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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00173427. The 2567 was sent electronically on 08/10/22.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/10/2022

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 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents with 16 residents included in the sample and three residents reviewed for beneficiary notification. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Notification of Medicare Non-Coverage (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service). The facility failed to complete the NOMNC for Resident (R)150. This placed the resident at risk for being uninformed of his rights for appeal and potential for financial liability related to the end of the Medicare Part A episode. Findings included:	F 582		

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F 582	Continued From page 2 - Review of R150's electronic medical record (EMR) documented the Medicare Part A episode began on 06/10/22 and ended on 06/24/22. R150 discharged from the facility on 06/25/22. The facility lacked documentation that staff issued the NOMNC to the resident or resident's Durable Power of Attorney (DPOA). The medical record lacked documentation of notification of the resident's right to appeal the decision of Medicare non-coverage and the resident's potential financial liability. On 07/27/22 at 04:00 PM Administrative Staff A stated the facility had not had a social services director/staff member for several months so the NOMNC had not been completed and given to the residents as it should have been. The facility did not provide a policy on beneficiary notification or NOMNC. The facility failed to provide the required NOMNC intended to inform the residents of his/her rights, and provide the contact information to appeal the end of therapy services covered under Medicare Part A. This failure prevented R150 from being fully informed of his rights for appeal and increased the potential for financial liability related to the end of the Medicare Part A episode.	F 582		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

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by:
The facility identified a census of 55 residents. The sample included 16 residents with five residents reviewed for activities of daily living (ADL's). Based on observation, record review, and interviews, the facility failed to provide consistent bathing opportunities for resident (R)27, R34, R16, R18, and R31. This deficient practice placed the residents at risk for decreased psychosocial wellbeing and increased skin complications.

Findings Included:

- The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included diagnoses of muscle weakness, retention of urine (lack of ability to urinate and empty the bladder), dementia (progressive mental disorder characterized by failing memory, confusion), major depressive disorder (major mood disorder), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), chronic kidney disease, and cognitive communication deficit.

R27's "Significant Change Minimum Data Set (MDS)" dated 06/16/22 noted a Brief Interview for Mental Status Score of six indicating severe cognitive impairment. The MDS indicated that he required extensive assistance from one staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing.

A review of R27's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" completed 07/16/22 indicated that he required extensive assistance with most of his ADL's related to his dementia. The CAA noted that ADL's were

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triggered for bathing due to weakness, limited range of motion, poor coordination, and visual impairment.

R27's "Care Plan" revised 02/28/22 noted that he had a self-care deficit related to his ADL's. The plan noted that he required assistance from one staff member and directed staff provided opportunities for bathing twice a week. The plan noted that staff provided bathing as needed.

A review of R27's "Bathing Look-Back" report from 04/01/22 through 07/28/22 (119 days) revealed R27 received seven baths/showers (4/4, 4/11, 4/14, 4/21, 4/25, 6/16, and 7/7). The report indicated no refusals occurred during the reviewed period.

On 07/27/22 at 10:00 AM R27 laid in bed and ate his breakfast. He wore a stained t-shirt and incontinence brief. R27's hair appeared greasy and uncombed. He reported that his personal hygiene had not been completed. He reported he could not recall when he last was given a bath by the staff but reported that it's been a while.

On 07/28/22 at 09:00 AM R27 laid in bed watching television. He wore clean clothes, but his hair still appeared greasy and unwashed. He noted that he did not receive a bath the previous night.

On 07/28/22 at 05:10 PM Certified Nurses Aid (CNA) M stated that the residents were given two baths a week at a minimum. She noted that the bathing schedule was followed to ensure that all residents were receiving the proper care. She stated that the baths and refusals were documented in the resident's chart and if a

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resident refused or missed a bath, an alternative bath was offered.

On 07/28/22 at 06:03PM an interview with Licensed Nurse (LN) G, she stated that the care staff had access to the care plans and could see when and how the residents received their shower. She stated that if a resident refused a bath or didn't get one, the nurse attempt an offer. She noted that the residents should be receiving two baths a week unless otherwise stated in the care plan. She stated that the bath sheets get turned into the nursing director.

The facility did not provide a policy related to bathing.

The facility failed to provide consistent bathing opportunities for R27. This deficient practice placed R27 at risk for decreased psychosocial wellbeing, and icnreased risk for skin breakdown, and infections.

- The "Medical Diagnosis" section within R34's Electronic Medical Records (EMR) included diagnoses of quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), traumatic brain injury, neuromuscular bladder dysfunction (dysfunction of the urinary bladder caused by a lesion of the nervous system), spinal cord injury, and cognitive communication deficit.

R34's "Quarterly Minimum Data Set (MDS)" dated 06/11/22 noted a Brief Interview for Mental Status Score of four indicating severe cognitive impairment. The MDS noted that he required extensive assistance from two staff for bed mobility, transfers, dressing, toileting, and

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personal hygiene. The MDS noted that he was totally dependent on two staff for bathing.

A review of R34's "Activities of Daily Living (ADL's) Care Area Assessment (CAA)" completed 04/10/22 indicated he was unable to perform the majority of his ADL's safely due to his quadriplegia related to his spinal cord injury. The CAA noted that interventions were care planned to prevent further decline in his ADL's.

R34's "Care Plan" revised 06/07/22 noted that he had a self-care deficit related to his quadriplegia and spinal injury injury. The care plan noted that he required extensive assistance from two staff for bathing and the use of a mechanical lift for all transfers.

A review of R34's "Bathing Look-Back" report from 04/01/22 through 07/28/22 (119 days) revealed R27 received six baths/showers (4/7, 4/14, 4/21, 4/25, 5/4, and 6/29). The report indicated no refusals occurred during the reviewed period.

On 07/26/22 at 01:30 PM R34 reported that he had not had a bath in a week. He was wearing clean clothing and sat in his electric wheelchair. His catheter bag hung under his chair in a dignity bag.

On 07/28/22 at 05:10 PM Certified Nurses Aid (CNA) M stated that the residents were given two baths a week at a minimum. She noted that the bathing schedule was followed to ensure that all residents were receiving the proper care. She stated that the baths and refusals were documented down in the resident's chart and if a resident refused or missed a bath an alternative

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bath was offered.

On 07/28/22 at 06:03PM an interview with Licensed Nurse (LN) G, she stated that the care staff had access to the care plans and could see when and how the residents received their shower. She stated that if a resident refused a bath or didn't get one the nurse offered one to the resident. She noted that the residents should be receiving two baths a week unless otherwise stated in the care plan. She stated that the bath sheets get turned into the nursing director.

The facility did not provide a policy related to bathing.

The facility failed to provide consistent bathing opportunities for R34. This deficient practice placed R34 at risk for decreased psychosocial wellbeing, and increased risk for skin breakdown, and infections.
- R16's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of a right femur (thigh bone) fracture, end stage renal (kidney) disease, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and pain.

R16's "Admission Minimum Data Set" (MDS) dated 06/27/22 recorded a Brief Interview for Mental Status score of 14 which indicated intact cognition. The MDS recorded no rejection of cares. R16 required extensive assistance of two staff for transfers and toileting, extensive assistance of one staff for other activities of daily living (ADLs) except eating, for which she was independent after setting up. The MDS

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documented R16 required assistance of one staff for bathing but noted bathing did not occur during the assessment period. The MDS documented R16 was frequently incontinent of urine but continent of bowel.

R16's "ADL Care Area Assessment" (CAA) dated 07/02/22 documented R16 needed assistance with her ADLs.

R16's "Care Plan" dated 06/29/22 recorded R16 required a sit to stand lift with assist of two staff for all transfers. Another intervention directed staff R16 required assistance of one staff for bathing and to offer bathing twice a week and as needed. Two staff were required to transfer R16 to the shower chair.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 06/23/22 to 07/26/22 (33 days) revealed R16 received two baths/showers (07/12/22 and 07/17/22). The "Bathing" task was documented "Activity Itself Did Not Occur" four occasions on the following dates: 06/27/22, 06/30/22, 07/04/22, and 07/07/22. The clinical record lacked documentation of refusal for bathing.

On 07/27/22 09:23 AM R16 sat in a wheelchair; staff pushed the wheelchair to the front entrance to wait for transportation to dialysis.

On 07/28/22 at 05:06 PM, Certified Nurse's Aide (CNA) M stated each unit had a bath/shower book with a list and staff checked that book at the start of their shift. CNA M stated the bath/shower was charted in the point of care (POC) electronic chart, and if a resident refused their bath/shower an alternative time or bath was offered. CNA M

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stated she reported to the charge nurse if the resident continued to refuse their bath/shower then the refusal was charted in POC.

On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated a bath/shower list for the residents was located in the staffing book on each unit by room number. LN G stated the CNA's notified the charge nurse if the resident refused their shower/bath, then the charge nurse attempted to find out why the resident had refused.

On 07/28/22 at 06:37 PM Administrative Nurse D stated the bath/shower list was by a standing schedule if the resident did not have a preference at the time of admission. Administrative Nurse D stated the charge nurse should check the bathing report routinely to monitor the bathing and if a resident was consistently refusing their bath/shower, an interview with the resident by the charge nurse should be conducted to find out the root cause for the refusals.

The facility was unable to provide a policy related to bathing.

The facility failed to provide consistent bathing for R16. This placed R16 at increased risk for skin complications and impaired dignity.

- R18's electronic medical record (EMR), under the "Diagnoses'" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-

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progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 was totally dependent on one staff member for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 was always incontinent of bladder and bowel.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDs recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after set up. R18 was totally dependent on one staff for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 was always incontinent of

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bladder and bowel.

The "ADLs Care Area Assessment" (CAA) dated 09/28/21 documented R18's diagnoses included dementia without behaviors, weakness, repeated falls, and dysphagia. R18 needed help with her ADLs. The "Urinary Incontinence CAA" recorded R18 needed extensive assistance using the toilet. She was incontinent of both bowel and bladder.

The "Care Plan" revised on 06/28/22 directed staff R18 required participation of one staff with bathing. It directed staff to bathe R18 twice weekly and as needed.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 04/01/22 to 07/26/22 (117 days) revealed R18 received eight baths/showers (05/13/22, 05/20/22, 05/23/22, 05/27/22, 06/03/22, 06/06/22, 07/01/22, and 07/23/22). The "Bathing" task was documented "Activity Itself Did Not Occur" four occasions on the following dates: 04/08/22, 04/11/22, 04/18/22, 06/13/22, 07/08/22, 07/12/22, and 07/16/22. The clinical record lacked documentation of refusal for bathing.

On 07/27/22 at 08:24 AM revealed R18 sat alone at the dining room table and ate breakfast unassisted. R18 repeatedly said "hey, hey." Despite the repeated verbalizations, no staff acknowledged or engaged with R18 at that time.

On 07/28/22 at 05:06 PM, Certified Nurse's Aide (CNA) M stated each unit had a bath/shower book with a list and staff checked that book at the start of their shift. CNA M stated the bath/shower was charted in the point of care (POC) electronic chart, and if a resident refused their bath/shower

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an alternative time or bath was offered. CNA M stated she reported to the charge nurse if the resident continued to refuse their bath/shower then the refusal was charted in POC.

On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated a bath/shower list for the residents was located in the staffing book on each unit by room number. LN G stated the CNA's notified the charge nurse if the resident refused their shower/bath, then the charge nurse attempted to find out why the resident had refused.

On 07/28/22 at 06:37 PM Administrative Nurse D stated the bath/shower list was by a standing schedule if the resident did not have a preference at the time of admission. Administrative Nurse D stated the charge nurse should check the bathing report routinely to monitor the bathing and if a resident was consistently refusing their bath/shower, an interview with the resident by the charge nurse should be conducted to find out the root cause for the refusals.

The facility was unable to provide a policy related to bathing.

The facility failed to ensure consistent bathing for R18, who preferred to be bathed at least twice weekly. This placed R18 at increased risk for skin complications and impaired dignity.

- R31's electronic medical record (EMR), under the "Diagnosis" tab, recorded diagnoses of functional quadriplegia (he complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord) and stage four pressure ulcer (pressure wound deep enough to

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reach bone and/or muscle).

