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F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure the residents right to participate in the development and implementation of his or her	F 553	POC approved MP 01/24/2023 Latest correction date 02/03/2023	

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John A. Stephenson	John A. Stephenson, Administrator	16 Jan 2023

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

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F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure the residents right to participate in the development and implementation of his or her	F 553		

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person-centered plan of care. Specifically, for 1 out of 20 sampled residents, a resident that was admitted to the facility on 11/2/22, had not had a care conference and the resident was unsure what the plan of care consisted of. Resident identifier: 16

Findings included:

Resident 16 was admitted to the facility on 11/2/22 with diagnoses which include acute osteomyelitis (left ankle and foot), chronic obstructive pulmonary disease, dementia, major depressive disorder, schizoaffective disorder, post-traumatic stress disorder, generalized anxiety disorder, cellulitis of left lower limb, peripheral vascular disease, chronic systolic heart failure, adult failure to thrive, muscle weakness, essential hypertension, and malignant neoplasm of unspecified part of unspecified bronchus or lung.

On 12/12/22 at 4:17 PM, an interview with resident 16 was conducted. Resident 16 stated that he was upset because he had been a resident at the facility for over a month and he was unsure of what his plan of care consisted of. Resident 16 stated that he did not know why he was at this facility, and that he did not have any meetings with staff concerning his plan of care.

On 12/13/22, resident 16's medical record was reviewed.

It was revealed that multiple sections in resident 16's care plan were incomplete.

a. The first incomplete focus area stated, "The resident has potential/actual impairment to

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skin integrity of the (SPECIFY location) r/t [related to]." The specific location was not filled out and there was no information given about what the impairment was related to. The goal for this care area stated, "The resident's skin injury (SPECIFY) of the (location) will be healed by review date." There was no information given about the specific skin injury or location. The interventions section was left blank.

b. The second incomplete focus area stated, "Resident requires long term care services related to:" There was no further information given. The goal section was left blank. The intervention stated, "Provide Care Conference for residents and families."

c. The third incomplete focus area stated, "The resident has Peripheral Vascular Disease (PVD) r/t". There was no further information given. The goal and the intervention were left blank.

d. The fourth incomplete focus area stated, "The resident has shortness of breath (SOB) r/t." There was no further information given. The goal stated, "The resident will have no complications related to SOB through the review date." The intervention section was left blank.

e. There was no behavioral care plan for resident 16's diagnosis of post-traumatic stress disorder.

f. There was no behavioral care plan for the resident 16's diagnosis of Major Depressive Disorder.

A progress note dated 11/9/22 at 8:57 AM, stated,

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"Care Conference: Attempted to hold care conference for [Resident 16]. He was lying in bed asleep. Asked [resident 16] if he wanted to have conference and he said no. Will attempt at a later day."

A review of resident 16's progress notes revealed there were no further attempts to have a care conference with resident 16.

On 12/14/22 at 2:16 PM, an interview with the Resident Advocate (RA) was conducted. The RA stated that the goal for new residents was to hold a care conference within the first seven days of the resident being at the facility. The RA stated that after the first care conference, the residents would then have a care conference every three months. The RA stated that care conferences were held to go over the residents' goals and their plan of care. The RA stated that she was unaware if resident 16 ever had a care conference. The RA stated that resident 16 did not want to participate in the first scheduled care conference and she did not know if the meeting was rescheduled.

On 12/15/22 at 9:22 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated that she had a one-on-one care conference with resident 16 on 12/5/22. It should be noted that 12/5/22, would have been 24 days after resident 16 was admitted to the facility. The DON stated that she spoke with resident 16 about what cares he wanted and his current goals. The DON stated that she did not know if there was any documentation of the care conference.

A review of resident 16's medical record revealed that there was no documentation of a care

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F 553	Continued From page 4 conference.	F 553		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Minimum Data Set (MDS) assessment did not accurately reflect the resident's status. Specifically, for 2 out of 20 sampled residents, a resident was incorrectly coded as not having a Traumatic Brain Injury (TBI) and a resident was incorrectly coded as being discharged to the hospital. Resident identifiers: 15 and 26 Findings included: 1. Resident 15 was admitted to the facility on 8/11/22 with diagnoses which include displaced trimalleolar fracture of left lower leg, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, essential hypertension, personal history of traumatic brain injury, difficulty in walking, other psychoactive substance abuse, major depressive disorder, mood disorder, and personal history of other venous thrombosis and embolism. Resident 15's admission MDS assessment dated 11/19/22, was marked "No" for resident 15 having a TBI. On 12/13/22 at 2:43 PM, an interview with the Assistant Director of Nursing (ADON) was	F 641		

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F 641	Continued From page 5 conducted. The ADON stated that she was responsible for filling out the resident MDS assessments. The ADON stated that the MDS for resident 15 should have been marked "Yes" for having a TBI. 2. Resident 26 was initially admitted to the facility on 8/6/22 and readmitted on 11/28/22 with diagnoses which include chronic osteomyelitis, non-pressure chronic ulcer, chronic respiratory failure with hypoxia, cellulitis, sepsis, prediabetes, hyperlipidemia, bipolar disorder, anxiety disorder, and plantar fascial fibromatosis. Resident 26's discharge MDS assessment dated 10/21/22, was coded as being discharged to an acute hospital. A progress note dated 10/21/22 at 12:06, titled "Discharge Summary" revealed that resident 26 was discharged home. On 12/13/22 at 2:43 PM, an interview with the ADON was conducted. The ADON stated that resident 26 had discharged home but was accidentally coded as being discharged to a hospital on the discharge MDS assessment.	F 641		
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	F 656		

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needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§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 interview and record review, the facility

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did not develop and implement a comprehensive person-centered care plan for each resident. Specifically, for 2 out of 20 sampled residents, a resident's care plan was left blank in multiple sections and a resident's wound care plan was not updated. Resident identifiers: 16 and 80.

Findings include:

1. Resident 16 was admitted to the facility on 11/2/22 with diagnoses which include acute osteomyelitis (left ankle and foot), chronic obstructive pulmonary disease, dementia, major depressive disorder, schizoaffective disorder, post-traumatic stress disorder, generalized anxiety disorder, cellulitis of left lower limb, peripheral vascular disease, chronic systolic heart failure, adult failure to thrive, muscle weakness, essential hypertension, and malignant neoplasm of unspecified part of unspecified bronchus or lung.

On 12/12/22 at 4:17 PM, an interview with resident 16 was conducted. Resident 16 stated that he was upset because he had been a resident at the facility for over a month and he was unsure of what his plan of care consisted of. Resident 16 stated that he did not know why he was at this facility, and that he did not have any meetings with staff concerning his plan of care.

On 12/13/22, resident 16's medical record was reviewed.

It was revealed that multiple sections in resident 16's care plan were incomplete.

a. The first incomplete focus area stated, "The resident has potential/actual impairment to

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skin integrity of the (SPECIFY location) r/t [related to]." The specific location was not filled out and there was no information given about what the impairment was related to. The goal for this care area stated, "The resident's skin injury (SPECIFY) of the (location) will be healed by review date." There was no information given about the specific skin injury or location. The interventions section was left blank.

b. The second incomplete focus area stated, "Resident requires long term care services related to:" There was no further information given. The goal section was left blank. The intervention stated, "Provide Care Conference for residents and families."

c. The third incomplete focus area stated, "The resident has Peripheral Vascular Disease (PVD) r/t". There was no further information given. The goal and the intervention were left blank.

d. The fourth incomplete focus area stated, "The resident has shortness of breath (SOB) r/t." There was no further information given. The goal stated, "The resident will have no complications related to SOB through the review date." The intervention section was left blank.

e. There was no behavioral care plan for resident 16's diagnosis of post-traumatic stress disorder.

f. There was no behavioral care plan for the resident 16's diagnosis of Major Depressive Disorder.

On 12/14/22 at 10:01 AM, an interview with the

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Resident Advocate (RA) was conducted. The RA stated that she would expect a care plan for post-traumatic stress disorder and depression for residents with those diagnoses.

On 12/14/22 at 1:46 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that she completed the resident care plans. The ADON stated that if a resident had a diagnoses of post-traumatic stress disorder or depression, the resident would have a care plan for those diagnoses. The ADON stated that she looked at resident 16's care plan and stated that it was incomplete. The ADON stated that the facility was trying to catch up on completing care plans.

On 12/15/22 at 9:22 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated that a resident with depression and or post-traumatic stress disorder should have a care plan. The DON stated that she was aware that some care plans were not completed. The DON stated that completing care plans was something that the staff needed more education on.

2. Resident 80 was admitted to the facility on 9/20/22 and readmitted on 10/19/22 with diagnosis which included, but were not limited to, aftercare following joint replacement surgery, encounter for removal of internal fixation device, presence of left artificial hip joint, acute respiratory failure, moderate protein-calorie malnutrition, difficulty in walking, benign prostatic hyperplasia, obstructive and reflux uropathy, hypertension, dementia, and acute kidney failure.

Resident 80's medical record was reviewed on

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12/13/22.

On 11/9/22 at 5:36 PM, a Nurses Note documented "cna [Certified Nursing Assistant], [name removed], reported a sore to resident's right heal [sic]. looks like it was a blister that broke open. placed a bandage on it."

On 11/10/22 at 2:39 PM, a Nurses Note documented "Notified [name of primary care physician removed] of sores on bilat [bilateral] heels. Orders given to place foam heel protectors when resident in bed and in wheelchair. Apply optifoam dressing and change MWF [Monday, Wednesday, Friday]. Both appear to be blister from resting heels of feet on wheelchair. No bleeding or drainage noted."

The Order Summary Report was reviewed. A physician's order dated 11/10/22, documented "Foam heel protectors while resident in bed or in wheelchair. Optifoam dressing to bilat heels." [Note: The order did not include a start date.]

The November 2022 Treatment Administration Record (TAR) was reviewed. The physician's order for the heel treatment was unable to be located on the TAR.

A care plan "Focus" initiated on 11/14/22, documented "The resident has potential/actual impairment to skin integrity of the (bilat hip surgical incision, blister bilat heels) r/t [related to]." The interventions initiated on 11/14/22, included:

a. Foam heel protecting boots while in bed and while in wheelchair.

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b. Keep skin clean and dry. Use lotion on dry skin. "Do not apply on (Specify: site of injury)."

c. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to Medical Director.

[Note: The care plan was not updated with the treatment orders.]

On 12/14/22 at 2:14 PM, an interview was conducted with the ADON. The ADON stated the staff had a morning stand up meeting and they would go over anything new with a resident. The ADON stated if a resident had a fall, a risk meeting would be held and interventions would be added to the care plan. The ADON stated she would update the resident care plans within 24 hours.

On 12/14/22 at 2:16 PM, an interview was conducted with the Wound Nurse. The Wound Nurse stated that the wound specialist came to the facility once a week and the Wound Nurse did rounds with the wound specialist. The Wound Nurse stated that the wound specialist addressed everything skin related even surgical wounds. The Wound Nurse stated every time a resident dressing was changed, which was three times a week, the resident care plan would be updated or at least reviewed.

On 12/15/22 at 1:01 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated a resident baseline care plan would be completed on admission. The RNC stated the Minimum Data Set nurse would

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F 656	Continued From page 12 complete the comprehensive care plan within two weeks after admission. The RNC stated the Wound Nurse would update the resident care plan at the time the wound was discovered. The RNC stated the resident care plan should be updated with any changes. The RNC further stated the staff went through the resident care plans quarterly.	F 656		
F 684 SS=E	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 observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, for 3 out of 20 sampled residents, a resident with orders to follow up with the Orthopedic Surgeon two weeks after discharge from the hospital did not have a follow up and the surgical staples were not removed until four weeks after discharge from the hospital. A resident with a nephrostomy tube did not receive wound care as ordered by the Physician Assistant (PA) professional wound specialist and a resident with a rash and itchy skin was not treated. Resident identifiers: 12, 15,	F 684		

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and 80.

Findings included:

1. Resident 80 was admitted to the facility on 9/20/22 and readmitted on 10/19/22 with diagnosis which included, but were not limited to, aftercare following joint replacement surgery, encounter for removal of internal fixation device, presence of left artificial hip joint, acute respiratory failure, moderate protein-calorie malnutrition, difficulty in walking, benign prostatic hyperplasia, obstructive and reflux uropathy, hypertension, dementia, and acute kidney failure.

Resident 80's medical record was reviewed on 12/13/22.

