| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 17E658 | A. BUILDING _____ B. WING _____ | 05/16/2024 |

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| F 000 | INITIAL COMMENTS | F 000 | | |

The following citations represent the findings of a recertification and partial extended health survey.

On 05/15/24 at 02:35 PM, Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template' and was informed of the IJ for resident (R) 14.

On 04/14/24 at approximately 02:00 PM Certified Nurse Aide (CNA) M assisted R14 into the courtyard off the dining room. CNA M then left for the day while R14 remained outside with no ability to contact the facility or get back inside. Around supper time, at approximately 04:00 to 05:00 PM, staff noted R14's absence. CNA P found R14 outside and R14 was unresponsive. Staff brought R14 inside the facility and assessed his vital signs. R14's body temperature was 104.9 degrees Fahrenheit (F.), and he had a pulse of 144 beats per minute. Staff began cooling measures and R14 became more responsive. R14 went to the Emergency Department where he received intravenous (IV-administered directly into the bloodstream via a vein) fluids for rehydration. The facility failed to ensure R14 received the care and services, including supervision to promote his safety and well-being. This failure placed R14 in immediate jeopardy.

The facility submitted a corrective action plan to remove the immediacy which included the following:
The facility will no longer employ the nurse on duty that day. The facility will train all current staff and will train all future employees including the agency staff on outdoor safety and neglect.
The facility provided re-training on the Abuse,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/30/2024

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 000 | Continued From page 1<br>Neglect, and Exploitation Policy. The facility created a procedure specific to the incident that all staff were trained on.<br>The administration will monitor outdoor times and safety on an ongoing basis. Staff will ensure residents outside receive adequate visual checks and adequate hydration.<br><br>On 05/16/24 during a partial extended survey, the surveyor verified the removal of the immediacy for R14. The scope and severity remained at a "G."<br><br>The 2567 was sent electronically on 05/30/24 | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 31 residents. There were 12 residents in the sample with one reviewed for abuse. Based on observation, interviews, and record review, the facility failed to | F 600 | | |

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| F 600 | Continued From page 2 | F 600 | | |

ensure Resident (R) 14 remained free from neglect when the facility failed to provide the necessary care and services, including supervision required by R14 to promote his safety and well-being. On 04/14/24 at approximately 02:00 PM Certified Nurse Aide (CNA) M assisted R14 into the courtyard off the dining room. CNA M then left for the day while R14 remained outside with no ability to contact the facility or get back inside. Around supper time, at approximately 04:00 to 05:00 PM, staff noted R14's absence. CNA P found R14 outside and R14 was unresponsive. Staff brought R14 inside the facility and assessed his vital signs. R14's body temperature was 104.9 degrees Fahrenheit (F.), and he had a pulse of 144 beats per minute. Staff began cooling measures and R14 became more responsive. R14 went to the Emergency Department where he received intravenous (IV-administered directly into the bloodstream via a vein) fluids for rehydration. The facility failed to ensure R14 received the care and services, including supervision to promote his safety and well-being. This failure placed R14 in immediate jeopardy.

Findings included:

- R14's Electronic Health Record (EHR) revealed diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), and muscle weakness.

The "Quarterly Minimum Data Set" (MDS), dated 02/14/24, documented the resident had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 13. The resident required

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| F 600 | Continued From page 3 | F 600 | | |

extensive staff assistance with activities of daily living (ADL) and was dependent on staff for chair-to-bed transfers and sit-to-lying positioning. R14 used a wheelchair for mobility. The resident received opioids (a class of medications to relieve pain), antianxiety (a class of medications that calm and relax people) medication, antidepressants (a class of medications used to treat mood disorders), hypoglycemic medications (medication used to lower blood sugar) and anticoagulant (class of medication used to prevent and treat blood clots) medications.

R14's "Care Plan," dated 02/23/24, directed staff to assist R14 with all ADL and self-care. The plan documented the resident used a wheelchair for mobility and required extensive assistance from two staff and a total body lift for transfers. The plan documented R14 enjoyed sitting outside daily when the weather was acceptable. The plan directed staff to monitor, document, and report any signs or symptoms of immobility, contractures (abnormal fixation of a joint or muscle) formation or worsening, skin breakdown, and fall-related injuries. The care plan directed staff to cue, reorientate, and supervise R14 as needed.