R31's "Admission Minimum Data Set" (MDS) dated 06/16/22 recorded a Brief Interview for Mental Status score of 14 which indicated intact cognition. The MDS recorded no rejection of cares. R31 was totally dependent on two staff for transfers. She required extensive assistance of one staff for dressing and limited assistance for other activities of daily living (ADLs) which included bed mobility and personal hygiene. She required supervision and one staff assist with eating. The MDS documented R31 was totally dependent on one staff for bathing. The MDS documented R31 had a swallowing disorder. The MDS recorded R31 had a feeding tube and received more than half her daily nutrition and hydration through the tube.

R31's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 06/22/22 documented she required assistance with all ADL's.

R31's "Care Plan" revised 06/15/22 documented she required assistance of two staff members for bathing. The "Care Plan" directed the staff to offer to assist R31 twice a week and as needed to get a bath/shower.

Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed from 06/13/22 to 07/26/22 (44 days) revealed R31 received no baths/showers. The "Bathing" task was documented "Activity Itself Did Not Occur" nine occasions on the following dates: 06/16/22, 06/20/22, 06/23/22, 06/30/22, 07/04/22, 07/17/22, 07/12/22, 07/22/22, and 07/26/22. The clinical record lacked documentation of refusal for

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bathing.

On 07/26/22 at 02:12 PM R31 reported she had never been offered a shower/bath; she laid in bed with the head of her bed elevated slightly. R31 had the blanket pulled to her chest level.

On 07/28/22 at 05:06 PM, Certified Nurse's Aide (CNA) M stated each unit had a bath/shower book with a list and staff checked that book at the start of their shift. CNA M stated the bath/shower was charted in the point of care (POC) electronic chart, and if a resident refused their bath/shower an alternative time or bath was offered. CNA M stated she reported to the charge nurse if the resident continued to refuse their bath/shower then the refusal was charted in POC.

On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated a bath/shower list for the residents was in the staffing book on each unit by room number. LN G stated the CNA's notified the charge nurse if the resident refused their shower/bath, then the charge nurse attempted to find out why the resident had refused.

On 07/28/22 at 06:37 PM Administrative Nurse D stated the bath/shower list was by a standing schedule if the resident did not have a preference at the time of admission. Administrative Nurse D stated the charge nurse should check the bathing report routinely to monitor the bathing and if a resident was consistently refusing their bath/shower, an interview with the resident by the charge nurse should be conducted to find out the root cause for the refusals .

The facility was unable to provide a policy related to bathing.

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F 677	Continued From page 15 The facility failed to provide consistent bathing for R31. This placed R31 at increased risk for skin complications and impaired dignity.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 16 residents with two residents reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to provide diabetic (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) monitoring for Resident (R)95 who required an acute hospitalization for dangerously low blood glucose levels. The facility also failed to complete daily weights on R37 for her congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid). This deficient practice placed R37 at risk for complications related to her CHF. Findings Included: - The "Medical Diagnosis" section within R95's Electronic Medical Records (EMR) included	F 684		

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diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), muscle weakness, hypertension (high blood pressure), cognitive communication deficit, fatigue, and acute kidney failure.

A review of R95's EMR revealed that she had admitted on 07/17/22. The EMR revealed that she currently had no "Minimum Data Set (MDS)" available for review.

R95's "Care Plan" dated 07/19/22 revealed that she was at risk for complication related to her diabetes mellitus. The plan indicated that she would take her medication as ordered by her physician. The plan also indicated that she was at risk for hypoglycemia (low blood sugar) related to a history of nausea and vomiting. The care plan noted that staff were to monitor her and document signs of sweating, tremors, increased heart rate, slurred speech, confusion, and lack of coordination. The care plan noted that staff were to monitor and document R95's intake for each meal.

A review of R95's "Physician's Orders" revealed an order dated 07/16/22 for glimepiride (medication used to reduce blood sugar levels). The order directed to give four milligrams (mg) by mouth once a day with breakfast for diabetes mellitus.

A review of the "Medication Administration Report" for July 2022 indicated that the medication was given daily as ordered.

A review of R95's "Blood Glucose Monitoring" order dated 07/15/22 revealed staff were to check

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her blood sugar twice daily at 08:00 AM and 08:00 PM. The order required documentation of R95's blood glucose (blood sugar) levels during each check. The order noted that if her blood sugar was below 60 milligrams per deciliter (mg/dL) or above 400 mg/dL staff would notify the physician. This order was changed on 07/22/22 and removed the blood sugar levels documentation requirement and only required staff to check off that they completed the glucose checks.

A review of R95's electronic "Medication Administration Record" (EMAR) revealed that the last documented blood sugar reading occurred on 07/24/22. The EMAR noted the reading of 106mg/dL at 09:31 AM.

Further review of R95's EMAR for 07/26/22 revealed that the 08:00 AM blood sugar check had been completed but lacked a measurement or result of the check. The 08:00 PM reading had been completed at 09:55 PM with a note indicating that R95 had been hospitalized.

A review of a "Health Status Note" dated 07/26/22 at 09:39PM indicated that R95 was found unresponsive in her recliner. Her blood sugar was tested at 09:55 PM and revealed to be less than 30mg/dL. The facility contacted emergency medical services and she was transported to an acute medical facility and admitted for hypoglycemia (less than normal amount of sugar in the blood).

A review of R95's "Eating Lookback" and "Snack" reports revealed no entries for her 7/25/22 and 7/26/22 meals to show her food intake.

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On 07/26/22 at 09:03AM R95 reported that she felt extremely cold and appeared to have mild tremors. She stated that she asked staff for a blanket, but no one had returned to help her. She denied pain , nausea, or vomiting.

On 07/26/22 at 09:45AM R95 revealed that she still did not receive her blanket. R95 was observed shivering as she sat in her recliner. She was upset that staff had not come back to check on her in almost 45 minutes.

On 07/26/22 at 10:30AM R95 had been placed in isolation due to testing positive for COVID-19 (contagious respiratory disease caused by the corona virus with symptoms of fever, chills, loss of taste and smell, and fatigue) R95 sat in her recliner with a blanket covering her. She stated that she was still cold but felt a little better.

On 07/27/22 at 07:22AM Administrative Nurse D revealed the R95 had been transferred to an acute care facility the previous night. She stated that staff were completing nightly checks and found her in her recliner unresponsive. She stated that R95 had been in isolation due to a recent positive COVID-19 test.

On 07/28/22 at 06:03 PM in an interview with Licensed Nurse G, she noted that the nurses followed the given doctor's orders and parameters for each medication. She stated that if a resident's blood sugar was outside of the given parameters the nurse should follow the orders. She stated each blood sugar check should have been documented in the resident's medication records. She noted that all staff had access to the care plan and the direct care staff have access to the Kardex (condensed

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information sheet of information pulled directly from the care plan) to view a resident's care needs. She stated that the Kardex included diabetic care, activities of daily living, and dietary orders.

On 07/28/22 at 06:37PM in an interview with Administrative Nurse D, she stated that all blood glucose checks should be recorded in the resident charts. She stated that if a resident's blood sugar were outside of parameters the medication orders should have been followed including notifying the physician. She stated that staff should never leave any of the resident's documentation blank.

The facility did not provide policies related to diabetes care.

The facility failed to provide physician ordered diabetic monitoring which included a blood glucose reading with notification parameters for R95. This placed R95 at increased risk for dangerously low or high blood glucose levels. resulting in an emergency hospitalization for dangerously low blood glucose levels.
- The electronic medical record (EMR) for R37 documented diagnoses of type two diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), and retention of urine (lack of ability to urinate and empty the bladder).

The "Annual Minimum Data Set" (MDS) dated 10/08/21 for R37 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. R37 required

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extensive assistance to total dependence of one staff for her activities of daily living (ADLs). R37 received a diuretic (a medication to promote the formation and excretion of urine) on seven of seven days during the look back period.

The "Quarterly MDS" dated 07/11/22 documented R37 had a BIMS score of 15 which indicated intact cognition. R37 required limited to extensive assistance of one staff with her ADLs. R37 received a diuretic on seven of seven days during the look back period.
The "Urinary Care Area Assessment" (CAA) dated 10/11/21 documented R37 was a long-term care resident with diagnoses that include retention of urine. R37 required extensive assistance with using the toilet.

The "HTN Care Plan" revised 07/23/19 directed staff to monitor for edema and let the physician know if any changes were noticed. It directed staff to give medications as ordered by physician and monitor for side effects.

The "Order Summary Report" for July 2022 for R37 documented an order dated 01/19/21 for furosemide (a strong diuretic) 20 milligrams (mg) one tablet by mouth one time a day for fluid retention.

The "Order Summary Report" for July 2022 for R37 documented an order dated 07/14/21 for a daily weight one time a day for edema.
.
The "Treatment Administration Record" (TAR) for April 2022 revealed that R37's daily weight was not obtained on two of 30 opportunities (04/04/22 and 04/09/22. The weight was not obtained and was documented as not applicable (NA) on 16 of

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30 opportunities (04/05/22, 04/06/22, 04/07/22, 04/08/22, 04/12/22, 04/13/22, 04/15/22, 04/16/22, 04/17/22, 04/20/22, 04/21/22, 04/22/22, 0427/22 and 04/30/22).

The May 2022 TAR revealed R37's weight was not obtained on 6 of 31 opportunities (5/05/22, 05/07/22, 05/08/22, 05/09/22, 05/13/22, and 05/30/22).

The June TAR for R37 revealed a weight was not obtained on four of 30 opportunities (06/07/22, 06/22/22, 06/24/22 and 06/26/22).

The July 2022 TAR for R37 revealed a weight was not obtained on two of 27 opportunities (07/05/22 and 07/24/22); NA was documented and weight was not obtained on four of 27 opportunities (07/07/22, 07/13/22, 07/14/22, 07/20/22 and 07/24/22).

On 07/28/22 at 05:06 PM Certified Nurse Aide (CNA) M stated the charge nurse would give each CNA a list each morning of who was to be weighed that day. After the aides obtained the weight, the CNA reported the weight to the nurse.

On 07/28/22 at 06:03 PM Licensed Nurse G stated the charge nurse printed out a list daily of who was to be weighed. Most residents only get weighed weekly but there are a few that are daily weights.

On 07/28/22 at 06:36PM Administrative Nurse D stated the charge nurse prints out a list daily of who should be weighed and then list was given to the CNA's to obtain. The CNA should document the weights in the resident's chart and give the list back to the nurse when completed. The nurse

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F 684	Continued From page 22 should document a note when a weight was not obtained. The "Weight Assessment and Intervention" policy reviewed 02/2021 documented: the nursing staff will measure resident weights on admission, and weekly for four weeks thereafter. If no weight concerns are noted at that point, weights will be measured monthly. Weights will be recorded in the individual's medical record. The facility failed to ensure a physician ordered daily weight was obtained for R37 who required the use of a diuretic for fluid retention. This deficient practice put R37 at increased risk for excess weight/fluid retention and adverse side effects.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 16 residents with one reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure staff followed Resident (R) 18's plan of care which directed R18 required assistance of one staff with the use of a transfer belt for transfers. This placed R18, who had a history of	F 689		

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falls, at increased risk for accidents and related injuries.

Findings included:

- R18's Electronic Medical Record (EMR), under the "Diagnoses' tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 was totally dependent on one staff member for bathing. She was unsteady with transfers and only able to stabilize with assistance.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe

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cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. R18 was totally dependent on one staff for bathing. She was unsteady with transfers and only able to stabilize with assistance.

The "ADLs Care Area Assessment" (CAA)" dated 09/28/21 documented R18's diagnoses included dementia without behaviors, weakness, repeated falls, and dysphagia. R18 needed help with her ADLs.

The "Care Plan" revised on 06/28/22 directed staff R18 required assistance of one staff, with the use of a gait belt (belt used to help transfer a person from one place to another) and handheld assistance for transfers.

On 07/2/22 at 09/15/22 AM CNA N placed her arms under R18's arms and around R18's waist and lifted her out of the wheelchair and pivoted her lower extremities. CNA N sat R18 onto the bed and laid R18 onto her back.