On 10/16/22 at 1:34 PM, a Fall Note documented "Resident found on floor of his room at 1045 [10:45 PM]. He came to rest on his left side. Staff assessed him and found a skin tear on his left elbow. Stopped the bleeding with direct pressure. He was then assisted to his wheelchair. We then cleaned and dressed the skin tear. He then was assisted to the nurses station so he could be monitored and neuro [neurological] checks made. Step daughter contacted and [name of primary care physician removed] was notified of citation. He was able to transfer to the toilet at 1200 [12:00 PM] when he would not weight bear on the rightleg [sic]. Palpated right femur and found a bump proximal to hip socket. [Name of primary care physician removed] was then called and he wanted him checked out at the ER [Emergency Room]. Non emergency transport was called. Transported at 1326 [1:36 PM] to the ER."

On 10/16/22 at 10:08 PM, a Nurses Note

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documented "Called the hospital for update. Resident has a broken L [left] femur. Staying over night at the hospital."

On 10/19/22, the Hospital History/Physical And Discharge Summary documented under the Physician Orders section "FOLLOW-UP APPT [appointment] w/pcp [with primary care physician] 3-5 days. [Name of Orthopedic Surgeon removed] in 2 weeks."

On 10/20/22, a physician's order documented "Daily dressing change of surgical incision until dry. Clean using wound cleanser, apply sterile border gauze. one time a day."

On 10/21/22 at 5:46 PM, a Nurses Note documented "changed dressings to hips bilaterally. incisions show no s/s [signs or symptoms] of infection. staples still in place. states pain 4/10. no other needs at this time. call light in reach."

On 11/1/22 at 2:19 PM, a Nurses Note documented "Resident admitted for left hip repair and orthopedic aftercare. ... Surgical incisions healing. No s/s of infection. Wound cleaned,dried and dressed. Pain medications and repositioning help to relieve pain."

On 11/2/22 at 10:12 AM, a Nurses Note documented "Resident comes to us with left hip repair and orthopedic aftercare. ... Compliant with medications and cares. ... Wounds cleaned, dried and dressed. NO signs of infection."

On 11/6/22 at 2:18 AM, a Fall Note documented "Resident stated that his left leg was hurting. Surgical wound inspected, intact without redness.

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Resident was transferred to his wheelchair and back to his bed. ..."

On 11/16/22 at 12:37 PM, a Nurses Note documented "Resident was picked up by a facility transport driver at 1145 [11:45 AM]. ... Wheeled to the car in wheelchair. He was helped into the vehicle. Paperwork signed." [Note: Resident 80 transferred to another Long Term Care Facility.]

The notes from the Long Term Care Facility that resident 80 transferred to were reviewed. The notes included, but were not limited to, the following:

a. On 11/17/22 at 10:02 AM, a Category: Telephone Order documented "Called [name of Orthopedic Surgeon removed] office in price, he is the surgeon who performed residents surgery on 10/17/22. Spoke with [name removed] (his nurse) resident has not had a follow up since surgery. Let her know that staples are still in place to all 3 incisions. She said the staples should have already been removed by now. Received new order: remove staples today."

b. On 11/17/22 at 12:31 PM, a Category: Medication, Treatment, Telephone Order documented "Met with [name of physician removed] to review plan of care, discussed redness to left anterior foot, pressure injuries to bilateral feet, staples still in place upon arrival to bilateral hips from surgery in October, has not had ortho [orthopedic] follow up since surgery. Informed him of follow up appointment made with [name of physician removed]. New orders received: Mupirocin ointment apply to wounds on feet BID [twice daily], D/C [discontinue] Staples, ... Informed daughter and resident of new orders,

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they agree with plan of care."

c. On 11/17/22 at 3:38 PM, a progress note documented "Assisted resident to bed, provided privacy to remove stapled [sic] to R [right] hip and L hip incisions as ordered by physician. 5 staples removed from R hip. 7 staples removed from each surgical site on L hip. Resident tolerated well. No complaints of pain. No complications noted. Applied bacitracin to all sites and applied dressings preventatively. Resident positioned for comfort, call light within reach and bed alarm in place. Resident denies any needs at this time. Implemented treatment to watch sites."

On 12/13/22 at 3:42 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the facility did not have any notes because resident 80 did not see the Orthopedic Surgeon prior to discharging to another Long Term Care Facility. The RNC stated resident 80 was scheduled to see the Orthopedic Surgeon on 11/21/22. The RNC stated that she had called the Orthopedic Surgeons office to find out when resident 80's appointment was scheduled. The RNC stated resident 80 discharged from the facility on the 11/16/22. The RNC stated that the Business Office Manager scheduled the resident appointments and was usually unable to get the residents in within the two week time frame that the hospital wanted. The RNC stated that the Administrator in Training would scan the hospital discharge orders into the resident's medical record and would give the packet to the Director of Nursing (DON).

On 12/13/22 at 3:54 PM, an interview was conducted with the Business Office Manager (BOM). The BOM stated that the DON would

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receive the resident admission packet from the hospital and within the packet was the residents appointments. The BOM stated the DON would make a copy of those appointments and bring them to her to schedule the appointments. The BOM stated a new resident would require a follow up with their Primary Care Physician (PCP) within 7 to 10 days after admission to the facility. The BOM stated that some surgeons and PCP were harder to get into than others. The BOM stated that surgeons were usually booked out three weeks. The BOM stated she had called the Orthopedic Surgeon for resident 80 and the earliest they could get him in was four weeks after resident 80 readmitted to the facility from the hospital. The BOM stated resident 80 had discharged from the facility prior to the appointment. The BOM stated that she would let the surgeon know what the hospital orders were. The BOM stated that resident 80's appointment was on 11/21/22, and that was the earliest the Orthopedic Surgeon could get resident 80 in. The BOM stated she did not make a progress note regarding the appointment but had wrote it on a post-it note. The BOM stated that the offices would also call if an opening happened but that was rare. The BOM stated the DON would make the referrals to the house doctor.

On 12/14/22 at 8:46 AM, an interview was conducted with the DON at another Long Term Care Facility. The DON stated that resident 80's surgical staples were removed at their facility. The DON stated that resident 80 was seen by the local Orthopedic Surgeon for a follow up on the Monday after admission. The DON stated resident 80 had not had a follow up since his surgery in October 2022.

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F 684	Continued From page 18 On 12/14/22 at 2:14 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the Orthopedic Surgeon could not get resident 80 in for an appointment within the two week period. The ADON stated that the facility staff could remove resident 80's staples if they got a physician's order to remove the staples. The ADON stated when a resident was readmitted to the facility from the hospital the orders were input into the medical record and the admission paperwork would be resigned. The ADON stated that the DON would go through the orders again and would input the orders and the physician visits. The DON would them give the physician visits to the BOM to schedule. The ADON stated if the resident was suppose to be seen within two weeks after discharge from the hospital she probably would have called and asked the Orthopedic Surgeon what they would have liked them to do. The ADON stated that she would have been able to remove the staples if there was a physician's order. On 12/14/22 at 2:52 PM, an interview was conducted with the RNC. The RNC stated she would have had a discussion with the Orthopedic Surgeon if he was unable to get the resident in for the two week follow up. The RNC stated she would have put in the physician's order and had the facility staff remove the staples if the Orthopedic Surgeon agreed and then the Orthopedic Surgeon would followup at the scheduled appointment. The RNC stated that resident 80's PCP did not see resident 80 within the three to five days after discharge from the hospital as ordered. The RNC stated that the PCP signed the admission orders but did not have a visit note.	F 684		

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2. Resident 12 was admitted to the facility on 1/29/18 and readmitted on 9/6/22 with diagnoses which included, but were not limited to, encounter for surgical aftercare following surgery on the genitourinary system, hydronephrosis with ureteral stricture, calculus of kidney, type 2 diabetes mellitus, sepsis due to Escherichia Coli, atrial fibrillation, hypertension, acute kidney failure, pain, and anxiety disorder.

On 12/12/22 at 2:41 PM, an interview was conducted with resident 12. Resident 12 stated that her nephrostomy tube was not connected to a bag and her down drain Foley catheter came out. Resident 12 stated that the nephrostomy tube was not connected to anything and she did not know if it was draining. Resident 12 stated that her nephrostomy was infected.

Resident 12's medical record was reviewed on 12/14/22.

On 11/1/22 at 8:01 PM, a Nurses Note documented "resident admitted to facility for PT [physical therapy]/OT [occupational therapy] strength training and medication management with dx [diagnosis] of surgical aftercare following surgery on the genitourinary system. ... she has a Foley catheter that is draining clear yellow urine, she also has a nephrostomy tube on the left flank that is draining clear yellow urine. ..."

On 11/8/22 at 3:26 PM, a Nurses Note documented "Dr. [doctor] appointment attended today. orders to exchange left nephrostomy tube. Consult to address infections. May also place new tube on right side."

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On 11/8/22 at 9:29 PM, a Nurses Note documented "... resident had a doctor appointment today and the Foley catheter was removed. resident has a nephrostomy tube on the left side that is putting out very little urine. ..."

On 11/12/22 at 9:43 PM, a Nurses Note documented "nephrostomy tube has had no output."

On 11/20/22 at 10:00 PM, a Nurses Note documented "no output from nephrostomy bag for afternoon shift."

On 11/21/22 at 6:00 AM, a Nurses Note documented "no output for night shift from nephrostomy."

On 11/30/22 at 3:03 PM, a Nurses Note documented "Placed a call to [name of urology clinic removed] concerning [name of resident 12 removed] nephrostomy. Reported to the FNP [Family Nurse Practitioner] that [name or resident 12 removed] is no longer producing urine from the urostomy. She stated that it will need to be replaced as soon as possible. They will return a call today when they are able to schedule the procedure."

On 11/30/22 at 8:15 PM, a Nurses Note documented "attempted to flush nephrostomy tube per doctor orders the valve leaked around the base where it connects to the part inserted into her back. DON notified it was not able to be flushed."

On 12/6/22 at 8:14 PM, a Nurses Note documented "... resident has a nephrostomy tube on the left side that has no output. ..."

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On 12/8/22 at 3:09 PM, a Nurses Note documented "During nephrostomy site dressing change, connection to the bag was found broken. This may be why the bag is no longer collecting. Urology was called to see what they would like to do with the site or if they would like to replace the bag. Waiting a call back."

On 12/8/22, a progress note by the PA professional wound specialist documented on the assessment that resident 12 had dermatitis associated with moisture. The wound orders included "Remove dressing, cleanse wound with standard wound care protocol, apply the following treatment order: Left Flank: apply nystatin/triamcinolone cream and cover with bordered foam, Change dressing once daily and PRN [as needed] if dislodged." "Clinical Notes: 12/8/22: Wound nurse reports patient is non-compliant with treatment and refused showers. Nephrostomy drain will not be removed by surgeon until surrounding skin is clear. Follow up: 1 week."

On 12/9/22 at 2:18 AM, a Nurses Note documented "padding applied to the sharp hard plastic piece of the nephrostomy tube where the bag had been connected. area cleaned and dressing applied to insertion site."

On 12/13/22 at 9:09 PM, a Nurses Note documented "... resident has a surgical site on her left flank with a nephrostomy tube coming out but there is no bag attached to the tube."

On 12/15/22 at 10:39 AM, an interview was conducted with the PA professional wound specialist and the Wound Nurse. The PA stated

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that he had seen resident 12 for the first time last week. The PA stated that he was trying to get the infection cleared up so the surgeon would take out resident 12's nephrostomy tube. The Wound Nurse stated that resident 12 had seen the Urologist but was told that they wound not take the nephrostomy tube out until it was healed. The Wound Nurse stated if the wound orders were not on the Treatment Administration Record (TAR) it was because she had not put the orders there yet. The Wound Nurse stated the facility staff were trying to get resident 12 to be more compliant with cares.

On 12/15/22 at 10:49 AM, an observation was conducted with the PA professional wound specialist and the Wound Nurse. The Wound Nurse was observed to clean the left flank area on resident 12 with wound cleaner. There were no bandages observed over the nephrostomy tube in the left flank area. The Wound Nurse was observed to apply the nystatin/triamcinolone cream to the left flank area and covered the nephrostomy tube with bordered foam. The PA stated to resident 12 that he wanted to continue with the daily dressing changes. The PA stated to resident 12 that the area looked good and by next week it should be cleared up and the PA would be able to call the Urologist and schedule to get the nephrostomy tube removed.

