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	175500	A. BUILDING _____ B. WING _____	11/20/2024

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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigation KS00188116. The 2567 was sent electronically on 12/02/24.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/02/2024

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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§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 21 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a baseline care plan within 48 hours of admission for Resident (R) 123. This placed the resident at risk for impaired care due to unidentified or uncommunicated care needs.

Findings included:

- R123's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary incontinence, hypertension (high blood pressure), gastroesophageal reflux disease (GERD-backflow of stomach contents to the esophagus), nutritional deficiencies, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),

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irritable bowel syndrome (IBS- abnormally increased motility of the small and large intestines), a history of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain) and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) without residual deficits.

The "Entry Tracking Record Minimal Data Set" (MDS) dated 11/08/24 recorded R123 admitted on 11/08/24 from home or the community.

R123's clinical record lacked a baseline care plan from the admission date of 11/08/24.

The "Physician Order" dated 11/08/24, directed staff to admit to the nursing home long-term care with diagnoses of diabetes, urinary incontinence, and a history of stroke.

The "Progress Note," dated 11/08/24 at 01:38 PM, documented R123's arrival at the facility via personal vehicle. Vital signs were obtained, and a family member assisted the resident with unpacking and getting the room situated as R123 wanted.

On 11/19/24 at 12:23 PM, observation revealed staff escorted R123 to her room. R123 reported she did not feel well and was dizzy. Licensed Nurse (LN) G obtained vital signs and a blood sugar level. R123's blood sugar level was low. LN G reported that R123 had a history of low blood sugar levels since admission.

On 11/19/20 at 01:00 PM, LN G reviewed R123's EMR and verified there was no baseline care

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F 655	Continued From page 3 plan. On 11/20/24 at 11:30 AM, Administrative Nurse D verified R123's EMR lacked a baseline care plan and said one should have been developed within 48 hours of admission. The facility's undated "Interim Temporary Care Plans" policy documented an interim plan of care is developed and initiated on admission to the facility. Continual evaluation of interim, temporary plans of care was completed by staff members caring for the elder. Revisions to the care plan will be ongoing and the current conditions, needs, and goals of the elder change. The facility failed to develop a baseline care plan within 48 hours of admission. This placed R123 at risk for impaired care due to unidentified and uncommunicated care needs.	F 655		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies	F 726		

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and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 21 residents. The sample included 12 residents and five nurse aides. Based on observation, record review, and interview, the facility failed to ensure three of the five staff members reviewed possessed the knowledge, skills, and competencies required for resident care needs. This placed the residents at risk of impaired care.

Findings included:

- Review of the training records and skills check for Certified Nurse Aide (CNA) O, P, and Q lacked evidence of the facility's procedure checklist related to the direct care of the residents.

On 11/20/24 at 10:33 AM, Administrative Nurse D stated the facility had conducted a skills check-off the previous summer for the nursing staff, and not all employees attended. Administrative Nurse D stated the facility had not rescheduled or

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F 726	Continued From page 5 completed any further competencies for staff who did not attend. The facility's undated "Required Training of Nurse Aides" documented the facility would ensure that nurse aides demonstrate competency in skills and techniques necessary to care for residents as identified through resident assessments and described in the plan of care. The facility failed to ensure three of the five staff members reviewed possessed the knowledge, skills, and competencies required for resident care needs. This placed the residents at risk of impaired care.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 6 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 21 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to obtain a stop date from the physician for the use of as-needed (PRN) lorazepam (antianxiety medication) for Resident (R) 9. This placed the resident at risk for complications related to psychotropic (alters mood or thought) medications and unnecessary medication.	F 758		

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Findings included:

- R9's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The "Significant Change Minimum Data Set" (MDS), dated 11/12/24, documented that R9 had short- and long-term memory problems with severely impaired cognition. The MDS documented R9 received hospice (end-of-life) services and did not receive antianxiety drugs.

R9's "Care Plan," dated 11/14/24, documented R9 had Alzheimer's dementia and anxiety. R9 could become agitated with care at times, including hitting and slapping. The care plan directed staff to provide opportunities for positive interaction and attention and directed staff to stop and talk with her when passing by, initiated 06/13/23. The plan directed staff to monitor behavior episodes, attempt to determine underlying causes, and document behavior and potential causes, initiated on 06/13/23 and revised on 10/25/23. The plan directed to administer psychotropic medications as ordered and monitor for side effects and effectiveness every shift initiated 06/13/23. The plan directed staff to discuss with the physician and family the ongoing need for the use of medication and review behaviors and interventions and alternate

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therapies attempted and their effectiveness as per facility policy, initiated on 06/13/23. Staff were to monitor, document, and report any adverse reactions to psychotropic medications, initiated on 06/13/23 and revised on 10/25/23.

The "Physician Order," dated 11/04/24, directed staff to administer lorazepam oral concentrate 0.25 milliliter (ml) every four hours as needed for agitation or restlessness. The order stated duration was indefinite.

On 11/19/24 at 08:13 AM, observation revealed Certified Nurse Aide (CNA) M woke R9 and told R9 what she was doing. While CNA M provided incontinence care, R9 frowned but did not cry out. R9 made a small noise during the transfer from her bed to a wheelchair. CNA M stated that R9 used to become more upset when staff worked with her, but she had declined.

On 11/19/24 at 01:58 PM, Licensed Nurse (LN) G stated R9 was more alert before her health declined and would become agitated with care, striking out at staff. LN G said staff monitored how many times each shift R9 had restlessness, agitation, and hitting.