On 07/28/22 at 05:06 PM Certified Nurses Aide (CNA) M stated everyone had the ability to see the care plan; the kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) had the resident's

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F 689	Continued From page 25 care information there. CNA M stated the information of how much assistance a resident need for transfers and the equipment that was needed to complete a safe transfer was on the kardex. On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated the kardex was were the nursing staff could find the information of how much assistance needed. On 07/28/22 at 06:37 PM Administrative Nurse D stated everyone including agency staff have access to the kardex which has the information available to know how much assistance and the equipment needed to care for the residents. Administrative Nurse D stated the information comes from the care plan and MDS. The facility was able to provide a policy related to accidents. The facility failed to ensure staff followed R18's plan of care which directed R18 required assistance of one staff with the use of a transfer belt for transfers. This placed R18, who had a history of falls, at increased risk for accidents and related injuries.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. The sample included 16 residents with four reviewed for bowel and bladder management and two reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) care. Based on observation, record review, and interviews, the facility failed to store Resident (R)11's urinary catheter in a sanitary manner to promoted dependent drainage without backflow. The facility additionally failed to

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provide R45 with a toileting program to prevent or reduce incontinence of bladder This deficient practice placed the residents at risk for complication related to urinary tract infections (UTI) and increased risk for incontinence.

Findings Included:

- The "Medical Diagnosis" section within R11's Electronic Medical Records (EMR) included diagnoses of hydronephrosis (excess urine accumulation in kidney(s) that causes swelling of kidneys), chronic kidney disease, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), retention of urine (lack of ability to urinate and empty the bladder), neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and dementia (progressive mental disorder characterized by failing memory, and confusion).

R11's "Annual Minimum Data Set (MDS)" dated 06/08/22 noted a Brief interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted that he was independent and required no assistance for bed mobility, transfers, walking, dressing, toileting, and personal hygiene. The MDS indicated that he required supervision for bathing and eating. The MDS noted that he had an indwelling urinary catheter related to urinary incontinence.

A review of R11's "Indwelling Catheter Care Area Assessment (CAA)" dated 06/10/22 indicated that he required an indwelling catheter related to his neurogenic bladder.

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R11's "Care Plan" revised 06/21/22 directed that his catheter be changed monthly. The plan indicated that staff ensured the positioning of the bag and tubing was below the level of R11's bladder and checked the tubing for kinks in the tubing each shift.

On 07/27/22 at 09:48 AM observation of R11's urinary catheter bag revealed that his catheter bag was inside a wash basin, under his bed, lying flat on its side with urine pooling in the lower tubing area. R11 stated that staff checked it each shift, but the bag was never hung.

On 07/28/22 at 10:49 AM R11's catheter bag was observed laying on its side inside the plastic basin under the bed, with urine pooling back into the catheter tubing.

On 07/28/22 at 05:05PM an interview with Certified Nurses Aid (CNA) M, she stated that staff checked the resident's catheter bag each shift. She stated that the bags should be hung from the bed with a dignity bag. She stated that the bag should never be left flat on its side.

On 07/28/22 at 06:03PM an interview with Licensed Nurse (LN) G, she stated that staff should check the catheter bag each shift and note the amount emptied. She stated that the bags should be hung below the bladder and with a dignity bag covering it. She stated that the bag should never be left on its side or in a position that urine could travel back up the tubing.

The facility did not provide a policy for related to urinary catheter maintenance.

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The facility failed to store R11's urinary catheter in a manner which allowed for dependent drainage to occur without backflow. This deficient practice placed the resident at risk for complication related to UTI and urine retention.

- The electronic medical record (EMR) for R45 documented diagnoses of: cerebral infarction (a stroke occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), benign prostatic hyperplasia (BPH-a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections).

The "Admission Minimum Data Set" (MDS) dated 07/17/22 for R45 documented a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. R45 required limited to extensive assistance of one staff member for activities of daily living (ADLs). R45 required extensive assistance with toileting. R45 was frequently incontinent of urine. R45 was not on a toileting program.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 07/23/22 for R45 documented R45 required assistance with toileting due to impaired mobility; R45 was occasionally incontinent.

The "Bladder Incontinence Care Plan" revised on 07/23/22 directed staff to ensure R45 had an unobstructed path to the bathroom. Staff were to offer to assist R45 to the bathroom/offer his urinal with morning cares, after meals and before bed. Staff were to check on R45 routinely throughout

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the night. Staff were to provide good peri-care (cleaning of the private area) after each incontinent episode. Staff were to keep R45's urinal within easy reach.

A "Documentation Survey Report" for July 2022 documented a task for a 72-hour Bowel and Bladder Monitoring was initiated for resident on 07/12/22 to be done every two hours. The report lacked documentation on five of 12 opportunities on 07/12/22. The report lacked documentation on 4 of 12 opportunities on 07/13/22. The report lacked documentation on eight of 12 opportunities on 07/14/22. On 07/15/22 the report lacked documentation on seven 12 opportunities. On 07/18/22 the report lacked documentation on 10 of 12 opportunities. On 07/20/22 the report lacked documentation on nine of 12 opportunities. On 07/22/22 the report lacked documentation on five of 12 opportunities. On 07/23/22 the report lacked documentation on 10 of 12 opportunities. On 07/24/22 the report lacked monitoring on 12 of 12 opportunities. On 07/25/22 the report lacked monitoring documentation on eight of 12 opportunities. On 07/26/22 the report lacked monitoring documentation on six of 12 opportunities. On 07/27/22 the report lacked monitoring documentation on four of 12 opportunities.

On 07/26/22 02:28 PM R45 sat in his room with his daughter, the call light in reach. R45 stated he has sat for hours at times in a wet brief without staff coming in the room to check on him or assist him with toileting. R45 further stated he would not always remember to turn on the call light when assistance was needed.

On 07/28/22 at 05:06 PM Certified Nurse Aide

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F 690	Continued From page 31 (CNA) M stated most of the residents were incontinent so she was not positive if R45 had been on a toileting program. On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated that not many residents were on a toileting program that she was aware of. Staff were to check on residents every two hours on rounds. LN G stated she had only worked on R45's wing a few times and was not familiar with his care. On 7/28/22 at 12:46PM Administrative Nurse F stated that voiding assessments were done on admission. The MDS pulls information from charting for bowel and bladder. R45 had not been on a toileting program. On 07/28/22 at 06:36 PM Administrative Nurse D stated R45 was on a toilet monitoring program upon admission. All residents on admission were monitored for 72 hours for their voiding patterns. The facility lacked a policy regarding incontinence care. The facility failed to consistently monitor voiding patterns and develop a resident-centered toileting program for R45 which placed him at risk for unnecessary incontinence.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		

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ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. The sample included 16 residents with one resident reviewed for hydration. Based on observation, record review, and interviews, the facility failed to provide consistent intravenous (IV - giving directly through the veins access) fluid therapy as ordered by the physician for Resident (R)11. This deficient practice placed the resident at risk for complication related to dehydration and related complications.

Findings Included:

-The "Medical Diagnosis" section within R11's Electronic Medical Records (EMR) included diagnoses of hydronephrosis (excess urine accumulation in kidney(s) that causes swelling of kidneys), chronic kidney disease, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), retention of urine (lack of ability to

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urinate and empty the bladder), neuromuscular dysfunction of bladder (bladder- dysfunction of the urinary bladder caused by a lesion of the nervous system), and dementia (progressive mental disorder characterized by failing memory, and confusion).

R11's "Annual Minimum Data Set (MDS)" dated 06/08/22 noted a Brief interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted that he was independent with no assistance for bed mobility, transfers, walking, dressing, toileting, and personal hygiene. The MDS indicated that he required supervision for bathing and eating. The MDS noted that he had no weight gain or loss within the last six months. The MDS noted that R11 received IV feeding.

A review of R11's "Dehydration Care Area Assessment (CAA)" dated 06/15/22 noted that he was at risk for dehydration related to his medical diagnoses and required nightly IV fluids to prevent dehydration and decline in health.

R11's "Care Plan" revised 06/21/22 indicated the he was independent with eating and drinking. The plan noted that he received IV fluids through his peripherally inserted central catheter (PICC -a form of intravenous access that can be used for a prolonged period of time) line. The plan noted that staff were to check the PICC Line site daily for signs of infections, kinks, and skin breakdown. The plan noted that the IV fluids were to be administered per the physician's orders.

R11's "Physician's Orders" revealed an order dated 05/20/20 for sodium chloride 0.45% solution to be administered intravenously at 125 milliliters per hour (ml/hr) to total 1,000 ml at

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bedtime each night for chronic kidney disease.

A review of R11's EMR from 02/01/22 through 07/28/2022 revealed that he had not received his overnight IV fluid administrations on 14 occasions (2/24, 3/3, 3/20, 5/13, 5/30, 6/11, 6/12, 6/15, 6/17, 7/19, 7/20, 7/22, 7/24, and 7/27). The EMAR revealed that only one of the missed IV administration dated (7/22) had an attached note that stated, "See Nursing Note".

A review of R11's "Progress Notes" revealed a "Health Status Note" on 07/22/22 at 02:52AM that stated that the facility did not have the IV fluid solution available for the previous two dates (7/19 and 7/20) and that the pharmacy was closed. The noted directed staff to follow-up with the pharmacy in the morning.

On 07/26/22 at 11:20 AM R11 stated that he was not receiving his nightly IV fluid administration like he was supposed to be and was worried that he would end up on dialysis (procedure where impurities or wastes were removed from the blood) because his kidneys would be shutting down on him. He stated that he started marking the days that he did not receive his treatments recently to keep track of the missed administration. A review of his calendar indicated that he missed 7/19, 7/20, 7/22, and 7/24. He stated that he was not sure why the facility continued missing the administrations but several times staff just did not come in to complete.

On 07/28/22 at 10:40 AM Central line dressing care was performed by Licensed Nurse (LN) H. During the dressing change, R11 revealed that he had not received his IV fluid therapy and that staff did not come in the offer it to him the previous

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F 692	Continued From page 35 night. LN H stated that they must be out of the fluid solution or something, but LN H would check. On 07/28/22 at 06:03 PM in an interview with LN G ,she stated that the facility's pharmacy was quick about delivering medication and fluids needed for the residents. She stated that the pharmacy makes multiple runs throughout the day and evening. On 07/28/22 at 06:37 PM in an interview with Administrative Nurse D, she stated that she was aware that R11 had missed two days of his IV fluid therapy due to having to order more fluid but was not aware of missing other administrations. The facility was not able to provide a policy related to fluids, hydration or IV medications. The facility failed to provide consistent IV fluid therapy for Resident (R)11, as ordered by his physician. This deficient practice placed the resident at risk for complication related to dehydration and chronic kidney disease.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		

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enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. The sample included 16 residents. Based on observation, record review and interview the facility failed to ensure that Resident (R) 21's abdominal binder was applied as directed to avoid possible dislodging of his percutaneous endoscopic gastrostomy (PEG-tube placed through abdomen into stomach to allow liquid nutrition) feeding tube. The facility further failed to ensure sanitary care was provided for R31's gravity bag and tubing used to administer enteral (provided directly to the digestive system through an alternative opening such as a feeding tube) nutrition and failed to assess residual as ordered by the physician. This placed the residents at increased risks for complications related to enteral feedings.

Findings Included:

- The Electronic Medical Record (EMR) for R21 documented diagnoses of cerebral infarction (stroke- occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) , hemiplegia and

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hemiparesis (paralysis of partial or total body function on one side of the body, hemiparesis is characterized by one sided weakness, but without complete paralysis) following cerebral infarction affecting dominant side.

The "Admission Minimum Data Set" (MDS) dated 06/26/22 for R21 documented R21 had both long and short-term memory problems. R21 had severely impaired cognitive skills for daily decision making. R21 was totally dependent on one to two staff for his activities of daily living (ADLs). R21 received his nutrition via tube feeding.