On 12/15/22 at 10:55 AM, a follow up interview was conducted with the Wound Nurse. The Wound Nurse stated that resident 12 had a hard time keeping the bandage on because of where it was placed. The Wound Nurse stated that she could not tell me exactly when the bandage fell off. The Wound Nurse stated that she changed resident 12's dressing on Wednesday. [Note:

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Resident 12's wound treatment was unable to be verified because the wound orders were not entered onto the TAR in resident 12's medical record.]

3. Resident 15 was admitted to the facility on 8/11/22 with diagnoses which include displaced trimalleolar fracture of left lower leg, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, essential hypertension, personal history of traumatic brain injury, difficulty in walking, other psychoactive substance abuse, major depressive disorder, mood disorder, and personal history of other venous thrombosis and embolism.

One 12/13/22 at 8:18 AM, an interview with resident 15 was conducted. Resident 15 stated that he had an itchy rash that was bothering him. Resident 15 stated that the rash was on his legs and started to spread to his back and torso. Resident 15 stated that he had told staff about the rash and requested to see a doctor, but staff told him that he did not have a rash. Resident 15 stated that the rash was "really itchy" and he stated that he sometimes bled due to scratching.

On 12/14/22, resident 15's medical record reviewed.

A Nurses Note dated 11/9/22 at 2:21 AM, stated, "[Resident 15] called staff in his room states he needs to see a medical professional because the rash that is on his leg has spread to his back. RN [Registered Nurse] assessed his back and hold him he does not have a rash on his back. He [resident 15] states it itches and there are bumps on his back. [Resident 15] was told he has

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random red bumps on his back that look like acne and not a rash. [Resident 15] then states he has it on his abdomen and his belly button, RN told him there is nothing on his abdomen, chest, legs, or belly button, [Resident 15] became upset with the RN and started scratching his abdomen and back yelling it itches. He then insists that the rash has spread. [Resident 15] was told there is not a doctor available at 2:20 [AM] in the morning. Staff left his room and left his door open [resident 15] then yelled 'shut my damn door.' RN went back in his room and told him he is not to yell that other people are trying to sleep. [Resident 15] was reminded he is supposed to leave his door open and insisted it be shut."

A review of resident 15's physician's orders was conducted. Resident 15 did not have any medications or physician's orders to treat symptoms of a rash.

On 12/15/22 at 8:21 AM, an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated that she recalled resident 15 complaining about a rash. CNA 2 stated she was not sure if the nurses contacted the doctor about the itchy rash.

On 12/15/22 at 9:59 AM, a follow up interview was conducted with resident 15. Resident 15 stated that he had told staff multiple times about his legs being itchy and he wished to speak with a doctor about the issue. An observation of resident 15's right leg was made. Resident 15's right leg had a small amount of blood on it. Resident 15 stated that his leg was bleeding due to scratching it.

On 12/15/22 at 10:04 AM, an interview with the

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F 684	Continued From page 25 ADON was conducted. The ADON stated that she worked with resident 15 twice a week and she did not recall resident 15 mentioning a rash. The ADON stated she was unaware of the nurses note dated 11/9/22 at 2:21 AM, which stated that resident 15 was complaining of a rash. The ADON stated that nurses typically pass that information onto the next shift or inform the doctor. On 12/15/22 at 10:55 AM, an interview with the Medical Director (MD) was conducted. The MD stated that he did not recall any staff member informing him about resident 15 having a rash. On 12/15/22 at 12:37 PM, an physician's order was placed for resident 15 that stated, "Dry skin (bilateral legs and thighs): Clean with wet wipes, pat dry. Apply A&D Ointment to affected areas BID. Every shift for dry skin AND as needed for relief of dry itchy skin. Apply PRN every 6 hrs [hours]."	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not ensure a resident with pressure ulcers received the necessary treatment and services, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, for 1 out of 20 sampled residents, a resident that developed pressure ulcers on both heels did not have the treatment implemented according to the physician's orders. In addition, the resident's left anterior pressure ulcer developed an infection. Resident identifier: 80.

Findings included:

Resident 80 was admitted to the facility on 9/20/22 and readmitted on 10/19/22 with diagnosis which included, but were not limited to, aftercare following joint replacement surgery, encounter for removal of internal fixation device, presence of left artificial hip joint, acute respiratory failure, moderate protein-calorie malnutrition, difficulty in walking, benign prostatic hyperplasia, obstructive and reflux uropathy, hypertension, dementia, and acute kidney failure.

Resident 80's medical record was reviewed on 12/13/22.

A Braden Scale for Predicting Pressure Sore Risk dated 10/21/22, documented that resident 80 was at risk for pressure sores with a score of 17. [Note: A score of 15 to 18 indicated At Risk.]

On 11/9/22 at 5:36 PM, a Nurses Note documented "cna [Certified Nursing Assistant], [name removed], reported a sore to resident's

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right heal [sic]. looks like it was a blister that broke open. placed a bandage on it."

On 11/10/22 at 2:39 PM, a Nurses Note documented "Notified [name of primary care physician removed] of sores on bilat [bilateral] heels. Orders given to place foam heel protectors when resident in bed and in wheelchair. Apply optifoam dressing and change MWF [Monday, Wednesday, Friday]. Both appear to be blister from resting heels of feet on wheelchair. No bleeding or drainage noted."

The Order Summary Report was reviewed. A physician's order dated 11/10/22, documented "Foam heel protectors while resident in bed or in wheelchair. Optifoam dressing to bilat heels." [Note: The order did not include a start date.]

On 11/11/22 at 2:34 PM, a Skin/Wound Note documented "resident's right heal [sic] dressing was changed. dead skin was removed from wound, macerated skin around the perimeter. new skin looks intact."

On 11/13/22 at 9:49 PM, a Skin/Wound Note documented "was addressing resident's heal [sic] wounds and he showed me his right elbow. it is swollen, pink, and spongy. not hot to touch no drainage noted, no pain indicated. looks like it needs to be drained.

The November 2022 Treatment Administration Record (TAR) was reviewed. The physician's order for the heel treatment was unable to be located on the TAR.

A care plan "Focus" initiated on 11/14/22, documented "The resident has potential/actual

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impairment to skin integrity of the (bilat hip surgical incision, blister bilat heels) r/t [related to]." The interventions initiated on 11/14/22, included:

a. Foam heel protecting boots while in bed and while in wheelchair.

b. Keep skin clean and dry. Use lotion on dry skin. "Do not apply on (Specify: site of injury)."

c. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to Medical Director.

The notes from the Long Term Care Facility that resident 80 transferred to were reviewed. The notes included, but were not limited to, the following:

a. On 11/16/22 at 4:30 PM, a Category: Skilled Charting documented "... Right hip has 5 staples, Left hip has 8 staples, no redness to sites. Buttock above gluteal crease has a dressing, removed dressing, skin is red and discolored, covered with a Allevyn dressing to provide protection. Right hand middle finger knuckle has a S/T [skin tear] with dry skin rolled up. cleaned and applied ABX [antibiotic]. ointment with a telfa dressing, Right anterior foot has dry blood, cleaned with NS [normal saline] 0.9 deep dark bruising with outer redness, Right outer foot a dark pressure sore 2.5cm [centimeters] x [by] 0.5cm. Right heel pressure sore discolored redness 3.5cmx3.5cm . Left heel dressing removed, odor is very strong gauze removed, pressure sore is white 7.8cm x 7.8cm unable to

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stage. Ankle with no edema feet puffy +1 ..."

b. On 11/17/22 at 12:31 PM, a Category: Medication, Treatment, Telephone Order documented "Met with [name of physician removed] to review plan of care, discussed redness to left anterior foot, pressure injuries to bilateral feet, staples still in place upon arrival to bilateral hips from surgery in October, has not had ortho [orthopedic] follow up since surgery. Informed him of follow up appointment made with [name of physician removed]. New orders received: Mupirocin ointment apply to wounds on feet BID [two times a day], D/C [discontinue] Staples, Bactrim DS [double strength] PO [by mouth] BID x [for] 10 days - for left anterior foot infection, Keflex 500 mg [milligrams] TID [three times a day] x 10 days for left anterior foot infection. Informed daughter and resident of new orders, they agree with plan of care."

c. On 11/17/22 at 2:38 PM, a Category: Medication documented "Keflex 500 mg tab PO TIDx10 days for infection of L [left]/foot; Bactrim DS 800mg/160 mg tab PO BID x 10 days for infection of L/foot. Pt tolerating it well. No adverse reaction noted at this time."

The Orthopedic Surgery note dated 11/29/22, documented "... he got some heel ulcers at the care center out there and these [sic] been treating with offloading and bandages and stuff of that nature. ... Not getting around much due to the heel sores. ..."

On 12/13/22 at 2:11 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated when entering a new physician's order into the resident's medical record she would go to the

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clinical assessment for the resident and click the orders tab. RN 1 stated for a wound order she would click new other for wounds and order type "wounds tar". RN 1 stated she would complete the "ordered by" and "communication method" phone, verbal, or written order. RN 1 stated she would complete the "description" area by entering the description of the order. RN 1 stated the scheduling details would be completed by clicking if the order was routine, one time only, or as needed. RN 1 stated that she would also add additional directions to the order. RN 1 stated that she would enter the start date of the order and an end date. RN 1 stated the end date for the order could be specific or indefinite. RN 1 stated she would then enter the time the order would start. RN 1 stated she would also add any supplementary documentation that could include a pain level. RN 1 stated if supplementary documentation was included the system would trigger the supplementary documentation be entered prior to administering the order. RN 1 verified the wound order for resident 80's heel dressings were not scheduled. RN 1 stated if the order was not scheduled the order would not be activated on the TAR.

On 12/14/22 at 8:46 AM, an interview was conducted with the Director of Nursing (DON) at another Long Term Care Facility. The DON stated that their facility Physician saw resident 80 after admission and thought that one of resident 80's heel wounds was infected. The DON stated that resident 80 was started on two antibiotics.

On 12/14/22 at 10:13 AM, an interview was conducted with the Wound Nurse. The Wound Nurse stated that resident 80 had multiple falls while he was a resident at the facility and resident

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80 had a few skin tears from the falls. The Wound Nurse stated that resident 80 had a skin tear on his elbow that was pretty bad and one on his hand. The Wound Nurse stated that resident 80 had mostly skin tears. The Wound Nurse stated that resident 80 had a stroke and was sent to the local hospital and then shipped to another hospital in the valley. The Wound Nurse stated that the heel wounds were not there before resident 80 was discharged to the hospital. [Note: The discharge to the hospital was on 9/30/22 and resident 80 was readmitted to the facility on 10/5/22.] The Wound Nurse stated that she was on leave a week in November and not in the facility. The Wound Nurse stated resident 80's heel blister was present when she returned. The Wound Nurse stated when she returned the nursing staff had precautions in place with heel protectors and pillows under resident 80's knees to elevate. The Wound Nurse was unable to state when resident 80's heel wounds were identified. The Wound Nurse stated that resident 80 had gotten better at using the call light to get up. The Wound Nurse stated there were wound orders for the skin tear but there were no wound orders for resident 80's heel wounds. The Wound Nurse stated when she returned from leave she officially took over as the wound nurse.

On 12/14/22 at 2:46 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that once the wounds were identified the staff notified the nurse. The RNC stated that the nurse would put a physician's order in place and some sort of treatment. The RNC stated the nurse would put in the order and notify the Wound Nurse and physician. The RNC stated the Wound Nurse and the physician assessed the wound and if the order was

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F 686	Continued From page 32 accurate they would not change the treatment. The RNC stated that the order for resident 80's heel treatment and heel protectors should have been separated and not entered together. The RNC stated it was an oversight that the wound order was not scheduled.	F 686		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure residents who displayed or were diagnosed with a mental disorder or psychosocial adjustment difficult, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Specifically, for 1 out of 20 sampled residents, a resident with a diagnoses of post-traumatic stress disorder and major depressive disorder who expressed adjustment difficulties was not offered behavioral health services. Resident identifier: 16 Findings included:	F 742		

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Resident 16 was admitted to the facility on 11/2/22 with diagnoses which include acute osteomyelitis (left ankle and foot), chronic obstructive pulmonary disease, dementia, major depressive disorder, schizoaffective disorder, post-traumatic stress disorder, generalized anxiety disorder, cellulitis of left lower limb, peripheral vascular disease, chronic systolic heart failure, adult failure to thrive, muscle weakness, essential hypertension, and malignant neoplasm of unspecified part of unspecified bronchus or lung.