The "Nurses Notes," dated 04/14/24 at 05:15 PM, recorded R14 was found outside, unresponsive, in his wheelchair with no shirt on. Staff wheeled him back in and obtained vital signs. The note recorded R14 had "drool" down his frontside, and his head was turned down to the left. R14 groaned when spoken to and he was able to minimally squeeze staff's hand with his left hand, but not with his right. Staff placed cold wet towels on the resident's neck, under his arms, and on his forehead and then wheeled the resident to the

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| F 600 | Continued From page 4 | F 600 | | |

nurse's station; staff called Emergency Medical Services (EMS). R14 started to cool down and he became more responsive. He was then able to sip on some water and take his evening medications before EMS arrived. When EMS arrived, R14 was loaded onto their cot via a full-body lift. The notes documented staff notified Administrative Nurse D, Administrative Staff A, and the resident's representative of the transfer.

A review of R14's EHR lacked evidence of a facility investigation including witness statements and analysis of causative factors regarding the event. Upon request, the facility was unable to provide an investigation related to the event.

On 05/14/24 at 03:00 PM observation revealed R14 sat in a wheelchair outside on the front patio. R14 wheeled from one door to the other trying to open each side of the double doors and was unable to do so. The surveyor summoned Administrative Staff B and asked if R14 was ok outside and if he could get back inside on his own. Administrative Staff B went to the door and assisted R14 inside. R14 stated he could not get in. Administrative Staff B asked R14 if he had his walkie-talkie. Administrative Staff B helped him locate his walkie-talkie which was rolled up in the front tail of R14's t-shirt. He appeared unaware he had it or how to use it.

On 05/15/24 at 10:20 AM Administrative Nurse D stated that on 04/14/24, a CNA took R14 outside to the West patio around 02:00 PM. She said the CNA was going off shift and the evening shift was coming on. Administrative Nurse D said apparently, the evening shift staff was not informed the resident was outside. She stated when the nurse was doing the afternoon

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| F 600 | Continued From page 5 | F 600 | | |

medication pass, the nurse looked for R14 and found him outside on the patio, unresponsive and drooling. Administrative Nurse D said staff immediately brought R14 inside, did the assessment, and called EMS; R14 was transported to the hospital and received two bags of IV fluids then returned to the facility to be monitored. Administrative Nurse D verified R14 did not have any means to contact the facility to request assistance while he was outside. Administrative Nurse D said the facility did not conduct a written investigation and did not have a formal staff in-service related to the incident. She said the facility administrative staff just went around and talked to the staff after the incident.

On 05/15/24 at 12:39 PM, Administrative Staff A stated when the resident came to the facility, he was more mobile and got around easier in his wheelchair. Administrative Staff A stated the resident had a flip phone he took out with him, and he used to be able to open the door and let himself outside. Administrative Staff A stated more recently, the resident relied on staff to let him out, and staff should provide R14 a walkie-talkie and 30-minute visual checks while he is outside. Administrative Staff A stated on 04/14/24, CNA M let R14 outside as she went off duty and the oncoming aides and agency nurse did not check on him or possibly, did not even know he was outside. Administrative Staff A stated the facility was still gathering information regarding the event.

On 05/15/24 at 01:25 PM, CNA M stated she let R14 outside on the patio sometime after 01:00 PM on 04/14/24. CNA M said another staff was in the dining room at that time and knew R14 was going outside. CNA M said an agency nurse was

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| F 600 | Continued From page 6 | F 600 | | |

also in the dining room. CNA M said she got off work at 02:00 PM and the nurse would get off at 06:00 PM. CNA M stated CNA P found the resident outside on the patio more than three hours later. CNA M said that CNA P told Administrative Staff A that she was not informed the resident was outside when she came on duty. CNA M stated the resident should have the walkie-talkie to call for staff while he is outside but then said she did not think R14 knew how to use it.

The facility's "Abuse, Neglect, and Exploitation" policy, undated, recorded the facility would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property by implementation of specific procedures listed in the required components of the policy. The policy recorded that each resident would be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse may include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Additionally, residents would be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type would be tolerated, and residents and staff would be monitored for protection. The facility would strive to educate staff members, volunteers, contractors, residents family members visitors, and other applicable individuals in techniques to protect all parties. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report to the Nursing Home Administrator. The Nursing Home

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Administrator would report "abuse" to the state agency per State and Federal requirements. It is the policy of the facility that all allegations and reports of, mistreatment, and neglect, including injuries of unknown sources, exploitation, and misappropriation of property are thoroughly investigated. The investigation is the process used to determine what happened. The designated facility personnel would begin the investigation immediately. A root cause investigation and analysis would be completed, and the investigation gathered would be given to the Administrator. The individual conducting the investigation would review the incident report, the resident's clinical record, and other pertinent documentation. All witness statements obtained would be filed with the investigation report. The investigation would include who was involved, resident statements, resident's roommate statements, involved staff and witness statements of events, injuries present, and environmental considerations. All investigations related to abuse, neglect, exploitation, or mistreatment would be reviewed by the Quality Assurance Performance Improve Committee (QAPI) and interventions would be monitored for continued improvement.

