated the resident was sent to the local hospital, again, on that date related to seizure activity and decreased level of consciousness.

Review of R46's comprehensive medical record revealed nothing to indicate a notice, in writing, was provided to the local ombudsman related to either of his transfers to the hospital.

3. Review of R121's Care Plan revealed R121 was admitted to the facility on 9/4/23 and discharged on 10/5/23.

Review of R121's Progress Note, dated 10/5/23, revealed a discharge summary that showed R121 was transferred to another long-term care facility with his responsible party. There was no evidence the Ombudsman had received a copy of the Discharge Notice.

Review of R121's Electronic Medical Record (EMR) showed no evidence the Ombudsman had received a copy of the Discharge Notice.

During an interview on 6/26/24, starting at 11:45 AM, the RA stated when a resident was discharged, a manilla packet was provided to the resident/representative that included the notice. The RS stated the receiving facility or community physician was faxed the resident's face sheet, progress notes, order summary, POLST (physician orders for life-sustaining treatment), and the PASRR (preadmission screening and resident review) evaluation. The RA confirmed the facility had not been notifying the Ombudsman of transfers/discharges. "We now

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F 623	Continued From page 24 notify them at the end of every month."	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident and/or their representative of the bed hold policy for 4 of 4 residents reviewed for hospitalizations (R3, R4,	F 625		

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R46, and R48).

Findings include:

The facility policy, Transfer or Discharge Notice, revised June 2024, revealed in pertinent part, transfer and discharge included movement of a resident from a certified bed in the facility to a non-certified bed outside of the facility. Transfer referred to movement of a resident to a bed in one certified facility to a bed in another certified facility when the resident expected to return to the original facility. The resident and representative are notified in writing of the following information, the facility bed hold policy.

The facility document, Long Term Care Resident Admissions Agreement, revised 5/24/23, included Readmission/Bed Hold Policy, revealed in pertinent part,
- Private Pay Residents: if resident leaves the facility for hospitalization, therapeutic leave, or any other reason (other than death, and if the resident is not eligible for, or receiving Medicaid benefits, the resident's bed would be reserved, and resident/resident representative (RR) would pay one-third the basic rate for any days reserved. The facility would continue to hold the bed until notified in writing by the resident/RR that the bed is no longer desired. If the resident elects in writing not to reserve a bed, the resident would be discharged from the facility and readmission to the facility would be subject to bed availability.
- Medical Assistance Residents: if the resident was eligible for, or receiving Medicaid benefits, and the resident leaves the facility for hospitalization or therapeutic leave, the resident's bed would be reserved for the applicable maximum number of days paid for a reserved

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bed under the state Medicaid program. If the hospitalization or therapeutic leave exceeds the bed reservation period, and if at the time of readmission, the resident requires the services provided by the facility, the resident would be entitled to the first available accommodation suitable for the resident's level of care. Resident's may reserve a bed by electing to pay the Medicaid per diem rate charged immediately prior to the leave, and by providing written advanced payment for the days included in the reservation period.
- Medicare Residents: if a Medicare Part A eligible resident is transferred/readmitted to a hospital, resident's eligibility would be determined the day the resident was admitted to the hospital. The resident's bed would be reserved at the basic rate unless the resident elects not to reserve in writing.

1. Review of R3' SCSA (significant change in status) Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 6/5/24, indicated the resident's most recent admission/entry or reentry to the facility was 6/3/24. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS listed diagnoses of atrial fibrillation, heart failure, hypertension, diabetes, and other injury of unspecified body region, subsequent encounter.

The Discharge tracking MDS for R3 dated 5/29/24, identified the resident had an unplanned discharge to the hospital on 5/29/24, with return anticipated.

The Entry tracking MDS for R3 dated 6/3/24, identified the resident returned from the hospital

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on 6/3/24.

Review of R3's Medical Record lacked documentation of the notification of the resident &/or their representative regarding the bed hold when R3 transferred to the hospital on 5/29/24.

2. Review of R4's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 6/2/24, identified a most reentry to the facility of 2/27/24, from the hospital. The MDS identified a Brief Interview of Mental Status (BIMS) score of 14 which indicated no cognitive impairment. The MDS documented diagnoses of hypertension, diabetes, Parkinson's, traumatic brain injury, and schizophrenia

The Discharge tracking MDS assessment, with an ARD of 2/25/24, identified the resident had an unplanned discharged with return anticipated to the hospital on 2/25/24.

The Entry tracking MDS assessment, with an ARD of 2/27/24, identified the resident returned from the hospital on 2/27/24.

Review of R4's medical record lacked documentation of the notification of the resident and/or their representative regarding the bed hold when R4 transferred to the hospital on 2/25/24.

During an interview on 6/26/24 at 12:34 PM, the Admission Coordinator stated the facility bed hold was signed on admission with facilities Admission Agreement. The Admission Coordinator stated a resident signed if responsible for self or resident representative signed if needed. The Admission Coordinator stated the bed hold was signed with

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the admission packet and with the re-admission packet, signing they agree to the prior terms. The Admission Coordinator stated the bed hold was not something the facility reviewed every time a resident transferred to the hospital, only at admission and re-admission.

During an interview on 6/26/24 at 4:38 PM, the Resident Advocate (RA) stated the facility did not officially provide residents with the bed hold form when resident transferred to the hospital. The RA stated it was not official, but that the facility would not give the resident's rooms away. The RA stated the facility did not have the resident and/or the resident representative sign a bed hod when they were transferred to the hospital, "we just don't give their bed away." The RA stated she did not have bed holds for R3 on 5/29/24, or R4 on 2/25/24, when they transferred to the hospital. The Resident Advocate stated, "they just kept their rooms."

3. Review of R46's Admission Record, revealed the resident was admitted to the facility on 1/28/22. Diagnoses included a history of stroke, type 2 diabetes, epilepsy, and dementia. The record indicated the resident was his own responsible party (RP) and that he had a brother who was listed as an emergency contact.

Review of R46's Quarterly MDS with an ARD of 3/29/24, revealed R46 had a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired.

Review of R46's Census Records, indicated the resident was out of the facility between 12/2/23 and 12/9/23 and again between 3/23/24 and 3/26/24.

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Review of R46's Progress Notes on:
- 12/2/23 indicated the resident was sent to the local hospital on that date related to seizure activity and decreased level of consciousness.
- 3/23/24 indicated the resident was sent to the local hospital, again, on that date related to seizure activity and decreased level of consciousness.

Review of R46's medical record revealed nothing to indicate the facility's bed hold policy and associated information related to the resident's rights regarding return to the facility was provided to the resident or his family member in writing with either of his transfers to the hospital.

4. Review of R48's Admission Record, indicated the resident was admitted to the facility on 11/12/21.

Review of R48's Quarterly MDS with an ARD of 5/16/24, revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition.

Review of R48's Nurses Note, dated 5/27/24 at 4:55 AM, specified a Nurse Practitioner from the hospital's emergency room called to let the facility know that R48 would be admitted to the hospital.

Review of R48's Admission Summary Progress Note, dated 5/29/24 at 11:01 PM, revealed R48 was readmitted to the facility from the hospital on 5/29/24 at 4:45 PM.

During an interview on 6/26/24 at 5:15 PM, R48 stated he was discharged from the facility and admitted to the hospital in May 2024, and he did not recall the facility providing him with any bed hold information.

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F 625	Continued From page 30 During an interview on 6/27/24 at 2:51 PM, the RA stated she was not aware the facility was required to provide written bed hold information when a resident was discharged from the facility to the hospital. The RA confirmed R48 was not provided any bed hold information when he was discharged from the facility and admitted to the hospital on 5/27/24. During an interview on 6/28/24 at 8:20 AM, the Director of Nursing (DON) stated the facility was not providing bed hold information to residents when a resident was sent to the hospital. The DON confirmed R48 was not provided any bed hold information when he was discharged from the facility and admitted to the hospital on 5/27/24.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		

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provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the comprehensive care plan had been developed and implemented for 1 of 2 residents (R) reviewed for behaviors (R2). The facility failed to include resident psychotropic medications, specific behaviors and specialized services recommended by PASRR (Pre-admission Screening and Resident Review - an in-depth federal assessment by a mental health

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professional to ensure that residents with a mental disorder receive care and services in the most integrated setting appropriate to meet their needs) on R2's care plan.

Findings include:

Review of facility policy, Care Planning-Interdisciplinary Team (IDT), revised April 2024, stated comprehensive, person-centered care plans were based on resident assessments and developed by the IDT.

Review of R2's Admission Minimum Data Set (MDS, federally mandated assessment) with an assessment referfence date (ARD) of 2/11/24, identified the resident was admitted to the facility on 2/5/24. The MDS coded the resident as being considered by the state level II PASRR process to have a serious mental illness. The MDS included a BIMS score of 9, which indicated moderately impaired cognition. The MDS identified inattention and disorganized thinking being present but fluctuated. The MDS listed diagnoses of hypertension, non-Alzheimer's dementia, traumatic brain injury, schizophrenia, and obsessive-compulsive disorder.

Review of the Quarterly MDS assessment for R2, with an ARD of 2/20/24, identified a BIMS score of 15, which indicated no cognitive impairment. The MDS identified inattention and disorganized thinking being present but fluctuated. The MDS coded the resident as having delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS listed diagnoses of hypertension, non-Alzheimer's dementia, traumatic brain injury, schizophrenia, and obsessive-compulsive disorder.

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Review of the Quarterly MDS assessment for R2, with an ARD of 5/22/24, identified a BIMS score of 15, which indicated no cognitive impairment. The MDS listed diagnoses of hypertension, non-Alzheimer's dementia, traumatic brain injury, schizophrenia, and obsessive-compulsive disorder.

Review of R2's Care Plan, initiated date of 2/26/24, identified R2 with schizoaffective disorder-bipolar type, paranoid schizophrenia, and borderline personality disorder. Interventions included: administer medications as ordered, behavioral health consults as needed, monitor/record/report to the physician as needed mood patterns signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocol, observe for signs/symptoms of mania or hypomania racing thoughts or euphoria.

During an observation on 6/24/24 at 3:51 PM, R2 at iron table in the smoke shack, smoking independently with fellow residents. R2 did not respond when spoken to.

During an observation on 6/25/24 at 7:45 AM, R2 in bed and would not respond when spoken to.

Review of the Level II PASRR dated 11/21/23, stated R2 was approved for nursing facility services, however, if psychiatric symptoms increase, inpatient hospitalization would be assessed. Diagnostic Formulation: the resident had a long history of mental illness and treatment for chronic mental health symptoms, a long history of severely impaired insight and judgement, leading to poor compliance with

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treatment and recurring exacerbation of symptoms. The resident had been followed by outpatient mental health and other treatment providers in the past while in a skilled nursing facility (SNF) for psychiatric treatment. Recommendations for specialized services for mental illness treatment: the resident should be referred for outpatient mental health treatment to ensure psychiatric stability and compliance with treatment, and to avoid decompensation and rehospitalization.

Review of R2's Order Summary, included an order for Paliperidone Palmitate Extended Release (medication to treat schizophrenia) 117mg (milligrams)/0.75ml (milliliters), inject 234mg intramuscularly every 30 days for schizoaffective disorder, with a start date of 4/8/24.

The Progress Notes for R2 revealed on:
-2/5/24 at 4:45 PM, admission summary noted stated the resident was admitted to the facility, alert and orientated to person, place, and time.
-2/8/24 at 9:50 AM, admission 72-hour charting note stated the resident acclimated well to his environment.
-2/12/24 at 3:57 PM, physician admission history and physical identified the resident was admitted to a psychiatric unit with a long history of non-compliance with medications.
-2/19/24 at 10:57 AM, resident advocate note stated a referral was sent for outpatient mental health services.
-4/8/24 at 3:23 PM, physician progress note stated the resident was resting comfortably without complaints.
-4/15/24 at 11:08 PM, the resident in room with the door closed. The resident kept to self, goes

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out to smoke and then back to room. The resident became nervous when informed of need for skin check. The resident stated his skin was fine.
-4/18/24 at 8:13 PM, nurse note stated the resident refused nighttime medications despite education.
-4/19/24 at 11:13 AM, nurse note stated the resident refused all morning medications and the resident stated he would not take any medications until he got his money. The resident's provider was updated.
-4/20/24 at 10:29 PM, order administration note stated the resident refused to take evening medications. The resident angry and upset each time and stated he would not take his medications until he received money for his smokes.
-4/21/24 at 3:30 AM, order administration note stated the resident refused all care and medication.
-5/4/24 at 12:31 PM, social service note stated the resident was alert and orientated x 3 and able to communicate needs. The resident's mood and behavior appropriate to setting. History of chronic paranoid schizophrenia and acute psychosis with paranoia. Mental health diagnosis managed with medication per clinical notes. The resident has a history of heavy alcohol use, suicide attempts, and inpatient psychiatric treatment. PASRR level II completed and approved for long term care.
-5/6/24 at 11:50 PM, nurse note stated the resident had been going in and outside, out of cigarettes, and anxious. The resident refused skin check and refused ointment for rash on chest. The resident increasingly became anxious when asked to check skin again. The resident stated he was over 3000 years old and that the nurse was his best friend from back then. The

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resident stated he worshipped some god that he could not remember the name.
-5/6/24 at 3:17 PM, physician progress note stated the resident was doing well and denied any physical complaints.
-6/9/24 at 5:56 PM, nurse note stated the resident refused meals, taking fluids and small snacks offered. Attempted to speak with resident about refusals and the resident did not wish to discuss reasons for refusal.
-6/10/24 at 4:59 PM, physician progress note stated the resident rested comfortably without complaints. The resident had good appetite and denied any issues.
-6/11/24 at 1:35 AM, nurse note stated the resident refused to eat on the day shift and was offered snacks and continued to refuse.
-6/12/24 at 3:52 PM, nurse note, assessment, stated the resident had changes in cognition and at times difficult to assess related to severe mental illness and diagnosis of dementia. The resident would talk in non-sense with severe delusions at times. Staff continually working with the resident and reminding him. Staff must talk the resident through his agitation and frustration due to his inability to communicate appropriately. The nurse must spend hours talking resident into taking medications and some days he continues to refuse. Resident has antipsychotic medication that the staff must convince resident to take. Resident would get severely agitated with others and staff. Staff remind the resident and assist with meals due to refusal to eat. The resident refuses medications and becomes severely agitated.
-6/13/24 at 10:24 AM, nurse note stated the resident refused all medications and vital signs and yelled at the nursing staff to leave the room.
-6/14/24 at 10:02 AM, resident advocate note

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stated he was voodooed and now transgender and would like female clothing. Attempted to visit with the resident and he refused.
-6/14/24 at 10:54 AM, nurse note stated, attempted to complete assessment twice this week and the resident refused unless the nurse gave the resident a pack of cigarettes daily for two weeks.
-6/17/24 at 10:06 AM, physician progress note stated the resident had changes in condition and at times difficult to assess due to severe mental illness and diagnosis of dementia. The staff continually work with the resident in reminding of ADL's (activities of daily living) and talking through his agitation and frustration when unable to communicate appropriately. Resident on medications for his mental illness, one being an injection. Resident has refused medications on several occasions.
-6/25/24 at 1:36 AM, nurse note stated the resident had several delusions and hallucinations during the shift. The resident refused care, slammed door, and yelled at staff members multiple times. The resident refused all medications except seizure medication. The resident not easily re-directed and resists the calm approach.

During an interview on 6/24/24 at 3:15 PM, Nurse Aide (NA) 10 stated R2 probably wouldn't talk, or he would "accuse you of something." NA10 stated R2 had increased behaviors and did not like anybody. NA10 stated R2 would be in the smoke shack if not in his room.

During an interview on 6/25/24 at 10:14 AM, Licensed Practical Nurse (LPN) 2 stated R2 was "super" schizophrenic, his medications were hit and miss. LPN2 stated the resident had a hard

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time and his behaviors were difficult. LPN2 stated the resident was delusional at times. LPN2 stated R2 was admitted to hospice in the last month, however, hospice had a difficult time with him because of his delusions and difficultly with providing care and communication with him due to behaviors. LPN2 stated R2 took his medications this morning, however, does refuse at times. LPN2 stated the facility had received an order for intramuscular injection for his psychotropic medication and had received one time. LPN2 stated the facility hoped that would be helpful with him. LPN2 stated the resident got easily agitated and when staff attempt to talk to him, he would take it wrong due to delusions. LPN2 stated the resident talks about voodoo and accuses the staff of spitting in his food, which causes his intake to fluctuate. LPN2 stated R2 smoked independently by self, however, at times would go outside in wheelchair and the staff would assist him.

During an concurrent interview and record review on 6/26/24 at 5:06 PM, the Resident Advocate (RA) stated the outpatient mental health provider utilized by the facility was behind on referrals, however, a new referral sent to a new outpatient provider in the area. The RA stated the Social Worker would visit with R2 regularly until outpatient mental health services were started. The RA confirmed the care plan lacked resident's behaviors and/or interventions for staff. The RA stated the Social Worker would complete resident care plans and would update as needed. The RA confirmed there were no antipsychotic medications included on R2's care plan and there had been no medication changes. The RA confirmed the recommended specialized services were not included on the resident's care plan. The

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F 656	Continued From page 39 RA stated she believed the behaviors started and/or increased when the resident started to have a co-pay and only received 45 dollars a month. The RA stated the resident would spend all of his money on cigarettes' and the facility also gave him a pack a week. The RA stated R2 would get all his money previously and he would say he had to smoke 2 packs of cigarettes a day, however, the resident did not smoke that much but it was a "control thing for him." During an interview on 6/27/24 at 9:15 AM, the Director of Nursing (DON) stated R2's care plan should include the resident's specific behaviors. The DON stated she knew the resident was delusional and had behaviors, and they were documented in the progress notes. The DON stated the facility had difficulty getting outpatient mental health services in the facility and have new company to utilize. The DON stated the Social Worker had been visiting with R2 regularly.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that 1 of 31 sampled residents (R) was invited to participate in the development and implementation of their comprehensive care plan (R6). This failure increased the potential for the care plan to not be person-centered.

Findings include:

Review of facility policy, Care Plans, Comprehensive Person Centered, last revised March 2022, indicated, "A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ... 1. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ... 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or

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her plan of care, including the right to: a. participate in the planning process; ... e. participate in establishing the expected goals and outcomes of care; ... 5. The resident is informed of his or her right to participate in his or her treatment and provided advanced notice of care planning conferences."