On 12/12/22 at 4:17 PM, an interview with resident 16 was conducted. Resident 16 stated that he was upset because he had been a resident at the facility for over a month and he was unsure of what his plan of care consisted of. Resident 16 stated that he did not know why he was at this facility, and that he did not have any meetings with staff concerning his plan of care. Resident 16 stated that he felt like he was going to die at this facility. Resident 16 stated that he felt like he was in a prison.

A review of resident 16's medical record was conducted on 12/13/22.

Resident 16's Minimum Data Set (MDS) assessment dated 11/10/22, was reviewed. The MDS assessment revealed that resident 16 had an anxiety disorder, depression, schizophrenia, and post traumatic stress disorder.

A Preadmission Screening Resident Review (PASRR) Level II dated 10/14/22, was reviewed. It should be noted that the PASRR Level II form was filled out while resident 16 was located at a

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different facility. Recommendations on the PASRR Level II form included:

a. "[Resident 16] would benefit from individual therapy and medication management. He is still an open client through [therapy provider name redacted] and could possibly benefit from these services while at the nursing facility."

b. Psychosocial needs identified included, "cognitive stimulation, need for insight and education, socialization, and support."

Resident 16's care plan was reviewed. There was no behavioral care plan for resident 16's diagnosis of post-traumatic stress disorder or major depressive disorder.

Resident 16's progress notes revealed behavioral concerns.

a. A progress note dated 11/4/22 at 12:34 PM, stated, "resident has been in bed with his cap over his face and blankets up over his head and doesn't respond when talked to. Very aggressive in taking the cup of his pill."

b. A progress note dated 11/4/22 at 2:33 PM, stated, "After lunch on Thursday November 3, 2022, Resident was at Nursing Station complaining of being 'in a prison.' Several staff members were trying to calm him down. Administrator [name redacted] tried to intercede. [Resident 16] turned his anger towards Administrator. He struck Admin [Administrator] in the chest and began pommeling Admin's torso and arms with his fist. Police were called. When they spoke with [resident 16], he calmed down and agreed to cooperate, including taking his

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medicine."

c. A progress note dated 11/21/22 at 10:16 AM, reported that resident 16 was highly aggressive.

d. A progress note dated 12/5/22 at 11:58 PM, reported that resident 16 had increased agitation.

e. A progress note dated 12/9/22 at 1:34 PM, stated, "Resident refused medications, shower and linen change. He said he doesn't like being told what to do and that it is none of anyone's business. Nurse and Admin let him know that because he is here so he is our business. Resident got upset and went out to the back courtyard. Later come inside and went to his room."

On 12/14/222 at 9:50 AM, a follow-up interview with resident 16 was conducted. Resident 16 stated that the facility had not offered any behavioral services or therapy.

On 12/14/22 at 10:01 AM, an interview with the Resident Advocate (RA) was conducted. The RA stated that she would expect a care plan for post-traumatic stress disorder and depression. The RA stated that resident 16 refused behavioral services. The RA stated that she did not document any attempted measures for getting resident 16 behavioral health services. The RA stated she did not document any refusals by resident 16.

On 12/14/22 at 11:59 PM, an interview with the Licensed Clinical Social Worker (LCSW) was conducted. The LCSW stated that resident 16

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F 742	Continued From page 36 had been receiving mental health services at his last facility but she was not sure if resident 16 had been offered behavioral health services while at this current facility. On 12/14/22 at 1:46 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that she completed the resident care plans. The ADON stated that if a resident had a diagnoses of post-traumatic stress disorder or depression, the resident would have a care plan for those diagnoses. The ADON stated that she looked at resident 16's care plan and stated that it was incomplete. The ADON stated that the facility was trying to catch up on completing care plans. On 12/15/22 at 9:22 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated that a resident with depression and or post-traumatic stress disorder should have a care plan. The DON stated that she educated staff on what to do if resident 16 expressed aggressive behaviors. The DON stated she was unsure if the RA had reached out to behavioral health services for resident 16.	F 742		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		

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F 757	Continued From page 37 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, for 2 out of 20 sampled residents, a resident's diuretic medication used to treat high blood pressure was not monitored according to the physician's ordered parameters. In addition, a resident's angiotensin-converting enzyme medication to treat high blood pressure was not monitored according to the physician's ordered parameters. Resident identifiers: 2 and 84. Findings included: 1. Resident 2 was admitted to the facility on 1/17/13 and readmitted on 4/29/19 with	F 757		

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diagnoses which included, but were not limited to, cerebral palsy, lymphedema, heart failure, dysphasia, major depressive disorder, and generalized edema.

On 12/13/22 at 8:14 AM, an observation was conducted of resident 2. Resident 2 was sitting in her motorized wheelchair and her hands and feet bilateral were observed to be swollen.

Resident 2's medical record was reviewed on 12/14/22.

A physician's order dated 10/18/22, documented "Torsemide Tablet 20 MG [milligrams] Give 60 mg by mouth two times a day for Edema management hold for sbp [systolic blood pressure] < [less than] 90 or hr [heart rate] <50."

The December 2022 Medication Administration Record (MAR) was reviewed. The Torsemide medication was scheduled to be administered at 6:00 AM and 1:00 PM. The 6:00 AM, administration did not include the SBP or HR prior to the medication being administered. The 1:00 PM, administration did not include the HR prior to the medication being administered.

On 12/15/22 at 9:57 AM, an interview was conducted with Assistant Director of Nursing (ADON). The ADON stated if there was a "heart" next to the medication on the MAR, the "heart" would indicate monitoring of vital signs. The ADON stated the Torsemide medication had BP monitoring for the evening dose but there was no monitoring on the MAR for the morning dose. The ADON stated that the order was combined on the MAR. The ADON stated that without the monitoring on the MAR the staff would not know if

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they should administer the medication or not. The ADON stated if the staff were going through the physician's order and reading the medication "Rights" then it would not be a problem if the monitors were not there because the staff would know to get the residents vital signs prior to the medication administration.

2. Resident 84 was admitted to the facility on 11/30/22 with diagnoses which included, but were not limited to, Parkinson's disease, Alzheimer's disease, dementia, psychotic disorder with delusions, asthma, essential hypertension, and low back pain.

Resident 84's medical record was reviewed on 12/14/22.

A physician's order dated 12/1/22, documented "Enalapril Maleate Tablet 10 MG Give 10 mg by mouth at bedtime for HTN [hypertension] hold for sbp<90 or hr<50."

The December 2022 MAR was reviewed. The Enalapril medication was scheduled to be administered at 8:00 PM. The 8:00 PM, administration did not included the SBP and HR prior to the medication being administered.

On 12/15/22 at 9:49 AM, an interview was conducted with the ADON. The ADON stated the resident vital signs should be done, every time, prior to the administration of the medication so as not to bottom the resident out. The ADON stated that she would obtain the resident vital signs right before administering the medication. The ADON stated the Enalapril did not have a "heart" next to it on the MAR so the system would not make the staff obtain a blood pressure prior to the

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F 757	Continued From page 40 administration. The ADON stated that the Director of Nursing entered the medication orders. The ADON stated the system would not let staff give the medication until they entered the blood pressure if there was a "heart" on the MAR next to the medication. On 12/15/22 at 10:21 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that medication parameters were inside the physician's orders under additional documentation. The RNC stated the BP would be on the MAR. The RNC stated there were pharmacy guidelines for the vital sign parameters but it would depend on the person, the physician, and the pharmacy. The RNC stated the staff would not see to obtain the resident vital signs if they were not on the orders. The RNC confirmed that resident 84 did have resident specific parameters on the physician's order. The RNC stated the parameters would be entered under supplemental documentation or there would be a progress note. The RNC was unable to find additional documentation that resident 84's vital signs were done prior to the medication administration.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 41 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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Based on interview and record review, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. A GDR must be attempted in two separate quarters, with at least one month between attempts, within the first year in which an individual was admitted on a psychotropic medication or after the facility had initiated such medication, and then annually. Specifically, for 1 out of 20 sampled residents, a resident taking a psychotropic medication that was initiated on 3/30/22, had not received a GDR and the medication was not clinically contraindicated. Resident identifier: 10.

Findings included:

Resident 10 was admitted to the facility on 3/29/22 with diagnoses which included, but were not limited to, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side, senile degeneration of brain, dementia, major depressive disorder, atrial fibrillation, encephalopathy, essential hypertension, and muscle weakness.

Resident 10's medical record was reviewed on 12/15/22.

A physician's order dated 3/30/22, documented "Sertraline HCl [hydrochloride] Tablet 100 MG [milligrams] Give 2 tablet by mouth one time a day for depression."

The Psychotropic Drug Review dated 9/13/22, documented Sertraline 100 mg, two tablets daily. The current dose of this medication was an

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increase and the start date of the dose was 8/9/22. [Note: Resident 10 had not had a dosage change since the initiation of the medication on 3/30/22.]

The Psychotropic Drug Review dated 11/8/22, documented Sertraline 200 mg daily. The date of the last reduction was 3/30/22. [Note: Resident 10 admitted to the facility on 3/29/22, and the medication was initiated on 3/30/22.]

On 12/15/22 at 12:28 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 10 has had less behaviors then he use to. The ADON stated that resident 10 asked the Regional Nurse Consultant (RNC) today if she would have sex with him. The ADON stated that she had not heard that out of resident 10 in a long time. The ADON stated that resident 10 would kick and scream. The ADON stated that resident 10 was very particular with who and when he freaked out. The ADON stated that resident 10 would scream at the Certified Nursing Assistants all the time. The ADON stated that she had suggested in-services for staff regarding resident behaviors. The ADON stated that sometimes she was involved in the process with GDRs. The ADON stated that resident 10 was stable and maintained and they would review resident 10 in 90 days. The ADON stated that this week would have been the psychotropic meeting and the pharmacist did review resident 10's chart. The ADON stated when the residents were stable the staff want them to stay stable and not have behaviors. The ADON stated when resident 10 first admitted to the facility he was a mess and had several behaviors. The ADON stated in her opinion she would not GDR resident 10's medications.

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F 758	Continued From page 44 On 12/15/22 at 1:01 PM, an interview was conducted with the RNC. The RNC stated the pharmacist had talked about resident 10 on two occasions and stated that he should have done a GDR with resident 10's Sertraline. The RNC stated she could not find a GDR on resident 10's Sertraline. Additional information was provided by the facility on 12/20/22, after the survey had been concluded. The Physician Rationale for Clinically Contraindicated Gradual Dose Reduction or Duplicative Medication: Sedative/Hypnotic was dated 12/19/22. The form documented the medication in consideration was Sertraline. The target symptoms and distressed behavior demonstrated was cooperative behavior and participation in activities. The box "Gradual Dose Reduction (GDR)/Dose Tapering is Clinically Contraindicated" was checked. The rational for dose duration greater than typically recommended documented "Currently decreasing dose of risperidone If [name of resident 10 removed] tolerates well will begin GDR of Sertraline." [Note: The risperidone was discontinued on 5/6/22.]	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 760		

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did not ensure that residents were free of significant medication errors. Specifically, for 1 out of 20 sampled residents, a resident returning from the hospital missed two doses of a seizure medication that was prescribed by the physician at the hospital. Resident identifier: 15

Findings included:

Resident 15 was admitted to the facility on 8/11/22 with diagnoses which include displaced trimalleolar fracture of left lower leg, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, essential hypertension, personal history of traumatic brain injury, difficulty in walking, other psychoactive substance abuse, major depressive disorder, mood disorder, and personal history of other venous thrombosis and embolism.

Resident 15's medical record was reviewed.

A progress note dated 12/13/22 at 11:50 AM, stated, "Resident having a seizure that lasts 2 minutes, came to and was A&O [alert and oriented] x 4 [oriented to person,place, time and event]. Started another seizure that started at 12:03 [PM] and has not responded."

A progress note dated 12/13/22 at 12:05 PM, stated, "While completing walking rounds RN [Registered Nurse] heard CNA [Certified Nursing Assistant] ask resident if he was okay, RN walked into room to find resident laying half on bed convulsing. RN lifted legs onto bed to make resident comfortable. RN stayed with resident until convulsing subsided assessed residents eyes non-reactive to light obtained set of vitals,

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started neuro [neurological] checks resident stated he hit his head on the wall. No injuries noted upon assessment. [Doctors name redacted] in the facility and assessed resident executive decision to send residents to the ER [Emergency Room] for CT [computerized tomography] scan."