The "Nutrition Care Area Assessment" (CAA) dated 06/29/22 for R21 documented he had a gastrostomy tube (G-tube-a surgical creation of an artificial opening into the stomach through the abdominal wall and a surgically inserted tube placed into the stomach through the abdominal wall for use of nutrient solution).

The "Tube Feeding Care Plan" revised 06/21/22 for R21 directed staff that R21 was always to have the abdominal binder on to prevent him from pulling at G-tube.

The "Order Summary Report" for July 2022 documented an order dated 06/29/22 for R21 for abdominal binder, to prevent R21 from pulling the PEG feeding tube every day and night shift.

On 07/27/22 at 09:13 AM R21 rested on his bed on his right side, bed in low position. R21's abdominal binder was not on the resident.

On 07/28/22 at 01:06 PM R21 rested in bed on his left side. R21's abdominal binder was not on.

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On 07/28/22 at 05:06PM Certified Nurse Aide (CNA) M stated she had worked with R21 minimal times and was not aware of him having an abdominal binder.

On 07/28/22 at 01:45PM Administrative Nurse E stated R21 did not always wear the abdominal binder. He had not worn the binder in several days.

On 07/28/22 at 06:36PM Administrative Nurse D stated R21's abdominal binder had not been worn by the resident for several days. Administrative Nurse D stated and the binder had been missing at one point but was found in laundry.

The facility did not provide a policy regarding tube feeding/care.

The facility failed to ensure staff applied R21's abdominal binder to help protect the resident from pulling on his PEG tube. This deficient practice placed R21 at increased risk for accidental PEG tube removal leading to increased risk of nutritional deficits.
- R31's Electronic Medical Record (EMR), under the "Diagnosis" tab, recorded diagnoses of functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord) and stage four pressure ulcer (pressure wound deep enough to reach bone and/or muscle).

R31's "Admission Minimum Data Set" (MDS) dated 06/16/22 recorded a Brief Interview for Mental Status score of 14 which indicated intact cognition. The MDS recorded no rejection of

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cares. R31 was totally dependent on two staff for transfers. She required extensive assistance of one staff for dressing and limited assistance for other activities of daily living (ADLs) which included bed mobility and personal hygiene. She required supervision and one staff assist with eating. The MDS documented R31 was totally dependent on one staff for bathing. The MDS documented R31 had a swallowing disorder. The MDS recorded R31 had a feeding tube and received more than half her daily nutrition and hydration through the tube.

The "Nutrition Care Area Assessment "(CAA) dated 06/21/22 documented R31 was admitted with a stage four pressure ulcer. R31 received some of her nutrition through her feeding tube. The "ADLs CAA" recorded R31's diagnoses include pressure ulcer and severe protein-calories malnutrition. R31 needed assistance with her ADLs.

R31's "Care Plan" dated 06/14/22 directed staff to check for tube placement and gastric contents/residual volume per facility protocol and record. The "Care Plan" dated 06/22/22 documented R31 was dependent with enteral feedings and water flushes and directed staff to follow physician ordered tube feeding.

Review of the EMR under "Orders" tab revealed the following physician orders:
Enteral feed every night shift. Change feeding syringe daily, label with name and date dated 06/13/22.
Enteral feed every shift. Check and record residual. If residual is greater than 150 milliliters (ml), hold feeding and call physician dated 06/13/22.

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Enteral feed every shift. Flush tube with at least 30 ml water before and after medication administration and feeding. Flush tube with five ml water between medications dated 06/13/22. Jevity (a fiber-fortified tube feeding formula) 1.2 Cal liquid give 20 ml via G-Tube at bedtime for tube feeding 20 ml an hour from 07:00 PM through 07:00 AM dated 07/08/22. Disconnect continuous feeding of Jevity at 07:00 AM and restart at 07:00 PM dated 07/08/22.

Review of the clinical record lacked documentation of residual amount for every shift.

On 07/26/22 at 02:10 PM a gravity bag with feeding formula hung from pole dated 07/23/22 07:00 PM at R31's bedside.

On 07/27/22 at 12:48 PM a gravity bag full of feeding formula hung from the pole dated 07/23/22 07:00 PM at R31's bedside.

On 07/28/22 at 08:17 AM Licensed Nurse (LN) H knocked on R31's door, entered and explained to R31 she was there to disconnect her tube feeding. LN H washed her hands, donned gloves, and disconnected tubing. LN H placed plug on the tube. LN H did not perform a flush and stated she had not seen a flush order on the "Medication Administration Record" (MAR). LN H stated that a gravity bag would only be hung and/or used for 12 hours, LN H stated the date on the gravity bag that contained formula was dated 07/27/22. LN H removed the gravity bag and placed bag into the trash. Two piston syringes were observed in R31's bathroom next to the sink; one undated and in a container full of water, another syringe on the counter next to the sink was dated 06/23/22.

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F 693	Continued From page 41 On 07/28/22 at 08: 48 AM LN H stated she found the flush order for R31 on the MAR. LN H stated she offered to flush R31's tube and R31 refused the flush because it was so late after being disconnected and R31 wanted to eat breakfast. On 07/28/22 at 05:06 PM LN G stated a tube feeding gravity bag was good until it was empty. LN G stated a tube feed syringe was good for three days if stored in a bag and kept in the bathroom cabinet by the sink. On 07/28/22 at 06:37 PM Administrative Nurse D stated physician orders should be followed for enteral feeding for any resident who received enteral feedings. Administrative Nurse D stated the gravity bag and syringe should be changed every 24 hours. Administrative Nurse D stated she reviewed the MAR and the residual amount was not in the clinical record. She said the order had been changed on the MAR to include a place to document the amount of residual for R31. The facility was unable to provide a policy related to eternal feeding. The facility failed to ensure for the staff recorded residual formula every shift as ordered by the physician, and failed to provide appropriate care and services for R31's feeding tube equipment, (gravity bag and piston syringes), which placed her at increased risk of tube feeding complications.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents and identified one resident was positive for Covid (highly contagious, potentially life-threatening respiratory infection). The sample included 16 residents with two reviewed for respiratory services. Based on observation, record review and interviews, staff failed to ensure Resident (R)18's nebulizer tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R18 at increased risk for respiratory infection and complications.

Findings included:

- R18's Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated

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09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 did not receive any respiratory treatments.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. The "Special Treatments and Programs" section, which included respiratory treatments, was not completed.

The "ADLs Care Area Assessment" (CAA) dated 09/28/21 documented R18's diagnoses included dementia without behaviors, weakness, repeated falls, and dysphagia. R18 needed help with her ADLs.

The "Care Plan" revised on 06/28/22 directed staff monitor dyspnea (for difficulty breathing) on

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exertion. Staff would remind R18 not to push beyond endurance.

R18's EMR recorded the following physician's orders:
Ipratropium-albuterol solution (Duoneb-medication used to open airways to assist with breathing) 0.5-2.5 milligrams (mg) / three milliliters (ml) inhale orally before meals and at bedtime for shortness of breath and wheezing via nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs). Document minutes spent with resident - time may include evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment dated 06/21/22.
Oxygen as needed one to five liters per minute (LPM) via nasal cannula titrate to keep sets greater than (>) 90% related to hypoxia (inadequate supply of oxygen) dated 12/31/21.
Oxygen tubing change weekly every night shift on Wednesday for hypoxia dated 12/31/21.
Oxygen clean concentrator filter weeklyevery night shift on Wednesday for hypoxia dated 12/31/21.

A "Physician Progress Note" dated 07/14/22 documented R18 was admitted to the facility for falls and weakness post-Covid. The note documented R18 had expiratory wheezing (whistling sounds made when exhaling) and wore oxygen as needed. The note directed R18's COPD was stable and directed to continue the DuoNeb four times daily and oxygen as needed.

Observation on 07/26/22 at 10:22 AM revealed R18's nebulizer tubing/mask was dated 07/13/22. The tubing laid, unbagged and exposed, on the

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F 695	Continued From page 45 bedside table. On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated she was not sure when the oxygen concentrator was cleaned but thought it was at least weekly. LN G said oxygen tubing was changed out weekly but was not sure what day of the week that fell on because night shift was responsible for that. LN G stated that breathing treatment mask tubing/mask and oxygen tubing should be dated and stored in a plastic bag. On 07/28/22 at 06:37 PM Administrative Nurse D stated the oxygen/nebulizer equipment was changed weekly by night shift nurses. Administrative Nurse D stated oxygen tubing and nebulizer equipment should be dated and stored in a plastic when not in use by the resident. The facility was unable to provide a policy related to respiratory management of respiratory supplies and safe storage of respiratory equipment. The facility failed to ensure R18's nebulizer tubing was stored in a sanitary manner to decrease exposure and contamination. This placed R18 at increased risk for respiratory infection and complications.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		

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by:
The facility had a census of 55 residents. The sample included 16 residents with two reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, interview, and record review the facility failed to obtain communication from the dialysis center regarding Resident (R) 16's and R146 health status with each procedure. The facility further failed to measure weights daily as ordered for R16 and R146, and obtain weekly labs for R16. This deficient practice placed R16 and R146 at risk for complication related to dialysis.

Findings Included:

- R16's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnoses of a right femur (thigh bone) fracture, end stage renal (kidney) disease, dependence on dialysis, Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and pain.

R16's "Admission Minimum Data Set" (MDS) dated 06/27/22 recorded a Brief Interview for Mental Status score of 14 which indicated intact cognition. The MDS recorded no rejection of cares. R16 extensive assistance of two staff for transfers and toileting, extensive assistance of one staff for other activities of daily living (ADLs) except eating, for which she was independent after setting up. The MDS documented R16 required assistance of one staff for bathing but noted bathing did not occur during the assessment period. The MDS documented R16

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was frequently incontinent of urine but continent of bowel. The MDS recorded R16 received dialysis.

R16's "ADL Care Area Assessment" (CAA) dated 07/02/22 documented R16 needed assistance with her ADLs. R16's "Nutrition CAA" recorded R16 received fluids in the hospital. The CAAs lacked mention of dialysis.

R16's "Care Plan" dated 06/24/22 directed staff R16 went for dialysis on Mondays, Wednesdays and Fridays and listed the location, chair time and transportation information. An intervention dated 06/24/22 directed staff to review the communication form or flow sheet after dialysis treatment and implement new orders or recommendations.

Review of the EMR under "Orders" tab revealed the following physician orders:
Dialysis every Monday, Wednesday, and Friday, with a chair time of 10:00 AM and completed at 01:30 PM, for end stage kidney disease. Pick up at 09:30 AM. Nurse to ensure that the dialysis communication form was sent with the resident to the dialysis treatment and the resident returns with the communication sheet, so the nurse could complete the form and turn it into medical records dated 06/24/22.

Weights on dialysis days, one time a day every Monday, Wednesday, and Friday for baseline weight dated 06/24/22.

Weekly labs to be drawn every Thursday and faxed to the infectious disease every Thursday evening dated 07/01/22.

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Review of the EMR under the "Misc." tab revealed "Dialysis Communication Sheets" reviewed from 06/24/22 through 07/27/22 lacked the following dialysis communication sheets on: 06/24/22. 06/27/22, 06/29/22, 07/01/22, 07/04/22, 07/13/22, 07/20/22, 07/25/22, and 07/27/22.

Review of EMR under the "Weights/Vital Signs" tab reviewed from 06/24/22 through 07/27/22 lacked documented weights on the following dialysis dates: 06/24/22, 06/27/22, 06/29/22, 07/01/22, 07/04/22, 07/08/22, 07/13/22, 07/15/22, and 07/22/22.

Review of the clinical record lacked labs results for the following dates: 07/07/22, 27/14/22, and 07/21/22.

On 07/27/22 09:23 AM R16 sat in a wheelchair; staff pushed the wheelchair to the front entrance to wait for transportation to dialysis.

On 07/26/22 at 05:06 PM Certified Nurse's Aide (CNA) M stated the staff would obtain the resident's weight and report it to the charge nurse and the nurse filled out the communication sheet. CNA M stated the staff would then push the resident to the front entrance to be transported to dialysis.