On 05/15/24 at 02:35 PM, Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template' and was informed of the facility's failure to ensure R14 received the care and services, including supervision to promote his safety and well-being placed R14 in immediate jeopardy.

The facility submitted a corrective action plan to remove the immediacy which included the following:
The facility will no longer employ the nurse on

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| F 600 | Continued From page 8<br>duty that day. The facility will train all current staff and will train all future employees including the agency staff on outdoor safety and neglect.<br>The facility provided re-training on the Abuse, Neglect, and Exploitation Policy. The facility created a procedure specific to the incident that all staff were trained on.<br>The administration will monitor outdoor times and safety on an ongoing basis. Staff will ensure residents outside receive adequate visual checks and adequate hydration.<br><br>On 05/16/24 during a partial extended survey, the surveyor verified the removal of the immediacy for R14. The scope and severity remained at a "G." | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established | F 609 | | |

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procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents with three reviewed for abuse. Based on observation, record review, and interview the facility failed to report an incident of neglect for Resident (R) 14 to the State Agency as required. This placed the resident at risk for ongoing neglect.

Findings included:

- R14 ' s Electronic Health Record (EHR) revealed diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities,) and muscle weakness.

The "Quarterly Minimum Data Set" (MDS), dated 02/14/24, documented the resident had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 13. The resident required extensive staff assistance with activities of daily living (ADL) and was dependent on staff for chair-to-bed transfers and sit-to-lying positioning. R14 used a wheelchair for mobility. The resident received opioids (a class of medications to relieve pain), antianxiety (a class of medications that

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calm and relax people) medication, antidepressants (a class of medications used to treat mood disorders), hypoglycemic medications ( medication used to lower blood sugar) and anticoagulant (class of medication used to prevent and treat blood clots) medications.

R14's "Care Plan," dated 02/23/24, directed staff to assist R14 with all ADL and self-care. The care plan documented the resident used a wheelchair for mobility and required extensive assistance from two staff and a total body lift for transfers. The plan documented R14 enjoyed sitting outside daily when the weather was acceptable. The care plan directed staff to monitor, document, and report any signs or symptoms of immobility, contractures (abnormal fixation of a joint or muscle) formation or worsening, skin breakdown, and fall-related injuries. The care plan directed staff to cue, reorientate, and supervise R14 as needed.

The "Nurses Notes," dated 04/14/24 at 05:15 PM, recorded R14 was found outside, unresponsive, in his wheelchair with no shirt on. Staff wheeled him back in and obtained vital signs. The note recorded R14 had "drool" down his frontside and his head was turned down to the left. R14 groaned when spoken to and he was able to minimally squeeze staff's hand with his left hand, but not with his right. Staff placed cold wet towels on the resident's neck, under his arms, and on his forehead and then wheeled the resident to the nurse ' s station; staff called Emergency Medical Services (EMS). R14 started to cool down and he became more responsive. He was then able to sip on some water and take his evening medications before EMS arrived. When EMS arrived, R14 was loaded onto their cot via a

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full-body lift. The notes documented staff notified Administrative Nurse D, Administrative Staff A, and the resident's representative of the transfer.

A review of R14 ' s EHR lacked evidence an investigation including witness statements and analysis of causative factors was done regarding the event. Upon request, the facility was unable to provide an investigation related to the event.

On 05/14/24 at 03:00 PM observation revealed R14 sat in a wheelchair outside on the front patio. R14 wheeled from one door to the other trying to open each side of the double doors and was unable to do so. The surveyor summoned Administrative Staff B and asked if R14 was ok outside and if he could get back inside on his own. Administrative Staff B went to the door and assisted R14 inside. R14 stated he could not get in. Administrative Staff B asked R14 if he had his walkie-talkie. Administrative Staff B helped him locate his walkie-talkie which was rolled up in the front tail of R14's t-shirt. He appeared unaware he had it or how to use it.

On 05/15/24 at 12:39 PM, Administrative Staff A stated on 04/14/24, CNA M let R14 outside as she went off duty and the oncoming aides and agency nurse did not check on him or possibly, did not even know he was outside. Administrative Staff A stated the facility was still gathering information regarding the event.

The facility ' s "Abuse, Neglect, and Exploitation" policy, undated, recorded the Nursing Home Administrator would report "abuse" to the state agency per State and Federal requirements.

The facility failed to report an incident of neglect

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| F 609 | Continued From page 12<br>for R14 to the State Agency as required. This placed the resident at risk for ongoing neglect. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to thoroughly investigate an incident of neglect for Resident (R)14. This placed R14 at risk for unidentified and ongoing neglect.<br><br>Findings included:<br><br>- R14 ' s Electronic Health Record (EHR) revealed diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk) spinal stenosis | F 610 | | |

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(degenerative condition of the spine that could cause weakness and loss of use of extremities,) and muscle weakness.