Review of R6's undated Admission Record, indicated the resident was admitted to the facility on 2/17/23 and had diagnoses which included chronic obstructive pulmonary disease, anxiety disorder, depression, and atherosclerotic heart disease.

Review of R6's SS [Social Service] Care Conference reports, revealed R6 was in invited to attend and attended a care plan meeting on 2/19/24. Further review of the R6's SS Care Conference reports revealed no information that R6 was invited to or participated in a care plan conference since 2/19/24.

Review of R6's Quarterly Minimum Data Set (MDS - a federally mandated assessment) with an Assessment Reference Date (ARD) of 4/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition.

Review of R6's Care Plan review history, indicated R6's care plan was most recently reviewed by facility staff on 5/5/24.

During an interview on 6/24/24 at 2:06 PM, R6 stated she did not recall being recently invited to participate in her care planning meetings.

During an interview on 6/27/24 at 2:51 PM, the

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F 657	Continued From page 42 facility's Resident Advocate (RA) confirmed resident care plan meetings were not occurring at least quarterly as required. The RA reviewed R6's EMR and confirmed R6's Care Plan was reviewed by staff on 5/5/24, but a care plan meeting with R6 in attendance had not occurred since 2/19/24. The RA stated she would schedule a care plan meeting with R6 as soon as possible. During an interview on 6/27/24 at 3:18 PM, R6 agreed the last care plan meeting she was invited to participate was in February 2024 and that she liked to attend her care plan meetings. During an interview on 6/28/24 at 8:20 AM, the Director of Nursing (DON) stated the care plan team was expected to have resident care plan meetings on a quarterly basis with the resident's participation.	F 657		
F 659 SS=E	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a qualified person administer intravenous (IV, delivered directly into the vein and/or artery) medication for 1 of 1 resident (R) observed during medication administration (R168). The facility failed to ensure the IV medication was administered by a	F 659		

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Registered Nurse (RN) or a Licensed Practical Nurse (LPN) with IV Certification. The facility reported a census of 68 residents.

Findings Include:

Review of R168's Minimum Data Set (MDS - federally mandated assessment, with an assessment reference date (ARD) of 6/3/24, identified R168 had intact cognition with a a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Diagnoses included cancer, multidrug-resistant organism, osteomyelitis (bone infection), and infection reaction due to internal joint prosthesis. The MDS coded the resident received antibiotics in the last seven days and received IV medications while a resident at the facility in the last 14 days.

During an observation on 6/25/24 at 9:53 AM, LPN2 flushed R168's PICC line (peripheral inserted central catheter line, type of access used for long term IV antibiotics) with 10 mls (milliliters) of sodium chloride 0.9% and proceeded to administer Vancomycin (antibiotic) 500 mg (milligrams) via PICC line by gravity. LPN2 returned at 11:01 AM, disconnected the vancomycin and flushed the PICC line with 10 mls of sodium chloride.

Review of the June 2024 Medication Administration Record (MAR) revealed orders for:
- Vancomycin HCl (hydrochloride) IV solution 500 mgs, two times a day for MRSA (methicillin resistant staph aureus) with a start date of 6/24/24 and stop date of 6/26/24. Signed off by LPN2, as administered the IV medication 1 of 3 times.
- Vancomycin HCl IV solution 750 mgs, two times

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a day for MRSA with a start date of 6/22/24 and stop date of 6/24/24. Signed off by LPN2, as administered the IV medication 1 of 4 times.
- Vancomycin HCl IV solution 1000 mgs, two times a day for MRSA with a start date of 6/10/24 and stop date of 6/22/24. Signed off by LPN2, as administered the IV medication 5 of 22 times.
- Vancomycin HCl IV solution 1000 mgs, two times a day for MRSA with a start date of 6/1/24 and stop date of 6/6/24. Signed off by LPN2, as administered the IV medication 1 of 11 times.
- Cefepime HCl (antibiotic) IV solution reconstituted 2 grams (GMs) every 8 hours for right shoulder septic arthritis and osteomyelitis with a start date of 6/11/24 until 7/18/24. Signed off by LPN2, as administered the IV medication 14 of 51 times.
- Cefepime HCl IV solution reconstituted 2 GMs every 8 hours for right shoulder septic arthritis and osteomyelitis for 6 days, start date of 5/29/24. Signed off by LPN2, as administered the IV medication 2 of 9 times.
- Sodium Chloride 0.9%, 10 mls flush every shift for maintenance, PICC in upper right arm, start date of 6/10/24. Signed off by LPN2, as administered the IV medication 8 of 35 times.

Review of LPN2's Personnel file revealed a date of hire 1/9/23. It also included an out of state, compact multistate LPN license, with an expiration date of 12/31/25. LPN2's personnel file lacked documentation of IV Certification.

During an interview on 6/27/24 at 9:15 AM, the Director of Nursing stated she believed LPN2 did have IV certification and would have to follow-up.

During an interview on 6/27/24 at 2:30 PM, the Administrator stated the facility contacted LPN2

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F 659	Continued From page 45 and had been informed by LPN2 that she thought she had completed the IV Certification training, however, she was unable to provide documentation to the facility. During an interview on 6/28/24 9:11 AM, the Administrator stated the facility thought LPN2 had her IV certification, and she did not. The Administrator stated he expected RN's or LPN's with IV certification to administer IV medications.	F 659		
F 661 SS=E	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 post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661		

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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:
Based on interview and record review, the facility failed to complete a discharge summary with a recapitulation of the resident's stay and status at the time of discharge, a reconciliation of discharge medications, a post-discharge plan of care indicating where the individual planned to reside and any arrangements that have been made for follow up care for 5 of 8 residents reviewed for discharge (R65, R117, 118, R120 and R125). This failure has the potential for unsafe discharges, delays in care and services and poor health outcomes.

Findings include:

Review of facility policy, Transfer or Discharge, Resident-Initiated, dated April 2024, revealed in pertinent part, the medical record will contain documentation "of the resident's or resident representative's verbal or written notice of intent to leave the facility; a discharge care plan; and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care..."

Review of facility policy, Discharge Summary and Plan, revised June 2024, revealed in pertinent part,
- "The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge...the medication reconciliation is documented...the post-discharge

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plan ... includes: a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals ..."
- "A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary."

Review of facility policy, Discharging a Resident without a Physician's Approval, revised June 2024, revealed in pertinent part, the physician must be notified when a resident/representative requests an immediate discharge. If the resident/representative requests discharge without physician approval, they will be asked to sign a release form. Refusal to sign must be documented in the resident's record and witnessed by two staff members. If the discharge setting appears unsafe, document discussions with the resident/representative about the implications, risks, the offers of more suitable locations and the refusal of those options.

1. Review of R65's Electronic Medical Record (EMR) revealed R65 was admitted on 9/15/22 and discharged on 2/6/24. Diagnoses included paraplegia (paralysis of the lower body), major depressive disorder, anxiety and alcohol abuse.

Review of 65's Care Plan revealed the resident required a short-term skilled stay. Interventions included coordination for continuation of care at discharge, appropriate discharge environment and participation of the resident or responsible party in discharge planning. The resident wishes to discharge home and will be able to verbalize

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required assistance and services he will need, initiated on 9/18/22.

Review of 65's Discharge Planning Review, dated 10/6/23, revealed the resident expected to remain in the facility and that discharge was not feasible. "Resident would need assistance with all adls [activities of daily living] and med [medication] management."

Review of R65's Progress Notes revealed on 2/6/24, R65 was taken home by a family member with medications and will return tomorrow. On 2/7/24 starting at 2:10 PM, attempts were made to reach R65 and the family member by phone. On 2/8/24, documentation revealed, in consultation with the Ombudsman, the resident was AMA (left against medical advice). On 2/9/24 the Resident Advocate (RA) documented at 11:18 PM that the Ombudsman received a phone call from the family member who said R65 was in the hospital. "Spoke to the hospital and they said they were admitting resident and that he had been in the er [emergency room] since wed [2/7/24].

There was no further documentation.

During an interview on 6/27/24 at 4:19 PM, the RA stated R65 went on an overnight stay and never came back. The RA said she spoke with the hospital who said R65 would not be returning to the facility but had selected an alternate placement. The RA stated [facility name] came and picked up R65's personal items. The RA stated these conversations should have been documented. The RA stated she provided a packet of paperwork to the receiving facility but that was also not documented.

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2. Review of R117's EMR revealed R117 was admitted on 1/23/24 and discharged on 4/15/24. Diagnoses included a leg fracture, congestive heart failure, diabetes and mild cognitive impairment.

Review of R117's Discharge Planning Review, dated 2/2/24, revealed the resident expected to be discharged to the community and that it was a feasible goal. "Resident needs assistance with adls [sic]. resident also needs wound care and therapy. Resident is here for short term care. He wants to do therapy and go back to [name of state].

Review of R117s Progress Notes on 1/24/24, revealed R117 was admitted with a left hip surgical wound and was a one person extensive assist with transfers, toileting, bed mobility and hygiene. On 4/10/24, the RA documented she spoke with R117 who said "he would not be signing up for medicaid and he planned to leave on friday to [name of city out of state]." On 4/12/24, the RA documented she reapproached R117 about staying in the facility and talked him into staying until Monday [4/15/24]. "He stated he does not want home health and he has a place down there he can afford and still have money [sic]." On 4/15/24, the RA documented a late entry note that she had spoken to R117 about staying until 4/16/24..."he stated he wanted to leave today i stated that i got him a bus ticket for tuesday. So he said sure ill stay until tomorrow [sic]."

There was no further documentation.

Review of Facility Reported Incident (FRI), for discharged resident R117, revealed R117 had not

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been seen since after dinner on 4/15/24. Documentation revealed a bus ticket reservation for 4/16/24 at 8:00 AM that was going to take R117 to the city and state he had requested.

During an interview on 6/26/24 at 1:13 PM, the RA stated the police would call if they had any updates. The RA stated the police told her that R117 wanted to leave on his own, was not an endangered person and his records were from another state, so they would notify the police in the city where R117 said he was returning. The RA stated she did not document these conversations and did not complete a discharge summary.

3. Review of R118's EMR revealed R118 was admitted to the facility on 11/17/23 and discharged on 3/17/24. Pertinent diagnoses included congestive heart failure, diabetes, history of falling, difficulty walking and unspecified symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage (loss of blood).

Review of R118's Baseline Care Plan, dated 11/18/23 revealed the discharge goal was to remain in the facility. Review of the Care Conference, dated 11/27/23, "Resident stated he thinks he would like to move to [other state] but at this time he is here for long term care." Review of the Discharge Planning Review, dated 2/19/24, the resident "expects to remain in this facility."

Review of R118's Progress Notes, revealed R118 had left the facility on 3/15/24 and was pulled over by police because he had been driving erratically and was taken to the emergency room for evaluation. R118 was returned to the facility

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on 3/17/24 at 2:30 PM and after consultation with providers, was sent to the hospital at 3:00 PM for a psych evaluation and possible different placement. "[R118's] son contacted facility and reports wanting assistance to get his dad placed in [another state]."

There was no further documentation.

During an interview on 6/26/24 at 1:09 PM, the RA stated they did not complete a discharge summary and R118 never returned to the facility from the transfer to the hospital.

4. Review of R120's EMR revealed R120 was admitted to the facility on 10/6/23 and discharged on 11/1/23. Diagnoses included traumatic brain injury, diabetes, schizophrenia, mild cognitive impairment, depression, and unsteadiness on feet.

Review of R120's Baseline Care Plan, dated 10/7/23 showed "Other - none stated" for the resident's discharge goal. Review of the Care Conference, dated 10/6/23, "Resident is here for long term care." Review of the Discharge Planning Review, dated 10/6/23, revealed the anticipated length of stay was 'short term' but the overall goal for discharge was 'unknown or uncertain' and that R120's treatment needs would be a medication regimen.

Review of R120's Progress Notes, revealed on 11/1/23, R120 was missing at approximately 5:40 AM. On 11/1 and 11/2, the facility documented orders for an LOA (leave of absence).

There was no further documentation.

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During an interview on 6/26/24, starting at 11:45 AM, the RA stated R120 was located and taken to the hospital and never returned to the facility. The RA stated this was not documented in the EMR and a discharge summary was not completed.

5. Review of R125's EMR revealed R125 was admitted to the facility on 5/27/23 and discharged on 7/8/23. Pertinent diagnoses included schizoaffective disorder, delusional disorder, psychoactive substance abuse, altered mental status, and other symptoms and signs involving cognitive functions and awareness.

Review of R125's Baseline Care Plan, dated 5/27/23 revealed the discharge goal was to return to the community. Review of the Care Conference, dated 5/30/23, revealed "Resident is here for short term care and plans to return home to her [friend] when he can come and get her." There was no evidence of a Discharge Planning Review.

Review of R125's Progress Notes, revealed on 7/8/23, R125 was picked up by a significant other and discharged home [address provided for out of state]. R125 was given her belongings, including medications. The medications were reviewed with the significant other.

There was no further documentation.

During an interview on 6/26/24, starting at 11:45 AM, the DON stated a discharge summary should be documented in the progress notes and provided an example from R127's record. The discharge summary note included a reason for discharge, recap of stay, discharge date, time and location, transport information, order

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F 661	Continued From page 53 summary, medication review, discharge education and recommended follow up with providers. Cross reference F689.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and	F 676		

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snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide eating assistance, which included being positioned upright in bed and being provided with a high wall plate as ordered, to ensure a resident maintained his ability to independently eat meals for 1 of 3 residents (R) reviewed for Activities of Daily Living (ADLs) (R1). This failure had the potential to cause weight loss and/or nutritional complications for this resident.

Findings include:

Review of facility policy, Assistance with meals, revised June 2024, revealed in pertinent part, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident ... 1. The food services department will deliver food carts to appropriate areas. 2. The nursing staff will prepare residents for eating. 3. The nursing staff and/or paid feeding assistants will take food trays into residents' rooms ..."

Review of R1's undated Admission Record, indicated the resident was originally admitted to the facility on 5/06/15, and had diagnoses which included paraplegia, traumatic brain injury (TBI) and type 2 diabetes mellitus.

Review of R1's Annual Minimum Data Set (MDS - federally mandated assessment), with an

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assessment reference date (ARD) of 4/15/24, revealed R1 had short term and long-term memory problems and a Brief Interview for Mental Status (BIMS) was not performed. The MDS indicated R1 required supervision or touching assistance with helper providing verbal cues or touching/steadying as resident completes the activity and had functional limitation in range of motion on one side of his upper extremities.

Review of R1's current Comprehensive Care Plan, reviewed by facility staff on 6/10/24, contained the following Focus area: "ADL Functional Rehabilitation Potential. [R1] requires assistance with all ADL's r/t [related to] impaired mobility & paraplegia secondary to hx [history] of TBI & anoxic brain injury . . . Res [Resident] is able to self-feed & complete personal hygiene/grooming with extensive/limited assist x [times] one." A care plan goal included "The resident will maintain current level of function through the review date." A care plan intervention/task included "Encourage the resident to participate to the fullest extent possible with each interaction."

Review of R1's current physician's Order Listing, revealed an order for R1 to receive a "Hi Wall Plate" at meals.

During a concurrent observation and interview on 6/25/24 at 7:44 AM, staff entered R1's room with his meal tray and exited the resident's room at 7:47 AM. R1 was in bed with his meal tray positioned in front of him on an overbed table. The meal tray consisted of scrambled eggs, toast, and a strawberry garnish on a regular plate, frosted flakes with milk poured on the cereal in a plastic cereal container, peanut butter sandwich

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sections, a cup of milk, and two juice cups of a strawberry kiwi beverage (which were covered with plastic wrap and had straws extending from their tops). No adaptive eating equipment, specifically a high wall plate, was observed on R1's meal tray. Review of the resident's tray slip served with R1's breakfast meal revealed under adaptive equipment that a high wall plate was to be served with the resident's meal. R1 was observed to be improperly positioned in bed to eat his meal and slid down in bed with his head and upper torso tilted very far to the right side. R1's right arm was observed to be pressed directly against the bed's mattress which did not allow R1 to fully extend his right arm. R1 was observed to have range of motion limitations to his left hand and arm. At this time R1 was asked if he was comfortable in bed. He replied, "No" and confirmed that he needed to be sitting in an upright position to make him comfortable. Continuous observation on 6/25/24 from 7:47 AM to 8:02 AM revealed R1 slid down in bed with his head and upper torso tilted to his right side while he ate his meal. During this time, no staff were observed to enter R1's room to check on R1. R1 was observed to use his right hand and arm to independently consume the toast, peanut butter sandwich sections and the two strawberry kiwi beverages which were within his reach but did not eat the scrambled eggs or frosted flakes that were served on his meal tray. R1 did not attempt to eat with his contracted left hand and arm. At 8:02 AM, R1 had a spoon in his right hand and attempted to reach his meal tray which contained his frosted flakes and scrambled eggs; however, he was unable to reach his food because his right arm was pressing directly against the bed's mattress. R1 stated he was attempting to eat his corn flakes but was unable to reach them. From

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8:02 AM to 8:06 AM R1 made multiple attempts to use his right hand and a spoon to eat food from his meal tray but was unsuccessful because they were out of his reach.

During an interview on 6/25/24 at 8:06 AM, Registered Nurse (RN) 2 was made aware that R1 was improperly positioned in bed while he attempted to eat his breakfast meal. RN2 stated she was aware R1 would slide down in bed and staff would reposition him upright.

During an observation and interview on 6/25/24 at 8:09 AM, revealed R1 was still slid down in bed and tilted to the right with his right arm pressing directly against the bed's mattress with his meal tray in front of him. R1 was observed to have a spoon in his right hand and made unsuccessful attempts to reach the food on his meal tray which included his frosted flakes and scrambled eggs. The Dietary Supervisor (DS) was present during this observation and R1 informed the DS that he needed to be positioned upright in bed. The DS confirmed R1 was slid down in bed and tilted to his right side with his right arm pressing directly against the bed's mattress and he was unable to reach the food on his meal tray. The DS also confirmed R1's food was served on a regular plate and the resident was not provided with a high wall adaptive plate at this meal.

During an observation on 6/25/24 at 8:14 AM, R1 was positioned upright in bed with his breakfast meal tray in front of him on an overbed table. While positioned in an upright position R1 was observed to use a spoon in his right hand to independently eat bites of the frosted flakes that were served on his meal tray without difficulty.