On 07/22/26 at 06:05 PM Licensed Nurse (LN) G stated dialysis communication sheets were filled out prior to the resident leaving for dialysis. Vital signs and a weight were obtained and documented on the communication sheet. LN G stated upon return from dialysis the communication was reviewed for any changes or new orders. Once the communication sheet was reviewed, it was sent to medical records to be

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scanned into the resident's EMR.

On 07/26/22 at 06+:37 PM Administrative Nurse D stated she was unable to locate the missing dialysis communication sheets, missing weights and weekly ordered lab results for R16. Administrative Nurse D stated a communication sheet should be filled out and set with the resident going to dialysis and reviewed upon the resident's return along with post dialysis assessment documented on the lower portion of the dialysis communication sheet. Administrative Nurse D stated if the dialysis communication sheet did not return with the resident the charge nurse would call the dialysis center have the sheet faxed and a progress note would be written.

The facility "Dialysis Communication "policy last revised February 2021 documented it was the policy of the facility to communicate openly and effectively with any provider of dialysis for a resident of the facility. The dialysis communication form would be used to send information to and from the from the facility to the dialysis center and back. Upon return of the resident from the dialysis center, the charge nurse of the resident would review the communication form and would obtain necessary post dialysis information.

The facility failed to obtain communication from the dialysis center regarding R16's health status with each procedure. The facility further failed to measure weights prior to dialysis and obtain weekly labs as ordered for R16. This deficient practice placed R16 at risk for complication related to dialysis.
- The Electronic Medical Record (EMR) for R146

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documented diagnoses of: dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and end stage renal disease (ESRD-a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life).

The "Entry Minimum Data Set" (MDS) recorded R146 admitted to the facility on 07/21/22.

The "Admission MDS for R146 was in progress at time of review.

The "Dialysis Care Plan" revised on 07/24/22 documented R146 had dialysis on Monday, Wednesday and Fridays. Staff were directed to monitor weight per physician order. Staff were to obtain vital signs and weight per protocol. Staff were to review the communication form or flow sheet after treatment and implement new orders or recommendations.

The "Orders" tab in the EMR for R146 documented an order dated 07/23/22 for dialysis every Monday, Wednesday and Friday with a chair time of 10:30AM for ESRD.

The "Orders" tab of the EMR recorded an order dated 07/23/22 for a daily weight due to hemodialysis treatments and the use of Lasix (a medication used to reduce extra fluid in the body [edema] caused by conditions such as heart failure, liver disease, and kidney disease).

The facility lacked evidence of "Dialysis Communication Sheets" for R146 for 07/21/22,

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07/25/22 and 07/27/22.

The"Weights/Vitals" tab in the EMR for R146 documented a weight only on 07/21/22, 07/24/22, and 07/25/22.

On 07/28/22 at 05:06 PM Certified Nurse Aide (CNA) M stated the charge nurse would give each CNA a list each morning of who was to be weighed that day. After the aides obtained the weight, the CNA reported the weight to the nurse. Residents on dialysis should get a daily weight but they also get weighed before they left for dialysis.

On 07/28/22 at 06:03 PM Licensed Nurse G stated weights for dialysis patients would get weighed the night before dialysis sometimes if they had an early chair time. Dialysis patients were weighed when they return from dialysis and had an assessment done. A dialysis communication sheet should go with the resident and return with the resident after treatment at the dialysis clinic.

On 07/28/22 at 06:36 PM Administrative Nurse D stated she expected the nurse's to complete the top portion of the communication sheet and the dialysis clinic would complete the middle portion of the sheet and the facility nurse would complete the bottom of the form upon returning from the dialysis clinic. Administrative Nurse D stated the nurse should call the dialysis clinic if the dialysis sheet had not been returned but she had been able to find any dialysis communication sheets for R146.

The facility "Dialysis Communication "policy last revised February 2021 documented it was the

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F 698	Continued From page 52 policy of the facility to communicate openly and effectively with any provider of dialysis for a resident of the facility. The dialysis communication form would be used to send information to and from the from the facility to the dialysis center and back. Upon return of the resident from the dialysis center, the charge nurse of the resident would review the communication form and would obtain necessary post dialysis information. The facility failed to obtain communication from the dialysis center regarding R146's health status with each procedure. The facility further failed to measure weights daily as ordered for dialysis for R146. This deficient practice placed R146 at risk for complications related to dialysis.	F 698		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 16 residents with two residents reviewed for dementia (progressive mental disorder characterized by failing memory, confusion). Based on observations, record reviews, and interviews, the facility failed to provide dementia care and services to support Resident (R)18's highest practicable level of well-being. This deficient practice placed R18 at risk for decreased quality of life and impaired well-being due related to dementia.	F 744		

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Findings included:

- R18's Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia, depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 was totally dependent on one staff member for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 was always incontinent of bladder and bowel. The MDS documented no toileting program or retraining had been attempted. The MDS recorded R18 had a history of falls prior to admission but no falls since admission. R18 weighed 88 pounds (lbs.). R18 received antidepressant (class of medications used to treat depression), and anticoagulants

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(blood thinner) for six days of the look back period.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. R18 was totally dependent on one staff for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 was always incontinent of bladder and bowel. The MDS documented no toileting program or retraining had been attempted. The resident had no falls since the previous assessment. R18 weighed 107 lbs. and the MDS lacked documentation regarding nutritional approaches. The MDS recorded R18 received antipsychotic (class of medication used to treat psychosis), antianxiety (class of medications used to treat anxiety), antidepressant, and anticoagulant for all seven days of the look back period. The MDS recorded a gradual dose reduction had not been deemed clinically inappropriate by a physician.

The "ADLs Care Area Assessment" (CAA)" dated 09/28/21 documented R18's diagnoses included dementia without behaviors, weakness, repeated falls, and dysphagia. R18 needed help with her ADLs. The "Cognitive Loss CAA" recorded R18 had dementia and due to her disease process, she had both short-term and long-term memory

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loss. She was inattentive and had disorganized thinking. The "Communication CAA" recorded due to R18's dementia, she had difficulty understanding others and making herself understood.

The "Care Plan" revised on 06/28/22 directed staff to provide R18 with a homelike environment; she preferred visible clocks, a calendar, low-glare light, consistent care routines, familiar objects, and reduced sensory noise. Interventions dated 07/07/22 directed staff to provide one to one activity such as reading books or magazines to R18. It further directed staff should assist and/or escort R18 to activities. An intervention dated 02/04/22 directed staff to walk R18 to dine and give her a target such as "let's walk to lunch" or "let's walk to bed so you can lay down." An intervention dated 01/20/22 directed staff to stop and talk to R18 as they passed by her. On 06/22/22, an intervention was added which directed when R18 had behavioral issues, such as repetitively calling out, R18 did best in a quiet, less stimulating environment. She usually liked to lay down in bed and relax when she was calling out.

On 07/27/22 at 08:24 AM revealed R18 sat alone at the dining room table and ate breakfast unassisted. R18 repeatedly said "hey, hey." Despite the repeated verbalizations, no staff acknowledged or engaged with R18 at that time.

On 07/28/22 at 09:15 AM CNA N removed R18 from the dining room table without asking R18 if she was finished eating breakfast and pushed her to her room. Without asking R18 if she wanted to lay down on the bed, CNA N placed her arms under R18's arms and around R18's waist and

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lifted her out of the wheelchair and pivoted her on her lower extremities. CNA N sat R18 onto the bed and laid R18 onto her back. CNA N then removed R18's slacks without asking R18's preference or announcing the intended cares. CNA N stated that R18's slacks were not wet, but she knew that R18 would urinate at some point.

On 07/28/22 at 12:43 PM to 12:52 PM CNA N stood next to R18 at the dining room table and assisted R18 with drinking. CNA N did not speak to or interact with R18 during the provision of care.

On 07/28/22 at 05:06 PM CNA M stated the facility reviewed dementia training monthly. CNA M stated she reported any behaviors to the charge nurse.

On 07/28/22 at 06:03 PM Licensed Nurse (LN) G stated dementia training was provided by the facility on a scheduled basis. LN G stated she did not remember the last time she had received dementia training.

On 07/28/22 at 06:37 PM Administrative Nurse D stated dementia training was possibly offered quarterly or at least annually.
The facility was unable to provide a policy related to dementia.

The facility did not provide a policy for dementia care/services.

The facility failed to provide dementia care and services to support R18's highest practicable level of well-being. This deficient practice placed R18 at risk for decreased quality of life and impaired well-being due related to dementia.

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. The sample included 16 residents with five residents reviewed for medication regimen review. Based on observation, record review, and interviews, the facility failed to ensure the Consulting Pharmacist (CP) identified and reported irregularities found with Resident (R)10's insulin (hormone used to treat/control blood glucose levels) administration and further failed to identify and report inappropriate diagnoses for antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing]and other mental emotional conditions) medication use for R18 and R37. This placed the affected residents at risk for unecessary medication treatment and related side effects.

Findings Included:

-The "Medical Diagnosis" section within R10's Electronic Medical Records (EMR) included diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), mild cognitive impairment, abnormal gait and mobility, and history of diabetic ketoacidosis (medical emergency were the high levels of blood sugar cause the body to breakdown fat leading to acid buildup in the blood).

R10's "Significant Change Minimum Data Set (MDS)" dated 05/26/22 noted a Brief Interview for

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Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that he had diabetes mellitus and received insulin.

A review of R10's "Nutritional Status Care Area Assessment" completed 05/29/22 noted that he received a regular diet. His blood sugar was monitored and he received insulin per his physician's order.

R10's "Care Plan" revised 06/06/22 indicated that he was at risk for complications related to his diabetes mellitus. The plan noted that staff were to monitor for signs related to changes in his blood sugar levels, administer his medication by the physician's order, and check his blood sugar as ordered.

A review of R10's "Physician's Orders" revealed an order for staff complete blood glucose monitoring before each meal and at bedtime. The plan instructed staff to notify the physician if blood sugars were found to be below 60 milligrams per deciliter (mg/dL) or above 400 mg/dL.

A review of R10's "Electronic Medication Administration Record (EMAR)" revealed that on five occasions (2/22, 3/12, 3/29, 7/13, and 7/26) from 01/01/22 through 07/27/22 R10's blood sugars were found to be outside of the given parameters but lacked documentation showing that the physician had been notified.

A review of R10's "Physician's Orders" revealed an order dated 05/10/22 to administer insulin aspart (short acting hormone which regulates blood sugar) subcutaneously (beneath the skin) before meals and at bedtime related to his type

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two diabetes. The order indicated that staff were to chart the blood sugar levels and amount of insulin given.

A review of R10's EMAR revealed eight missed insulin administrations between 05/01/22 and 07/27/22. R10's EMAR revealed no explanation of the missing insulin administrations or if the physician had been notified.

The "Monthly Medication Review" failed to identify missing insulin administration for 04/2022, 05/2022, and 06/2022.

On 07/26/22 at 11:20AM R10 reported that he was not satisfied with the management of his blood sugar by the facility. He reported that his blood sugar usually stayed around 150mg/dL while at home but had lately been too high for him to feel comfortable. He noted that staff had missed some blood glucose readings but felt that they were doing their best.

On 07/28/22 at 07:32AM R10's blood glucose was checked by Licensed Nurse (LN) H. LN H completed hand hygiene and donned gloves, cleaned the glucometer and gathered supplies for the check. LN knocked on the door and identified the task to R10. LN H assessed the finger for glucose check and cleaned it with an alcohol wipe. LN H allowed site to dry and used lancet (device used to pierce the skin for blood samples) to draw blood for the glucometer and wiped the first drop of blood away. LN H attained the blood glucose reading of 123mg/dL. LN H cleaned the used supplies . LH H removed his gloves and completed hand hygiene before leaving the room.

On 07/28/22 at 06:03PM in an interview with

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Licensed Nurse (LN) G, she noted that the nurse followed the given doctor's orders and parameters for each medication. She stated that if a resident's blood sugar was outside of the given parameters the nurse should follow the orders. She stated that if the order indicated to notify the physician the nurse would attach a nursing note of the given physician instructions. She stated that the documentation should never be left blank and should always have an indicator if a medication was held or given.