The "Quarterly Minimum Data Set" (MDS), dated 02/14/24, documented the resident had intact cognition, with a Brief Interview for Mental Status (BIMS) score of 13. The resident required extensive staff assistance with activities of daily living (ADL) and was dependent on staff for chair-to-bed transfers and sit-to-lying positioning. R14 used a wheelchair for mobility. The resident received opioids (a class of medications to relieve pain), antianxiety (a class of medications that calm and relax people) medication, antidepressants (a class of medications used to treat mood disorders), hypoglycemic medications ( medication used to lower blood sugar) and anticoagulant (class of medication used to prevent and treat blood clots) medications.

R14's "Care Plan," dated 02/23/24, directed staff to assist R14 with all ADL and self-care. The care plan documented the resident used a wheelchair for mobility and required extensive assistance from two staff and a total body lift for transfers. The plan documented R14 enjoyed sitting outside daily when the weather was acceptable. The care plan directed staff to monitor, document, and report any signs or symptoms of immobility, contractures (abnormal fixation of a joint or muscle) formation or worsening, skin breakdown, and fall-related injuries. The care plan directed staff to cue, reorientate, and supervise R14 as needed.

The "Nurses Notes," dated 04/14/24 at 05:15 PM, recorded R14 was found outside, unresponsive, in his wheelchair with no shirt on. Staff wheeled

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him back in and obtained vital signs. The note recorded R14 had "drool" down his frontside and his head was turned down to the left. R14 groaned when spoken to and he was able to minimally squeeze staff's hand with his left hand, but not with his right. Staff placed cold wet towels on the resident's neck, under his arms, and on his forehead and then wheeled the resident to the nurse ' s station; staff called Emergency Medical Services (EMS). R14 started to cool down and he became more responsive. He was then able to sip on some water and take his evening medications before EMS arrived. When EMS arrived, R14 was loaded onto their cot via a full-body lift. The notes documented staff notified Administrative Nurse D, Administrative Staff A, and the resident's representative of the transfer.

A review of R14 ' s EHR lacked evidence an investigation including witness statements and analysis of causative factors was done regarding the event. Upon request, the facility was unable to provide an investigation related to the event.

On 05/14/24 at 03:00 PM observation revealed R14 sat in a wheelchair outside on the front patio. R14 wheeled from one door to the other trying to open each side of the double doors and was unable to do so. The surveyor summoned Administrative Staff B and asked if R14 was ok outside and if he could get back inside on his own. Administrative Staff B went to the door and assisted R14 inside. R14 stated he could not get in. Administrative Staff B asked R14 if he had his walkie-talkie. Administrative Staff B helped him locate his walkie-talkie which was rolled up in the front tail of R14's t-shirt. He appeared unaware he had it or how to use it.

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On 05/15/24 at 10:20 AM Administrative Nurse D stated that on 04/14/24, a CNA took R14 outside to the West patio around 02:00 PM. She said the CNA was going off shift and the evening shift was coming on. Administrative Nurse D said apparently, the evening shift staff was not informed the resident was outside. Administrative Nurse D verified R14 did not have any means to contact the facility to request assistance while he was outside. Administrative Nurse D said the facility did not conduct a written investigation and did not have a formal staff in-service related to the incident. She said the facility administrative staff just went around and talked to the staff after the incident.

On 05/15/24 at 12:39 PM, Administrative Staff A stated on 04/14/24, CNA M let R14 outside as she went off duty and the oncoming aides and agency nurse did not check on him or possibly, did not even know he was outside. Administrative Staff A stated the facility was still gathering information regarding the event.

The facility ' s "Abuse, Neglect, and Exploitation" policy, undated, recorded it is the policy of the facility that all allegations and reports of, mistreatment, and neglect, including injuries of unknown sources, exploitation, and misappropriation of property are thoroughly investigated. The investigation is the process used to determine what happened. The designated facility personnel would begin the investigation immediately. A root cause investigation and analysis would be completed, and the investigation gathered would be given to the Administrator. The individual conducting the investigation would review the incident report, the resident's clinical record, and other pertinent

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| F 610 | Continued From page 16<br>documentation. All witness statements obtained would be filed with the investigation report. The investigation would include who was involved, resident statements, resident's roommate statements, involved staff and witness statements of events, injuries present, and environmental considerations. All investigations related to abuse, neglect, exploitation, or mistreatment would be reviewed by the Quality Assurance Performance Improve Committee (QAPI) and interventions would be monitored for continued improvement.<br><br>The facility failed to thoroughly investigate an incident of neglect for R14. This placed R14 at risk for unidentified and ongoing neglect | F 610 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the | F 657 | | |

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resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to review and revise Resident (R) 26's "Care Plan" with interventions for the care of R26's stasis ulcers (open wound caused by problems with blood flow (circulation ) in your leg veins) on her shins. This deficient practice placed the resident at risk for decreased quality of care due to uncommunicated care needs.