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F 676	Continued From page 58 During an interview on 6/25/24 at 5:30 PM, Nurse Aide (NA) 2, who provided care for R1, stated R1 used his right hand to independently eat his meals. NA2 stated R1 would slide down in bed and needed to be positioned upright when served meals in bed. During an interview on 6/27/24 at 12:55 PM, Physical Therapy Assistant (PTA) stated he observed R1 on 6/25/24 after he was informed R1 had difficulty eating his breakfast meal on this date. The PTA stated R1 had range of motion limitations in his left hand and arm and utilized his right hand and arm to eat meals. The PTA stated R1 could independently eat meals but needed to be positioned upright to access and eat food and beverages that were served on his meal trays. During an interview on 6/28/24 at 8:20 AM, the Director of Nursing (DON) stated R1 ate meals with his right hand, and she expected staff to position R1 upright at meals, so he could eat his meals independently.	F 676		
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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 684		

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failed to ensure 1 of 30 sampled residents (R) were provided adequate quality of care related to physician services (R46). Specifically, a neurology follow-up appointment ordered by R46's physician was never scheduled. This failure created the potential for medical issues to remain unaddressed for the residents.

Findings include:

Review of R46's Admission Record, revealed the resident was admitted to the facility on 1/28/22 with diagnoses including history of stroke. A diagnosis of epilepsy was added to the resident's diagnosis list after a hospitalization in December of 2023 during which the resident was hospitalized the first time for seizure activity.

Review of R46's Quarterly Minimum Data Set (MDS-federally mandated assessment) with an assessment reference date (ARD) of 3/29/24, revealed the resident had a brief interview for mental status (BIMS) score of 11 out of 15, which indicated the resident was moderately cognitively impaired.

Review of R46's Seizure Care Plan, dated 12/28/23, indicated R46 had a seizure disorder related to severe sepsis and his diagnosis of epilepsy. The Care Plan indicated the resident was to be given medication as ordered to control seizure activity and was to have physician management of his seizures via communication with staff.

Review of R46's Progress Note, dated 3/23/24 8:34 AM, indicated "Resident found in his wc [wheelchair] in activity room having a seizure. Not responding, awake BREATHING. Returned to

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bed continues non- responsive with head and eye twitching. (Medical Director) notified given 2mg (milligrams) IM (Intramuscular) Ativan (a medication used to calm the nervous system and control seizures) per order. Resident unchanged after 20 minutes continues with twitching on O2 2l (oxygen two liters). Provider again notified will send to ER (Emergency Room) per order."

Review of R46's Census Records, indicated the resident was out of the facility between 3/23/24 and 3/26/24, during which time he was admitted to the local hospital.

Review of R46's Progress Note, dated 3/23/24 at 1:34 PM, indicated R46 had been admitted to the Intensive Care Unit (ICU) at the local hospital.

Review of R46's Nursing Admission Summary, dated 3/26/24, revealed the facility was to schedule a follow-up appointment with a neurologist related to his seizure activity.

Review of R46's Hospital Discharge Instructions, dated 3/26/24, indicated "Follow up with (Neurologist). Call ASAP (as soon as possible). Appointments may be booked out 4 - 6 months."

Review of R46's Electronic Medical Record (EMR) revealed no evidence to show a neurology appointment had ever been made for the resident per the 3/26/24 hospital discharge summary and facility nursing admission summary.

During an interview with the Director of Nursing (DON) on 6/27/24 at 12:43 PM, she confirmed no follow-up appointment had been made for R46 after his return from the hospital on 3/26/24. She stated her expectation was the appointment

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F 684	Continued From page 61 should have been made promptly after R46's return from the hospital and stated the facility was working on making an appointment for him to be seen.	F 684		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent elopements for 6 of 9 residents (R27, R118, R120, R121, R125 and R127) reviewed for elopement. This failure created a reasonable expectation that without corrective action, serious injury, harm, impairment, or death was likely to occur to the 19 residents currently assessed as high risk for elopement. The facility census was 68. The facility also failed to accurately assess a resident for safe smoking (R27), and failed to supervise residents (R11 and R27) to ensure they demonstrated safe smoking practices according to the facility smoking policy for 2 of 5 residents reviewed for smoking. A. On 6/26/24 at 6:35 PM, an Immediate Jeopardy (IJ) was identified when the facility	F 689		

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failed to implement the Centers for Medicare & Medicaid Services (CMS) regulation to assess, care plan, monitor and supervise residents at risk to prevent elopements. A removal plan was accepted, and the Immediate Jeopardy was removed on 6/27/24 at 5:00 PM, after the implementation of the plan was verified onsite by the surveyors. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "E".

The facility provided the following acceptable removal plan on 6/26/24:
- R27 will receive education about signing out prior to going to the community. The Director of Nursing (DON) will perform an updated wander risk assessment, plan of care and skin check.
- The Regional Nurse Consultant (RNC) will initiate training on how to conduct a Wander/Elopement Risk Assessment. Training recipients will include the DON, Assistant DON (ADON), Social Worker (LCSW) and Resident Advocate (RA).
- The DON/designee will re-assess each resident's Wander/Elopement Risk to identify residents at risk for Wandering/Elopement using the risk assessment.
- The DON/designee will review and update the care plans with individualized interventions for residents who scored a nine or higher on their risk assessment.
- The Elopement Book will be updated to include each resident identified at risk to wander/elope.
- The DON/designee will train nursing staff on the elopement definition/policy, routine assessments, individualized care plans, elopement book, frequent rounding, and required documentation for an elopement.
- The DON/designee will train all other staff

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members on the elopement policy, how to suspect elopement/wandering behaviors and where to find the elopement binders.
- Training will be verified through testing and validated with random rounding.
- The facility leadership will provide education to alert and oriented residents about signing out in the Leave of Absence Book when they leave the facility.

In addition, the facility will hold weekly Elopement Prevention Meetings, discuss non-compliance with the sign-out procedures with the State Ombudsman and provide additional communication with the resident. The RNC will provide weekly spot checks and then monthly spot checks for three months to ensure compliance.

During staff interviews on 6/28/24 between 7:30 AM and 8:30 AM, Nurse Aide (NA) 15, Housekeeper 1 (H1), the Physical Therapy Assistant (PTA), NA1, NA3, Licensed Practical Nurse (LPN) 1, Registered Nurse (RN) 3, the Minimum Data Set (MDS) Coordinator and the Dietary Supervisor stated they received Elopement Training over the last two days. These staff explained the definition of elopement, and they shared the training they received on the elopement policy, elopement binder and sign out procedures for residents. These staff then stated they had a test after the training. In addition, RN3 stated nurse training included care planning, documenting in the progress notes, completing a wandering assessment and frequent rounding. RN3 stated wander assessments were regularly completed at admission and quarterly.

Review of the IJ removal documentation,

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revealed the content of the Elopement Binder Training, a revised June 2024 list of Residents at Risk for elopement (17 residents), the Wandering and Elopements policy, the Emergency Procedure- Missing Resident policy, the Signing Residents Out policy, the Wandering Risk Scale - V3 assessment template, the Inservice communication, Guardian Angel Rounds with residents, and staff test results.

Findings include:

Review of facility policy, Wandering and Elopements, last revised June 2024, revealed in pertinent part:
- "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents."
- "If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety."

Review of facility policy, Emergency Procedure-Missing Resident, last revised June 2024, revealed in pertinent part:
- "When the resident is found: a. Notify all staff members. b. Examine the resident for injuries. c. Notify the attending physician of the resident's status. d. Contact the family/responsible person and inform of his/her status (ensure all the above steps are documented in the nursing notes)."
- "Document the incident and events objectively in the resident record, including: a. Circumstances and precipitating factors. b. Interventions utilized to return the resident to the unit. c. Resident's response to the interventions. d. Results of reassessment upon the resident's return and the

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condition of the resident. e. Care rendered. f. Notification of police, family, and physician. g. Physician orders following notification. h. Additional prevention strategies implemented."
- "Ensure care plan is updated."
- "Evaluate implementing additional measures, such as the addition of a wander bracelet [also known as a wander guard] if not in current use and 15-minute safety checks, and document in the resident record."

Review of facility policy, Signing Residents Out, last revised March 2024, revealed in pertinent part: "Each resident leaving the premises (excluding transfers/discharges) must be signed out... must indicate the resident's expected time of return." In addition, medications will be provided (unless prohibited by law) and instructions provided on how to administer; the Dietary manager will be notified of the leave and the resident will be signed back in upon return to the facility.

1. Review of the facility-initiated report (FRI), for discharged resident R118, revealed R118 had not returned from a leave of absence (LOA) that began on 3/15/24 at 3:00 PM. On 3/16/24 at 5:00 PM, the Floor Nurse 6 notified administration that a hospital three and a half hours from the facility, called to say that R118 was at their hospital in stable condition. R118 had been sent to the emergency room (ER) after being pulled over by police while driving 'erratically' after buying a car. On 3/17/24, R118 returned to the facility and stated he was not staying. R118 was sent to the hospital for further evaluation. The facility investigation revealed the resident had not signed out of the facility in the LOA binder but that he told staff he was leaving. Further review showed the

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nurses charted poorly about the LOA and that R118 was assessed as a high risk for wandering.

Staff interviews in the FRI revealed:
- Floor Nurse 6 was told R118 had left and went to the ER.
- Floor Nurse 7 had put in an order that the resident was on a LOA.
- Licensed Practical Nurse (LPN) 2 assumed R118 was discharged but found out he wasn't. "He had left the facility many times, went out on cab drives etc."

The documented corrective action included:
- floor staff trained about LOA protocols, what high-risk wandering meant for elopement risk, and when to notify the Administrator/DON when a resident was not in facility.
- re-assess all residents wandering risk and review residents who score as high risk wandering with the interdisciplinary note (IDT) to validate interventions are in place to prevent elopements.
- update the elopement book to verify it was current.
- monitor (for eight weeks) the LOA book and progress notes to verify residents are signing out and to validate documentation was consistent with standards of practice.

On 6/26/24, the facility provided evidence of staff training, revised wandering assessments and eight-week audits. However, the facility could not provide evidence of the IDT meetings regarding elopement interventions; or an elopement book that would communicate to staff the residents at risk for wandering/elopement.

On 6/26/24 at 10:15 AM, in the conference room,

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which included the Administrator, DON and Regional Nurse Consultant, the Administrator stated there was no additional FRI documentation and that they did not have an elopement book.

Review of R118's electronic medical record (EMR) revealed R118 was admitted to the facility on 11/17/23 and discharged on 3/17/24. Pertinent diagnoses included congestive heart failure, diabetes, history of falling, difficulty walking and unspecified symptoms and signs involving cognitive functions following other nontraumatic intracranial hemorrhage (loss of blood). The Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 2/23/24, revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 11 out of 15.

Review of R118's Progress Notes revealed on 1/3/24, R118 was asking about housing options. On 1/11/24, the RA documented a car dealership called to ask if it was safe for R118 to buy a vehicle because R118 was trying to purchase one. On 1/17/24, LPN3 documented the resident was laconic (using very few words), isolative and uncooperative with cares. On 1/19/24, LPN4 documented R118 referred to the facility as a 'jail'. On 1/22/24, the RA documented R118 answered 'yes' to thoughts he would be better off dead or hurting himself. The RA documented, "Resident specified he has thoughts of hurting himself and has method and plan to go out into traffic." On 1/22/24, a nurses note documented, "He stated to police that he doesn't want to be here at this facility, and he just wants to leave."

However, a review of R118's Care Plan revealed

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no evidence of R118's wander/elopement risk or interventions for safe LOAs.

Continued review of R118's progress notes revealed on 3/15/24 at 4:42 PM, Floor Nurse 7 documented R118 was on LOA at this time. There was no evidence of where he went, if we were given medication, or when he was expected to return.

During an interview on 6/26/24 at 11:45 AM with the Administrator, DON and RA, the RA stated that when R118 was a new admission, he would go to the store by taxi and was compliant with telling people he was leaving, where he was going and when he would be back, often returning before he said he would. When asked if the risk assessment and care plan were updated after R118 attempted to buy a car in January and after he stated he thought of hurting himself in traffic, the DON reviewed the EMR and said "No." The DON further stated the nurses had not documented the LOA correctly and had not communicated the LOA with facility management. When asked if the facility had implemented the corrective action documented in R118's elopement investigation on 3/15/24, the DON stated the facility did not know where the elopement book was, and they were still in the process of putting an IDT note in the EMR about each resident identified as high risk. The DON stated after R118's elopement they started a quality assurance performance improvement plan but that elopements have not been handled in the same way as falls - which include a daily huddle, new risk assessment and care plan updates.

2. Review of the FRI, for discharged resident R121, revealed R121 had walked out of the

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facility without staff knowledge on 9/29/23 at 4:50 PM. Registered Nurse (RN) 3 became aware of the elopement at 5:10 PM and staff conducted a search and reported the incident. The investigation revealed that a passerby saw R121 walking unsteadily and called the police. Emergency Medical Services (EMS) assisted R121 back to the facility and R121 was placed on one to one supervision to ensure his safety. In addition, the documentation showed R121 had a BIMS score of 6 (reflects severe cognitive impairment) and that he would like to go home.

Review of R121's EMR revealed R121 was admitted to the facility on 9/4/23 and discharged on 10/5/23. Pertinent diagnoses included traumatic brain injury, other symptoms and signs involving cognitive functions and awareness, reduced mobility, anxiety, seizures, anticoagulant (medication to thin the blood) use, cognitive communication deficit, and vascular dementia.

Review of R121's Progress Notes revealed on 9/6/23, RN5 documented R121 "displayed some minor anxiety with wandering and asking to go to [name of city]." On 9/7/23, Floor Nurse 8 documented R121 "is confused at baseline, no safety awareness, resident is a potential elopement risk." On 9/7/23, RN3 documented, "Resident is A&O x 1 [alert and oriented times one] has trouble remembering date, time and place. resident [sic] confused about situation and attempts leave the building. Resident has short attention span, short term memory impairment and very impulsive with poor safety awareness. Resident is redirectable." On 9/10/23, a nurse documented, "Exited facility 2 times today and brought back." On 9/23/23, LPN2 documented, "Very agitated and restless difficult to redirect.

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Attempting to walk to road." On 9/23/23, the Social Worker documented R121's feelings of uncertainty with not being able to leave the building. On 9/23/23, RN3 documented R121 continued with agitation and exit-seeking behavior and that "This Nurse needed to run out to stop Resident from either trying to get on bus at bus stop in front of facility, and then to stop him from heading east on sidewalk, on two separate incidents." On 9/23/23, IDT event review documentation revealed, "Resident has been checked on frequently by Nurse and by CNA staff. Staff acted to dissuade him from entering Lobby or trying to leave building via front door. Resident set off alarms at more than one of the other doors, pressing on bar but not knowing the code."

However, a review of R121's Care Plan revealed no evidence of R121's wander/elopement risk and interventions until the elopement on 9/29/23.

Continued review of R121's progress notes revealed RN3 documented on 9/29/23 that at 5:15 PM, the resident was not in his room for dinner and that he was last seen at 4:45 PM sitting in the lobby.

During an interview on 6/26/24 at 11:45 AM with the Administrator, DON and RA, the RA stated R121 was a low risk for elopement on admission but once he became a risk, we did a lot for him - we tried to find him a new facility to transfer to, we had the Admissions person hang out with him during business hours and we placed a wander guard on him, but he would take it off. The RA stated the documentation in the record and care plan does not reflect these interventions prior to R121's elopement on 9/29/23. The DON confirmed the record did not identify if a wander

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guard was ordered and monitored for effectiveness.

3. Review of the FRI, for discharged resident R125, revealed LPN3 reported that on 6/12/23 at 11:30 PM, after a building search, R125 was missing. The investigation revealed another resident saw R125 get on the bus. R125 had not signed out. When R125 was located and returned to the facility, she agreed to wear a wander guard. The documentation also showed R125 had a BIMS score of 9 (this reflects moderate cognitive impairment).

Review of R125's EMR revealed R125 was admitted to the facility on 5/27/23 and discharged on 7/8/23. Pertinent diagnoses included schizoaffective disorder, delusional disorder, psychoactive substance abuse, altered mental status, and other symptoms and signs involving cognitive functions and awareness.

Review of R125's Wandering Risk Scale assessment, dated 6/6/23, revealed the resident was a high risk to wander and an elopement risk. The interventions selected on the assessment form included obtaining consent for wander guard placement and to initiate 15 minute checks.

Review of R125's Progress Notes revealed admission charting on 5/28/23 that R125 had a history of wandering and was admitted to the facility because she had got off a bus and was lost. Further documentation revealed R125 "forgets instructions almost immediately." On 5/31/23, RN6 documented R125 "later escorted back into [facility] by UTA [acronym unknown] guard, [R125] had gotten on the bus wanting to get to [an out of state city]." Interventions included

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R125's room by the nurse station and staff monitoring as closely as possible.

Review of R125's Care Plan revealed R125 was at risk for impaired safety related to wandering, dated 5/28/23; and had impaired cognitive function or impaired thought process related to confusion dated, 6/9/23. Interventions did not include the documented elopement on 5/31/23, the placement of a wander guard, 15-minute checks, being close to nursing station or any measurable supervision parameters. The care plan also failed to identify R125's individualized history of leaving by bus and getting lost.

Review of physician orders revealed a wander guard was ordered on 6/13/23, after the second elopement on 6/12/23.

Continued review of R125's progress notes revealed on 6/12/23, R125 was absent from the facility but had been seen an hour ago. On 6/13/23 at 8:00 AM, the hospital called and said R125 was ready for re-admission to the facility.

During an interview on 6/26/24 at 11:45 AM with the Administrator, DON and RA, the RA stated R125's family would send her by bus across the country and that R125 would get off at the wrong bus stop. "We admitted her from the hospital. She never wanted to be here." The DON and RA stated they were not aware of the 5/31/23 elopement documentation by RN6 that showed R125 was escorted back to the facility by the UTA guard. The DON stated that RN6 was a night nurse that no longer worked at the facility. The DON stated the facility would make sure to have better interventions in place to prevent elopements and that the facility was already

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addressing this as part of their state plan of correction. The DON confirmed she did not see a care plan for R125's wander guard. The DON stated she was working with the MDS Coordinator and all the licensed nurses to update the care plans for residents at risk for elopement.

4. Review of the FRI, for discharged resident R120, revealed LPN3 reported that on 11/1/23, a nurse aide (NA) was unable to locate the resident at 5:45 AM. The investigation revealed that a staff member had left R125 to attend to another resident and that R125 had been seen wandering around the building. R125 had left the facility and eventually phoned the facility to be picked up but when staff arrived to pick him up, R125 was no longer at the location. The resident was ultimately located and taken to the hospital and R125's guardian decided to transfer the resident to another facility. There was no documentation that showed whether the resident was wearing the wander guard at the time of elopement.