On 07/28/22 at 06:37PM in an interview with Administrative Nurse D, she stated that the nurses should be reviewing the medications for gaps or missed dosages and reporting it there are holes in the EMAR. She stated that the pharmacy had not been reviewing the resident's insulin orders and she was not sure if they should be contacting for missing documentation. She stated that staff should follow the physician's orders for giving insulin and checking blood sugar. She stated that staff should have noted if the physician was notified and the mar should have never had missing gaps or missing documentation.

On 08/01/2022 at 03:58AM in an interview with CP, she stated that she conducts the monthly pharmacy review and notifies the facility of recommendation regarding medication irregularities. She stated that R10 has had a few missed administrations due to his continual refusal of cares and staff should have documented each refusal as it occurred. She noted that R10 recently had his insulin dose reduced due to improved glucose levels and improved hemoglobin testing results.

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The undated facility policy "Medication Regimen Review" documented the CP would review the medication regimen of each resident in enough detail to determine if any apparent irregularities existed. The CP would report any apparent irregularities in writing to the attending physician, the director of nursing and the medical director. The MRR log would be maintained in the resident's clinical record. The log should be kept as part of the resident's active clinical record to reflect at least 12 months of reviews.

The facility failed to ensure the CP identified and reported irregularities found with R10's missed insulin administrations. This deficient practice placed R10 at risk for complications related to his diabetic medication regimen.
- R18's Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered

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level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 was totally dependent on one staff member for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 received antidepressant (class of medications used to treat depression), and anticoagulants (blood thinner) for six days of the look back period. R18 did not receive and respiratory treatments.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. R18 was totally dependent on one staff for bathing. She was unsteady with transfers and only able to stabilize with assistance. The MDS recorded R18 received antipsychotic (class of medication used to treat psychosis), antianxiety (class of medications used to treat anxiety), antidepressant, and anticoagulant for all seven days of the look back period. The MDS recorded a gradual dose reduction had not been deemed clinically inappropriate by a physician.

The "Psychotropic [altering mood or thought] Medication Care Area Assessment" (CAA) dated

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09/28/21 documented R18 had depression and received an antidepressant. The "Cognitive Loss CAA" recorded R18 had dementia and due to her disease process, she had both short-term and long-term memory loss. She was inattentive and had disorganized thinking.

The "Care Plan" recorded an intervention dated 06/10/22 which directed staff to administer R18's antipsychotic medications as ordered and monitor/document for side effects and effectiveness. It directed staff to monitor/record/report to nurse/MD side effects and adverse reactions of psychoactive medications which included unsteady gait, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia (inability to sleep), loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to R18.

R18's EMR recorded a "Physician's Order" for: Seroquel tablet (antipsychotic) give 12.5 milligram (mg) by mouth three times a day for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) mood stability.

Review of the "Monthly Medication Review" (MMR), performed by the CP, reviewed from September 2021 through June 2022 lacked evidence the CP identified and reported the inappropriate diagnosis for antipsychotic medication for F18.

On 07/27/22 at 08:24 AM revealed R18 sat alone at the dining room table and ate breakfast unassisted. R18 repeatedly said "hey, hey."

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Despite the repeated verbalizations, no staff acknowledged or engaged with R18 at that time.

On 07/28/22 at 06:36 PM Administrative Nurse D stated that mood was not an appropriate diagnosis for an antipsychotic medication. The pharmacist did the monthly record review. Administrative Nurse D received the pharmacy reviews and she would take care of the nursing recommendations and then forward the rest to the physician to be addressed.

On 06/01/22 at 04:00 PM CP GG stated she reviewed the resident's clinical record monthly and sent the reported to the director of nursing by email. CP GG stated the diagnosis of mood/anxiety was not an appropriate diagnosis for R18, with a diagnosis of dementia.

The undated facility policy "Medication Regimen Review" documented the CP would review the medication regimen of each resident in enough detail to determine if any apparent irregularities existed. The CP would report any apparent irregularities in writing to the attending physician, the director of nursing and the medical director. The MRR log would be maintained in the resident's clinical record. The log should be kept as part of the resident's active clinical record to reflect at least 12 months of reviews.

The facility failed to ensure the CP identified and reported the inappropriate diagnosis for R18's antipsychotic medication. This placed R18 at risk for unnecessary medications leading to adverse side effects.
- The Electronic Medical Record (EMR) for R37 documented diagnoses of type two diabetes mellitus (DM- when the body cannot use

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glucose, not enough insulin made or the body cannot respond to the insulin), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 10/08/21 for R37 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. R37 required extensive assistance to total dependence of one staff for her activities of daily living (ADLs). R37 required the use of insulin injections (a hormone which regulates blood sugar), antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression).

The "Psychotropic [alters mood and thoughts] Drug Use Care Area Assessment" (CAA) dated for R37 documented R37 took both a daily antidepressant and antianxiety medication.

The "Psychotropic Care Plan" revised 10/25/21 for R37 directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness.

The "DM Care Plan" revised 07/12/19 directed staff to administer medications as ordered; monitor effectiveness and refer to current insulin orders.

The July 2022 "Order Summary Report" documented an order for R37 aripiprazole (Abilify-an antipsychotic medication used alone or with other medications to treat mental disorders)

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give 1.5 milligrams (mg) by mouth one time a day for mood.

The July "Order Summary Report" for R37 documented an order dated 07/18/22 for blood glucose monitoring before meals and at bedtime for type two DM.

The July 2022 "Order Summary Report" documented an order dated 06/28/2021 for Humalog (fast acting insulin) solution 100 unit/milliliter (ml) to inject per sliding scale if 150 - 200 give four units; 201 - 250 give six units; 251 - 300 give eight units; 301 - 350 give 10 units; 351 - 400 = 14 units Call the doctor if greater than 400, before meals for high blood sugar related to type two DM if blood sugar is below 150 do not give Humalog.

The March 2022 "Medication Administration Report" (MAR) for R37 revealed that R37's blood sugar was not obtained, and Humalog was not administered on five of 93 opportunities (03/04/22, 03/11/22, 03/13/22, 03/21/22 and 03/28/22).

The April 2022 MAR for R37 revealed that R37's blood sugar was not obtained, and Humalog not administered as ordered on four or 90 opportunities (4/09/22 morning, 04/09/22 noon, 04/28/22 and 04/29/22).

The May 2022 MAR for R37 revealed R37's blood sugar was not obtained, and Humalog not administered as ordered on five of 93 opportunities (05/05/22, 05/07/22 on two opportunities, 05/08/22, and 05/30/22.

The July 2022 MAR for R37 reveled R37's blood

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sugar was not obtained, and Humalog was not administered as ordered on five of 81 opportunities reviewed (07/05/22, 07/20/22, and 07/24//22 on three opportunities).

Review of the "Medication Regimen Review" (MRR) for R37 for the months of January 2022 to June 2022 lacked evidence the CP notified the facility of the inappropriate diagnosis for Abilify and lacked evidence of notification regarding missed blood glucose readings and insulin administration.

On 07/28/22 at 06:03PM Licensed Nurse (LN) G stated that blood sugars were typically obtained before meals and as needed, and insulin was given as ordered.

On 07/28/22 at 06:36 PM Administrative Nurse D stated that mood was not an appropriate diagnosis for an antipsychotic medication. Blood sugars should be obtained before each meal and at bedtime or as ordered by the physician and then insulin given as directed. The pharmacist did the monthly record review. Administrative Nurse D received the pharmacy reviews and she would take care of the nursing recommendations and then forward the rest to the physician to be addressed.

The undated facility policy "7.10: Medication Regimen Review" documented: the CP will review the medication regimen of each resident in sufficient detail to determine if any apparent irregularities exist. The CP will report any apparent irregularities in writing to the attending physician, the director of nursing and the medical director. The MRR log will be maintained in the resident's clinical record. The log should be kept

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F 756	Continued From page 69 as part of the resident's active clinical record to reflect at least 12 months of reviews. The facility failed to ensure the CP identified and reported an inappropriate diagnosis for the antipsychotic medication Abilify. The facility further failed to ensure the CP identified and reported when R37's blood glucose was not obtained, and insulin was not administered as ordered. This failure had to potential of unnecessary medication use and unwarranted side effects.	F 756		
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 §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	F 757		

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by:
The facility identified a census of 55 residents. The sample included 16 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to provide adequate monitor blood glucose (sugar) levels administer physician ordered insulin (medication used to control blood glucose levels) for Resident (R)10 and R37. This deficient practice placed the residents at risk for abnormal blood glucose levels and related complications.

Findings Included:

-The "Medical Diagnosis" section within R10's Electronic Medical Records (EMR) included diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), mild cognitive impairment, abnormal gait and mobility, and history of diabetic ketoacidosis (medical emergency were the high levels of blood sugar cause the body to breakdown fat leading to acid buildup in the blood).

R10's "Significant Change Minimum Data Set (MDS)" dated 05/26/22 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS indicated that he had diabetes mellitus and received insulin.

A review of R10's "Nutritional Status Care Area Assessment" completed 05/29/22 noted that he was receiving a regular diet, but his blood sugar

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was being monitored and he received insulin per his physician's order.

R10's "Care Plan" revised 06/06/22 indicated that he was at risk for complications related to his diabetes mellitus. The plan noted that staff were to monitor for signs related to changes in his blood sugar levels, administer his medication by the physician's order, and check his blood sugar as ordered.

A review of R10's "Physician's Orders" revealed an order for staff complete blood glucose monitoring (blood sugar) before each meal and at bedtime. The instructed staff to notify the physician if blood sugars were found to be below 60 milligrams per deciliter (mg/dL) or above 400 mg/dL.

A review of R10's "Electronic Medication Administration Record (EMAR)" revealed that on five occasions (2/22, 3/12, 3/29, 7/13, and 7/26) from 01/01/22 through 07/27/22 R10's blood sugars were found to be outside of the given parameters but lacked documentation showing that the physician had been notified.

A review of R10's "Physician's Orders" revealed an order dated 05/10/22 to administer insulin aspart (short acting hormone which regulates blood sugar) subcutaneously (beneath the skin) before meals and at bedtime related to his type two diabetes. The order indicated that staff were to chart the blood sugar levels and amount of insulin given.

A review of R10's EMAR revealed eight missed insulin administrations between 05/01/22 and 07/27/22. R10's EMAR revealed no explanation

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of the missing insulin administrations or if the physician had been notified.

On 07/26/22 at 11:20AM R10 reported that he was not satisfied with the management of his blood sugar by the facility. He reported that his blood sugar usually stayed around 150mg/dL while at home but had lately been too high for him to feel comfortable. He noted that staff had missed some blood glucose readings but felt that they were doing their best.

On 07/28/22 at 07:32AM R10's blood glucose was checked by Licensed Nurse (LN) H. LN H completed hand hygiene and donned gloves, cleaned the glucometer and gathered supplies for the check. LN knocked on the door and identified the task to R10. LN H assessed the finger for glucose check and cleaned it with an alcohol wipe. LN H allowed site to dry and used lancet (device used to pierce the skin for blood samples) to draw blood for the glucometer and wiped the first drop of blood away. LN H attained the blood glucose reading of 123mg/dL. LN H cleaned the used supplies . LH H removed his gloves and completed hand hygiene before leaving the room.

On 07/28/22 at 06:03PM in an interview with Licensed Nurse (LN) G, she noted that the nurse followed the given doctor's orders and parameters for each medication. She stated that if a resident's blood sugar was outside of the given parameters the nurse should follow the orders. She stated that if the order indicated to notify the physician the nurse would attach a nursing note of the given physician instructions. She stated that the documentation should never be left blank and should always have an indicator if a medication was held or given.

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On 07/28/22 at 06:37PM in an interview with Administrative Nurse D, she stated that the nurses should be reviewing the medications for gaps or missed dosages and reporting it there are holes in the EMAR. She stated that the pharmacy had not been reviewing the resident's insulin orders and she was not sure if they should be contacted for missing documentation. She stated that staff should follow the physician's orders for giving insulin and checking blood sugar. She stated that staff should have noted if the physician was notified and the EMAR should have never had missing gaps or missing documentation.

The facility did not provide a policy related to medication administration.