Findings included:

- R26's Electronic Medical Record (EMR) documented R26 had diagnoses of weakness, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

R26's "Quarterly Minimum Data Set" (MDS), dated 04/22/24, documented the resident had a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented R26 required partial to moderate staff assistance with most activities of daily living (ADLs). The MDS documented R26 had one unhealed unstageable

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(depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction).

R26's "Care Plan, " revised 05/01/24, documented R26 had localized edema in bilateral extremities and received Magic Cup (a frozen nutritional supplement)twice a day for wound healing. The care plan documented R26 required limited staff assistance with most ADLs. The care plan lacked a section regarding skin integrity with instructions to staff on how to care for R26's bilateral lower legs.

The "Physician Clinical Visit," dated 05/03/24, documented R26 had bilateral venous ulcerations to her legs. Physical therapy (PT) would see R26 weekly for wound care.

On 05/14/24 at 07:41 AM, observation revealed R26 sat in a recliner in her room. Her lower legs were covered by her pants.

On 05/15/24 at 10:17 AM, Licensed Nurse (LN) G stated R26 had venous stasis ulcers to her bilateral lower legs. LN G was unaware of what the ulcers looked like or what treatment was ordered for R26's ulcers since the resident went to the hospital for her wound care.

On 05/16/24 at 09:37 AM, Administrative Nurse D verified R26's "Care Plan" lacked a section regarding skin integrity. Administrative Nurse D stated she was responsible for updating the care plan regarding skin integrity and stated that R26 should have one.

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| F 657 | Continued From page 19<br><br>The facility's "Care Plan Revisions Policy," undated, documented changes in resident's condition always require changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care.<br><br>The facility failed to update R26's "Care Plan" with information regarding the venous ulcers on her bilateral lower legs. These deficient practices placed the residents at risk for decreased quality of care due to uncommunicated care needs. | F 657 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to ensure an environment free from accident hazards with staff left a gallon chemical bottle in an unlocked bottom cabinet in one of three kitchenettes. This placed the 12 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries.<br><br>Findings included: | F 689 | | |

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| F 689 | Continued From page 20<br>- On 05/13/24 at 11:44 AM, observation revealed an unlocked cabinet underneath the sink, in a kitchenette, located off the family dining room. The unlocked cabinet contained a plastic gallon bottle of Attack Myer Enzyme (a molecule that enhances cleaning performance while decreasing environmental impact) odor digester, drain opener, and maintainer. The label on the bottle reads "Keep out of reach of children, avoid contact with eyes," and "may cause skin irritation."<br><br>On 05/13/24 at 11:48 AM, Licensed Nurse (LN) G verified the above finding and stated the cabinet should be locked. LN G took the bottle to the locked housekeeping closet.<br><br>On 05/15/24 at 11:29 AM, Administrative Nurse D stated she expected staff to store chemicals in a locked cabinet.<br><br>Upon request, the facility did not provide a chemical storage policy.<br><br>The facility failed to ensure an environment free from accident hazards when staff stored harmful chemicals in an unlocked cabinet. This placed the 12 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries. | F 689 | | |
| F 727 SS=F | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. | F 727 | | |

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§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. Based on observation, record review, and interview, the facility failed to provide a full-time Registered Nurse as Director of Nursing (DON) and failed to provide Registered Nurse (RN) coverage eight consecutive hours a day, seven days a week placing all residents who resided in the facility at risk of lack of inadequate care.

Findings included:

- A review of the January - December 2023 nursing schedule revealed no Registered Nurse for eight consecutive hours on more than 50 dates.

On 05/15/24 at 09:44 AM, Administrative Staff A verified the facility did not employ a full-time RN as DON. Administrative Staff A verified the lack of Registered Nurse coverage on the dates reviewed and stated he had not been able to get an RN for eight consecutive hours. Administrative Staff A stated he was unable to get an RN except every once in a while from an agency.