Review of R120's EMR revealed R120 was admitted to the facility on 10/6/23 and discharged on 11/1/23. Diagnoses included intracranial injury, traumatic brain injury, diabetes, schizophrenia, mild cognitive impairment, depression and unsteadiness on feet. The Quarterly MDS, with an ARD of 10/19/23, revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15.

Review of R120's Wandering Risk Scale assessment, dated 10/6/23, revealed the resident was a low risk but then showed R120 was at risk for exit seeking as evidenced by, "Resident states keeping him here is illegal and this is not a prison." Interventions selected on the assessment

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included placing resident in room that allows for increased supervision from staff, obtain consent for wander guard placement, medication review and psychosocial assessment. "Wander guard was placed on resident, resident removed wander guard and said it was illegal to place on him and he is not giving it back."

Review of R120's Progress Notes revealed on 10/29/23, a nurse documented R120 was agitated and wanted the wander guard off, "says he was told he only had to wear it for a couple of days."

Review of physician orders revealed no evidence of a wander guard.

Review of R120's Care Plan revealed R120 was at risk for impaired safety related to wandering. "He has impaired insight," dated 10/7/23. Interventions failed to include the placement of a wander guard or increased supervision by staff.

Continued review of R120's progress notes revealed on 11/1/23 at 6:50 AM, the resident was noted missing at 5:40 AM. The search revealed the rear fence had been broken out.

During an interview on 6/26/24 at 11:45 AM with the Administrator, DON and RA, the DON reviewed R120's assessment and stated the information in the assessment was conflicting and that R120 was at risk for wandering/elopement. The DON stated R120 did have a wander guard that he would remove, but it was not ordered or care planned in the EMR even though the guardian wanted it and the physician had ordered it. "The nurse should have put the order in the record."

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5. Review of the FRI, for discharged resident R127, revealed on 5/16/23 at 6:40 PM, Floor Nurse 10 became aware of R127's elopement when police brought R127 to nurses' station after being found wandering up the road. Resident was placed on 15-minute monitoring. The investigation revealed R127 had exited the building during shift change when the front door wander guard system was malfunctioning. Doors were scheduled for repair on 5/24/23.

Review of R127's EMR revealed R127 was admitted to the facility on 3/9/21 and discharged on 11/2/23. Diagnoses included senile degeneration of the brain, dementia, anxiety, and bipolar disorder. The resident was also on hospice. The Quarterly MDS, with an ARD of 9/17/23, revealed a blank BIMS score.

Review of R127's Wandering Risk Scale assessment, dated 2/10/23, revealed the resident was a high risk to wander and at risk for exit seeking as evidenced by "poor safety awareness and cognition, hx [history] of wandering around facility in w/c [wheelchair]." Interventions included placing resident in a room that allows for increased supervision from staff, obtain consent for wander guard placement and medication review.

Review of R127's Progress Notes revealed a nurse's note on 3/3/22 that revealed R127 consistently wandering and redirected. On 8/15/22, resident found outside building and several attempts to go through exit doors "he will go to the road if was not found by nurse, resident has a wander guard in place, but he waits in front of the exit doors until other residents open the

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door then he escapes." On 4/14/23, tries to wander out of the building. Wander guard on and working.

Review of R127's Care Plan revealed R127 was at risk for elopement with history of attempts to leave facility. Interventions included redirecting away from doors, identify patterns of wandering and intervene as appropriate. May have wander guard on and check for placement/function every shift. Dated 10/11/22.

Continued review of R127's progress notes revealed on 5/16/23, the resident had been trying to leave the building all day with both non-pharmacological and pharmacological interventions implemented. Around 5:00 PM R127 was taken to the dining room. At 5:30 PM the police arrived with R127. The wander guard alarm was not heard. Nursing staff to keep a close eye on him and monitor wander guard function.

During an interview on 6/26/24 at 11:45 AM with the Administrator, DON and RA, the RA and DON confirmed the wander guard alarm at the front door was not working the day R127 eloped. The facility immediately called the vendor to come and fix the door. The RA stated the police found him on the sidewalk right in front of the apartments by the facility. "He was found quickly."

On 6/25/24 at 5:13 PM, Registered Nurse (RN) 1 stated wander guards were used when residents' cognition was in question and that the care plan should reflect the individual interventions needed for residents at risk for elopement.

During an interview on 6/25/24 at 5:15 PM, NA7

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stated residents were to use the sign out book if they were leaving the facility. NA7 stated he has seen a few residents who he felt were unsafe to leave the facility, leave the facility and he brought them back inside. "This was awhile back" and he does not recall the resident names, but he reported it to the nurse. NA7 stated they have had elopement trainings during staff meetings and staff do rounds. NA7 stated they have group chat with staff members to notify everyone when a resident is missing.

During an interview on 6/25/24 at 5:16 PM, NA6 stated she had not received training on elopement but that a resident had to be located and returned safely and to notify the nurse. NA6 stated she was not aware of any policies for elopement, but she believed they were in the handbook. NA6 stated she was not aware of residents at risk for elopement and did not know about a list.

During an interview on 6/25/24 at 5:30 PM, LPN2 stated she has received training on elopements and that elopements were discussed at monthly staff meetings. LPN2 stated it was an elopement if a resident does not sign out or tell anyone and leaves the grounds. LPN2 stated elopement assessments were completed on admission and as needed with changes. LPN2 stated there were currently no residents that wore a wander guard and there were no residents at risk to elope.

On 6/26/24 at approximately 4:30 PM, the facility provided a list of Residents at Risk for elopement, dated June 2024. The list identified 19 residents.

During an interview on 6/26/24 that started at 11:45 AM with the Administrator, DON and RA,

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they stated the elopement process needs to be "beefed up." The Administrator stated the investigation will include as much information as possible and include interviews with staff and residents. The

During continued interview, the Administrator, DON and RA stated that they have a resident population that does not want to sign out even though they have educated the residents about signing out or notifying a staff member that they are leaving. They stated that they educated the front receptionist yesterday and this morning about being alert to when residents leave. The Administrator stated the front door receptionist only works during business hours and that after hours, there were different ways to supervise and monitor residents - every two hour checks/rounding. The DON stated it will take all staff to brainstorm ways to stop elopements from happening. The DON stated they were still figuring out what to do when a resident refuses to say where they are going but that redirecting the conversation to make it about whether they need to take their medication or food with them may help with cooperation. The RA stated when the COVID lockdown ended, they began to have more issues with residents signing out. The RA also stated that changes in management made it difficult to have consistent approaches to LOAs, elopement and reporting. The RA and DON stated they are in a better place to implement policies and build a strong and consistent team. The DON stated they believe they admit residents they can care for but that things change. "We then work with the Ombudsmen to discharge the resident safely."

6. Review of R27's Admission Record, indicated

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the resident was admitted to the facility on 3/28/19. Diagnoses including Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, mild cognitive impairment, and muscle weakness.

Review of R27's Quarterly MDS with an ARD of 4/4/24, indicated a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired.

During observations, on 6/25/24, starting at 12:53 PM, R27 was seen smoking outside at the front of the parking lot, adjacent to a busy street in front of the facility. At 1:45 PM, R27 got on a public bus in front of the facility and left.

During a concurrent interview and record review starting at 2:00 PM, RN2 stated R27 was in RN1's care today. At 2:04 PM, RN1 stated R27 should notify staff when he leaves the premises. "He does not really leave that often. We have a book to sign out in." RN1 looked at the book and said there was no record of him signing out. RN1 attempted to reach R27 but R27 did not answer the phone. RN1 stated he would have to let the Administrator and DON know R27 had left without signing out or telling him.

During additional interviews at 2:17 PM, NA4 and NA5 said they were caring for R27 today and he did not tell them he was leaving the premises. At 2:20 PM, the Receptionist stated it was hard to monitor who was coming and going. She stated if someone was running out in the road she would try to catch them but she has never had to do that. She stated R27 did not tell her he was going anywhere. "He also goes to his car a lot to hang out."

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At 3:38 PM, R27 was observed back at the facility.

Review of the FRI at 4:45 PM, revealed the facility submitted a report of potential neglect and other/elopement to the state. Documentation showed that RN1 was able to contact R27 by telephone and R27 returned an hour later. R27 had gone to a store and forgot to sign out. Resident educated on LOA policy.

Review of R27's Progress Note, dated 6/25/24 at 2:46 PM revealed R27 had left facility without proper staff notifications. R27 was called and he was able to verbalize he was at the store one block up the street.

During an interview on 6/26/24 at 10:06 AM, RN1 stated he was able to get a hold of R27 by phone yesterday after he called R27's relative, who gave RN1 a different contact number to try. RN1 stated he was not educated on doing additional charting on the elopement. RN1 was unable to provide an elopement binder.

During continued interview, RN4 stated she was taking care of R27 today and she was instructed to chart additional monitoring for R27 but was unaware of specific interventions to implement. "That would be pretty useful." RN1 and RN4 stated they were not aware of updates to R27's care plan and had not received additional communication about yesterday's incident.

During an interview on 6/26/24, starting at 10:37 AM, RN3 stated there was no elopement book but there was a sign in/out book. RN3 he was not aware of R27's elopement yesterday. At 10:39 AM, NA2 stated she was not aware of an

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Elopement Book. NA2 stated she was not aware that R27 left the building yesterday and was not provided any new interventions for caring for R27. At 10:43 AM, the Receptionist stated she had not been provided an update or education on resident supervision for R27.

During an interview on 6/26/24 at 5:45 PM, R27 stated he does not sign out when he leaves and he was not going to sign out. R27 stated he left all the time without telling anyone where he was going but that "they should know" where he was. R27 stated staff never cared where he was going until "you all came in."

B. Review of facility policy, Smoking Safety - Resident Noncompliance/Unsafe Conditions, dated 5/24/23, revealed in pertinent part,
- "Individuals who are noncompliant, potentially dangerous, exercise poor judgement and show a lack of concern for the welfare of others will be counseled and smoking privileges will be suspended or revoked if there is a pattern persistent, hazardous behavior;"
- "The following behaviors and/or conditions may restrict, suspend, cause revocation of the resident's smoking privileges (1st and 2nd offenses) and/or result in an Involuntary Discharge: 1. Smoking in any non-designated area, such as resident rooms, bathrooms, hallways, elevators, stairways, and/or smoke-free courtyard. 2. Cognitive impairment, poor judgement, compromised manual dexterity and/or mobility. 3. Self-harmful behaviors, such as burning clothing, hands, fingers, face, or lips. This category includes residents who are generally "careless" while smoking and may present a significant risk of fire setting. If needed, a risk vs. benefit will be done. 4. Short attention span, poor

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safety awareness, wandering/pacing and becoming easily distracted making smoking dangerous for the individual and those around him/her. 5. Inconsiderate behaviors such as not respecting the rights of others while smoking (i.e., blowing smoke at another person, littering with cigarette butts, dropping ashes at will, not making an effort to use the ashtray, etc.) 6. Engaging in any type of trading/bartering/begging/panhandling or other behavior deemed unsafe by facility staff."

Review of the undated Smoking Policy, reviewed and signed by each resident and found in the EMR under the Miscellaneous tab, read,
- "Policy: The facility will enforce all state and federal agencies regulations for the prevention of fire and protection of life and property. Procedure: Residents and visitors will be allowed to smoke in the designated smoking area out the Southwest Corner of the building. -Absolutely NO smoking in front of Mt. Olympus building. -Smoke in designated areas ONLY. -Must supply your OWN cigarettes. - Facility will NOT provide your cigarettes. - Do NOT ask residents or staff for cigarettes. - No smoking INSIDE building cigarettes or vapes. Residents who exhibit unsafe behavior while smoking, will be under periodic observation by facility personnel or responsible adult while smoking. "NO SMOKING" signs will be placed throughout the facility wherever oxygen or flammable liquids are used or stored. Ashtrays of noncombustible material and safe design, and metal containers with self-closing cover devices are provided in the designated smoking area."

1. Review of R27's Admission Record, indicated the resident was admitted to the facility on 3/28/19. Diagnoses including Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes,

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mild cognitive impairment, and muscle weakness.

Review of R27's Quarterly MDS with an ARD of 4/4/24, indicated a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired. The MDS did not indicate whether the resident was a smoker (this section of the assessment was left blank).

Review of R27's Smoking Care Plan, dated 5/20/24, indicated R27 was a daily smoker. The Care Plan indicated the resident was capable of smoking independently and safely. The document indicated R27 was to be educated about smoking risks and hazards as well as the facility's policy related to smoking including smoking locations, times, and safety concerns.

Review of R27's most recent Smoking Safety Evaluation, dated 4/3/24, indicated the resident only smoked occasionally and was safe to smoke independently. The Smoking Questionnaire section of the assessment was not complete. This section indicated the following questions (worth one point each): 1. Resident demonstrates impaired orientation in one or more of the following areas: Person, Place, Time. 2. Resident has a diagnosis of neuropathy or other neurocognitive impairment. 3. Resident demonstrates one or more of the following cognitive impairments: Poor safety awareness, impaired short-term memory, impulsiveness. 4. Resident has a history of unsafe smoking practices. 5. Resident demonstrates non-compliance with smoking policy (i.e., smoking in designated areas only, appropriate disposal of cigarettes). 6. Resident has condition or diagnosis that impairs ability to call for assistance if needed and/or which impairs

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resident's ability to exit designated smoking areas independently. Scoring for the evaluation indicated a score of zero points was needed to smoke independently. One to three points indicated the resident may require set-up assistance with smoking, and four to six points indicated the resident was unable to smoke independently and required supervision to smoke. R27's score was zero.

Review of R27's signed Smoking Policy (see above), reviewed, and acknowledged by the resident on 2/15/23.

During an observation on 6/24/24 at 2:45 PM, R27 was observed sitting in his wheelchair in the front parking lot under a tree in front of the building close to the road (not in the facility's designated smoking area). The resident was smoking a cigarette. There were no staff supervising the resident and no fire safety equipment or ashtrays/cigarette butt receptacles were observed in the area. At 3:15 PM R27 remained under the tree at the edge of the parking lot at the front of the building, smoking. The resident finished smoking and flicked the butt of his cigarette onto the ground under the tree. When asked if he was a smoker, he stated, "I smoke. Yes. I smoke under the tree out there (at edge of parking lot)." R27 was asked if he was aware of where the facility's designated smoking area was and he stated he knew where the smoking area was, however, he did not like to smoke there because when he smoked there, other residents asked him for cigarettes. When asked what he would do if his cigarette dropped and started a fire or began to burn him, he indicated he did not know what he would do and made a noise as if he was blowing up. R27

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stated, "I keep my cigarettes on myself, and my lighter, too."

During an observation on 6/25/24 at 12:53 PM, R27 was observed smoking a cigarette at the edge of the front parking lot under the tree. The resident was not supervised by staff and no fire suppression equipment or cigarette receptacles/ash trays were observed near the resident while he smoked. At 3:28 PM, after returning from a leave from the building. The resident was smoking a cigarette as above at the same place.

2. Review of R11's Admission Record, dated 6/27/24, indicated the resident was admitted to the facility on 6/21/19 with diagnoses including paranoid schizophrenia, gout, and vascular dementia related to alcohol consumption.

Review of R11's Annual MDS with an ARD of 4/9/24, indicated a BIMS score of 10 out of 15, which indicated the resident was moderately cognitively impaired. The MDS indicated the resident was a smoker.

Review of R11's Smoking Care Plan, dated 4/14/24, indicated R11 was a daily smoker. The Care Plan indicated the resident was capable of smoking independently and safely. The document indicated R11 was to be educated about smoking risks and hazards as well as the facility's policy related to smoking including smoking locations, times, and safety concerns. The care plan also indicated staff was to monitor the resident for cigarette burns on his clothing.

Review of R11's most recent Smoking Safety Evaluation, dated 4/19/24, indicated the resident

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was a smoker and was safe to smoke independently. The Smoking Questionnaire section of the assessment indicated R11's score was a zero.

Review of R11's signed Smoking Policy (see above), reviewed and acknowledged by the resident on 1/8/24.

During an observation on 6/25/24 at 9:45 AM, R11 was wandering around the facility parking while smoking a cigarette. The resident was not in the designated smoking area and was not being supervised by any staff. There were no fire suppression equipment or cigarette butt receptible/ash trays in the parking lot where the resident was smoking. The resident smoked his cigarette for about five minutes and then entered the facility through the front door. At 1:01 PM, R11 was observed wandering around the side parking lot smoking a cigarette. The resident was not in the designated smoking area and there were no staff supervising the resident while he smoked nor were there any fire suppression equipment or receptacles to discard the resident's cigarette ashes/butt. The resident wandered around in the side parking lot while smoking his cigarette for about 10 minutes before he flicked the cigarette butt on the ground and went back into the facility through the facility's front door. At 3:21 , R11 was observed in the parking lot on the opposite side of the building than the previous observation (not the designated smoking area). The resident pulled a pack of cigarettes out of his pocket, lit the cigarette, and wandered around the parking lot while smoking his cigarettes. The resident smoked for about five minutes, flicked the butt of the cigarette onto the ground in the parking lot, and went back inside the facility. The

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resident was unsupervised and there were no receptacles to discard the resident's cigarettes ashes/butts or fire suppression equipment observed in the area.

During an interview on 6/25/24 at 3:31 PM, the Receptionist stated she was aware residents smoked in areas other than the designated smoking area. She stated residents smoked in the front of the building daily, and staff tried to get the residents to the sides of the building or to the designated smoking area, but the residents would not follow this direction. The Receptionist stated she had reported the concern to Administration, but the residents continued to smoke in the front of the building and in other areas not designated for smoking. She stated, "We posted (no smoking) signs out there (in front of the building). They (Residents) aren't allowed to smoke out there. There is only so much I can do."

During an interview on 06/25/24 at 5:01 PM, Nursing Assistant (NA) 3 indicated she was familiar with both R11 and R27 and confirmed both residents were smokers. She stated R11 had pretty severe dementia and frequently wandered around in the facility's parking lot. NA3 stated there was only one supervised smoker residing in the facility and there were designated smoking times for supervised smoking and there was a designated smoking area all residents were expected to use. She stated neither R11 nor R27 were supervised smokers. NA3 stated she had never seen R11 smoke anywhere but the designated smoking area but stated R27 liked to smoke under the tree in the parking lot in front of the building. She stated she thought there was an ash tray in the front of the building where R27 liked to smoke but was not sure. NA3 stated the

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residents had just been gathered sometime the month before (she could not remember exactly when) to go over the facility's smoking rules. NA3 stated, "We have had an issue where they (Residents) smoke in the front (of the building) and that is a big "No." She stated she had occasionally seen residents smoke in front of the building and when she did, she did her due diligence by directing them to the designated smoking area. NA3 stated she had informed administration of residents smoking in non-designated areas and stated she thought the facility's Receptionist was supposed to be monitoring who went in and out of the building to smoke and management was taking turns making rounds around the outside of the building to check for safe smoking.