A progress note dated 12/13/22 at 12:41 PM, stated, "Resident had another seizure that started at 12:19 [PM], convulsing, pupils non-reactive. Ambulance arrived at 12:20 [PM]. [Resident 15] still not responding. Transferred him to stretcher, still not responding. In care of ambulance crew. Left at 12:32 [PM]."

A progress note dated 12/14/22 at 11:15 AM, stated, "Resident returned from [hospital name redacted] at 12:35 [PM] transported by out [sic] transport driver. Came into the building in wheelchair with staff pushing him. Alert and oriented to self, situation, and place. He is on regular diet and regular texture ...Kepprais [sic] a new order from the hospital. He needs follow up in 2 weeks ...".

A document titled "Patient Discharge Summary Report" Dated 12/14/22 and time stamped 9:39 AM, revealed that resident 15 had a new medication order. The new medication order was for Levetiracetam (Keppra) 500 milligrams (mg) by mouth twice a day. The document stated that the last dose given was at 12/14/22 at 8:40 AM.

On 12/15/22 at 10:55 AM, an interview with the Medical Director (MD) was conducted. The MD stated that resident 15 was started on Keppra due to the recent seizures.

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F 760	Continued From page 47 Resident 15's physician's orders were reviewed. It was revealed that Levetiracetam (Keppra) was not listed as one of resident 15's medications. On 12/15/22 at 1:00 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that when a resident returned from the hospital, the new medication orders were added to the residents' orders immediately. The ADON stated that the new orders for resident 15's Keppra should have been added to his medication list because she entered the orders in when resident 15 returned to the facility. The ADON reviewed his current medication list and saw that the new order for Keppra was not listed. The ADON stated that the order could have been missed. On 12/15/22 at 1:12 PM, resident 15's medication orders were updated, and it was revealed that Levetiracetam (Keppra) Tablet 500 mg given by mouth two times a day was added to resident 15's medications. It should be noted that resident 15 missed two doses of Levetiracetam (Keppra) 500 mg since returning from the hospital on 12/14/22.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an	F 791		

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F 791	Continued From page 48 outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) 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 locations; §483.55(b)(3) 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; §483.55(b)(4) 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; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not obtain routine dental services to meet the needs of the resident. Specifically, for 1 out of 20 sampled residents, a	F 791		

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resident with missing teeth, gum swelling, reported pain, and had a recommendation from the Speech-Language Pathologist (SLP) was not provided dental services for six months. In addition, the resident had not been scheduled for the extractions and the last dental visit was in November 2022. Resident identifier: 12.

Findings included:

Resident 12 was admitted to the facility on 1/29/18 and readmitted on 9/6/22 with diagnoses which included, but were not limited to, encounter for surgical aftercare following surgery on the genitourinary system, hydronephrosis with ureteral stricture, calculus of kidney, type 2 diabetes mellitus, sepsis due to Escherichia Coli, atrial fibrillation, hypertension, acute kidney failure, pain, and anxiety disorder.

On 12/12/22 at 3:25 PM, an observation was conducted of resident 12's teeth. Resident 12 was missing teeth and they were observed to be decayed. Resident 12 stated that she did not want to talk about her teeth. Resident 12 stated that she saw a dentist before the pandemic and the dentist was going to extract all of her teeth. Resident 12 stated that the dentist pulled half of her teeth out prior to the pandemic and then the dentist died. Resident 12 stated another dentist was going to finish pulling her teeth but he wanted to do the dental work while she sat in her wheelchair because she would be unable to get into the dental chair. Resident 12 stated the in house dentist came to the facility but she never got to see him. Resident 12 stated other residents were in line for the dentist but the staff did not come get her. Resident 12 stated that her teeth hurt intermittently.

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Resident 12's medical record was reviewed on 12/14/22.

The admission Minimum Data Set assessment dated 9/12/22, documented that resident 12 had obvious or likely cavities or broken natural teeth.

The care plan focus initiated on 3/4/19 and revised on 9/28/22, documented "[Name of resident 12 removed] has poor dentition/broken teeth, resident doesn't like the MS [mechanical soft] texture." The goal initiated on 3/4/19 and revised on 12/12/22, documented "[Name of resident 12 removed] will be free of infection, pain or bleeding in the oral cavity by review date." The interventions included:

a. Initiated on 6/26/19 and resolved on 6/23/22, "RESOLVED: 6/26/19 [Name or resident 12 removed] had teeth extracted on 6/25/19: No rinse of oral cavity for 24 [hours] then rinse with warm salt water solution. No sucking from straw and soft diet for a week. Sleep reclined during recovery- resident prior to teeth extraction prefers to sleep in recliner every night."

b. Initiated on 3/4/19, "Administer medications as ordered. Monitor/document for side effects and effectiveness."

c. Initiated on 3/4/19, "Coordinate arrangements for dental care, transportation as needed/as ordered."

d. Initiated on 3/4/19, "Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted."

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On 5/3/22 at 2:56 PM, a Therapy Notes documented "SLP completed facility-requested swallowing assessment to ensure patient safety and determine efficacy of current diet texture. ... The patient stated that she had begun process of extraction in preparation for dentures however her dentist passed away. She currently is missing upper and lower molars on the left with upper right molars broken. She had gum swelling and reported pain in a front lower incisor. She demonstrated increased mastication time with solid textures. SLP recommends diet upgrade from NDD3 [National Dysphagia Diet level 3] to regular easy to chew textures at this time as the patient enjoys and can safely tolerate french toast and other soft breads. SLP also recommends a dentist consult. No swallowing treatment to be provided at this time. Oral impairment is related to dentition."

On 6/21/22 at 1:37 PM, a Care Conference documented "Care Conference: [Name of resident 12 removed] care conference held today. [Name of resident 12 removed] states she needs to have f/u [follow up] appt [appointment] with dentist. She would like to continue plan to pull teeth and get dentures. Suggested either using jerry [sic] chair for next appt or going to surgical center if appropriate. [Name of resident 12 removed] expressed a dislike for the food. She states she likes when she is served Mexican. She states she has no s/s [signs or symptoms] of UTI [urinary tract infection] at this time. Has completed oral abx [antibiotics]."

On 12/15/22 at 10:07 AM, an interview was conducted with the Business Office Manager (BOM). The BOM stated the facility was partnered with a mobile dental care and they

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would come into the facility to do dental cleanings. The BOM stated the mobile dental care would also do cavities but they were pretty new to the facility. The BOM stated the mobile dental care would come back to the facility with notes and recommendations for extractions. The BOM stated if the resident was not on the dental care the BOM would schedule with the resident's dentist. The BOM stated that the Director of Nursing (DON) would give her a sticky note regarding resident appointments and the BOM would schedule the appointments. The BOM stated there were certain insurance requirements to be on the dental care. The BOM stated the dental care was for long term care residents with Medicare or Medicaid. The BOM stated that the mobile dental care came to the facility and spoke to the residents about the dental program. The BOM stated the residents had to sign up for the dental program in order to receive services. The BOM checked her computer and stated that resident 12 was in the process of signing up for the dental care. The BOM stated that resident 12 had been in the process since the end of October 2022. The BOM stated the dental care would send the paper work to the resident's family members. The BOM stated the dental care should have sent the packet to resident 12 if she was alert and oriented and her own representative. The BOM stated that sometimes the families were overwhelmed with the paperwork and the BOM helped them complete the paperwork if they brought it into the facility.

On 12/15/22 at 10:15 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the facility had a dental care service that came to the building to check all the residents. The ADON stated that

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resident 12 had mentioned wanting to get all of her teeth pulled to get dentures. The ADON stated the process of removing resident 12's teeth was started prior to the pandemic and the dentist had to stop. The ADON stated that she thought resident 12 was on the dental list to get started again. The ADON stated that the Resident Advocate (RA) would be the one to get the residents on the dental list.

On 12/15/22 at 11:49 AM, an interview was conducted with the RA. The RA stated the facility just started with the mobile dental care and they covered Medicaid patients. The RA stated the mobile dental care were just in the facility on 12/2/22. The RA stated that all Medicaid residents were signed up for the dental care. The RA stated the mobile dental care came to the facility in November 2022 to see who wanted to be seen. The RA stated the facility was contracted with a local dentist for dental work. The RA stated if a resident had a toothache the RA would go to the BOM and look over the transport schedule to see what was available and make an appointment. The RA stated that she would keep record of who was seen by the dental care. The RA stated that resident 12 was signed up with the dental care program. The RA referenced her dental list and stated that resident 12 was not seen by the mobile dental care on 12/2/22. The RA stated that resident 12 had an exam by the mobile dental care on the 11/11/22. The RA stated the mobile dental care had not given her a recommendation on a dentist as of yet for resident 12.

The dental list was reviewed and resident 12 was seen by the mobile dental care on 11/11/22. The notes section documented that resident 12 had a complete exam and was missing 13 teeth.

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"[Resident 12] would like to have remaining teeth extracted and get an upper and lower complete dentures." There was no documentation under the next visit section.

On 12/15/22 at 2:07 PM, a follow up interview was conducted with the RA. The RA stated that she had just called the mobile dental care and had left a message and was waiting for them to call back regarding resident 12. The RA stated that resident 12 had refused the extractions because resident 12 did not want to have the extractions done in her wheelchair.

Additional information was provided by the facility on 12/20/22, after the survey had been concluded.

On 12/19/22 at 11:52 AM, a Care Conference note was created and documented "To give further explanation. [Name of resident 12 removed] had stated that she wanted to remain in her own chair for the procedure of having her teeth removed. The dentist had stated due to the nature of the procedure she would not be able to remain in her own chair. Since [name of resident 12 removed] is Non weight bearing and the dentist does not have a lift, that would not be possible. Further appt were canceled until a resolution could be found. Currently seeking contract with [name of dental company removed] services. Hoping they can find a solution. Follow up to: 06/21/2022 13:37 [1:37 PM] Care Conference."

On 12/20/22 at 9:36 AM, a Nurses Note was created and documented "[Name of dental care removed] dentist in the building to perform cleanings and follow up dental care. [Name of

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F 791	Continued From page 55 resident 12 removed] states she does not wish to get up at this time." [Note: The note created by the DON was in reference to a note effective 12/2/22 at 9:36 AM. This note was unable to be located during the survey.]	F 791		
F 812 SS=D	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 and interview, it was determined that the facility did not store, prepare, and distribute food in accordance with professional standards for food services safety. Specifically, a staff member was observed not sanitizing or changing gloves while distributing food in the dining room. On 12/12/22 at 12:00 PM, the lunch dining	F 812		

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F 812	Continued From page 56 service in the main dining room was observed. a. At 12:05 PM, the Dietary Aide (DA) was observed to serve a resident in the main dining area their lunch tray. The DA was observed to have disposable medical gloves on. The DA was observed to enter the kitchen after serving a resident, adjusted her surgical mask, did not change the gloves or sanitize her hands. b. At 12:10 PM, the DA was observed to serve a resident in the main dining area their lunch tray. The DA was observed to have disposable medical gloves on. The DA removed the covering on the fruit cup, scratched her face, and returned to the kitchen to get the resident a juice drink. The DA was observed to return to the kitchen and did not change the gloves or sanitize her hands. The DA was observed walking around the kitchen and then proceeded to stack napkins. On 12/15/22 at 8:14 AM, an interview with the Dietary Manager (DM) was conducted. The DM stated that during dining, staff were expected to take off gloves and sanitize their hands when they walked into the kitchen. The DM stated that when gloves were being used in the kitchen, staff were expected to remove the gloves and sanitize or wash their hands before leaving the kitchen.	F 812		
F 883 SS=E	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	F 883		

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receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been 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:

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F 883	Continued From page 58 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive 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 did not ensure that each resident was offered an influenza and/or pneumococcal immunization and that the medical record included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, for 3 out of 20 sampled residents, residents that had consented to the pneumococcal immunization did not have documentation that the pneumococcal immunization was provided. In addition, a resident that had consented to the influenza immunization did not have documentation that the influenza immunization was provided. Resident identifiers: 19, 23, and 24. Findings included: 1. Resident 19 was admitted to the facility on 7/20/22 with diagnoses which included hypothyroidism, altered mental status, and essential hypertension. On 12/12/22, resident 19's medical record was reviewed. A signed pneumococcal immunization consent form dated 7/20/22, was located in resident 19's medical record but both the consent and decline	F 883		

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options were marked on the form. No documentation could be found that indicated whether resident 19 had or had not received the pneumococcal immunization.