The facility's "Job Description-Director of Nursing Policy," undated, documented the purpose under the direction of the facility administrator, the

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| F 727 | Continued From page 22<br>DON's primary responsibility was to ensure the provision of quality nursing care on a 24-hour basis to the elders of this facility in accordance with Federal, State and Local standards and regulations.<br>The facility's Nursing Services-Registered Nurse (RN) Policy, "revised in February 2023, documented the facility would utilize the services of an RN for at least eight consecutive hours per day, seven days per week. The facility would designate an RN to serve as the Director of Nursing on a full-time basis.<br><br>The facility failed to employ a full-time DON and failed to have RN coverage for eight consecutive hours daily. This placed the 31 residents at risk for inadequate care. | F 727 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§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.<br>(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.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the | F 756 | | |

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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.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the physician acknowledged and responded to the Consultant Pharmacist's recommendation for the required stop date for Resident (R)19's as needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R19 at risk for unintended effects related to psychotropic (alters mood or thoughts) drug medications.

Findings include:

- R19's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental or emotional reaction characterized by

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apprehension, uncertainty, and irrational fear,) and hypertension (HTN-elevated blood pressure.)

R19's "Annual Minimum Data Set" (MDS), dated 03/01/24, recorded R19 had moderately impaired cognition. The MDS recorded R19 was independent with most activities of daily living (ADL.) The MDS recorded R19 received an antianxiety and antidepressant (medication used to treat depression) medication during the observation period.

R19's "Care Plan," dated 01/17/24 recorded R19 had trouble sleeping and behavior problems and received lorazepam (antianxiety medication) two tablets at bedtime, and may take one additional dose in the middle of the night. The care plan documented the staff would monitor the times the resident had insomnia and report any adverse reactions to the anti-anxiety medication.

The "Physician's Order," dated 03/05/24, directed the staff to administer lorazepam (antianxiety) oral concentrate 0.5 milligrams (mg)/milliliter (ml), Give 0.5 ml every 24 hours PRN for anxiety, one dose during the night. The order lacked a stop date.

R19's EMR lacked evidence of a physician-ordered duration which included a rationale for the extended use of the PRN lorazepam.

A review of the Consultant Pharmacist's monthly review for R19 revealed on 03/08/24 the pharmacist recommended the lorazepam needed a 14-day stop date. R19's clinical record lacked evidence the physician responded to the recommendation.

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| F 756 | Continued From page 25<br><br>On 05/14/24 at 07:30 AM, observation revealed R19 sat in a recliner in the 400-hall living room dressed in street clothes watching TV. Continued observation revealed Certified Medication Aide (CMA) U administered the resident's morning medications.<br><br>On 05/14/24 at 10:00 AM, Administrative Nurse D verified the resident received lorazepam PRN that lacked a stop date. Administrative Nurse D verified the pharmacist had sent monthly reviews to the facility for concerns and had recommended a stop date for the lorazepam. Administrative Nurse D said the recommendation was sent to the physician however he had not responded with a duration for use and rationale or discontinuation of the medication.<br><br>The facility's "Use of Psychotropic Drug Use" policy, undated, documented the resident's need for psychotropic medication would be monitored, as well as when the resident received an optional benefit from the medication dose can be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of PRN orders for psychotropic drugs to manage behaviors. The resident admitted to the facility with a PRN psychotropic medication would have a 14-day stop date. Before the end of the 14 days, the ordering practitioner would assess the resident's response to the PRN medication and would document a thoughtful risk-benefit rationale statement for continued use of the medication. If the assessment indicates continued use of the medication, a specific duration would be included in the re-order of the medication. No PRN antipsychotic may be ordered longer than 14 days. | F 756 | | |

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| F 756 | Continued From page 26<br><br>The facility failed to ensure the physician acknowledged and responded to the Consultant Pharmacist's recommendation for R19. This placed the resident at risk for unnecessary psychotropic medication side effects. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§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;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a | F 758 | | |

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diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for R19's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. This placed R19 at risk for unintended effects related to psychotropic (alters mood or thoughts) drug medications.

Findings include:

- R19's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear,) and hypertension (HTN-elevated blood pressure.)

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R19's "Annual Minimum Data Set" (MDS), dated 03/01/24, recorded R19 had moderately impaired cognition. The MDS recorded R19 was independent with most activities of daily living (ADL.) The MDS recorded R19 received an antianxiety and antidepressant (medication used to treat depression) medication during the observation period.

R19's "Care Plan," dated 01/17/24 recorded R19 had trouble sleeping and behavior problems and received lorazepam (antianxiety medication) two tablets at bedtime, and may take one additional dose in the middle of the night. The care plan documented the staff would monitor the times the resident had insomnia and report any adverse reactions to the anti-anxiety medication.

The "Physician's Order," dated 03/05/24, directed the staff to administer lorazepam (antianxiety) oral concentrate 0.5 milligrams (mg)/milliliter (ml), Give 0.5 ml every 24 hours PRN for anxiety, one dose during the night. The order lacked a stop date.

