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	175500	A. BUILDING _____ B. WING _____	08/02/2021

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/12/2021

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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§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents, with 12 sampled, including one for dignity. Based on observation, interview, and record review, the facility failed to provide quality dignified care for Resident (R) 25 by allowing his fingernails to be overgrown with a dark substance under them after he requested staff trim them.

Findings include:

- Review of R25's "Signed Physician Orders" dated 06/15/21 documented the following diagnoses: diabetes mellitus without complications (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and major depressive disorder (major mood disorder).

Review of the "Admission Minimal Data Set" (MDS) dated 07/06/21 documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. R25 required the assistance of one staff member for personal hygiene.

Review of the "ADL Function/ Rehabilitation Potential Care Area Assessment" (CAA) dated 07/06/21 documented staff will care plan to maintain the current level of functioning, risk factors were current disease processes.

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Review of the "Care Plan" dated 07/06/21 documented R25 required physical assistance of one staff with bathing/showering, and staff were to check nail length and trim and clean on bath day, and as necessary, and report any changes to the nurse.

Review of the "Electronic Health Record" (EHR) under the "Task" tab for the CNA's, lacked information regarding bathing or nail care.

On 07/27/21 at 01:58 PM, an observation of R25's fingernails revealed they were of uneven lengths and had a dark substance under them.

On 07/28/21 at 09:28 AM observed R25 sat in his wheelchair in the commons area with fingernails uneven and had a dark substance under his fingernails.

On 07/28/21 at 01:05 PM, R25 sat in the dining room, fingernails were still not cut or cleaned, and R25 asked if the surveyor could cut them for him.

On 07/29/21 at 09:55 AM, R25 was in the commons room attending an activity and observation revealed his fingernails continued with the dark color substance under the nails, and nails were of uneven lengths.

On 08/02/21 at 09:19 AM, R25 sat in the common area, nails continued to have dark substance under them and differing lengths. He stated he would not mind them being trimmed but was tired of asking for it.

On 07/28/21 at 01:30 PM, Certified Nurse Aide (CNA) E stated R25 received his baths at night,

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day shift would brush his teeth, but staff performed nail care on his bath days. CNA E said, to find the last time his nails received care, you would look in the EHR under task, and the last task information would document that information.

On 07/29/21 at 10:20 AM, CNA F revealed R25 mainly required assistance with toileting, dressing, and used a slide board to transfer. On his bath days, they would check his nails, and with being a diabetic, a CNA could not trim his nails for him, but they could clean them. CNA F stated there were forms with the bathing that they would fill out and that it had skin and nail assessment on it. If the resident had diabetes, they would inform the nurse that his nails needed trimmed.

On 08/02/21 at 10:20 AM, Licensed Nurse (LN) C stated if the residents had diabetes, it would be the nurse's responsibility to trim or cut the finger and toenails. LN C stated she was unaware of R25's need for nail care but would make time to accomplish this task.

On 08/02/21 at 12:06 PM, Administrative Staff B stated nails for diabetic residents were cleaned by the nurses, and she expected the nurses to keep up on diabetic resident's toe and fingernail trimming or cutting. She expected the CNAs to let the nurse know if a resident required nail care.

Review of the facility's undated "Right to Dignity" policy documented the facility would groom the elder as they wished, including nail care.

The facility failed to maintain R25's dignity by allowing his nails to become overgrown and have

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F 550	Continued From page 4 a dark substance under them.	F 550		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		

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can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

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regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents. Based on observation, interview, and record review, the facility failed to provide the residents with a way to file a grievances anonymously.

Findings included:

- During the initial tour of the facility on 07/27/21 at 10:00 AM, there were no grievance forms or a way to submit those forms anonymously noted in the facility.

On 07/28/21 at 02:01 PM, Resident (R) 14 stated they did not have forms to fill out for a grievance during the resident council meeting.

On 07/28/21 at 02:21 PM, Activity Staff D stated they did not have forms to fill out for grievances, that the residents would tell the staff what the issue was and that the residents could call the

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F 585	Continued From page 7 Ombudsman with any concerns. On 08/02/21 at 12:12 PM, Activity staff D stated she had not developed a procedure for residents to file an anonymous grievance. On 08/02/21 at 05:00 PM, Administrative Staff A stated she did not know they needed an anonymous way to file a grievance. Review of the facility's undated "Complaints or Grievances" policy documented that each resident may voice grievances to administrative staff or outside representatives of their choice, free from interference, coercion, discrimination, or reprisal. The facility failed to allow residents to exercise their right to file a grievance, including the right to file an anonymous grievance, without interference, coercion, discrimination, or reprisal.	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents, with 12 included in the sample, including one for respiratory care. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for Resident (R) 12 which included oxygen use and care.