During an interview on 6/25/24 at 5:16 PM, NA6 stated she had been employed with the facility for three to four months and stated she was not aware of the policies and had not been trained related to safe resident smoking. She stated she was aware there were designated smoking times for residents who needed assistance with smoking and indicated the facility's designated smoking area in the back of the building. NA6 stated there were some independent residents who smoked in the front of the building away from the building. NA6 was not able to answer as to whether residents were allowed to smoke in the front of the building or not.

During an interview with Licensed Practical Nurse (LPN) 2 on 6/25/24 at 5:30 PM, she stated she had been employed with the facility for almost two years and had been trained related to the facility's smoking policies and procedures twice in that time. She stated independent smokers were

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allowed to smoke wherever they wanted to except where there were signs designating an area that was "No Smoking." She stated some residents were assisted with smoking in the facility's "Smoke Shack (designated smoking area)." LPN2 stated residents had to be frequently told not to smoke directly in front of the building. She indicated residents would walk out to the sidewalk in front of the facility but were not allowed to smoke right next to the building. LPN2 indicated there were some residents who had to be frequently reminded to smoke in appropriate areas due to dementia. She stated administration was aware of the problem and she had seen them telling residents to smoke elsewhere, however there were some residents who were not rule followers and did not like to be told what to do. She stated, "We have to constantly remind them (residents)."

During an interview on 6/25/24 at 6:06 PM, NA2 stated she was familiar with R11 and R27 and stated the designated smoking area was out in the back of the building in the "Smoke Shack." She stated she had occasionally seen residents attempting to smoke in the front of the building and staff had to tell them to go to the designated smoking area. She stated, "There is always that one ... always one who tries to smoke up there." NA2 stated the facility did not have any ashtrays or fire safety equipment in the front or on the sides of the building because those areas were not designated for smoking.

During an interview on 6/26/24 at 3:49 PM with the Administrator and the DON, the Administrator stated residents were expected to be smoking in the facility's designated smoking area and stated cigarette butts and ashes were expected to be

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F 689	Continued From page 90 discarded properly in ashtrays. Both indicated there was no fire suppression equipment nor were there any smoking material receptacles in which to discard cigarette ashes or butts in any other area of the facility than the designated smoking area. During a follow-up interview on 6/26/24 at 4:11 PM, the DON stated staff should be redirecting residents if they were seen smoking in non-designated areas. She stated some residents had been addressed for failing to follow the smoking rules, but several residents continued to fail to follow the smoking rules. She stated it was something the facility needed to address.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		

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F 700	Continued From page 91 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to review the risks and benefits of bed rails with the residents (R) or resident representative and failed to obtain informed consent prior to the installation of bed rails for 4 of 4 residents reviewed for bed rails (R12, R15, R19 and R27). The facility also failed to assess the resident for risk of entrapment prior to installation for 2 of 4 residents reviewed (R12 and R15). Findings include: Review of the facility policy, Bedrails Safety and Bed Rails, with a revision date of 6/24, revealed in pertinent part: - "The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent." *Bed rails, side rails and grip bars were used interchangeably throughout the document. 1. Review of R15's Care Plan revealed that R15 was readmitted to the facility on 7/12/23. Diagnoses included multiple sclerosis (MS - a disease that affects the nerves), paraplegia (inability to move leg muscles), and muscle weakness. The Quarterly Minimum Data Set (MDS - federally mandated assessment) with an	F 700		

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assessment reference date (ARD) of 5/10/24 revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. Furthermore, the MDS revealed that R15 depends on or requires maximum assistance with dressing, toileting, bathing, and transferring from staff.

Review of R15's Care Plan, dated 7/11/23, revealed that R15 used the "side rails for bed mobility and positioning."

Review of the Physician Order, dated 6/11/21, revealed R15 was to have " 1/4 hand grip bars to promote independent bed mobility and repositioning."

Review of R15's Electronic Medical Record (EMR) revealed no evidence that an informed consent explaining the risks/benefits of the bedrails, or an assessment for entrapment was obtained prior to their installation.

During a concurrent observation and interview in the resident's room on 6/25/24 at 9:14 AM, R15 was resting in bed. The bed had two bed rails in the up position on the top right and left sides of the bed. R15 stated he used the bed rails to assist with turning and repositioning when staff were providing care or when lying in bed. The bed rails were secured tightly to the bed, with no gaps observed between the rail and the mattress.

2. Review of R19's Care Plan revealed R19 was readmitted to the facility on 4/6/22. Diagnoses included cervical spine fusion (joining of the bones in the neck), chronic pain, incomplete paraplegia, and obesity. The Quarterly MDS with an ARD of 2/17/24, revealed the resident had

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intact cognition with a BIMS score of 14 out of 15. Furthermore, the MDS revealed that R19 was dependent or requires maximum assistance with dressing, toileting, bathing, and transferring.

Review of R19's Care Plan, dated 10/11/22, revealed R19 used side rails to promote independence with bed mobility and positioning.

Review of the Physician Order, dated 7/7/20, revealed R19 was to have "side rails for bed for mobility and positioning & promoting independence."

Review of R19's EMR revealed that R19 had an Entrapment/Restraints Evaluation completed on 2/22/22. However, there was no evidence that R19 had given informed consent and that he had been provided with the risks/benefits of the bedrails prior to their installation.

During a concurrent observation and interview in the resident's room on 6/24/24 at 3:30 PM, R19 was resting in bed watching TV. The bed had two full-size bed rails in the up position on the top right and left sides. R15 stated he used the bed rails for repositioning.

During an interview on 6/25/24 at 1:43 PM, Licensed Practical Nurse (LPN) 1 stated residents used bedrails to aid in turning when staff were providing care. LPN1 stated that R15 had bed rails as a safety precaution and repositioning due to his MS diagnosis. LPN1 stated bed rail consents were required for residents who have had a previous fall or have been identified as a fall risk.

During an interview on 6/26/24 at 8:04 AM, Nurse

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Aide (NA) 5 stated that R15 and R19 used the bed rails to roll from side to side during care. NA5 mentioned that she has not known of any bedrail issues since she started work at the facility.

During an interview on 6/26/24 at 8:37 AM, NA1 stated that R15 and R19 used the bed rails to roll from side to side during care. NA1 stated that she has not known of any bedrail issues since she started work at the facility.

During an interview on 6/26/24 at 11:44 AM, Registered Nurse (RN) 4 stated that R15 and R19 used the bed rails to move in bed. RN4 stated she does not know of any issues with the bed rails.

3. Review of R27's Admission Record revealed R27 was admitted to the facility on 3/28/19. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, and mild cognitive impairment.

Review of R27's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 4/4/24, revealed the resident had moderate cognition impairment with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The assessment indicated the resident was able to move independently in his bed and was able to independently transfer in and out of his bed and into his wheelchair. The assessment indicated R27 was not using side rails on his bed.

Review of R27's Order Recap Report, dated 6/27/24, indicated no orders for the resident's use of side rails on his bed.

Review of R27's Assistive Devices Care Plan,

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dated 5/20/24, indicated R27 was using mobility bars for bed mobility. The Care Plan indicated the resident was to be provided with education on proper bed mobility and an evaluation was to be done related to bed mobility.

Review of R27's most recent Entrapment/Restraints Evaluation, dated 4/3/24, indicated the resident was using two ¼ side rails on his bed to assist with mobility.

There was no evidence in the EMR to indicate R27 had been provided with information related to the risk and benefits of using side rails on his bed and had given informed consent for the use of the rails on his bed.

During an observation on 6/25/24 at 9:16 AM and on 6/26/24 at 7:54 AM, 1/4 sized rails were observed to be in the raised position on both sides of the head of the resident's bed.

4. Review of R12's Care Plan revealed R12 was admitted to the facility on 3/8/22. Pertinent diagnoses included history of falling, dependence on wheelchair, epilepsy with partial seizures, insomnia, and pervasive developmental disorder. The Quarterly MDS, with an ARD of 5/20/24, showed a dash in place of a numeric score for the BIMS assessment. Review of professional reference from the Centers of Medicare and Medicaid (CMS), Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, revealed in pertinent part, "The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items."

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F 700	Continued From page 96 During a concurrent observation and interview on 6/27/24 at 8:30 AM, R12 was eating breakfast in bed and stated she was going to get up at 9:00 AM. Two quarter (1/4) rails were observed in the up position at the top of either side of the bed. R12 stated she used them "sometimes." Further review of R12's Care Plan revealed R12 used "1/4 hand grip bars to promote independent bed mobility and repositioning." Review of R12's Physician Orders, revealed the hand grip bars were ordered on 6/11/21. Review of R12's Entrapment/Restraints Evaluation, dated 2/18/23, revealed an incomplete assessment that did not document the entrapment risk (section was blank) and the selection of 1/2 rails were selected, instead of 1/4 side rails. Review of R12's EMR, revealed no evidence of an informed consent, explaining the risks and benefits of bed rail use. During an interview with the Director of Nursing (DON) on 6/27/24 at 10:30 AM, she confirmed orders had not always been entered, the risk/benefit reviewed, and informed consent had not been obtained from the residents for use of side rails. She stated her expectation was these things should have been obtained prior to installation.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730		

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F 730	Continued From page 97 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an annual performance review was completed for 3 of 3 Nurse Aides (NA) reviewed (NA1, NA13 and NA14). Findings include: During an interview on 6/26/24 at 8:04 AM, NA5 stated that she was unaware of performance reviews. NA5 stated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) routinely inquire with the NAs about areas where they feel they need additional training. During an interview on 6/26/24 at 8:37 AM, NA1 stated the DON and ADON had conducted a periodic performance review with her. Review of NA1, NA13 and NA14 personnel files on 6/27/24 revealed no evidence performance reviews were conducted in the past 12 months. During an interview on 6/28/24 at 8:47 AM, the Administrator stated that he was waiting for the performance reviews for NA1, NA13, and NA14 from the Human Resources (HR) department. During an interview on 6/28/24 at 10:05 AM, the Administrator stated they did not have performance reviews for NA1, NA13 and NA14.	F 730		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		

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F 759	Continued From page 98 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Two errors were made with a total of 33 opportunities for error, resulting in a 6.06% error rate. The errors involved 2 of 6 residents (R) reviewed for medication administration (R10 and R43). These failures created the potential for both residents to experience negative effects related to errors with their medication administration. Findings include: On 6/27/24 at 9:00 AM, facility policies related to medication administration and insulin pen administration were requested. The policies were not provided to the survey team prior to survey exit. 1. Review of R10's Order Recap Report, indicated an order dated 4/26/24 for the resident to receive insulin glargine (Lantus) long-acting insulin 20 units subcutaneously (injected under the skin) one time daily to control her blood sugar. During an observation on 6/26/24 at 8:00 AM, Registered Nurse (RN) 2 was observed dialing up a 20 unit dose of insulin on the insulin pen and administered the dose to R10. The insulin pen	F 759		

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was not primed prior to dialing up the 20-unit dose of insulin to ensure there was no air in the syringe with administration of the medication (therefore creating the potential for the resident to receive a smaller dose of insulin that ordered).

During an interview on 6/26/24 at 10:19 AM, RN2 indicated she had been working at the facility for about 16 months and was familiar with R10. She stated no one had ever instructed her on how to use an insulin pen since she started working at the facility, including directing her to prime the pen prior to administering insulin to residents. She stated, "[Insulin] pens are new to me."

2. Review of R43's Order Recap Report, indicated an order dated 8/6/22 for the resident to receive aspirin 81 milligrams (mg) once daily for heart health.

During an observation on 6/25/24 at 7:48 AM, RN1 was observed to administer an enteric coated aspirin instead of the chewable aspirin ordered by the resident's physician, creating the potential for the aspirin to dissolve in the resident's digestive system more slowly than indicated.

During an interview on 6/25/24 at 7:56 AM, RN1 indicated he had been working at the facility for about two years and was familiar with R43. He confirmed the order indicated R43 was supposed to receive chewable aspirin rather than the enteric coated aspirin administered and stated chewable aspirin was available in the medication cart. RN1 indicated he simply misread the order.

During an interview on 6/26/24 at 3:19 PM, the Director of Nursing (DON) indicated physician's

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F 759	Continued From page 100 orders were expected to be followed related to the administration of all medications. She stated she was unsure what the process was related to priming an insulin pen prior to administration of insulin. During a follow-up interview with the DON on 6/27/24 at 11:21 AM, she acknowledged insulin pens were to be primed prior to administration of insulin to ensure proper dosing of insulin. During an interview with the Consulting Pharmacist on 6/28/24 at 8:54 AM, he stated insulin pens were expected to be primed prior to dialing up the insulin dose to be given. He stated, "They (nursing staff) change the needle every time and so they need to make sure to prime...clear the air from the needle every time. That is the case with any needle you use [for the administration of medication]."	F 759		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency	F 790		

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F 790	Continued From page 101 dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure routine/follow-up dental services were provided for 1 of 2 residents (R) reviewed for dental care (R27). This failure created the potential for the resident to experience complications related to poor dentition. Findings include: Review of facility policy, Dental Services Policy, dated June 2024, revealed in pertinent part, "Routine and emergency dental services are available to meet the resident's oral health	F 790		

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services in accordance with the resident's assessment and plan of care;" and "1. Routine and 24-hour emergency dental services are provided to our residents through: a. A contract agreement with a licensed dentist that comes to the facility monthly; b. Referral to the resident's personal dentist; c. Referral to community dentists; or d. Referral to other health care organizations that provide dental services."

Review of R27's Admission Record revealed R27 was admitted to the facility on 3/28/19. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, and mild cognitive impairment.

Review of R27's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 4/4/24, revealed the resident had moderate cognition impairment with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. The MDS indicated the resident had mouth or facial pain and discomfort or difficulty with chewing related to his dentition during the assessment reference period.

Review of R27's Order Recap Report, dated 6/27/24, indicated orders for the resident to see the dentist as needed.

Review of R27's Care Plan, dated 5/20/24, indicated nothing related to the resident's dental health.

Review of R27's Dental Progress Notes, dated 1/26/24, indicated on that date, R27 had stopped the dental team while they were in the building seeing other residents, had asked to be seen,

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and had been seen for a limited oral evaluation. The note indicated the resident requested to have teeth extracted and upper and lower denture made if possible. The progress note indicated the following recommended services:
- A comprehensive oral evaluation; An Intra-oral complete X-ray; Extraction of erupted tooth or exposed root (multiple); Complete upper denture, initial placement; and Complete lower denture, initial placement.

There was no evidence found in R27's electronic medical record (EMR) to show the resident had been seen by the dentist for follow-up to his 1/26/24 dental evaluation.

During an interview on 6/24/24 at 3:10 PM, R27 was observed to have one tooth sticking up from his right bottom gum and he stated, "I need the dentist." R27 stated he had been trying to be seen by the dentist for seven months, and the facility had not made an appointment for him. He stated, "I need this tooth out (pointing at the tooth protruding from his bottom right gum). They (facility staff) haven't done anything about it. It hurts when I eat. Look at it. It's jagged and it sticks up."

During an interview with the Resident Advocate (RA) on 6/26/24 at 3:09 PM, she stated R27 had benefits, however, was not 100% connected with the insurance carrier so he was not able to see them for dental services. She stated she had tried to get the resident to apply for Medicaid, but he did not want to do that. The RA stated, "We could get him into the University. They have free dental [services]." When asked if she had reviewed all possibilities for dental care with R27, she stated she did not remember. The RA was not able to

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F 790	Continued From page 104 find any documentation to show dental options had been reviewed with R27 related to the services recommended during his 1/26/24 dental evaluation. The RA stated she would discuss possible dental services with R27 later that day. During an interview on 6/27/24 at 10:25 AM, the Director of Nursing (DON) stated the facility should have followed up to ensure R27 was provided with needed/requested dental services.	F 790		
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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was covered, labeled, dated, did not have expired manufacturer's "use by" dates, and did not have	F 812		

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signs of spoilage in 4 areas (kitchen, activity room, and 2 of 3 (Ensign Peak and Quail Hallow) resident unit refrigerators and freezers). Additionally, the facility failed to ensure nutritional milk shakes served from the kitchen's tray line were served at an internal temperature of 41 degrees Fahrenheit (F) or below. This had the potential to affect all 68 residents who consumed food prepared in the facility's kitchen, and activity room, or those residents who consumed food stored in the resident refrigerator and freezer on the Ensign Peak and Quail Hallow units.

Findings include:

Review of facility's policy, Food Receiving and Storage, revised June 2024, revealed in pertinent part,
- "Food shall be stored in a manner that complies with safe food handling practices ... Dry foods that are stored in bins are removed from original packaging, labeled, and dated ("use by" date). Such foods are rotated using a "first in- first out" system ... All food stored in the refrigerator or freezer are covered, labeled, and dated ("use by" date) ... Refrigerated foods are labeled, dated, and monitored so they are used by their "use-by "date, frozen, or discarded ... All food items to be kept at or below 41 [degrees] F are placed in refrigerator located at the nurses' station and labeled with a "use by" date ... All foods belonging to residents are labeled with the resident's name, the item, and the "use by" date."

1. During an observation on 6/24/24 from 11:15 AM to 11:50 AM, during the initial kitchen inspection, with the Dietary Supervisor (DS) present, revealed the following:
a. Food stored in the kitchen's reach-in

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refrigerator showed a 16-ounce pound cake which had been opened but was not dated, an opened 20-pound box of uncooked beef patties that was not completely closed, and an opened 10-pound box of chicken corn dogs.

During an interview on 6/24/24 at 11:20 AM, the DS confirmed the above findings. The DS stated staff were expected to date foods when opened and to completely close opened food when placed in storage.

b. Food stored in the kitchen's walk-in refrigerator showed the following opened foods were not dated when opened and did not contain a manufacturer's expiration date; a one-gallon container of mayonnaise, a one-gallon container of thousand island dressing, a one-gallon container of Italian dressing, a one-gallon container of yellow mustard, a one-gallon container of pickle relish, and a one-gallon container of pickle chips.