R19's EMR lacked evidence of a physician-ordered duration which included a rationale for the extended use of the PRN lorazepam.

On 05/14/24 at 07:30 AM, observation revealed R19 sat in a recliner in the 400-hall living room dressed in street clothes watching TV. Continued observation revealed Certified Medication Aide (CMA) U administered the resident's morning medications.

On 05/14/24 at 10:00 AM, Administrative Nurse D verified the resident received lorazepam PRN that

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| F 758 | Continued From page 29<br>lacked a stop date.<br><br>The facility's "Use of Psychotropic Drug Use" policy, undated, documented the resident's need for psychotropic medication would be monitored, as well as when the resident received an optional benefit from the medication dose can be lowered or discontinued. Both the physician and the nursing staff would evaluate the effectiveness of PRN orders for psychotropic drugs to manage behaviors. The resident admitted to the facility with a PRN psychotropic medication would have a 14-day stop date. Before the end of the 14 days, the ordering practitioner would assess the resident's response to the PRN medication and would document a thoughtful risk-benefit rationale statement for continued use of the medication. If the assessment indicates continued use of the medication, a specific duration would be included in the re-order of the medication. No PRN antipsychotic may be ordered longer than 14 days.<br><br>The facility failed to ensure R19 lorazepam had a 14-day stop date or a physician-ordered specified duration with the rationale. This placed R19 at risk for adverse psychotropic medication side effects. | F 758 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 761 | | |

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| F 761 | Continued From page 30<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 31 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to store medications appropriately when staff did not label Resident (R)4s' insulin (a hormone that allows cells throughout the body to uptake glucose) flex pens with the date opened and discard date on one treatment cart. These deficient practices placed the affected resident at risk for ineffective medications.<br><br>Findings included:<br><br>- On 05/13/24 at 10:30 AM, observation of the treatment cart revealed the following:<br>R4's Basaglar (long-acting insulin) flex pen lacked an open date and discard date.<br><br>On 05/13/24 at 10:35 AM, Administrative Nurse D | F 761 | | |

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| F 761 | Continued From page 31<br>verified the nurses were to date the flex pens when opened and discard the expired insulin and expired medications.<br><br>The facility's "Medication Storage and Labeling" policy, undated, documented medications and biologicals in medication rooms, carts, boxes, and refrigerators were maintained within secured (locked) locations, clean and sanitary, and maintained temperatures in accordance with manufacture specifications. Insulin pens containing multiple doses of insulin are meant for single-resident use only and must never be used for more than one person. Insulin pens must be clearly labeled with the resident's name and other identifiers to verify that the correct pen is used on the correct resident; insulin pens should be stored in a sanitary manner to prevent cross-contamination.<br><br>The facility failed to label and date the resident's flex pens with date opened and discard dates placing the residents at risk for ineffective medication. | F 761 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services | F 849 | | |

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when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes

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responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

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| F 849 | Continued From page 34<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient. | F 849 | | |

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| F 849 | Continued From page 35<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient.<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 31 residents. The sample included 12 residents with two reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for | F 849 | | |

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Resident (R)12. This placed R12 at risk for inappropriate end-of-life care.

Findings included:

- R12's Electronic Health Record (EHR) revealed diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure,) aphasia (a condition with disordered or absent language function), and dementia (progressive mental disorder characterized by failing memory, and confusion.

R12's "Significant Change Minimum Data Set" (MDS), dated 04/09/24, recorded R12 was admitted to the facility on 02/26/20 and received hospice treatment.

R12's "Nursing Care Plan," dated 01/10/24, recorded R12 required pain medication and staff administered per physician order. The care plan documented the resident had behavioral problems, was resistant to care, and would become physically aggressive towards staff. The care plan lacked any information regarding the resident's hospice services and lacked evidence of coordination of care between the hospice and the facility. The facility did not have a communication book or external document.

On 04/08/24 at 08:37 AM, "Nurse's Note" documented the resident with the resident' was admitted to hospice.

The facility did not have a communication book or external document related to R12's hospice services.

On 05/13/24 at 12:38 PM, observation revealed

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R12 sat in a high-backed wheelchair at the dining room table. Staff assisted her in eating a pureed ham sandwich, pureed Cheetos, and pureed mixed fruit with thickened water and thickened juice.

On 05/15/24 at 10:45 AM, Administrative Nurse D verified the facility had initial hospice admit notes with limited care plan information, however lacked a complete plan of care. Administrative Nurse D verified the facility should have the information at the facility in the electronic health records and said the facility had trouble receiving information from the hospice. Administrative Nurse D verified the facility care plan lacked any information the resident received hospice services and would immediately put the information in the facility care plan and get the notes and updated care plan from hospice.