The facility failed to follow the physician's orders to notify the medical doctor on five occasion of the blood sugars being outside of the given parameters and failed to administer insulin on five occasions. This deficient practice placed R10 at risk for complications related to his diabetic care.
- The Electronic Medical Record (EMR) for R37 documented diagnoses of type two diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 10/08/21 for R37 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. R37 required extensive assistance to total dependence of one

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staff for her activities of daily living (ADLs). R37 required the use of insulin injections (a hormone which regulates blood sugar), antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression).

The "DM Care Plan" revised 07/12/19 directed staff to administer medications as ordered; monitor effectiveness and refer to current insulin orders.

The July "Order Summary Report" for R37 documented an order dated 07/18/22 for blood glucose monitoring before meals and at bedtime for type two DM.

The July 2022 "Order Summary Report" documented an order dated 06/28/2021 for Humalog (fast acting insulin) solution 100 unit/milliliter (ml) to inject per sliding scale if 150 - 200 give four units; 201 - 250 give six units; 251 - 300 give eight units; 301 - 350 give 10 units; 351 - 400 = 14 units Call doc if greater than 400, before meals for high blood sugar related to type two DM if blood sugar is below 150 do not give Humalog.

The March 2022 "Medication Administration Report" (MAR) for R37 revealed that R37's blood sugar was not obtained, and Humalog was not administered on five of 93 opportunities (03/04/22, 03/11/22, 03/13/22, 03/21/22 and 03/28/22).

The April 2022 MAR for R37 revealed that R37's blood sugar was not obtained, and Humalog not

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F 757	Continued From page 75 administered as ordered on four or 90 opportunities (4/09/22 morning, 04/09/22 noon, 04/28/22 and 04/29/22). The May 2022 MAR for R37 revealed R37's blood sugar was not obtained, and Humalog not administered as ordered on five of 93 opportunities (05/05/22, 05/07/22 on two opportunities, 05/08/22, and 05/30/22. The July 2022 MAR for R37 reveled R37's blood sugar was not obtained, and Humalog was not administered as ordered on five of 81 opportunities reviewed (07/05/22, 07/20/22, and 07/24//22 on three opportunities). On 07/28/22 at 06:03PM Licensed Nurse (LN) G stated that blood sugars were typically obtained before meals and as needed, and insulin was given as ordered. On 07/28/22 at 06:36 PM Administrative Nurse D stated that blood sugars should be obtained before each meal and at bedtime or as ordered by the physician and then insulin given as directed. A facility did not provide a policy for medication administration or glucose monitoring. The facility failed to ensure R37's blood glucose was obtained, and insulin administered as physician ordered. This failure had to potential of unnecessary medication use and unwarranted side effects.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

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§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
(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

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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:
The facility identified a census of 55 residents. The sample included 16 residents with five residents sampled for unnecessary medication review. Based on observation, record review and interview, the facility failed to ensure that Resident (R)37 and R18 had an appropriate diagnosis for their antipsychotic (a class of medications used to treat psychosis and other mental emotional conditions) medications: Abilify and Seroquel. This place R37 and R18 at risk for unnecessary antipsychotic medication administration and related side effects.

Findings included:

- The Electronic Medical Record (EMR) for R37 documented diagnoses of type two diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia without behavioral disturbance (a progressive mental disorder characterized by failing memory, confusion), hypertension (HTN-elevated blood pressure), retention of urine (lack of ability to urinate and empty the bladder), persistent mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time),

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anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement.

The "Annual Minimum Data Set" (MDS) dated 10/08/21 for R37 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated an intact cognition. R37 required extensive assistance to total dependence of one staff for her activities of daily living (ADLs). R37 required the use of insulin injections (a hormone which regulates blood sugar), antianxiety (a class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of depression).

The "Psychotropic [alters mood and thoughts] Drug Use Care Area Assessment" (CAA) dated for R37 documented R37 took both a daily antidepressant and antianxiety medication.

The "Psychotropic Care Plan" revised 10/25/21 for R37 directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness.

The July 2022 "Order Summary Report" documented an order for R37 aripiprazole (Abilify-an antipsychotic medication used alone or with other medications to treat mental disorders) give 1.5 milligrams (mg) by mouth one time a day for mood.

On 07/28/22 at 06:03PM Licensed Nurse (LN) G

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stated she was unsure about an appropriate diagnosis for Abilify use.

On 07/28/22 at 06:36 PM Administrative Nurse D stated that mood was not an appropriate diagnosis for an antipsychotic medication.

The "Psychotropic Medication Use" policy reviewed 02/2021 documented: Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. Antipsychotic medication shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the "Diagnostic and Statistical Manual of Mental Disorders": schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania); Schizophreniform disorder (a psychotic disorder that affects how you act, think, relate to others, express emotions and perceive reality); Tourette's Disorder (a neurological disorder characterized by involuntary tics and vocalizations and often the compulsive utterance of obscenities) or Huntington disease (a rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder). Diagnoses alone do not warrant the use of psychotropic medication.

The facility failed to ensure an appropriate indication for use for R37's antipsychotic

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medication, Abilify. This failure had to potential of unnecessary antispychotic medication use and related side effects.
- R18's Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one staff. R18 was totally dependent on one staff member for bathing. She was unsteady with transfers and only able to stabilize with assistance. R18 received antidepressant (class of medications used to treat depression), and anticoagulants (blood thinner) for six days of the look back period. R18 did not receive and respiratory treatments.

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The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. R18 was totally dependent on one staff for bathing. She was unsteady with transfers and only able to stabilize with assistance. The MDS recorded R18 received antipsychotic (class of medication used to treat psychosis), antianxiety (class of medications used to treat anxiety), antidepressant, and anticoagulant for all seven days of the look back period. The MDS recorded a gradual dose reduction had not been deemed clinically inappropriate by a physician.

The "Psychotropic [altering mood or thought] Medication Care Area Assessment" (CAA) dated 09/28/21 documented R18 had depression and received an antidepressant. The "Cognitive Loss CAA" recorded R18 had dementia and due to her disease process, she had both short-term and long-term memory loss. She was inattentive and had disorganized thinking.

The "Care Plan" recorded an intervention dated 06/10/22 which directed staff to administer R18's antipsychotic medications as ordered and monitor/document for side effects and effectiveness. It directed staff to monitor/record/report to nurse/MD side effects and adverse reactions of psychoactive

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medications which included unsteady gait, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia (inability to sleep), loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to R18.

R18's EMR recorded a "Physician's Order" for: Seroquel tablet (antipsychotic) give 12.5 milligram (mg) by mouth three times a day for anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and mood stability.

On 07/27/22 at 08:24 AM revealed R18 sat alone at the dining room table and ate breakfast unassisted. R18 repeatedly said "hey, hey." Despite the repeated verbalizations, no staff acknowledged or engaged with R18 at that time.

On 07/28/22 at 06:36 PM Administrative Nurse D stated that anxiety/mood was not an appropriate diagnosis for an antipsychotic medication for R18 with a diagnosis of dementia. Administrative Nurse D stated she felt the pharmacist would have caught the inappropriate diagnosis for an antipsychotic medication during the monthly medication review.

The "Psychotropic Medication Use" policy reviewed 02/2021 documented: Residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective. Antipsychotic medication shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the "Diagnostic and Statistical Manual of Mental

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F 758	Continued From page 83 Disorders": schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania); Schizophreniform disorder (a psychotic disorder that affects how you act, think, relate to others, express emotions and perceive reality); Tourette's Disorder (a neurological disorder characterized by involuntary tics and vocalizations and often the compulsive utterance of obscenities) or Huntington disease (a rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder). Diagnoses alone do not warrant the use of psychotropic medication. The facility failed to ensure an appropriate diagnosis for antipsychotic medication use for R18, who had a diagnosis of dementia. This placed R18 at risk for unnecessary medications leading to adverse side effects.	F 758		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by:	F 807		

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The facility identified a census of 55 residents. The sample included 16 residents with two residents reviewed for hydration. Based on observations, record reviews, and interviews, the facility failed to respond to and provide Resident (R)18, who required thickened liquids, with her requested drinks during meal service. This deficient practice placed R18 at increased risk for dehydration and impaired comfort.

Findings Included:

- R18's Electronic Medical Record (EMR), under the "Diagnoses" tab, recorded diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), history of falling, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 09/22/21 recorded a Brief Interview for Mental Status (BIMS) was not conducted because the resident was rarely or never understood. The staff interview documented R18 had short-and-long-term memory problems and moderately impaired decision making. R18 had inattention, disorganized thinking and an altered level of consciousness which did not fluctuate. The MDS recorded no behaviors. R18 required extensive assistance from one staff for all activities of daily living (ADLs) except eating, for which she required limited assistance of one

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staff. The MDS recorded R18 had a history of falls prior to admission but no falls since admission. R18 weighed 88 pounds (lbs.). The nutritional approachs while a resident was not completed.

The "Quarterly MDS" dated 06/25/22 recorded a BIMS score of zero which indicated severe cognitive impairment. She had disorganized thinking and inattention which did not fluctuate. The MDS recorded R18 had behavioral symptoms not directed at others (such as screaming or disruptive sounds) daily. The MDS documented R18 had no rejection of cares. The MDS recorded R18 was dependent on staff for locomotion and required extensive assistance of one staff for ADLs, except eating for which she was independent after setting up. R18 weighed 107 lbs. and the MDS lacked documentation regarding nutritional approaches.

The "ADLs Care Area Assessment" (CAA)" dated 09/28/21 documented R18's diagnoses included dementia without behaviors, weakness, repeated falls, and dysphagia. R18 needed help with her ADLs. The "Nutrition CAA" recorded R18 needed a puree diet with nectar thick liquids

The "Care Plan" revised on 06/28/22 directed staff R18 needed to be fed. R18 was an aspiration (when a foreign body, such as food, enters the lungs) risk and needed to be supervised at all meals; R18 tended to eat quickly. Encourage R18 to alternate small bites and sips and not user a straw.

A "Physician's Order" dated 01/14/22 for regular diet, pureed texture, and nectar thickened liquids.

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On 7/28/22 08:15 AM R18 sat alone in a wheelchair at the dining room table, and ate breakfast unassisted. R18 stated "hey, hey" a few times out loud. At 08:35 AM R18 asked for more juice to drink. A staff member took R18's empty cup and placed it on the kitchen counter and left the area. At 08:40 AM Dietary Staff BB asked R18 what happened to her glass of juice; R18 was not sure, Dietary Staff BB noted R18's glass was on the counter. Dietary Staff BB asked R18 if she would like more thickened juice, and R18 stated yes. Dietary Staff BB had to go to the other kitchenette for thickened juice. R18 drank the juice and at 08:45 AM asked for another cup of juice, Dietary Staff CC stated "ok" to R18. At 09:03 AM Certified Nurse Aide (CNA) N removed R18 without asking R18 if she was finished with breakfast and pushed R18 in the wheelchair to her room.

On 07/28/22 at 09:05 AM Dietary staff CC stated R18 did not receive the glass of juice that was requested because R18 had already consumed three glass of juice. Dietary Staff CC confirmed R18 was not on a fluid restriction. Dietary Staff CC stated there was no more nectar thickened liquid available except iced tea on that unit. Dietary Staff CC acknowledged she had not offered the iced tea to R18 nor did she get R18 more nectar thickened juice.

On 07/28/22 04:50 PM Dietary Staff BB stated every kitchenette should have the thickened liquids available for the residents on the unit that consume specialized food items. Dietary Staff BB stated the thickened juice must have run out on the unit.

The facility was unable to provide a policy related

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F 807	Continued From page 87 to hydration. The facility failed to respond to and provide R18, who required thickened liquids, with her requested drinks during meal service. This deficient practice placed R18 at increased risk for dehydration and impaired comfort.	F 807		
F 812 SS=E	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: The facility identified a census of 55 residents and one facility kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dining services related to food preparation, equipment cleaning and food storage during service. This deficient practice placed the residents at increased risk related to food borne	F 812		

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illnesses and food safety concerns.