During an interview on 6/24/24 at 11:30 AM, the DS confirmed the above findings. The DS stated staff were expected to date food when opened.

c. Food stored in the kitchen's walk-in freezer revealed an opened 15.75-pound box of omelets that was not completely closed.

During an interview on 6/24/24 at 11:35 AM, the DS confirmed the above findings. The DS stated staff were expected to completely close opened food when placed in storage.

d. Bread products stored on bread racks in the kitchen revealed nine undated thawed loaves of sliced bread and one undated package of thawed

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hamburger buns.

During an interview on 6/24/24 at 11:40 AM, the DS confirmed the above findings. The DS stated she did not know when these bread products should be discarded because they were not dated. The DS explained she had not previously directed staff to date bread products but would start directing staff to date and discard bread products per the bread vendor's storage guidelines.

During an interview on 6/26/24 at 12:20 PM, the DS stated the facility's bread vendor's storage guidelines specified their bread products should be discarded if not used within seven days after being thawed.

2. During an observation on 6/26/24 at 12:10 PM, the kitchen staff were serving resident lunch meals from the kitchen tray line. At this time, the food temperature log for this meal was reviewed. Review of the food temperature log revealed staff had not recorded the temperature of the cold nutritional shakes being served from the tray line. Staff was observed serving four-ounce cartons of nutritional shakes from a pan that was placed on an opened cart on the tray line.

During an observation on 06/24/24 at 12:23 PM, the facility's Consultant Registered Dietitian (CRD) 1 entered the kitchen and placed the nutritional shakes being served from the opened cart in a pan of ice.

On 6/26/24 at 12:45 PM, the DS was requested to use a calibrated thermometer to monitor the internal temperature of one of the nutritional shakes that was on the tray-line's open cart as

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staff continued to prepare resident meal trays. Temperature monitoring revealed the internal temperature of the four-ounce nutritional shake was measured at 50 degrees Fahrenheit (F). The DS confirmed staff had not monitored the internal temperature of the nutritional shakes prior or during the lunch tray line meal service. The DS stated staff were expected to monitor the temperature of the nutritional shakes prior to the start of the tray line meal service and to store and serve the shakes from a pan of ice on the tray line. The DS stated the nutritional shakes should be served from the kitchen's tray line at a temperature of 41 degrees F or below.

3. During an observation of the resident refrigerators and freezers on the facility's units revealed the following food storage concerns:

a. On 6/27/24 at 10:15 AM, the food stored in the facility's Ensign Peak resident unit freezer revealed a nine ounce box of sausage, egg, and cheese croissants, which contained one croissant, that had an expired "use by" date of 12/22/23 printed on the box, and an opened 48 ounce container of chocolate yogurt, that had a resident's name hand written on the container, contained yogurt that was discolored, had a heavy accumulation of ice crystals and appeared freezer burnt.

During an interview on 6/27/24 at 10:15 AM, the facility's CRD 2 confirmed the package of sausage, egg, and cheese croissants had an expired "use by" date of 12/22/23 and the container of chocolate yogurt appeared freezer burnt were stored in the Ensign Peak freezer. CRD 2 agreed the sausage, egg, and cheese croissant, and the container of chocolate yogurt

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should be discarded.

On 6/27/24 at 10:20 AM, food stored in the Ensign Peak resident refrigerator revealed an unlabeled and undated plastic bag which contained an uncooked hot dog, a one pound 12-ounce package of hot dog buns (which contained 8 hot dog buns) with an expired "best by" date of 6/1/24, and an undated and unlabeled package that contained eight hot dog buns.

During an interview on 6/27/24 at 10:20 AM, the DS confirmed the above findings. The DS stated it was the dietary staff's responsibility to check the food stored in the facility's unit resident refrigerators and freezers and to discard any foods that had expired expiration/use by dates, appeared spoiled, or were not labeled or dated.

b. During a concurrent observation and interview on 6/27/24 at 10:45 AM of the food stored in the facility's Quail Hollow resident refrigerator revealed six individually wrapped cheese sticks that were not dated and did not contain a manufacturers' expiration date. The DS confirmed the above findings. The DS stated the dietary staff were responsible for checking the food stored in the resident unit refrigerators and were expected to discard any food that was not dated.

4. During an observation on 6/27/24 at 10:30 AM, food stored in the facility's activity room refrigerator and freezer revealed the following food storage concerns:

a. In the freezer section of the activity room's refrigerator there were four three-pound eight-ounce packages of uncooked and undated

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F 812	Continued From page 110 whole wheat rolls that did not have an expiration date or "use by" date on their package. b. In the activity room's refrigerator there were nine pasteurized shell eggs which did not have an expiration or "use by" date, an opened twenty-ounce bottle of ketchup with an expired "best by" date of 5/28/24, and an undated and unlabeled plastic bag which contained shredded cheese. During an interview on 6/27/24 at 10:35 AM, the DS confirmed the above findings. The DS stated it was the activity staff's responsibility to check the food stored in the activity room's refrigerator and freezer and to discard any food that had an expired "use by" or expiration dates or that were not labeled and dated. During an interview on 6/27/24 at 10:41 AM, the Activity Director (AD) stated she had not been checking the food stored in the activity room's refrigerator and freezer to see if the food was labeled and/or dated or had expired expiration or "use by" dates. During an interview on 6/27/24 at 5:40 PM, the Administrator stated the activity staff should be following the facility's "Food Receiving and Storage" policy to ensure food was properly stored in the activity department's refrigerator and freezer.	F 812		
F 842 SS=D	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.	F 842		

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(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

§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

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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 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 observation, record review, and interview, the facility failed to have complete and accurate documentation in the clinical record for 1 of 45 residents reviewed (R3). On 5/29/24, R3 sustained a fracture of the right lower leg resulting in a transfer to the local emergency room and admission to the hospital; however, there was no documentation of the incident or hospital admission in the residents record.

Findings include:

Review of facility policy, Transfer or Discharge Notice, last revised June 2024, revealed in pertinent part, transfer and discharge included

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movement of a resident from a certified bed in the facility to a non-certified bed outside of the facility. Transfer referred to movement of a resident to a bed in one certified facility to a bed in another certified facility when the resident expected to return to the original facility. The reason for the transfer or discharge would be documented in the resident's medical record.

Review of R3' SCSA (significant change in status) Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 6/5/24, indicated the resident's most recent admission/entry or reentry to the facility was 6/3/24. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS listed diagnoses of atrial fibrillation, heart failure, hypertension, diabetes, and other injury of unspecified body region, subsequent encounter.

The Discharge tracking MDS for R3 dated 5/29/24, identified the resident had an unplanned discharge to the hospital on 5/29/24, with return anticipated.

The Entry tracking MDS for R3 dated 6/3/24, identified the resident returned from the hospital on 6/3/24.

The Care Plan for R3, revised 6/10/24, identified the resident at risk for altered ADL's (activities of daily living) related to functional ADL activity decline with a right spiral femoral fracture, non-weight bearing, and splint to right lower extremity on 6/3/24.

During an interview on 6/24/24 at 2:02 PM, during the initial tour of the facility, R3 was observed in a

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motorized wheelchair in her room with a transfer sling underneath her and an ace wrap bandage on her right lower leg. Her leg was elevated on a pillow and footrest. R3 stated she had been in the hospital due to running into the wall and door frame with her motorized wheelchair, resulting in a spiral break of her right leg. R3 stated two gentlemen were in the hall and wouldn't move, however, she did not know if the gentleman were responsible for her hitting the wall and doorframe. The resident stated the facility re-built her motorized wheelchair while she was in the hospital.

During an interview on 6/25/24 at 9:48 AM, R3's family member (FM1) stated her sister had told her there were gentlemen in the hall when she ran her motorized wheelchair into the wall, however, the staff that were present at the time stated the gentlemen were fellow residents who had hollered at R3 to stop prior to hitting the wall. FM1 stated R3 broke her lower right leg and had done the same thing in July 2023, when she ran her motorized wheelchair into the wall. FM1 stated the facility adjusted the motorized wheelchair, to require the facility staff to assist the resident with mobility.

During an observation on 6/25/24 at 10:01 AM, the facility staff assisted the resident in her motorized wheelchair down the hall to the dining room area.

Review of R3's Progress Notes revealed on:
- 5/24/24 at 11:14 PM, pharmacy note stated medication and chart reviewed and no medication irregularities noted.
- 5/25/24 at 4:15 AM, order administration note stated pain medication not administered due to

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resident sleeping too soundly.
- 5/26/24 at 3:33 AM, order administration note stated pain medication held due to the resident being too tired to arouse.
- 5/29/24 at 7:12 PM, order administration note stated the resident was at the hospital.
- 5/30/24 at 5:00 AM, order administration note stated the resident was at the hospital.
- 5/30/24 at 9:15 AM, order administration note stated the resident was admitted to the hospital.
- 6/3/24 at 12:51 PM, order administration note stated the resident was hospitalized and awaiting return.
- 6/4/24 at 2:59 AM, admission 72-hour charting, stated the resident's primary diagnosis was fracture of the right spiral femur into the knee joint with non-surgical fix. Resident had cast to right lower leg.

Review of the Facility Incident Report (FRI) dated 5/29/24 at 5:28 PM, revealed R3 was assessed in electric wheelchair with right side against the hallway door. The resident moved away from the door to assess the lower extremity. R3's right lower leg was rotated outward, removed show and sock, and stabilized the leg. R3 had pain to inner and outer ankle with light touch. The resident able to wiggle toes, unable to rotate leg. R3 stated she was driving her chair, it was on low inside speed, and drove into the door in the hallway.
Immediate Action: assessed resident, right lower extremity rotated outward and unable to rotate. Vitals taken and order received to transfer the resident to the hospital for possible fracture.
Injuries Observed at Time of Incident: unable to determine, right outer ankle.
Level of Consciousness: alert
Mobility: wheelchair bound

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Mental status: not documentation
No injuries Observed Post Incident.
Predisposing Environmental Factors: no documentation.
Predisposing Physiological Factors: no documentation.
Predisposing Situation Factors: no documentation, blank.
Other information: resident driving wheelchair and ran into the hallway door, causing twisting of right lower extremity.
No witnesses found.
Family member and physician notified.
Notes: 5/30/24: resident transferred to hospital per provider orders and x-ray revealed right tibial spiral fracture. R3 admitted to the hospital related to pain control and physical therapy to return to baseline. 6/3/24: R3 returned from the hospital via stretcher for pain management. Therapy provided a tilt manual wheelchair for safety and electric wheelchair sent to be fixed for resident safety.
Document identified as "Privileged and Confidential, not part of the Medical Record."

The medical record for R3 lacked documentation of the incident that occurred on 5/29/24, and/or transfer to the hospital, that resulted in a spiral fracture of the right lower leg.

During a concurrent interview and record review on 6/26/24 at 12:39 PM, Registered Nurse (RN) 3 stated when residents were transferred to the hospital an electronic transfer form was completed in the residents electronic medical record (EMR). RN3 stated the form included the name of the nurse that report would have been given to at the hospital. While reviewing R3's EMR, RN3 confirmed R3's EMR did not have a

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F 842	Continued From page 117 transfer form completed on 5/29/24 and confirmed there was no documentation in the resident's progress notes regarding the transfer to the hospital and/or the incident that occurred. During an interview on 6/26/24 at 4:00 PM, RN2 stated when resident's were transferred to the hospital an electronic transfer form was completed in the resident's EMR. RN2 stated documentation of the transfer would be included in the progress notes. During a concurrent interview and record review on 6/27/24 at 9:15 AM, the Director of Nursing (DON) reviewed R3's progress notes and confirmed the incident from 5/29/24 was not included. The DON confirmed the facilities incident report dated 5/29/24 for R3, was not part of R3's medical record. The DON stated she expected documentation to be in R3's progress notes of the incident that occurred on 5/29/24.	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	F 849		

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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 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

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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 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.

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F 849	Continued From page 120 §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 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.	F 849		

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F 849	Continued From page 121 (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, 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 interview and record review, the facility failed to ensure the designated interdisciplinary (IDT) team member obtained hospice documentation that reflected the cares provided by hospice staff for 1 of 1 resident (R) reviewed for hospice (R27). Specifically, hospice services were not thoroughly coordinated. This failure created the potential for end of life issues to remain unaddressed for R27. Findings include: Review of facility policy, Hospice Program Policy, dated April 2024, read in pertinent part,	F 849		

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- "Hospice services are available to residents at the end of life;"
- "Our facility has designated the Director of Nursing and or Assistant Director of Nursing to coordinate care provided to the resident by our facility staff and the hospice staff ... He or she is responsible for the following ...
- d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident; (2) Hospice election form; (3) Physician certification and recertification of the terminal illness specific to each resident; (4) Names and contact information for hospice personnel involved in hospice care of each resident; (5) instructions on how to access the hospice's 24-hour on-call system; (6) Hospice medication information specific to each resident; (7) Hospice physician and attending physician (if any) orders specific to each resident."

Review of R27's Admission Record, indicated the resident was admitted to the facility on 3/28/19 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, and mild cognitive impairment. The record indicated the resident was receiving hospice services.

Review of R27's Quarterly Minimum Data Set (MDS - federally mandated assessment, with an Assessment Reference Date (ARD) of 4/4/24, indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was receiving hospice services.

Review of R27's Order Summary Report, indicated orders for the resident to receive hospice services while residing in the facility.

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F 849	Continued From page 123 Review of R27's Terminal Illness/Hospice Care Plan, dated 5/20/24, indicated R27 was receiving hospice services related to his terminal illness end-stage heart failure. The "Care Plan" indicated the resident's comfort was to be maintained per management of his terminal illness by hospice and facility staff. The Care Plan indicated R27 was to be seen by the hospice nurse at least weekly, and by a hospice aide at least twice per week to provide care and service in the facility. Review of R27's comprehensive record revealed no hospice documentation in the resident's record to show services had been provided between 1/19/24 and 4/17/24. In addition, the resident's record revealed inconsistent documentation to show the resident was visited by the hospice nurse and the hospice aide between 6/01/24 and 6/28/24 (only three hospice aide visits documents and one hospice nurse visit document were uploaded into the Electronic Medical Record (EMR) during that time). During an interview on 6/26/24 at 12:45 PM, Registered Nurse (RN) 4 indicated she was R27's nurse and was familiar with the resident. She stated hospice documentation was not kept in a binder at the nurse's station, but rather it was uploaded into each resident's EMR under the Miscellaneous tab. During an interview on 06/27/24 at 10:25 AM, the Director of Nursing (DON) confirmed the above hospice documentation had never been received by the facility and stated she would have medical records staff attempt to obtain the missing documentation.	F 849		

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F 849	Continued From page 124 During a follow-up interview on 06/28/24 at 10:15 AM, the DON confirmed her expectation was that all hospice documentation was included in each resident's record timely to facilitate coordination of care. She stated R27's hospice provider had been asked to transmit all documentation at least weekly moving forward.	F 849		
F 880 SS=F	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	F 880		

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infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
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 observation, interview and record review, the facility failed to maintain an infection

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control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections.

Specifically, the facility failed to:
1. Implement Enhanced Barrier Precautions (EBP) throughout the facility.
2. Document a Water Management Program which included an assessment of where waterborne pathogens could grow and spread in the facility.
3. Ensure staff disposed of soiled personal protective equipment (PPE) to avoid cross-contamination (1 of 3 observations).
4. Ensure staff used gloves and performed hand hygiene according to policy during resident cares (1 of 2 observations).

Findings include:

Review of facility policy, Infection Prevention and Control Program, last revised October 2024 [sic], revealed in pertinent part that infection prevention includes "educating staff and ensuring that they adhere to proper techniques and procedures ... following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).

Review of professional reference from the Centers of Disease Control and Prevention (CDC), Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 7/2/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html, revealed in pertinent part,
- "Enhanced Barrier Precautions (EBP) are an

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infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities ... EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: 1. Wounds or indwelling medical devices, regardless of MDRO colonization status 2. Infection or colonization with an MDRO ... Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care."

1. During the initial facility tour of the facility on 6/24/24, starting at approximately 11:30 AM, there were no resident rooms that indicated the use of enhanced barrier precautions, either through signage or PPE supplies. However, review of the facility matrix provided by the facility on 6/24/24, revealed there were eight residents with an indwelling catheter, one resident with a stage four pressure ulcer, and two residents with intravenous therapy.

During an interview on 6/24/24 at 11:37 AM, R40 stated he was receiving daily wound care for pressure ulcers and pointed to the wound care supplies, gowns, gloves, and masks that were in his room, just inside the door. There was no visible indication to communicate to staff or visitors when EBPs were to be performed.

Review of R40's Electronic Medical Record (EMR) revealed in R40's Care Plan that R40 required EBP as part of wound management.

During a subsequent facility tour on 6/26/24 at 8:00 AM, EBP signage and PPE carts were

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implemented throughout the facility.

During an interview on 6/27/24 at 8:51 AM, Registered Nurse (RN) 4 stated she received training on EBP on 6/26/24. RN4 stated if staff had questions about EBPs they were to ask the Director of Nursing (DON), the Infection Preventionist (IP) or the Administrator.

Review of the Infection Control Binder provided by the Infection Preventionist (IP) on 6/27/24, revealed Infection Prevention and Control Committee Minutes, dated 4/18/24, documented EBP was a new protocol and that training would be implemented on 4/25/24.

During an interview on 6/27/24 starting at 1:28 PM, the IP stated the facility found out about the EBP requirement in April and they had started the EBP training, but they never finished the implementation. The IP stated staff were trained on EBP starting 6/26/24.

During staff interviews on 6/28/24 between 7:30 AM and 8:30 AM, Nurse Aide (NA) 15, Housekeeper 1 (H1), the Physical Therapy Assistant (PTA), NA1, NA3, Licensed Practical Nurse (LPN) 1, the Minimum Data Set (MDS) Coordinator and the Dietary Supervisor stated they were trained this week of EBP. However, staff were still not sure if the EBP applied to one or both residents in the room where there was signage.

2. On 6/27/24 at 3:42 PM, the Administrator provided the CDC's Developing a Water Management Program industry guide and stated the facility used this guide and would follow it. Review of the guide included the inclusion of a

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description and flow diagram of the building water system and devices to identify where Legionella could grow and spread.

During an interview on 6/27/24 at 10:06 AM, the Maintenance Supervisor stated he was new in his position and would ask his supervisor about the water management program documentation.

During an interview on 6/27/24 starting at 1:28 PM, the IP stated she was not responsible for the water management program.