Findings Include:

- Review of R12's "Electronic Health Record"

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(EHR) dated 06/11/21 documented the following diagnoses: schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), COVID-19, shortness of breath (SOB), and localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

Review of the "Significant Change Minimum Data Set" (MDS) dated 11/05/20 documented a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. R12 utilized oxygen (O2) therapy.

Review of the "Quarterly MDS" dated 06/08/21 documented a BIMS of 13, indicating intact cognition and he utilized O2.

Review of the "Care Plan" dated 03/30/21 lacked documentation for the care and maintenance of R12's oxygen.

On 07/29/21 at 02:18 PM, R12 participated in an activity in the dining room. The staff brought an oxygen concentrator to the dining room for R12's use.

On 08/02/21at 09:45 AM, R12 sat in a recliner in his room with O2 via nasal cannula in place. R12 stated he used O2 all the time. The humidifying bottle lack a date of last change.

On 07/28/21 at 01:43 PM, Certified Nursing Aide (CNA) E stated R12 used the O2 in the afternoon

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F 656	Continued From page 10 for his shortness of breath, like having an activity in the dining room. He used the O2 before walking to the dining room. On 07/29/21 at 10:15 AM, CNA F stated R12 was independent during the day, but towards evenings he would need a little bit of help, and he used O2 as needed. On 08/02/21 at 10:30 AM, Licensed Nurse (LN) C stated the oxygen use should be noted on the care plan for each resident using oxygen. On 08/02/21 at 12:04 PM Administrative Nurse B stated she believed the care of oxygen delivery items should be included on the care plan, when asked about oxygen use and care. The facility did not provide a policy regarding care plans, as requested on 08/02/21 at 01:04 PM. The facility failed to develop and implement a comprehensive person-centered care plan for R12 to include oxygen use and care.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		

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release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents, with 12 sampled, including one for discharge to the community. Based on interview and record review, the facility failed to complete a discharge summary to include the recapitulation of Resident (R) 28's stay.

Findings included:

- A review of the "Minimum Data Set" (MDS) documented R28 admitted on 06/16/21 and discharged on 06/18/21, with no MDS completed.

Review of the "Electronic Health Records (EHR) Physician Orders" documented an order to discharge to Home Care and to follow up with the provider in one week dated 06/18/21.

Continued review of the EHR revealed no discharge papers, including a recapitulation of

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F 661	Continued From page 12 stay, located within R28's record. Interview with Social Services Director (SSD) D on 07/29/21 at 08:20AM stated she did not complete a recapitulation of the stay and that it was the nurses' responsibility to do this. Interview with Administrative Nurse B on 08/02/21 at 11:54 AM confirmed the facility lacked a completed recapitulation of R28's stay. Review of the undated "Admission, Transfer and Discharge Policy" documented the facility staff documented in the clinical record discharge information provided to the resident including a summary of the care, treatment and services provided and progress reached toward goals. The facility failed to appropriately document the discharge summary, including the recapitulation of stay for R28.	F 661		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including 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 reported a census of 26 residents, with 12 sampled, including one for respiratory care. Based on observation, interview, and record	F 695		

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review, the facility failed to provide respiratory care consistent with professional standards of practice for Resident (R) 12.

- Findings Include:

Review of Resident (R) 12's "Electronic Health Record" (EHR) dated 06/11/21 documented the following diagnoses: Schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), Chronic Obstructive Pulmonary Disease (COPD) - (a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), COVID 19, shortness of breath (SOB), and localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

Review of the "Significant Change Minimum Data Set" (MDS) dated 11/05/20 documented a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognition. Staff had identified R12 as utilizing oxygen (O2) therapy.

Review of the "Quarterly MDS" dated 06/08/21 documented a BIMS of 13, indicating intact cognition. Staff had identified R12 used oxygen.

Review of the "Care Plan" dated 03/30/21 lacked documentation for the care and maintenance of R12's oxygen.