2. Resident 23 was admitted to the facility on 10/19/22 with diagnoses which included cerebral infarction, type 2 diabetes mellitus, unsteadiness on feet, schizophrenia, and acute kidney failure.

On 12/12/22, resident 23's medical record was reviewed.

A signed pneumococcal immunization consent form dated 10/19/22, was located in resident 23's medical record but no documentation could be found that indicated resident 23 had received the pneumococcal immunization.

3. Resident 24 was admitted to the facility on 11/4/22 with diagnoses which included pneumonia, chronic obstructive pulmonary disease, hypoxemia, chronic viral hepatitis C, personal history of traumatic brain injury, paranoid schizophrenia, and chronic respiratory failure.

On 12/12/22, resident 24's medical record was reviewed.

A signed pneumococcal immunization consent form dated 11/4/22, was located in resident 24's medical record but no documentation could be found that indicated resident 24 had received the pneumococcal immunization.

A signed influenza immunization consent form dated 11/4/22, was located in resident 24's medical record but no documentation could be

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F 883	Continued From page 60 found that indicated resident 24 had received the influenza immunization. On 12/13/22 at 8:32 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated the facility held vaccination clinics for the staff and residents who wanted to get vaccinated. CNA 1 stated the facility had just held a flu clinic for anyone who wanted the influenza vaccination. On 12/13/22 at 10:18 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated the facility had a weekly in-service which included education on COVID-19 and the vaccine. The IP stated they had occasional vaccine clinics for residents and staff. The IP stated they just had a influenza vaccination clinic and that a COVID-19 vaccination clinic would be coming up.	F 883		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of	F 885		

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transmission, including if normal operations of the facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to inform residents, resident representatives, and resident families of the occurrence of a single confirmed infection of coronavirus disease of 2019 (COVID-19), or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other by 5:00 PM the next calendar day. Specifically, three facility staff members tested positive for COVID-19 and residents, resident representatives, and resident families were not notified of the outbreaks.

Findings included:

Review of the "Facility COVID Testing - Employee Outbreak" tracking log revealed the following:

a. On 11/17/22, the Administrator (ADM) tested positive.

b. On 11/21/22 Therapy 1 tested positive

[Note: The Resident Advocate (RA) tested positive on 10/26/22, the results were not documented on tracking log.]

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Resident progress notes were reviewed for residents 1, 10, 12, 13, 19, 23, and 24. No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

The facility's Policies and Procedures for "Infection Prevention and Control" were reviewed. Under section "Interventions for Resident Care when COVID-19 is Confirmed" it stated "Family Notification: The facility will follow guidance from CDC [Centers for Disease Control and Prevention] and CMS [Centers for Medicare & Medicaid Services] about notifying families and responsible parties about the spread of COVID-19 in the facility:

Following the occurrence of a single confirmed infection of COVID-19 OR

Three or more residents or staff with new onset of respiratory symptoms occurring within seventy-two hours of each other.

This notification should include all efforts made by the facility to manage the confirmed infection or cluster of symptomatic residents/staff. Notification may be made through email, website posting, and/or telephone message by 5pm the next calendar day after a COVID-19 infection is confirmed or a cluster of symptomatic residents/staff is identified. After the initial notification, updates must be provided when there are new confirmed infections or clusters. If no new cases are identified, weekly updates must be provided until the infections are resolved."

The facility's website was reviewed. In the

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COVID-19 Facility Status section, the Coronavirus COVID-19 Update revealed the website was last updated on 8/2/22. The last paragraph stated, "No news is good news - so if we haven't updated this statement, it means we haven't had any positive tests or other significant issues regarding COVID-19."

On 12/12/22 at 2:22 PM, an interview was conducted with the Administrator in Training (AIT). The AIT stated families were notified when there was a COVID-19 outbreak via a phone call. The AIT stated they also posted the information on the front door. The AIT stated the Director of Nursing (DON) oversaw the phone calling but delegated the task to other staff members. The AIT stated she did not know how notifications were documented but stated the RA or DON would know.

On 12/12/22 at 2:37 PM, an interview was conducted with the ADM. The ADM stated he tested positive for COVID-19 on Thursday, November 17, 2022. The ADM stated he went into the building, was tested, then left. The ADM stated he had been in the facility Monday through Wednesday prior to testing positive. The ADM stated he did not consider it an outbreak. The ADM stated he was unsure if the residents and their families were notified that he had COVID-19. The ADM stated when someone tested positive for COVID-19, they tried to determine who that person had been in contact with at the facility and tested those specific individuals. The ADM stated he felt the DON would be better able to answer the questions and proceeded to call her.

On 12/12/22 at 2:49 PM, an interview was conducted with the DON via phone. The DON

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stated that the RA notified resident families via phone when there was a COVID-19 outbreak. The DON stated she was unsure how the RA documented the notification phone calls, as this was a new responsibility for the RA. The DON stated that the ADM left the building the day he tested positive and had not been in the building prior. The DON stated the ADM had been at a conference Monday through Wednesday prior to being tested on Thursday. The DON stated there was a folder with this information in her desk. The DON stated the last resident outbreak was a while ago, probably August. The DON stated the facility sent a resident to the hospital where they got COVID-19 and when they returned to facility, they were still positive for COVID-19. The DON stated the last staff outbreak was before Thanksgiving. The DON stated the staff member tested positive and was sent home.

On 12/13/22 at 11:17 AM, an interview was conducted with the RA. The RA stated when there was a COVID-19 outbreak, she was responsible to call all resident families and write a progress note that stated the call was made. The RA stated that no one had tested positive for COVID-19 since she received this assignment so she had not made any notification phone calls yet. The RA stated she was assigned the task in August 2022. The RA stated she came to work on 10/26/22, and was tested for COVID-19. The RA stated the test came back positive for COVID-19. The RA stated she had only been at work for three hours before testing positive. The RA stated she had no idea if anyone notified residents or called resident families. The RA stated the last resident who tested positive for COVID-19 that she recalled was in July.

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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 887 SS=E	Continued From page 65 COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the	F 887 F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465102	A. BUILDING _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	250 EAST 600 NORTH PRICE, UT 84501

(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 887	Continued From page 66 benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure the resident's medical record included documentation that indicates, at a minimum, the following: that the resident or resident representative was provided education regarding the benefits and potential risks associated with the Coronavirus disease of 2019 (COVID-19) vaccine; each dose of COVID-19 vaccine administered to the resident; or if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. Specifically, for 5 out of 20 sampled residents, the facility did not provide the resident or resident representative with education of the benefits and potential risks associated with the COVID-19 vaccination. In addition, the resident's medical record did not include documentation regarding the residents' COVID-19 vaccination refusal or	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 67	F 887		

acceptance. Resident identifiers: 14, 15, 19, 23, and 24.

Findings included:

1. Resident 14 was admitted to the facility on 5/10/21 with diagnoses that included non-ST-elevation myocardial infarction, type 2 diabetes mellitus with hypoglycemia, major depressive disorder, chronic pain syndrome, heart failure, and peripheral autonomic neuropathy.

On 12/12/22, resident 14's medical record was reviewed.

No documentation was found regarding resident 14's COVID-19 immunization status.

No documentation was located that indicated resident 14 or resident 14's representative were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine.

2. Resident 15 was admitted to the facility on 8/11/22 with diagnoses which included encounter for orthopedic aftercare, displace trimalleolar fracture of left lower leg, epilepsy and epileptic syndromes with complex partial seizures, essential hypertension, and personal history of traumatic brain injury.

On 12/12/22, resident 15's medical record was reviewed.

No documentation was found regarding resident 15's COVID-19 immunization status.

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F 887	Continued From page 68	F 887		

No documentation was located that indicated resident 15 or resident 15's representative were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine.

3. Resident 19 was admitted to the facility on 7/20/22 with diagnoses which included hypothyroidism, altered mental status, post COVID-19 condition, and essential hypertension.

On 12/12/22, resident 19's medical record was reviewed.

No documentation was found regarding resident 19's COVID-19 immunization status.

No documentation was located that indicated resident 19 or resident 19's representative were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine.

4. Resident 23 was admitted to the facility on 10/19/22 with diagnoses which included cerebral infarction, type 2 diabetes mellitus, unsteadiness on feet, schizophrenia, and acute kidney failure.

On 12/12/22, resident 23's medical record was reviewed.

No documentation was found regarding resident 23's COVID-19 immunization status.

No documentation was located that indicated resident 23 or resident 23's representative were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 69	F 887		

5. Resident 24 was admitted to the facility on 11/4/22 with diagnoses which included pneumonia, chronic obstructive pulmonary disease, hypoxemia, chronic viral hepatitis C, personal history of traumatic brain injury, paranoid schizophrenia, and chronic respiratory failure.

On 12/12/22, resident 24's medical record was reviewed.

No documentation was found regarding resident 24's COVID-19 immunization status.

No documentation was located that indicated resident 24 or resident 24's representative were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine.

On 12/13/22 at 8:32 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated the facility held vaccination clinics for the staff and residents who wanted to get vaccinated. CNA 1 stated the facility had just held a flu clinic for anyone who wanted the influenza vaccination.

On 12/13/22 at 10:18 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated the facility had a weekly in-service which included education on COVID-19 and the vaccine. The IP stated they had occasional vaccine clinics for residents and staff. The IP stated they just had a influenza vaccination clinic and that a COVID-19 vaccination clinic would be coming up.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F553 – Right to participate in Planning Care

Parkdale Health and Rehab intends to establish and maintain more accurate documentation, keep up to date care plans and hold timely care conferences.

Resident 16's had a care conference on: 11/29/2022 The plan of care was reviewed with resident 16 and all questions were answered to his satisfaction.

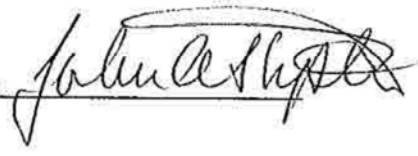
All residents had the potential to be affected. A facility audit of all residents was completed by 1/18/23 to ensure all residents have had a care plan meeting within the past 90 days. Any residents identified who have not had a care plan meeting had one scheduled at the resident and resident representative's convenience.

Director of Nursing provided training with Resident Advocate by 1/13/2023 about requirements for care conferences and the regulatory requirements of involving each resident in his or her plan of care.
Facility staff to document in the medical record after the care conferences to discuss who was in attendance and include a summary of the conversation.

A weekly focused audit to be done by the Resident Advocate or Designee of facility residents to ensure that care conferences were held as scheduled and documentation was entered in the medical record. After eight weeks, audits will continue monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F641-Accuracy of MDS assessment

Parkdale Health and Rehab intends to ensure MDS Assessments accurately reflect the resident's status.

Resident 15's MDS was corrected to indicate the TBI on 12/14/2022.
Resident 21 no longer resides at the facility.

All residents have the potential to be affected. A facility audit of 20% of residents to be done to compare MDS diagnosis coding with the MDS. Any issues were corrected and addressed per protocol.

MDS Coordinator received training by the Regional Director of Clinical Reimbursement on MDS accuracy and common coding errors on 12/30/2021. This training will continue as errors are identified.

A focused weekly audit of MDS's to be done by the Regional Director of Clinical Reimbursement to identify errors for a total of eight weeks. After eight weeks, the audit frequency will be increased to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F656-Develop/Implement Comprehensive Care Plan

It is the intent of Parkdale Health and Rehab to establish and maintain accurate Care Plans.

Resident 16's Plan of Care was updated on 12/24/2022 to address incomplete focuses and address the diagnoses of Post-Traumatic Stress Disorder and Major Depressive Disorder.
Resident 80 no longer resides at the facility

All facility residents can be affected. A facility audit to be completed by 1/18/2023 of all current resident's care plans to ensure they were each comprehensive and individualized.
Psychotropic Diagnoses and Wound care plans to be reviewed by 1/18/2023 to ensure they were properly care planned with current interventions.

An Inservice was held at 4:30pm on Thursday January 12, 2023, by the Director of Nursing with all nursing staff to educate on care plan requirements.
MDS coordinator was trained by Regional Director of Clinical Reimbursement on 12/30/2022 about requirements of a comprehensive plan of care.
Wound Care Nurse education on 12/8/22 about updating the plan of care when wounds are developed and with changes of interventions.

A weekly focused audit to be completed by the Director of Nursing or designee for eight weeks to ensure care plans are created timely and updated with any change of conditions. After eight weeks, the audit frequency will be increased to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature

F684-Quality of Care

It is the intent of Parkdale Health and Rehab to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Resident 12's Nephrostomy tube was removed by resident, and she is refusing further interventions
Resident 15 no longer resides at this facility.
Resident 80 no longer resides at this facility.