Findings Included:

- On 07/26/22 at 07:25 AM an initial kitchen walk-through revealed two staff members prepping food in the kitchen area were not wearing hairnets while working with food during the prepping of breakfast. At 07:26 AM Dietary Staff CC stated that the kitchen did not have any hairnets available at that time.

An inspection of the dry food storage area revealed opened containers of pancake syrup, Worcestershire sauce, and peanut butter with no opened dates labeled.

An inspection of the dry food mixer revealed dried food residue on the base of the mixer around the buttons.

An inspection of the walk-in refrigerator unit revealed heavy dust and debris buildup of the air-conditioning units blower fan vents with bread, partially covered with parchment paper, directly in the path of the blower unit.

An inspection of the food racks inside the walk-in refrigerator unit revealed metal bins of mashed potatoes and peas labeled "Wednesday" with no dates. The rack contained open but undated pita bread, peas, tortillas, two bags of cheddar cheese, and ham. The egg storage carton within the walk-in refrigerator contained a broken egg with the yoke running onto the other eggs in the carton.

On 07/28/22 at 04:50 PM Dietary Staff BB stated that the kitchen staff should have been wearing

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F 812	Continued From page 89 hairnets at all times in the kitchen. She stated that the kitchen should be cleaned throughout the day during meal services and a deep clean each night. She noted that opened food should be labeled, and prepped foods should be dated. She stated that staff should check daily for food storage. The facility did not provide a food storage or kitchen cleaning policy. The facility failed to maintain sanitary dining services related to food preparation, equipment cleaning and food storage during service. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assessment and assurance (QAA) program to identify quality issues and develop performance improvement plans. This deficient practice placed the resident's at risk for ineffective care. Findings Included:	F 867		

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- The facility failed to ensure residents were provided Notice of Medicare Non-coverage (NOMNC) notices. (Refer to F582)

The facility failed to ensure bathing and personal hygiene was provided for residents who required assistance from staff to complete the care. (Refer to F677)

The facility failed to implement a physician order for daily weights to monitor for excess weight/fluid retention and failed to implement adequate blood glucose monitoring. (Refer to F684)

The facility failed to provide a toileting program to reduce or prevent bladder incontinence. The facility failed to provide consistent catheter (tube inserted into the bladder to drain urine) care of indwelling catheters. (Refer to F690)

The facility failed to provide a physician ordered abdominal binder (a protective wrap type device used to protect a feeding tube, failed to change out the enteral (a form of nutrition that is delivered into the digestive system as a liquid) dietary feeding bag to promote sanitary enteral feeding and failed to document residual feeding. (Refer to F693)

The facility failed to maintain dialysis (blood purifying treatment given when kidney function is not optimum) communications reports for and failed to obtain physician ordered daily weights or implement a nutritional/fluid management program related to dialysis. (Refer to F698)

The facility failed to implement/provide person-centered dementia (progressive mental

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disorder characterized by failing memory, confusion) care. (Refer to F744)

The facility failed to ensure the Consultant Pharmacist (CP) reported missing glucose monitoring and insulin administration and failed to ensure the CP reported the incorrect diagnosis for an antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications. (Refer to F756)

The facility failed to administer physician ordered insulin (hormone which regulates blood sugar) and do glucose monitoring and failed to document physician notification of blood sugars out of parameters. (Refer to F757)

The facility failed to ensure residents with dementia had appropriated diagnoses for antipsychotic medications. (Refer to F758)

The facility failed to ensure that dietary service staff stored opened foods properly and failed to maintain clean food prep equipment and refrigerated areas. (Refer to F812)

The facility failed to properly monitor and maintain monthly antibiotic use. (Refer to F881)

The facility failed to provide/offer pneumococcal vaccinations to residents. (Refer to F883)

On 07/28/22 at 07:08 PM Administrative Staff A stated the Quality Assurance Process Improvement (QAPI) team met monthly to review data and problems the committee had reviewed. Administrative Staff A stated he had certain staff members that he had assigned to designated areas each were to review monthly. Issues

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F 867	Continued From page 92 brought to the QAPI committee were addressed and a resolution goal was three days. A review of the facility's "Quality Assurance Process Improvement (QAPI)" policy reviewed 11/2018 noted that the facility will develop, implement, and maintain an effective, comprehensive, data-drive QAPI program that focuses on indicators of the outcomes of care and quality of life. The program will address all systems of life and management practices. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. The facility QAPI program will be reviewed at least annually and updated as needed. Triggered care areas will be investigated based on priority. Reports will be reviewed, then a root cause will be determined, then a PIP will be created to include a definition, team analysis, measures and interventions. The PIP would be documented upon completion and updated monthly prior to the monthly QAPI meeting. The facility failed to identify and develop performance improvement plans for potential quality deficiencies through the QAPI plan to correct identified quality issues. This deficient practice placed the resident's at risk for ineffective care.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. Based on observation, record review, and interview, the facility failed to ensure that proper hand hygiene was followed during peri-care for Resident (R) 21 and failed to ensure sanitary handling of a sling and disinfection of the Hoyer Lift (total body mechanical lift used to transfer residents) after use for R96. The facility failed to ensure sanitary storage of clean linens. These deficient practices put facility residents at risk for the spread of infections and/or communicable diseases.

Findings Included:

- On 07/26/22 at 08:00 AM an inspection of the "Blue Hallway" linen closet revealed clean towels, hospital gowns, sheets, rags, and Hoyer Lift

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slings stored on a metal rack. The clean linen shared a room with a sink, specimen refrigerator and trash can. No cover was observed over the clean linen rack.

An inspection of the "Green Hallway" linen closet revealed clean towels, hospital gowns, sheets, rags, and Hoyer Lift slings stored on a metal rack. The Hoyer lift slings were partially touching the floor. The clean linen shared a room with a sink, specimen refrigerator and trash can. No cover was observed over the clean linen rack.

On 07/26/22 at 08:20 AM a used, bloody, band-aid was observed on the floor outside of room 205. This band-aid remained in the hall until 11:03 AM.

On 07/27/22 at 01:25PM an observation of R21's peri-care was completed. Certified Nurse Aid (CNA) M prepped the resident for peri-care by donning gloves and positioning him. CNA M removed the covers exposing R21's brief. CNA M placed a trash bag on the bed and then pulled out several clean sanitary wipes from the package and placed them in the trash bag. CNA M removed R21's brief and positioned him for peri-care. CNA M then put her hand in the "clean" wipes trash bag and grabbed several wipes before putting some back into the bag of clean wipes bag. CNA M completed R21's peri-care using the wipes.

On 07/28/22 at 01:25 PM while completing a Hoyer lift transfer of a R96, CNA M tossed the Hoyer lift sling onto the bed resulting in the sling bouncing off the bed and landing on the floor. The sling was immediately picked up off of the floor but was not cleaned or sanitized before applying

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it on R96. After transferring the resident to his wheelchair, CNA M placed the Hoyer lift back in its stored area in the hall without sanitizing it.

On 07/28/22 at 05:03 PM in an interview with CNA M, she stated that the Hoyer lifts must be cleaned before, during, and after being used to transfer resident. She stated that if the equipment becomes contaminated, staff were responsible for cleaning and sanitizing it. She stated that clean practices are used during peri-care to prevent infections.

On 07/28/22 at 05:30 PM in an interview, Licensed Nurse (LN) G stated that staff were always required to wipe down the medical equipment after use and complete hand hygiene before and after providing care for a resident.

On 07/28/22 at 06:37 PM in an interview, Administrative Nurse D stated that staff were expected to wipe down all medical equipment before and after using it. She stated staff receive in-service training for infection control practices.

The facility policy "Infection Prevention and Control Manual dated 2019 documented: Disinfected items must not come into contact with contaminated or non-disinfected items. Tools, implements, linens and other non-electrical must immediately after service is completed be cleaned and disinfected. Disinfectant wipes or sprays may be used with the item is too large to be submerged in disinfectant.

The facility failed to ensure staff practiced standard infection control precautions to prevent the spread of infection when staff failed to disinfect shared equipment, handle care

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F 880	Continued From page 97 equipment and supplies and store clean linens in a sanitary manner. This had the potential to increase the risk for transmission of infectious disease to residents.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents. Based on interview and record review, the facility failed to ensure principles of antibiotic stewardship were followed to ensure antibiotics were used in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance in an ongoing, proactive manner. Findings included: - Review of the "Infection Control Log" for tracking and trending infections from January 2022 through June 2022, revealed the following: January, February and March logs lacked documentation of organism identifications for monitoring trends in infection. The May 2022 log was not done/unavailable for	F 881		

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F 881	Continued From page 98 review. The "Infection Preventionist" (IP) was not available to interview. On 07/28/22 at 06:37 PM Administrative Nurse D stated she had reviewed the monthly infection surveillance book and had noted the lack of organism tracking and facility trending. The facility policy "Infection Prevention and Control Program Manual Antibiotic Stewardship and MDROs"" dated 2019 documented tracking and reporting of antibiotics use and outcomes will be completed the facility to identify adherence to facility policy and procedures, use and outcomes. Tracking allowed the facility to identify patterns, prevalence, of antibiotic use as well as specific ordering data. Outcomes including resistant organisms were tracked by the Infection Preventionist and discussed with the Quality Assurance Committee for action planning. The facility failed to proactively apply the principles of antibiotic stewardship, for the residents of the facility from January through March 2022 and May 2022 to ensure antibiotics were administered in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance.	F 881		
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,	F 883		

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F 883	Continued From page 99 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza 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	F 883		

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F 883	Continued From page 100	F 883		

following:
(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:
The facility identified a census of 55 residents. The sample included 16 residents with five reviewed for vaccination status. Based on record reviews, and interviews, the facility failed to obtain influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination and pneumococcal (pneumonia infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination consents, declinations or administration information for Resident (R) 37, R10, and R35, and R18. This placed the residents at increased risk for influenza, pneumonia, and related complications.

Findings included:

- Review of R37's electronic medical record (EMR) revealed the "Annual Minimum Data Set" (MDS) dated 10/08/21 recorded R37 received an influenza vaccination and was offered and declined a pneumococcal vaccine. R37's clinical recorded lacked evidence of an informed declination for pneumococcal. The facility provided a signed declination for the pneumococcal vaccine dated 07/29/19 which stated the resident had received the vaccination in the hospital. The EMR lacked verification R37

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received the vaccination.

Review of R10's "Admission MDS" dated 11/23/21 in the EMR recorded R10 was offered and declined the influenza and pneumococcal vaccine. R10's clinical record lacked evidence the vaccines were offered and lacked evidence of informed declination.

Review of R35's "Admission MDS" dated 12/14/21in the EMR revealed R35 was not current on influenza or pneumococcal vaccines. The MDS recorded R35 was offered both and declined both. R35's clinical record lacked evidence of informed declination of the vaccines.

Review of R18's EMR revealed an "Admission MDS" dated 09/22/21 which recorded R18 did not receive the influenza vaccine as it was medically contraindicated, and the pneumococcal vaccine was offered and declined. The clinical record recorded R18 received an influenza vaccine on 10/08/21. The clinical record lacked evidence of an informed declination for the pneumococcal vaccine.

The "Infection Preventionist" (IP) was not available to interview.

On 07/28/22 at 06:37 PM Administrative Nurse D stated influenza and pneumococcal vaccination are offered at the time of admission and the resident signed a consent or declination for the vaccine. Administrative Nurse D stated the signed form was then sent to medical records after the vaccine was given if the resident consented. Administrative Nurse D was not sure if the IP tracked the pneumococcal vaccination rate.

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F 883	Continued From page 102 The facility's "Pneumococcal Vaccine program" policy, dated 2019, directed the facility to obtain pneumococcal vaccine information for both pneumococcal vaccines. The policy directed all new admission be screened and given both pneumococcal vaccines unless ordered otherwise by the primary physician. The policy recoded every admission as screened and given the vaccine if indicated after receiving education regarding the vaccine; a record of vaccinations was placed in the resident's medical record and in their vaccination record. The facility failed to obtain influenza and pneumococcal vaccination consents, declinations or administration information for R 37, R10, and R35, and R18. This placed the residents at increased risk for influenza, pneumonia, and related complications.	F 883		