During a subsequent interview and record review on 6/27/24 at 2:01 PM, the Maintenance Supervisor provided the following water management documentation:
- Legionella Surveillance and Detection procedures which provided information about what to do for a resident that contracts pneumonia from Legionella bacteria. It did not include a policy or procedure for the water management program.
- monthly water temperatures audits throughout the building showing a range of temperatures between 110 and 120.
- results from a third-party vendor that took water cultures in 2023. The results showed no evidence of legionnaires in the facility areas that were tested.

The Maintenance Supervisor stated he would notify his supervisor and the Administrator if the water cultures had any water-borne pathogens that required mitigation. He also stated that water temperatures under 110 degrees could encourage bacteria growth. The Maintenance Supervisor stated he would try to locate the 2024 water cultures, the facility assessment for the

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building's water system and any additional legionnaire policies.

During an interview on 6/27/24 at 3:25 PM, the DON stated she might have documentation related to the water management but that she was not responsible for the program.

During an interview on 6/27/24 at 3:26 PM, the Maintenance Supervisor stated he did not have any more documentation and stated, "We'll have to get a company to help with that [conducting an assessment]."

3. During an observation on 6/27/24 at 10:05 AM, NA8 was observed exiting room 11 holding a soiled gown and walking from room 11 down the hall towards the nursing station. The gown was not contained in a bag.

During an interview on 6/27/24 at 10:10 AM, NA8 stated she exited the room with a used colostomy bag and covered it with the gown. "I didn't want the room to small. I didn't know I should not walk in the hallway with a dirty gown." NA8 stated that normally, if it was just the gown and gloves, she would discard the PPE in the resident's room before exiting.

During an interview on 6/27/24 starting at 1:28 PM, the IP stated the NA should have bagged the gown and colostomy bag if she was going to remove them from the room. The IP stated staff have been confused about the difference between using red bins and regular garbage bins for PPE disposal.

4. Review of R52's Quarterly Minimum Data Set (MDS, federally mandated assessment) with an assessment reference date (ARD) of 5/24/24,

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revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS)score of 9 out of 15. The MDS coded the resident as requiring extensive physical assistance of 1-2+ staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS identified the resident always being incontinent of bowel and bladder. The MDS listed diagnoses of hypertension, obstructive uropathy (condition where flow of urine was blocked), non-Alzheimer's dementia, and bipolar disorder.

Review of R52's Care Plan for R52, revised 12/21/22, identified the resident had an ADL (activities of daily living) self-care performance deficit related to fracture of right femur without routine healing.

During an observation on 6/26/24 at 9:52 AM, Nurse Aide (NA) 5 and NA2 donned (put on) gown and gloves and entered R52's room to perform personal care. NA5 removed the front of the brief and cleansed R52. NA5 and NA2 assisted R52 to roll over and NA5 cleansed the resident in a circular, scrubbing, motion on the buttocks. NA5 did not change gloves and/or perform hand hygiene before the new brief was placed or before reaching into the top drawer of the cupboard looking for barrier cream. NA2 provided barrier cream and NA5 proceeded to apply barrier cream to R52's bottom with the same gloves used to clean the resident. NA2 then removed the soiled brief and disposable chuck, placing it in the garbage. Both NA5 and NA2 proceeded to pull up the resident's covers with the same dirty gloves. NA2 and NA5 failed to change gloves and/or perform hand hygiene from dirty to clean throughout the process of providing

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F 880	Continued From page 132 care for the resident. During an interview on 6/27/24 at 9:15 AM, the Director of Nursing (DON) stated she expected the NA's to change gloves and perform hand hygiene when moving from dirty to clean tasks. The DON stated the NA's recently had education regarding cares and infection control.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure clinical staff followed antibiotic initiation protocols for 1 of 2 residents (R) reviewed for antibiotic use (R21). Specifically, R21 was ordered and administered antibiotics prior to meeting McGeer's criteria for an urinary tract infection (UTI); and the facility failed to obtain a second urinalysis (UA) after the lab communicated the first UA had been contaminated. This failure increased the potential for antibiotic resistance, making it more difficult to treat future bacterial infections. Findings include: Review of facility policy, Antibiotic Stewardship	F 881		

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Policy, dated June 2024, revealed in pertinent part, "Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program;" and "11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued."

Review of R21's Admission Record revealed R27 was admitted to the facility on 4/20/21. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes, resistance to multiple antimicrobial drugs and chronic kidney disease.

Review of R21's Quarterly Minimum Data Set (MDS - federally mandated assessment), with an assessment reference date (ARD) of 4/29/24, revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 out of 15.

Review of R21's Progress Notes, dated:
- 5/12/24 at 10:50 AM, read, in pertinent part, "UA [urinalysis] sent to (lab) per order."
- 5/12/24 at 12:14 PM, read "'Urinalysis' results were reported to [Nurse Practitioner (NP)], PO [oral] Macrobid [antibiotic] 100 mg [milligrams] x [times] 7 days while we wait for the sensitivities, order in placed, first dose was administered at 12:15 (PM)."
- 5/13/24 at 9:50 PM, read in pertinent part, "Resident on PO ABX [antibiotics] for presumptive Dx [diagnosis] of UTI [urinary tract infection], pending C&S [culture and sensitivity] results. [R21] denies dysuria [discomfort when

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urinating] or any other complaint at this time."

- 5/14/24 9:40 AM, read "Continues on Macrobid for UTI no c/o [complaints of] pain or burning with urination, having some loose stool with no other problems. "
- 5/16/24 at 10:18 AM, read "Final results of urine collected on 5/12 received and reviewed by NP. NNO [No new orders]."
- 5/17/24 through 5/19/24, revealed R21 was administered the remaining seven-day course of his antibiotics with no antibiotic side effects and no signs or symptoms of UTI.

Review of R21's Urinalysis (UA) and Culture and Sensitivity (C&S) results, dated collected 5/12/24, resulted on 5/15/24, and initialed as reviewed by the resident's provider on 5/16/24, indicated results of four colony types of mixed gram-positive and gram-negative organisms. The result indicated, "Mixed microbiota [microorganisms] consistent with contamination during collection. Please recollect specimen using appropriate collection methods if clinically indicated."

Review of R21's Infection Surveillance Form, dated 5/13/24, followed McGeer's Criteria for the diagnosis and treatment of UTI. The Form indicated the criteria required antibiotic use for a UTI: "Both criteria 1a and 1b must be present for residents WITHOUT an indwelling catheter:
- 1a. At least 1 of the following sign or symptom sub-criteria: a. Acute dysuria or acute pain, swelling or tenderness of the testes, epididymis [inflammation of the back of the testicles], or prostate; b. Fever or leukocytosis (See Constitutional Criteria in Residents of Long-Term Care Facilities) and at least 1 of the following

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urinary tract sub-criteria: i. Acute costovertebral angle [lower back] pain or tenderness ii. Suprapubic [bladder] pain iii. Gross hematuria [blood in urine] iv. New or marked increase in incontinence v. New or marked increase in urgency vi. New or marked increase in frequency; c. In the absence of fever or leukocytosis [high white blood cell count], then 2 or more of the following localizing urinary tract sub-criteria: i. suprapubic pain ii. Gross hematuria iii. New or marked increase in incontinence iv. New or marked increase in urgency v. New or marked increase in frequency;"
- "1b. One of the following microbiologic sub-criteria: a. At least 10 5 cfu/mL [colony forming unit per milliliter] of no more than 2 species of microorganisms in a voided urine sample or b. At least 10 2 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter."

R21's form incorrectly indicated the resident met criteria for 1a and 1b based on the resident's symptoms and results of the urinalysis.

Review of R21's Acute Infection Care Plan, dated 5/13/24, indicated R21 was on antibiotics for a current acute infection related to an abnormal urinalysis result. The Care Plan indicated the resident was on Macrobid for seven days and indicated laboratory tests were to be completed, as ordered, and reports of results were to be communicated to the resident's physician.

Review of R21's Medication Administration Record (MAR), dated 5/1/24 through 5/30/24, indicated R21 was administered the full seven-day course of his antibiotics (Macrobid) from 5/12/24 through 5/19/24.

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F 881	Continued From page 136 There was no evidence found in R21's record to indicate R21 ever had any symptoms of a UTI between 5/11/24 and 5/22/24, except for the potential blood on his brief reported by the resident on 5/11/24. During an interview on 6/27/24 at 10:30 AM, the Director of Nursing (DON) confirmed the facility followed the McGeer's Criteria for diagnosis and treatment of infection. The DON confirmed the criteria for had not been met for R21 for a diagnosis of UTI. The DON stated that staff reported R21 had been having blood on his incontinence pad, as well as pain related to his potential UTI (which was never documented in the resident's record) and stated she was not aware McGeer's Criteria was not met when the UA results showed four or more mixed colonies of bacteria indicating a contaminated urine specimen for R21. The DON confirmed the facility had failed to repeat the UA and C&S when the C&S indicated the results were contaminated. The DON stated, "They (staff) should have re-done the UA and C&S based on the results of the C&S."	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		

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F 883	Continued From page 137 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure a resident and/or representative received education regarding the benefits and side effects of pneumococcal immunization prior to administration (R3) and failed to administer a pneumococcal vaccine after informed consent was obtained (R21) for 2 of 5 residents reviewed for immunization.

Findings include:

Review of facility policy, Infection Prevention and Control Program, last revised October 2024 [sic], revealed in pertinent part that policies and procedures for immunization include obtaining proxy consent and process for administering the vaccines.

1. Review or R3's immunization record revealed on 11/10/23, the resident received Prevnar 20. However, there was no documentation that R3's power of attorney (POA) had provided informed consent.

During an interview on 6/27/24 at 9:43 AM, the Infection Preventionist (IP) stated she would have obtained verbal informed consent from the POA and should have documented this in the progress notes. The IP stated she would look for the informed consent but that she probably did not have evidence of speaking with the POA.

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During an interview on 6/27/24 at 1:27 PM, the IP stated that going forward, consent conversations will be documented in the medical record.

2. Review of professional reference from the Centers of Disease Control and Prevention (CDC), Pneumococcal Vaccine Timing for Adults, retrieved on 7/2/24 from https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf, revealed in pertinent part, that an adult 65 or older, would have a complete pneumococcal vaccine series with either one dose of Prevnar 20; or a combination of two different types of Prevnar (13, 15 or 20) and/or Pneumovax (PPSV23) based on the resident's previous vaccination history and age.

Review of R21's immunization record revealed R21 was over 65 years old and had received one pneumococcal vaccination on 11/1/18. Based on the CDC vaccine schedule, R21 was eligible to receive a second pneumococcal vaccination to complete the series, unless medically contraindicated. Review of R21's Immunization Consent, dated 2/5/24, revealed R21 consented to receiving the pneumococcal vaccine. A second Immunization Consent, dated 2/22/24, revealed R21 received information about the risks and benefits of the vaccine. However, there was no evidence that in the last four months, R21 had been administered the vaccine or that it was contraindicated.

During an interview on 6/27/24 at 9:43 AM, the IP stated she would see if R21's insurance provider had administered the vaccine.

During an interview on 6/27/24 at 1:25 PM, the IP

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F 883	Continued From page 140 stated they requested an updated immunization record from the insurance provider. During an interview on 6/27/24 2:57 PM, the IP stated the insurance provider had no record of R21 receiving the second pneumococcal vaccine. The IP stated she would get an order and that they should have provided the vaccine when he consented.	F 883		
F 941 SS=D	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 5 staff members reviewed for training completed effective communication training (Registered Nurse (RN) 2, Licensed Practical Nurse (LPN) 2 and Nurse Aide (NA) 14. Findings include: During an interview on 6/26/24 at 8:04 AM, NA5 stated that there was no online training. NA5 stated that training was done during staff meetings, and there was a sign-in sheet. NA5 stated that infection control training (IC) was conducted during last month's meeting. During an interview on 6/26/24 at 8:37 AM, NA1 stated that training was conducted one to two times a month during the staff meetings. NA1 stated that the NAs have huddles three times a week to discuss IC changes.	F 941		

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F 941	Continued From page 141 During an interview on 6/26/24 at 11:44 AM, RN4 stated that training was conducted monthly during the staff meetings and on a one-on-one basis. On 6/27/24, review of the initial training documents provided revealed that the staff had not received communication training. On 6/28/24 at 8:47 AM, the Administrator stated that he would have the Director of Nursing (DON) look for documentation showing that staff received communication training. On 6/28/24 at 1005, the Administrator provided documentation showing that communication had been conducted. However, RN2, LPN2 and NA14 were not listed on the sign-in sheet indicating that they had attended.	F 941		

Plan of Correction
Mt Olympus Health & Rehab
June 6, 2024

Administrator Signature:  **Date: 7/26/24**

F-554 Resident Self-Admin Meds-Clinically Appropriate

Corrective action

Resident # 21 self-administration safety screen completed for resident's request to keep and administer his saline nasal spray and rescue inhaler at bedside. Resident was deemed safe to self-manage these (2) medications following the assessment completed by Nursing. Order was implemented and updated CarePlan.
Resident # 51 Resident was offered to participate in self-administration safety screen by shift nurse on 7/17/24 to keep meds at bedside, and he declined.
Resident # 63 Resident was offered to participate in self-administration safety screen by shift nurse on 7/17/24 to keep meds at bedside, and he declined.

Identification of others

The Director of Nursing/designee completed facility observational audit of resident room for medications at bedside. Any concerns were followed up on by following facility policy on self-administration.

Systemic Changes

The Director of Nursing/designee educated licensed nurses on self-administration policy and assessment necessary for residents to be deemed able to safely administer their own medications.

Ongoing monitoring

The Director of Nursing/designee to perform weekly focused observational audit of resident rooms to ensure no medications at bedside without proper assessment to validate residents are safe to maintain medications at bedside and self-administration assessment and care plans are up to date.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-578 Request/Refuse/Discontinue Treatment; Formulate Adv Di

Corrective action

Resident # 2 Resident Advocate assisted resident to complete POLST form with appropriate signature and was uploaded into resident medical chart.
Resident # 12 Resident Advocate followed up with family for POA documentation and it was identified they do not have legal POA at this time. POLST was completed with resident and uploaded into residents' medical chart.

Resident # 30 Resident advocate established contact with public guardian office and was notified of a new guardian being assigned to residents' case, updated guardian information in resident chart and requested a visit from her to sign documents.

Identification of others
The Director of Nursing/designee completed facility audit of residents residing in facility for completed advance directives to ensure appropriate signatures. Any concerns were addressed.

Systemic changes
Corporate LCSW/designee to provide education to Director of Nursing, Assistant Director of Nursing and Resident Advocate on requirement of completion of advance directives upon admission or with change of condition, education also to include; when residents who are incapacitated or cognitively unable to understand the advance directive options at time of admission then family representative or legal guardian to be contacted for completion and signage of form.

Ongoing monitoring
The Director of Nursing/designee to complete weekly focused audit of new admission advance directives, POLST for appropriate signatures and timely completion.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-600 Abuse

Corrective action
Resident # 27 was assessed by the facility consultant LCSW on 7/22/24 to assess for any unaddressed psychosocial concerns. Any concerns were addressed.

Identification of others
Administrator/Designee will have IDT complete Angel room rounds. Any concerns identified during the interviews will be addressed immediately by administrator (Abuse Coordinator).

Systemic Changes
Abuse Policy was reviewed by Administrator and Regional Vice President (RVP) and updated as indicated.
Education was initiated by the Administrator to the facility staff regarding the abuse policy including reporting allegations of abuse, reporting allegations of abuse to the proper authorities, and conducting thorough investigations. Thorough investigations to include immediate protection of the residents, interviewing the alleged victim, alleged assailant, any witness, other residents who could potentially be affected by the alleged violation, family/visitors if there are any who may have pertinent information, assessing the alleged victim, conducting observations of cares if pertinent, conducting searches if necessary, and implementing pertinent interventions to attempt to prevent recurrence.
Administrator will utilize abuse checklist to ensure all steps of abuse reporting and investigation were followed and completed.

Monitoring/QAPI

The Director of Nursing/designee to complete focused audit daily through review of 24hour report, grievances, and Risk Managment (Monday-Friday) to validate that any allegations of abuse are being reported per facility policy and that allegations of abuse are thoroughly investigated.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-623 Notice Requirements Before Transfer/Discharge

Corrective action
Resident # 4 Ombudsman was notified by Resident advocate of acute hospital stay that started on 2/25/24.

Resident # 46 Ombudsman was notified by Resident advocate on 7/18/2024 of hospital stays occurring on 12/2/2023-12/9/2023 AND 3/23/2024-3/26/2024.

Resident # 121 Ombudsman was notified by Resident Advocate on 7/18/2024 of discharge that occurred on 10/5/2023.

Identification of others
The Administrator/Designee to review all discharges from the past 30 days to ensure discharged residents were reported to the ombudsman.

Systemic Changes
Regional Nurse/designee provided education to the Resident Advocate regarding the discharge process and need to notify Ombudsmen.

Monitoring/QAPI
The Administrator/Director of Nursing will review all discharges weekly to ensure proper documentation and reporting of all discharges.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-625 Notice of Bed Hold Policy Before/Upon Transfer

Corrective action
Resident # 3 was provided the facility bed hold policy and obtained signature on 7/18/24.
Resident # 4 was provided the facility bed hold policy and obtained signature on 7/18/24.
Resident # 46 was provided the facility bed hold policy and obtained signature on 7/18/24.
Resident # 48 was provided the facility bed hold policy and obtained signature on 7/18/24.

Identification of others
DON/Designee to audit discharges in the last 7 days to validate resident received bed hold policy.

Systemic Changes
The Director of Nursing/designee will provide education to Resident advocate and floor nurses on policy of bed hold notification; Bed hold policy will be provided to resident upon admission to facility and with acute transfer. Education to include documenting the discharge details and the bed hold policy provided upon being sent out. The bed hold notice will be kept at nurses' station for resident or representative when sending out to hospital.

Monitoring/QAPI
The Administrator/Director of Nursing will review all discharges weekly to ensure proper bed hold policy was provided to residents upon acute transfer from facility.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-656 Develop/Implement Comprehensive Care Plan

Corrective action
Resident # 2 Care plan reviewed and updated with psychotropic medication, specific behaviors and specialized services.

Identification of others
The Director of Nursing/designee will audit the facilities care plans to check for appropriate care planning of behaviors and PASRR recommendations.