A facility audit to be performed by 1/18/2023 to ensure that residents with wounds or skin impairment have treatment/services in place per professional standards of practice. Treatment orders to be obtained for any areas of concern and care plan updated to reflect new interventions.

An Inservice with facility employees completed at 4:30pm on Thursday, January 12, 2023, by Director of Nursing to review proper order placing procedures, MD notification, and proper documentation of wound care.
An in-service with the Director of Nursing was completed on 1/12/2023 by Regional Nurse Consultant about performing 48-hour chart checks for residents who have admitted to the facility to ensure treatments are properly treated per professional standards of practice and documented in the medical record.
Facility Director of Nursing or Designee to interview facility floor staff daily to identify potential situations where treatment should be initiated or revised, such as drains not functioning properly, residents not keeping dressings in place, or resident concerns of itchy/dry skin.

Facility Director of Nursing or Designee to perform weekly focused audits to review residents with skin/wound impairments to ensure treatment and services are provided per professional standards of practice and documented in the medical record. After eight weeks, audits will be moved to monthly until QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F686-Treatment/SVCS to Prevent/Heal Pressure Ulcer

Parkdale Health and Rehab aims to establish and maintain an effective Wound Management Team to provide residents with the necessary treatment and services to prevent healing, infection, and new ulcers from developing.

Resident 80 no longer resides at this facility.

A facility audit of residents with wounds was completed by 1/18/2023 to ensure each wound was being provided treatment per physician's orders.

The facility wound care nurse to receive training on the standard of treatment for wound treatment from Professional Wound Specialist team by 1/18/2023.
Facility nursing staff to receive training on managing residents with substantial risk for skin breakdown, interventions to prevent pressure injuries, actions to take when a pressure injury is identified, and on ensuring orders for treatment are entered in the electronic medical record.
Director of Nursing to receive training from Regional Nurse Consultant about auditing orders ensuring orders are properly entered into the electronic medical record.

Facility Director of Nursing/Designee to do a weekly focused audit of residents with wounds to ensure that treatments are in place and being documented on per standard of practice.
Facility Director of Nursing/Designee to do a weekly focused audit of new wounds to ensure treatment was entered per standard of practice, care plans were updated, and treatment orders were entered per protocol.
After eight weeks of audits, both audits will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F742-Treatment of Psych Concerns

Parkdale Health and Rehab aims to provide appropriate treatment and services to a resident diagnosed with any mental disorder or who has a history of trauma and/or post-traumatic stress disorder.

Resident 16's level II PASRR was reviewed, and recommendations were entered into the plan of care and psychological services were scheduled. Resident is refusing them at this time.

A facility audit of residents with mental health or PTSD diagnosis by 1/18/2023 to ensure that each resident has the opportunity for mental health services.

Resident advocate will receive additional training with LCSW/ Designee by 1/20/2023 on how to recognize when a SS consult is necessary.

The resident advocate will complete a weekly focused audit of residents with mental health disorders to ensure psychosocial needs are being met and appropriate interventions are in place. After eight weeks of audits, both audits will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F757-Unnecessary Medications

It is the intent of Parkdale Health and Rehab to ensure that each resident's drug regimen is free from unnecessary drugs.

Resident 2's medications were reviewed by the Medical Director on 1/10/2023 and the monitoring order Torsemide was adjusted to allow staff the ability to enter the vital signs as indicated.
Resident 84's medications were reviewed by the Medical Director on 1/10/2023 and the monitoring order for the Enalapril was adjusted to allow staff the ability to enter the vital signs as indicated.

A facility audit of all residents with blood pressure medications was performed by 1/18/2023 and the parameters were reviewed to ensure they were firing correctly in the electronic health record. Any errors were corrected per protocol.
The facility reviewed parameters for Blood Pressure Medications with the Medical Director and parameters were removed from any resident that the physician has determined is stable and does not need daily vitals checks.

An in-service was held by the Director of Nursing on 1/12/23 for all nursing staff to review the facility protocols on blood pressure parameters. Staff were educated on who to contact if they are unable to enter the required vital signs in the electronic health record.

A weekly focused audit to be completed by the Director of Nursing/Designee of residents on blood pressure medications to ensure parameters are followed and vitals documented as ordered. After eight weeks of audits, both audits will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F758-Unnecessary Psychotropic/PRN Use

It is the intent of Parkdale Health and Rehab to establish and maintain a psychotropic medication regimen free from unnecessary psychotropic drug use.

Resident 10 GDR (Gradual Dose Reduction) was completed on 12/15/2022

Complete a facility audit of all residents currently using psychotropic medication to ensure targeted behaviors are identified on each psychotropic meeting form. Have physician rational for clinically contraindicated form signed by medical director immediately following psychotropic meeting each month. Continue to contract with LCSW and pharmacist to ensure accuracy of psychotropic meetings.

LCSW and Pharmacist consultant educated DON on 1/10/2023 about Gradual dose reduction regulations and psychotropic medications regulatory compliance. LCSW and Pharmacist consultant will continue to educate DON and RA each month during psychotropic meetings. Also available for questions or concerns outside of meeting times as needed.

Parkdale DON will forward monthly psychotropic audit form to regional nurse consultant who will audit monthly psychotropic reporting using audit form to ensure targeted behaviors are identified and Physician Rational for Clinically Contraindicated GDR forms have been signed by physician.

Parkdale DON/designee to complete Weekly focused Audit of psychotropic medication to ensure appropriate GDR forms are in place. After eight weeks of audits, both audits will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F760-Residents are Free of Significant Medication Error

It is the intent of Parkdale Health and Rehab to ensure that each resident is free of any significant medication errors.

Resident 15 was reviewed for the medication error and an incident report as generated to document investigation. Resident was monitored for ill effects from missing the two doses of levetiracetam (Keppra) and there were none.

The Director of Nursing/Designee performed a facility audit by 1/18/2023 of residents who admitted back from the hospital in the past month to identify any medications missing. Any orders found were addressed per facility protocol.

A facility in-service was done by Director of Nursing on 1/12/2023 about the process of reviewing discharge orders from the hospital and ensuring a double check is completed to catch any missing medications. Nursing staff will be given a test to validate their understanding of order placing procedures.
An in-service with the Director of Nursing was completed on 1/13/23 by Regional Nurse Consultant about performing 48-hour chart checks for residents who have admitted to the facility to ensure medications are entered into the electronic medical records per protocol.

A weekly focused audit of residents who have been admitted to the facility to ensure medications were transcribed correctly into the electronic health record. After eight weeks of audits, the audit will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F791-Routine/Emergency Dental Srvcs in NFs

It is the intent of Parkdale Health and Rehab to ensure that each resident receives routine and 24-hour emergency dental care.
Resident 12 was reviewed by a dentist and the swelling/pain has resolved. The resident was scheduled for dental services as needed.

A facility wide audit of dental services was performed by 1/18/2023 to ensure residents have received routine and emergent dental services based on their needs.

An education was done by the Director of Nursing with all facility nursing staff on 1/12/23 on accurate and timely documentation.
Contract Services with Aria partners started in November of 2022. Parkdale will continue contracting dental services with Aria partners each month to provide dental services. Those residents not eligible for Aria partners will be seen at outside Dental Offices.

A weekly focused audit will be performed by the Director of Nursing/Designee to ensure residents with dental pain have received emergent indicated services.
A weekly focused audit will be performed by the Director of Nursing/Designee to ensure residents attend their routine dental appointments as scheduled.
After eight weeks of audits, the audit will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F812-Food Procurement/Store/Prepare/Serve-Sanitary

It is the intent of Parkdale Health and Rehab to establish and maintain Food Procurement/Store/Prepare/Serve-Sanitary services.

No residents were found to be affected by this practice.

The Corporate Director of Nutrition to do a training with the Facility Dietary Manager about training procedures to ensure sanitary/safe food delivery by 1/21/23.
Facility staff (including dining service personnel) to r training on 1/12/23 about proper hand hygiene during food delivery to residents.

A weekly focused audit to be completed by Dietary Manager/Designee to ensure staff are using proper hand hygiene/PPE when delivering food to residents with meals. After eight weeks of audits, the audit will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F883-Influenza and Pneumococcal Immunizations

It is the intent of Parkdale Health and Rehab to establish and maintain an efficient vaccination protocol.

Resident 19: Facility staff reviewed pneumococcal immunization documentation and offered vaccination per protocol. Documentation was entered into the medical record.
Resident 23: Facility staff reviewed pneumococcal immunization documentation and offered vaccination per protocol. Documentation was entered into the medical record.
Resident 24: Facility staff reviewed pneumococcal immunization documentation and offered vaccination per protocol. Documentation was entered into the medical record.

A facility wide audit was completed by the Director of Nursing on 1/18/23 to ensure all residents have received vaccinations they requested. Any deficits were addressed, and documentation entered the medical record.

An education was completed on 1/12/23 with facility nurses about ensuring residents are offered vaccinations when they can receive them and to include documentation in the medical record. Facility Infection Preventionist created a spreadsheet to track resident immunizations which will be updated at least monthly.

A weekly focused audit to be done by the Director of Nursing/Designee of new admissions to ensure they have received the indicated vaccinations with documentation in the medical record. After eight weeks of audits, the audit will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F885-Reporting Residents, Representatives and Families

Parkdale Rehab aims to create and maintain an appropriate process for informing residents, resident representatives, or families about the spread of covid-19 in the facility by following CDC and CMS guidelines.

Resident 1- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Resident 10- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Resident 12- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Resident 19- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Resident 23- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Resident 24- No documentation was found that indicated residents, resident representatives, or resident families were notified of the COVID-19 outbreaks on 10/26/22 and 11/21/22.

Infection Preventionist will inform Resident Advocate when an outbreak has happened within 2 hours of knowledge. RA will document in each resident's chart using progress notes that the resident, family representative and or family members have been informed of a covid-19 outbreak before 5pm on the next business day as per CDS and CMS guidelines. Parkdale website will remain up to date with the most up-to-date information regarding outbreak status.

Regional Nurse Consultant will educate Infection preventionist by 1/18/2023 about current CDC and CMS guidelines and regulations regarding covid outbreak. Regional Nurse Consultant will educate Resident Advocate on how to create an appropriate progress note.

Administrator will use an audit tool created to identify if a progress note has been made and notification of resident, resident representative/ family members have been contacted after each covid-19 positive case.

The administrator will report his/her results of the audit in QAPI meeting

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

F887-Covid 19 Immunization

It is the intent of Parkdale Health and Rehab to establish and maintain a COVID consent form unique to Parkdale, which will be used for each resident.

Resident 14- Reviewed immunization, consent form obtained, resident consented to receive covid-19 vaccine
Resident 15- no longer resides at this facility
Resident 19- Reviewed immunization, consent form obtained, resident declined consent to receive covid-19 vaccine
Resident 23- Reviewed immunization, consent form obtained, resident declined consent to receive covid-19 vaccine
Resident 24- Reviewed immunization, consent form obtained, resident consented to receive covid-19 vaccine

Facility audit of current residents by 1/20/2023 by DON to ensure they have a covid vaccine consent form.

An in-service was held Thursday, January 12th at 4:30pm to educate nursing staff on new consent form. Nursing staff will notify Infection Control Specialists about who needs vaccinations immediately after completing admission paperwork. The infection preventionist will then arrange to have Covid vaccinations as needed.
Parkdale has developed our own individual consent form for COVID-19 Immunizations and implemented it in the admission process.

A weekly focused audit will be completed by the infection preventionist/designee to ensure appropriate consent forms are available to residents.
DON will complete focused weekly audit of new admissions to ensure they have an appropriate covid vaccine consent form.
After eight weeks of audits, both audit frequencies will be moved to monthly until the QA committee determines a lesser frequency is indicated.