Review of "Physician Orders" dated 07/27/21 in EHR lacked an order for the use of oxygen or care of equipment used to provide oxygen.

Review on 08/02/21 at 10:30 AM of Licensed

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	175500	A. BUILDING _____ B. WING _____	08/02/2021

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F 695	Continued From page 14	F 695		

Nursing (LN) and Certified Nursing Aide (CNA) tasks in EHR lacked documentation of oxygen tubing changes.

Review of the "Medication Administration Record (MAR) and "Treatment Administration Record" (TAR) in the EHR for January 2021 through July 29, 2021 lacked documentation of any oxygen care or use for R12.

On 07/29/21 at 02:18 PM, R12 was participating in an activity in the dining room. Staff brought an oxygen concentrator to the dining room for R12 to use.

On 08/02/21at 09:45 AM, R12 was sitting in a recliner in his room with oxygen via nasal cannula in place. R12 stated he uses oxygen all the time. Oxygen tubing and humidifying bottle lack date of last change.

On 07/28/21 at 01:43 PM, CNA E stated that R12 used the oxygen in the afternoon for his shortness of breath, like having an activity in the dining room. He would use the oxygen before walking to the dining room. They believed the LN staff were responsible for changing the oxygen tubing and maintain the humidifier.

On 07/29/21 at 10:15 AM, CNA F stated R12 was independent during the day, but towards evenings he would need a little bit of help, and he was on oxygen as needed. CNA F stated she thought the tubing was changed every 30 days by the nurse.

On 08/02/21 at 10:30 AM, LN C stated that oxygen tubing and humidifier bottles were to be changed and dated. She believed LN staff would document on the "Treatment Administration

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F 695	Continued From page 15 Record" (TAR) on the night shift. However, she was unsure if they were all changed at once or scheduled individually. On 08/02/21 at 12:04 PM Administrative Nurse B stated the LN staff were to change the tubing and humidifier bottles weekly by the night nurse and documented it on "tasks." Administrative Nurse B stated she believed the care of such things should have been care planned. She would expect that facility staff change the tubing and humidifier weekly, document the changes, and label the tubing and humifider. She confirmed there were no orders for the care of oxygen supplies for R12. The facility did not provide a policy, as requested on 08/02/21 at 01:04 PM. The facility failed to provide respiratory care consistent with professional standards of practice for R12.	F 695		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:	F 838		

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F 838	Continued From page 16 §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,	F 838		

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such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents. Based on interview and record review the facility failed to address staffing in the "Facility Assessment" to document resources required to provide necessary care to the residents in regard to staffing across all shifts. This failure had the ability to affect all resident care in the facility.

Findings included:

- Review of the undated "Facility Assessment" documented no determination of facility staffing.

Interview with Administrative Staff A on 08/02/21 at 01:10 PM revealed the facility assessment did not have a breakdown of how staffing was determined. Administrative Staff A stated she had not completed the facility assessment since last year.

Interview with Administrative Nurse B on 08/02/21 at 01:55PM revealed she made the schedule for the nursing staff and the facility determined staffing based on the acuity of the residents.

Review of the undated "Facility Assessment Policy" stated the facility assessment was the foundation to determine staffing levels and competencies to include an evaluation of the overall number of facility staff needed to ensure

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F 838	Continued From page 18 sufficient number of qualified staff were available to meet the needs of the residents. The facility failed to address staffing in the "Facility Assessment" to document resources required to provide necessary care to the residents in regard to staffing across all shifts. This failure had the ability to affect all resident care in the facility.	F 838		
F 882 SS=C	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.	F 882		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 26 residents. Based on interview and record review, the facility failed to ensure the staff person designated as the Infection Preventionist (IP) who was responsible for the facility's Infection Prevention and Control Program (IPCP) completed the specialized training in infection prevention and control.

Findings included:

- On 08/02/21 at 02:30 PM, Administrative Nurse B revealed that she was responsible for the Infection Prevention and Control Program (IPCP), and she lacked certification as an Infection Preventionist (IP). Furthermore, she revealed the facility lacked a certified IP.

Review of the undated "Job Description-Infection Preventionist" documented that the person in this role was to possess current, specialized training and certification in Infection Control (CIC) in an approved course.

The facility failed to ensure the person designated as the IP completed the required certification.