The "Hospice Program" policy, undated, documented upon admission to hospice care, staff would provide services using an interdisciplinary approach involving appropriate communication between Hospice, resident, family, and external resources. A coordinated comprehensive plan of care would be jointly developed by the facility and hospice personnel including directives for managing pain and other symptoms associated with hospice care and must be revised as necessary to reflect the resident's current clinical, psychosocial, and spiritual condition. Ongoing care plan meetings are to be held quarterly, in-depth meetings annually, and upon significant resident status change, regardless of whether an assessment was recently completed. The policy documented the hospice information would be placed in a 3-ring binder specifically for hospice residents.

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| F 849 | Continued From page 38<br><br>The facility failed to coordinate care between the facility and the hospice provider for R12, who received hospice services. This deficient practice placed him at risk for inappropriate end-of-life care. | F 849 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | |

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| F 880 | Continued From page 39 | F 880 | | |

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

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview the

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facility failed to implement a water management program for the Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella) and other waterborne pathogens. This placed the residents in the facility at risk for infectious disease.

Findings Included:

- On 05/16/24 at 11:00 AM, Maintenance Staff U verified he was not aware of any routine facility water management checks and verified the 300 hall was presently not in use. Maintenance Sraff U stated staff do not flush water in the unoccupied rooms but did occasionally use the shower room in the 300 hall for one resident at the facility.

On 05/16/24 at 11:20 AM, Administrative Staff A verified the city checked the water monthly but stated he did not have any records of the monthly checks. Administrative Staff A verified the facility lacked a system to check regarding standing water and potential growth inside the facility and lacked a system to mitigate the risk of Legionella.

The facility's "Legionella Surveillance" policy, undated, documented the purpose of the policy was to ensure as far as possible, all users of the facility are protected from the incidence of Legionnaire's disease. The Director of Environmental Services is responsible for all relevant details regarding roles and responsibilities and testing regimens contained in the policy and procedure. It is the policy of the

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facility to ensure that appropriate precautions for the control of Legionella bacteria are identified through the "Legionella" risk assessment process and appropriate control measures implemented to ensure, so far as is reasonably practicable, the health, safety, and welfare of residents, visitors, staff members, and volunteers. The minimum standards to be met included but not limited to:
Carrying out suitable and sufficient Legionella assessments.
Description of building water systems.
Identification of areas where Legionella could grow and spread.
Preparation of an action plan or written scheme for preventing or controlling the risk, where appropriate. (Include in the plan of any area where medical procedures may expose residents to water mists including hydrotherapy and respiratory therapy services.)
Implementation. Management monitoring and recording of precautions to include regular inspection, microbiological monitoring, temperature checks, and flushing where appropriate.
Plans to intervene when control limits are not met.
Continuous monitoring of program compliance.
Documentation of all monitoring.
Seeking suitable advice and assistance from competent persons and Specialist consultants, where appropriate.
Appointment of a person or persons to be managerially responsible for the water system at each premise. The facility has established and maintained, an infection prevention and control group designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy further

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| F 880 | Continued From page 42<br>documented the requirements will be met by the following: inspection of water storage tanks, water would be measured at 86 degrees or below after two minutes of running, and hot water storage or distribution would be measured at 122 degrees at outlets after one minute of running. All cases of Legionella would be reported to the local health department and the State health departments.<br><br>The facility failed to implement a water management program to test and manage waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(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;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza | F 883 | | |

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| F 883 | Continued From page 43<br>immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(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;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 31 residents. The sample included 12 residents with five residents reviewed for immunization. Based on record review and interviews the facility failed to obtain the resident or the DPOA signed consent to receive the influenza immunizations for | F 883 | | |

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Resident (R) 4, R13, and R18. This placed the residents at risk for influenza infection and related complications.

Findings included:

- Review of R4, R13, and R18's clinical medical records lacked evidence the facility or the resident's representative received or was offered the current influenza vaccine during the flu season.

On 05/16/24 at 11:00 AM, Administrative Nurse D stated residents were offered the influenza vaccinations yearly and the facility sent out the consent forms. Administrative Nurse D said the facility did not receive all the forms back and did not follow up, so some residents did not receive the yearly flu vaccinations. Administrative Nurse D verified some of the residents' representatives were hard to get ahold of and did not return the forms.

The facility's "Immunization Policy," revised 03/13/24, documented that all residents would be offered vaccinations on admission and annually. he policy documented each resident's immunization status would be determined, if possible, before vaccination and would be documented in the resident's clinical record.

The facility failed to offer or obtain informed declinations for the flu vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from influenza.