Systemic Changes
The Director of Clinical Reimbursement/designee will educate MDS coordinator regarding development and accuracy of comprehensive care plans.
Regional Nurse Consultant/Designee will provide education to IDT team on care planning of behaviors identified and PASRR recommendations.
The Director of Nursing/designee will utilize 24hour report review (M-F) in morning clinical meetings and care plan according to documented behaviors, psychotropic medications, PASRR recommendations.

Monitoring/QAPI
The Director of Nursing/designee will perform a weekly focused audit weekly for residents due for quarterly review of comprehensive care plans to include PASRR recommendations and behaviors with appropriate interventions.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-657 Care Plan Timing and Revision

Corrective action

Resident # 6 Resident attended Care Conference with IDT team on 6/27/24, discussed resident's plan of care and any concerns were addressed.

Identification of others
The Director of Nursing/designee conducted and audit of IDT Care Conferences by reviewing residents' charts for the last 14 days to validate they were held per facility protocol. Any concerns identified were addressed.

Systemic Changes
The Administrator/designee provided education to the interdisciplinary team on the requirement for departments to hold care conferences per facility protocol.

A Tracking form has been implemented for Resident Advocate to ensure care conferences are occurring on admit, quarterly and as needed.

Monitoring/QAPI
The Director of Nursing/designee will perform a weekly focused audit to ensure care conferences were offered and provided per policy.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-659- Qualified Persons

Corrective Action

Resident # 168 – Resident has been assessed by Director of Nursing and any concerns were addressed.

Identification of others

The Director of Nursing/designee will audit employed LPNs at the facility for qualifications and certifications necessary for IV medication administration.

Systemic Changes

The Director of Nursing/designee will educate all LPN about qualifications required for administration of IV medication or cares. The Director of Nursing/designee will coordinate IV certification class for LPNs that work in facility.

Monitoring/QAPI

The Director of Nursing/designee will complete focused audit weekly on any newly hired nurses to verify licensure status and any certifications regarding IV administration.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-661- Discharge Summary

Corrective Action

Resident # 65 Discharge summary was completed and entered in resident chart 7/18/24
Resident # 117 Discharge summary was completed and entered in resident chart 7/18/24
Resident #118 Discharge summary was completed and entered in resident chart 7/18/24
Resident # 120 Discharge summary was completed and entered in resident chart 7/18/24
Resident # 125 Discharge summary was completed and entered in resident chart 7/18/24

Identification of others

The Director of Nursing/designee reviewed discharges in the last 7 days to validate that required paperwork was provided and resident information was communicated to new provider/facility, and documentation reflects what paperwork was sent.

Systemic Changes

The Regional Nurse Consultant/designee provided training to the Interdisciplinary Team on documentation requirements per facility policy. IDT will complete the discharge summary assessment to ensure that all relevant information is captured in summary.

Monitoring/QAPI

The Director of Nursing/designee will conduct a focused weekly audit of the discharge planning process weekly to validate that the IDT has met, required paperwork/documentation has been completed, reviewed and sent with the resident as well as appropriate coordination of discharge plan and notification to resident/representative has been documented.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-676- Activities of Daily Living (ADLs)/ Maintain Abilities

Corrective Action

Resident # 1 was provided a walled plate during meals and DON/Designee educated nursing staff on proper positioning during meals time. Care plan was updated.

Identification of others

The Director of Nursing/designee conducted observational rounds and interviews to validate that residents who required positioning during mealtime were assisted to position safely and correctly. An audit was conducted to

validate adaptive eating devices are in place. Any concerns identified were corrected and care plans revised as needed.

Systemic Changes

The Director of Nursing/designee provided education to the nursing staff on the requirement to provide safe and appropriate positioning for safe oral intake during meals times.

Monitoring/QAPI

The Director of Nursing/designee will conduct observational rounds, resident interviews three (3) times weekly to ensure residents requiring specific positioning and any adaptive eating equipment during oral intake are receiving this assistance.
These audits to continue three times weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate.

F-684- Quality of Care

Corrective Action

Resident #46 Referral appointment was made for neurology for November 12, 2024. Resident notified.

Identification of others

The Director of Nursing /designee conducted a focused audit on all residents from the past 14 days for follow up appointments. Including; admit

Systemic Changes

The Administrator/designee will provide education to transportation staff to ensure all follow-up appointments are arranged and coordinated with clinical management. If the provider doesn't accept resident insurance facility will arrange appointment with a provider who does.

Monitoring/QAPI

The Director of Nursing/designee through review of new orders and admission orders, will audit weekly for any follow up appointments to ensure they were arranged promptly by transportation and added to transport calendar and coordinated with clinical staff.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.

F-689- Free of Accident Hazards/Supervision/Devices

Corrective Action

Resident # 27 Wander risk assessment and Safe smoking evaluation completed. Care plan updated.
Resident # 118 No longer resides in the facility
Resident # 120 No longer resides in the facility
Resident # 121 No longer resides in the facility
Resident # 125 No longer resides in the facility
Resident # 127 No longer resides in the facility
Resident # 11 No longer resides in the facility

Identification of others

The Director of Nursing/designee completed updated wander risk assessments on all residents residing in facility and updated care plan with custom interventions. Any concerns were immediately corrected.

The Director of Nursing/designee completed audit of Residents who reside in facility that smoke cigarettes for current and accurate smoking assessment, smoking binder and current care planning of smoking needs.

Systemic Changes

The Regional Nurse Consultant/designee provided education to IDT team including Administrator, Director of Nursing, Resident advocate, that When alert & oriented residents are noncompliant with the sign-out procedures, the Administrator/Designee to contact the State Ombudsman to provide additional communication with the resident. If resident continues with non-compliance, the facility will attempt to find appropriate discharge location.

The Director of Nursing/designee provided education to all staff on LOA protocol, elopement protocol, wandering assessments, care planning of interventions and Elopement binders.

The Director of Nursing/designee to maintain elopement binders at each nurse's station and at front reception desk with updated wander/elopement risk residents.

The IDT team will hold a weekly Elopement Prevention Meeting to verify that new admissions or residents with change of condition have been screened for wander/elopement risk, and that residents identified at risk with score of 9 or above have been placed in the Elopement Book.

The administrator/designee will ensure that smoking assessments are completed upon admission and added to the smoking binder for identification of assisted vs independent smokers and that care plan is reflecting resident needs.

Monitoring/QAPI

The Director of Nursing/designee to complete weekly focused audit of LOA binder to verify leave of absence protocol is followed by residents, Elopement binder is up to date with newly identified residents at risk and care plan interventions are appropriate.

The Administrator/designee to complete weekly focused audit of smoking area for Resident understanding and compliance. In addition will audit to verify that smoking list and resident care plans have been updated to reflect new admission smoking needs.

The Regional Nurse Consultant to round weekly in the facility at random to spot check facility employee knowledge, compliance with care planning, and knowledge of elopement policy & procedure. After the facility is determined to be in full compliance with F689, this rounding to be conducted monthly x 3 months.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated. The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.

F-700-Bedrails

Corrective Action

Resident # 12 Entrapment/restraint assessment was completed, Risk v benefits discussed with resident, and consent obtained 7/17/24, care plan updated to reflect needs.

Resident # 15 Entrapment/restraint assessment was completed, Risk v benefits discussed with resident, and consent obtained 7/17/24, care plan updated to reflect needs.

Resident # 19 Entrapment/restraint assessment was completed, Risk v benefits discussed with resident, and consent obtained 7/17/24, care plan updated to reflect needs.

Resident # 27 Entrapment/restraint assessment was completed, Risk v benefits discussed with resident, and consent obtained 7/17/24, care plan updated to reflect needs.

Identification of others

The Director of Nursing/designee to perform audit of all residents in facility with bedrails in place. Audit includes completed NSG: Entrapment/Restraints Evaluation, consent for use is received (with education on risk vs benefit of use) by Resident or POA and care plan is accurate with implemented adaptive equipment. Any concerns identified were corrected.

Systemic Changes

The Regional Nurse Consultant/designee to provide education to IDT team regarding policy for bedrail use including assessment, Resident/POA consent with risk vs benefits, care planning.

The Director of Nursing/designee to audit all new admission orders utilizing 48hour chart check to verify that residents who qualify or request use of bedrail have been assessed for safety using entrapment/restraint evaluation, consent and education has been provided to Resident and or POA and care plan is appropriate for use.

Monitoring/QAPI

The Director of Nursing/designee will complete focused audit weekly of admissions to ensure process of bedrail use was followed. Including assessment, education, consent and applicable care planning.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.

F-730- Nurse Aide Perform Review – 12Hr/Year In- service

Corrective Action

NA # 1 Nurse aide Performance evaluation was completed by Director of Nursing on 7/16/24

NA# 13 Nurse aide Performance evaluation was completed by Director of Nursing on 11/16/23

NA# 14 Nurse aide Performance evaluation was completed by Director of Nursing on 6/21/24

Identification of others

The Director of Nursing/designee will complete an audit of current aides for compliance with performance evaluations and education in accordance with regulation F-730. Any concerns identified were corrected.

Systemic Changes

The Director of nursing/designee will coordinate monthly review with HR for aides who are due for their annual performance review and associated education.

The Director of Nursing/designee will complete Performance evaluation of identified aides due for performance evaluations.

Monitoring/QAPI

The Administrator/designee to conduct weekly focused audit weekly of aides due for annual performance evaluations and associated education.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.

F-759-Free of Medication Error Rates of 5% or More

Corrective Action

Resident # 10 – Director of Nursing completed audit of Residents blood sugar results for last 30 days. Resident remained at baseline. No concerns were identified. Direct education was provided to floor nurses including a review of her insulin orders and education on priming insulin pen to ensure accuracy of insulin administration.

Resident # 43 – Resident was assessed by Director of Nursing and has no concerns related to receiving enteric coated aspirin instead of chewable aspirin. Direct education was provided to floor nurses to use five rights when administering medications for accuracy.

Identification of others

DON/Designee to audit current residents who receive insulin via insulin pen and for all Residents who have chewable aspirin ordered.

Systemic Changes

Director of Nursing/designee to provide education to licensed nurses regarding proper techniques to use of insulin multidose vial pen. Education included priming the insulin pen as follows: dial up 1 to 2 units. Press the injection button to let out any air bubbles (called "priming"). If you see a small drop of insulin, come out the tip of the pen, then it is ready for administration. Then Dial up the dose counter to the number of units you'll be injecting.

Director of Nursing/designee to provide education to licensed nurses to follow the 5 rights of medication administration. Specifically ensuring order followed for chewable versus enteric coated medication.

Monitoring/QAPI

Director of Nursing/designee to complete focused observational audit of insulin administration with floor nurses for accuracy of insulin multidose vial pen. Observational audit will also include giving chewable medication versus enteric coated.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated. The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.

F-790 Routine/Emergency Dental Services in SNFs

Corrective Action

Resident # 27 Resident Advocate spoke with resident regarding dental concerns, coordinated dental appointment on 7/12/24 @9am. Resident refused to go to the appointment.

Identification of others

Resident advocate/designee completed an audit of current residents to validate residents have received routine and emergent dental services based on their needs.

Systemic Changes

Director of Nursing/designee provided education to resident advocates regarding dental policy.

Director of Nursing/designee provided education to clinical staff to notify Resident Advocate of any Resident dental concerns observed or reported for appointment follow up.

Monitoring/QAPI

Resident Advocate/Designee to complete weekly focused audit to validate residents attend their routine dental appointments as scheduled.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee bimonthly and as needed until a lesser frequency is deemed necessary.

F-812- Food Procurement, Store/Prepare/Serve - Sanitary

Corrective Action-

We have addressed and corrected all issues that were out of compliance. We have cleaned all food storage areas including the refrigerators and freezers. We have ensured that all food items are now properly covered, labeled, and dated. Additionally, any expired items or items without proper dates have been removed. Nutritional milkshakes served from the kitchen are kept on ice and are replenished to ensure that they are served at an appropriate temperature. Our food service practices now fully adhere to professional standards for food safety.

Identification of others

The Administrator/designee will conduct an audit of the entire kitchen, including dishes, to ensure all areas meet professional sanitation standards. Any concerns will be addressed.

Systemic Changes

Dietitian/designee will provide education to dietary staff regarding sanitation standards. Dietary manager/designee trained CNA Coordinator and Activities on proper storage and labeling of food.
The dietary manager will do weekly audit of resident fridges at nurses' stations and in activity areas.

Monitoring/QAPI

Administrator / designee will audit resident fridges located on the nursing unit and in the activity room and kitchen snacks.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
QAPI - Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

F-842-Resident Records - Identifiable Information

Corrective Action

Resident # 3 Director of nursing completed late entry regarding incident on 5/29/24:

Late Entry: Note Text: Assessed pt to have RLE rotated outward and unable to rotate at all. Pt vitals as follows. 153/76, 99% on 2 L o2, pulse 75, RR 16, Temp 97.5. NP notified with new order to transfer pt to U of U ER for possible fracture. Pt aware and wants to remain in chair and be hoyered to stretcher. Contacted Golds Cross for transfer, contacted sister Carol and notified of pt current condition and plan to xfr to U of U.
Medical Records were requested and obtained from University of Utah hospital and uploaded into residents' medical records.

Identification of others

DON/Designee will audit documentation for residents sent to the hospital in the last 14 days. Re-admit paperwork was received from hospital and uploaded to resident chart.

Systemic Changes

The Director of Nursing /designee has educated licensed nursing staff regarding ensuring that they document on residents being transferred to hospital, including completion of E-Interact assessment and progress note to reflect resident status, interventions implemented and outcomes.

The Administrator/designee has educated medical records ensuring that they upload documents timely in resident chart.

Monitoring/QAPI

The Administrator/designee will conduct weekly focused audit to validate Electronic Health Record documentation is uploaded in accurate charts and timely.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee bimonthly and as needed until a lesser frequency is deemed necessary.

F849-Hospice Services

Corrective Action

Resident # 27 Hospice notes were obtained from Enhabit, A-Plus and Quality Hospice in accordance with their plan of care. All visit notes, changes to plan of care and orders were uploaded into the resident medical chart.

Identification of others

Director of Nursing/Designee will audit current residents on Hospice to ensure medical records are received timely and uploaded to resident medical record. Any coordination of care concerns was addressed.

Systemic Changes

Director of Nursing/Designee and Medical records given education regarding timely coordination between Hospice and facility.

Medical Record to audit resident records weekly to ensure hospice documentation is uploaded to resident records.

Monitoring/QAPI

Administrator/designee to complete weekly focused audit of hospice records to ensure documentation from visits are uploaded to resident records.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated. The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee bimonthly and as needed until a lesser frequency is deemed necessary.

F-880-Infection Control –

Corrective Action

No residents were identified for F880

Identification of others

Director of Nursing/Designee to audit current residents in the facility to ensure enhanced barrier precautions are in place.

Systemic Changes

Director of Nursing to provide education on infection control practices including hand hygiene, appropriate use of PPE, Enhanced barrier precaution protocol.

Director of Nursing/designee to complete enhanced barrier precaution assessment on all new admissions and with new MDRO infections to ensure PPE and signage is available as appropriate.

.**Monitoring/QAPI**

Administrator/designee to complete focused observational rounds three (3) times weekly to monitor for adherence to infection control protocol, Enhanced barrier precautions are followed and appropriate hand hygiene.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated. The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee bimonthly and as needed until a lesser frequency is deemed necessary.

F881 Antibiotic stewardship program

Corrective Action

Resident # 21 Director of Nursing completed assessment of resident and he has no signs/symptoms of Urinary tract infection. Resident just completed abx course for respiratory infection and is stable.

Identification of others

The Director of Nursing/designee conducted an audit on all residents from the past 7days that were prescribed antibiotics to ensure that McGreers criteria was met, and antibiotic stewardship program was followed.

Systemic Changes

The Director of Nursing/Designee provided education to the Infection Preventionist and Physician regarding antibiotic stewardship process and procedure.

Infection Preventionist/Designee will open the Infection Control Surveillance Assessment to ensure proper documentation is in place for new infections and determine if it meets McGreers criteria.

Monitoring/QAPI

Director of Nursing/designee to complete weekly audit of residents prescribed antibiotics to ensure McGreers Criteria is met for antibiotic use.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.

The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee bimonthly and as needed until a lesser frequency is deemed necessary.

F-883- Influenza and Pneumococcal Immunizations

Corrective Action

Resident # 3 Residents Pneumococcal vaccine were audited against CDC recommendations and identified that she is current. Historical Pneumococcal vaccines were updated into medical chart. Obtained signed vaccine consent from resident to reflect consent obtained from CNS pharmacy and administration of Pneumococcal vaccine given at facility 11/10/23, uploaded into resident chart.

Resident # 21 Residents Pneumococcal vaccine were audited against CDC recommendations and identified that she is current. Historical Pneumococcal vaccines were updated into medical chart.

Identification of others

The Director of Nursing/designee reviewed residents who reside at the facility to see that immunizations were offered and consent/refusal and education to resident or representative was charted in resident record. Any concerns identified were corrected.

Systemic Changes

Director of Nursing/designee to obtain immunization records for new admissions and update into resident record to identify which immunizations resident is due for. These immunization consent forms will be available in new admission packets.

Director of Nursing/designee re-educated nursing staff to offer immunizations on admit and when applicable dose is due. Once consent is received, an order will be entered into PCC and immunization is administered with appropriate documentation and follow-up monitoring.

Monitoring/QAPI

The Director of Nursing/designee will audit weekly on new admissions for updated immunization information in chart, immunization consents and administration of immunizations as applicable.
These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.

F-941- Communication Training

Corrective Action

RN#2 Communication training was provided to all staff by the Director of Nursing on 7/17/24-7/23/2024

LPN#2 Communication training was provided to all staff by the Director of Nursing on 7/17/24-7/23/2024

NA#14 Communication training was provided to all staff by the Director of Nursing on 7/17/24-7/23/2024.

Identification of others

All residents who reside in the facility are at risk related to this alleged deficient practice.

Systemic Changes

The Administrator/designee will provide communication training to all staff with expectation to be able to interact and communicate in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in effective communication.

Monthly all staff meetings will be held with an updated training calendar to ensure all mandatory training topics are addressed. New hires will receive communication training at new hire orientation.

Monitoring/QAPI

The Administrator/designee will complete an audit monthly for completion of monthly training in accordance with the training outline. Audit to include attendance verification to ensure all staff members have received training and new hires have been provided with communication training as applicable.

These audits to continue weekly x 8 weeks until QAPI Committee determines a lesser frequency is indicated.
The Administrator/designee will report findings and trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed necessary.