Identified trends will be reviewed/reported monthly and as needed to the Quality Assurance Committee until a lesser frequency is deemed appropriate

Compliance date is Friday, February 3rd, 2023

Administrator Signature 

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	465102	A. BUILDING 01 B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	250 EAST 600 NORTH PRICE, UT 84501

(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
E 000	Initial Comments Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 12-14-2022 in the presence of the facility manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	E 000	Cole Julian approval:01-03-2023 poc:01-19-2023	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required	E 039		

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

John A. Stephenson, IV Administrator 12/29/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465102	A. BUILDING **01** B. WING _____	**12/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	**250 EAST 600 NORTH** **PRICE, UT 84501**

(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
E 000	Initial Comments Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 12-14-2022 in the presence of the facility manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	E 000		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required	E 039		

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

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

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E 039	Continued From page 1 community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual	E 039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	**250 EAST 600 NORTH** **PRICE, UT 84501**

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E 039	Continued From page 2 facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or	E 039		

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E 039	Continued From page 3 (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 4 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 5 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario,	E 039		

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E 039	Continued From page 6 and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 7 exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and	E 039		

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E 039	Continued From page 8 emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 9 emergency plan, as needed. This REQUIREMENT is not met as evidenced by: E-0039 Based on record review and interview made in the presence of the facility manager on 12-14-2022 it was determined that the facility failed to conduct exercises to test the emergency plan at least annually. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed. This deficiency affected the testing requirements	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 10 of the emergency preparedness program. Findings include: 1-During the record review it was discovered that the facility did not have any record that they had completed the required testing standard for testing the emergency plan.	E 039		
K 000	INITIAL COMMENTS K-000 Initial Comments. Statutory and regulatory authority for this Life Safety Code survey that was conducted on 12-14-2022 in the presence of the facility manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) Life Safety from fire.	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: K-100 Based on observations made in the presence of the facility manager on 12-14-2022 during the facility tour it was determined that the facility did not maintain Cooking Facilities in	K 100		

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K 100	Continued From page 11 accordance with NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Section 6.2.3.3 This deficiency affected 2 areas of the exhaust grease filters bank. Findings include: The grease filters in the dietary exhaust hood were not arranged so that all exhaust air passes through the grease filter, the filter bank had 2 gaps of approximately 1 inch allowing grease to be vented out into the exhaust duct. Ref: 2012 NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Section 6.2.3.3	K 100		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: K-291 Based upon observations made during the record review made in the presence of the facility manager on 12-14-2022 it was determined that the facility did not provide an emergency lighting system in accordance with NFPA 101 20.2.9.1. This deficiency affected all of the required tests. Findings include: 1-During the record review the facility failed to provide documentation for the 90 min annual test of the emergency lighting system. Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds in	K 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465102	A. BUILDING **01** B. WING _____	**12/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	**250 EAST 600 NORTH** **PRICE, UT 84501**

(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
K 291	Continued From page 12 accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).	K 291		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: K-0511 Based upon observations made in the presence of the facility manager on 12-14-2022, it was determined that the facility did not maintain electrical equipment in accordance with NFPA 101 19.5.1 and 9.1.2. This deficiency affected 2 GFCI outlets. Findings include 1-During the facility tour it was observed that the outlet in the beauty salon on the east wall was not GFIC protected and was observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7) 2- During the facility tour it was observed that the	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465102	A. BUILDING **01** B. WING _____	**12/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	**250 EAST 600 NORTH** **PRICE, UT 84501**

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K 511	Continued From page 13 outlet in the laundry room on the north wall was not GFIC protected and was observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7)	K 511		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-914 Based on observations made in the presence the facility manager on 12-14-2022 it	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465102	A. BUILDING **01** B. WING _____	**12/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKDALE HEALTH AND REHAB	**250 EAST 600 NORTH** **PRICE, UT 84501**

(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
K 914	Continued From page 14 was determined that the facility did not perform Maintenance and testing on the receptacles at the patient bed locations for integrity, continuity, polarity, and retention force of the grounding blades in accordance with NFPA 99,2012,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4. This deficiency could affect all residents. Findings include: During the facility tour it was observed that the receptacles at or near the resident beds and exam rooms were not hospital grade and were not being tested annually. All receptacles near resident beds and exam rooms shall be tested or a hospital grade receptacle in accordance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.	K 914		

Parkdale Health and Rehabilitation
250 East 600 North – Price, Utah
Plan of Correction for Life Safety Inspection performed Wednesday, December 14, 2022

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

E 039 – Disaster Drill Testing Requirements

Cole Julian
approval:01-03-2023
poc: 01-04-2023

No Residents were affected by this citation E 039.

All Residents had the potential to be affected by staff not testing our Emergency Plan per federal guidelines.

Identify the Root Cause resulting in the facility's failure to meet the requirements of testing the Facility Emergency Plan

The Parkdale Administration failed to recognize the requirement to have two Disaster Drills per year instead of one.

Develop solutions and systematic changes that need to be taken to address the root cause

Maintenance Director gave an Inservice to Department Heads at our IDT Meeting at 9:30 AM Thursday, December 29, 2022 about the requirement for exercising the facility disaster plan twice per year. This inservice will also be given at our Resident Council Meeting on Thursday, January 19, 2022.

Implement didactic teaching to facility staff and residents as indicated by the above Root Cause Analysis

Maintenance Director will provide a table-top disaster plan exercise, with an appropriate Facilitator, at our All-Staff meeting on Thursday, January 12, 2023.

Perform and document audits that incorporate a realistic and relevant behavioral evaluation of staff adherence to disaster drill practices.

A spreadsheet will be created that includes this requirement to have two disaster drills performed per year that will be included in a regular Maintenance Rounds. This maintenance Rounds will be performed monthly by Administrator and Maintenance Director. Any problems will be reported in daily Stand-up meeting immediately.

Integrate corrective action measures into the facility's Quality Assessment and Performance Improvement plan for one complete Survey cycle

A report of these Maintenance Rounds will be given in our monthly Quality Assurance meeting, including the exercising two disaster drills per year.

Persons responsible for this PoC: Alec Stephenson, Administrator and Anthony White, Maintenance Director

Compliance date is January 19, 2023

K 100 – Cooking Facilities (Exhaust Grease Filters

No Residents were affected by this citation K 100.

All Residents had the potential to be affected by grease filters not being arrayed per federal guidelines.

Identify the Root Cause resulting in the facility's failure to meet the requirements of a proper Cooking Facility requirement

The Parkdale Administration failed to notice the two gaps in the filter array above the stoves in the dietary department.

Develop solutions and systematic changes that need to be taken to address the root cause

Maintenance Director will place a stainless steel plate at the left end of the filter array that will assure that no gaps will occur between any of the filter panels in the hood above the kitchen stoves, by Thursday, January 12, 2023.

Implement didactic teaching to facility staff and residents as indicated by the above Root Cause Analysis

Maintenance Director will educate Dietary Department staff on the requirements of proper grease filter banks at a Dietary Department inservice on Thursday, January 12, 2023.

Perform and document audits that incorporate a realistic and relevant behavioral evaluation of staff adherence to disaster drill practices.

A spreadsheet will be created that includes inspection of the grease filter bank at least monthly. This will be included in a regular Maintenance Rounds by Administrator and Maintenance Director. Any problems will be addressed by Maintenance Director immediately.

Integrate corrective action measures into the facility's Quality Assessment and Performance Improvement plan for one complete Survey cycle

A report of these Maintenance Rounds, including inspecting the grease filters will be given in our monthly Quality Assurance meeting.

Persons responsible for this PoC: Alec Stephenson, Administrator and Anthony White, Maintenance Director

Compliance date is January 19, 2023

K 291 – Emergency Lighting

No Residents were affected by this citation K 291.

All Residents had the potential to be affected by staff not testing emergency lighting per federal guidelines.

Identify the Root Cause resulting in the facility's failure to meet the requirements of proper testing of emergency lighting

The Parkdale Administration failed to understand the requirement for a 90-minute annual test of facility lighting, as well as the functional 30-second monthly testing with a minimum of three weeks and a maximum of 5 weeks between tests.

Develop solutions and systematic changes that need to be taken to address the root cause

Maintenance Director completed the annual 90 minute test of Parkdale's emergency lighting on Thursday, December 22, 2022. Maintenance Director will also create a spreadsheet that documents the monthly functional testing of the emergency lighting system as well as the annual 90-minute test.

Implement didactic teaching to facility staff and residents as indicated by the above Root Cause Analysis

Maintenance Director will educate Parkdale administrative staff on the requirements of emergency lighting testing at our Department Head meeting on Tuesday, December 27, 2022.

Perform and document audits that incorporate a realistic and relevant behavioral evaluation of staff adherence to disaster drill practices.

A spreadsheet will be created that includes:

1. The 90-minute annual test of the facility emergency lighting system; and
2. The monthly functional testing that documents a minimum of 3 weeks between tests, and no more than 5 weeks between tests, for not less than 30 seconds each.

This spreadsheet will be included in a regular Maintenance Rounds to be conducted monthly by Administrator and Maintenance Director.

Integrate corrective action measures into the facility's Quality Assessment and Performance Improvement plan for one complete Survey cycle

A report of these Maintenance Rounds will be given in our monthly Quality Assurance meeting, including the 90-minute annual emergency lighting test and the monthly functional 30-second tests.

Persons responsible for this PoC: Alec Stephenson, Administrator and Anthony White, Maintenance Director

Compliance date is January 19, 2023

K 511 Utilities – Gas and Electric (GFIC in Laundry and Beauty Shop)

No Residents were affected by this citation K 511.

All Residents had the potential to be affected by lack of outlets in laundry and beauty salon that are GFCI protected.

Identify the Root Cause resulting in the facility's failure to meet the requirements of NFPA 54 relating to GFCI outlets within 6 feet of a sink or tub.

Parkdale Administration failed to understand the requirement that outlets that are within 6 feet of a sink should be GFCI protected.

Develop solutions and systematic changes that need to be taken to address the root cause

On Thursday, December 22, 2022, the Maintenance Director removed the two non-compliant outlets in the laundry room and the beauty salon, and replaced them with the protected GFCI outlets.

Implement didactic teaching to facility staff and residents as indicated by the above Root Cause Analysis

Maintenance Director will educate Parkdale administrative staff on the requirements of GFCI protection if an outlet is within 6 feet of a sink, at our Department Head meeting on Tuesday, December 27 2022.

Perform and document audits that incorporate a realistic and relevant behavioral evaluation of staff adherence to disaster drill practices.

Inspection of GFCI outlets properly placed will be included on a monthly Maintenance Rounds checklist.

Integrate corrective action measures into the facility's Quality Assessment and Performance Improvement plan for one complete Survey cycle

A report of these Maintenance Rounds will be given in our monthly Quality Assurance meeting, including the inspection of GFCI outlets near sinks.

Persons responsible for this PoC: Alec Stephenson, Administrator and Anthony White, Maintenance Director

Compliance date is Thursday, January 19, 2023

K 914 – Electrical Systems – Maintenance and Testing of Non- Hospital-Grade receptacles

No Residents were affected by this citation K 914.

All Residents have the potential to be affected by improper testing of Resident room and Resident area outlets per federal guidelines.

Identify the Root Cause resulting in the facility's failure to meet the requirements of K 914.

Parkdale administration failed to understand that outlets near Resident beds and in other Resident areas must either be a hospital-grade, or, if they are not, each outlet needs to be tested annually for integrity, continuity, polarity and retention force of the grounding blades.

Develop solutions and systematic changes that need to be taken to address the root cause

1. Maintenance Director will take a facility map and mark where each outlet in Resident bed areas and Resident exam rooms and common areas, by Thursday, January 19, 2023;
2. Maintenance Director will then number each outlet in question, and will mark each outlet with the established number, by Thursday, January 19, 2023;
3. Maintenance Director and Administrator will create a spreadsheet listing each outlet in question;
4. Maintenance Director will perform a test of each of the identified outlets and will document the date of the test on the spreadsheet. Maintenance Director will complete one facility sweep and document such, by Thursday, January 19, 2023.

Implement didactic teaching to facility staff and residents as indicated by the above Root Cause Analysis

Maintenance Director will educate Parkdale administrative staff on the requirements of outlets found near Resident beds or in Resident areas, at our Department Head meeting on Tuesday, December 27, 2022.

Perform and document audits that incorporate a realistic and relevant behavioral evaluation of staff adherence to infection control practices.

Maintenance director and Administrator will create a flowsheet of each identified, numbered outlet that meets the conditions outlined above. The flowsheet will give the date the test was performed, the results of the test, and any corrective action that was taken if a specific outlet is considered faulty.

Integrate corrective action measures into the facility's Quality Assessment and Performance Improvement plan for one complete Survey cycle

This flowsheet will be included on the agenda of our monthly Quality Assurance (QAPI) meeting

Persons responsible for this PoC: Alec Stephenson, Administrator and Anthony White, Maintenance Director

Compliance date is January 19, 2023