On 11/20/24 at 09:35 AM, Administrative Nurse D verified when a physician ordered PRN lorazepam, staff should obtain a specific stop date.

The facility's "Psychotropic Medication Use" policy stated any resident admitted with a PRN psychoactive medication would have a 14-day stop date. Any psychotropic medication ordered by a physician as an emergency treatment for behaviors would have an automatic 72-hour stop

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F 758	Continued From page 9 date during which the physician and nursing staff would assess the potential root cause for the behaviors and interventions that may replace or be used as adjunct therapy for the behaviors. The physician's order must include a qualifying diagnosis and a list of specific targeted behaviors for which the staff would monitor. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. The facility failed to obtain a stop date from the physician for the use of PRN lorazepam for R9, placing the resident at risk for complications related to psychotropic medications and unnecessary medication.	F 758		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(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	F 849		

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

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

§483.70(n)(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

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for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 21 residents. The sample included 12 residents with two reviewed for hospice services. Based on observation, interview, and record review the facility failed to ensure a communication process and collaboration between the hospice provider and the facility for Resident (R) 9 and R17 to coordinate hospice services provided including visit frequency and assessment, medications, and medical equipment. This placed the residents at risk of impaired end-of-life care.

Findings included:

- R9's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by

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apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition).

The "Significant Change Minimum Data Set" (MDS), dated 11/12/24, documented that R9 had short- and long-term memory problems with severely impaired cognition. The MDS documented R9 received hospice services.

R9's "Care Plan," dated 11/14/24, documented R9 had Alzheimer's dementia and anxiety. R9 could become agitated with care at times, including hitting and slapping. The care plan directed staff to provide opportunities for positive interaction and attention and directed staff to stop and talk with her when passing by, initiated 06/13/23. The plan directed staff to monitor behavior episodes attempt to determine underlying causes, and document behavior and potential causes, initiated on 06/13/23 and revised on 10/25/23. The plan directed to administer psychotropic medications as ordered and monitor for side effects and effectiveness every shift initiated 06/13/23. The plan directed staff to discuss with the physician and family the ongoing need for the use of medication and review behaviors and interventions and alternate therapies attempted and their effectiveness as per facility policy, initiated on 06/13/23. Staff were to monitor, document, and report any adverse reactions to psychotropic medications, initiated on 06/13/23 and revised on 10/25/23. The care plan directed staff to allow R9 time to answer questions and to verbalize feelings, perceptions, and fears daily. The care plan

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directed staff to consult with pastoral care or social services, initiated on 12/06/23. The care plan lacked any mention of hospice services.

A review of R9's clinical record lacked information regarding hospice staff assessments, care, or visits.

On 11/19/24 at 08:13 AM, observation revealed Certified Nurse Aide (CNA) M woke R9 and told R9 what she was doing. While CNA M provided incontinence care, R9 frowned but did not cry out. R9 made a small noise during the transfer from her bed to a wheelchair. CNA M stated that R9 used to become more upset when staff worked with her, but she had declined.

On 11/19/24 at 11:37 AM, Certified Nurse Aide (CNA) N and CNA O stated the charge nurse usually let CNA staff know if a resident was on hospice. They reported there was a list in the shower room that documented who hospice was giving a shower or bath and when. They also stated that the residents on hospice got incontinence products from the hospice company. They stated that the hospice also provided equipment, like wheelchairs and oxygen.

On 11/19/24 at 01:25 PM, CNA M verified that R9 received hospice services. CNA M said the hospice nurse visited weekly and the hospice aide came weekly to bathe R9.

On 11/19/24 at 02:20 PM, Licensed Nurse (LN) G stated the last hospice care plan was dated 11/06/24 and verified the facility's care plan did not include any hospice information. She verified the facility did not receive hospice assessment findings or visit notes.

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The facility's "Hospice Agreement," dated 05/15/18, was last signed on 05/01/20 by both parties. The nursing facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving facility and hospice services. Each clinical record shall completely and accurately document all services provided to and events concerning (including evaluations, treatments, progress notes, and physician orders for each hospice patient. The nursing facility and hospice shall each retain the records and the records shall be readily accessible and organized. to facilitate retrieval by either party.

The facility failed to ensure a communication process and collaboration between the hospice provider and the facility for R9. This placed the resident at risk of impaired end-of-life care.

- R17's Electronic Medical Record (EMR) included diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), non-displaced fractures (broken bone) of the second cervical (neck/spine) vertebra, second and third thoracic (mid back area) vertebra (bone of the spinal column), first, third, and fourth lumbar (lower spine) vertebra, osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with a current pathological fracture (a break in a bone that is caused by an underlying disease),

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and nutritional deficiency.

The "Significant Change Minimum Data Set" (MDS), dated 09/23/24, documented R17 had moderately impaired cognition. R17 required partial/moderate assistance with personal hygiene and upper body dressing, and substantial/extensive assistance with toileting, lower body dressing, bathing, bed mobility, and transfers; walking was not attempted due to medical condition or safety concerns. R17 was occasionally incontinent of urine. R17 received scheduled and as-needed pain medication for pain which was frequent and affected sleep and day-to-day activities. The MDS further documented that R17 received hospice services (specialized end-of-life care with a focus on comfort).

R17's "Care Plan" dated 09/26/24, documented R17 received hospice care services. The care plan directed staff to adjust provisions of activities of daily living to compensate for the resident's changing abilities, assess and respect the resident's wishes, encourage support systems of family and friends, and keep the environment quiet and calm. The care plan further directed staff to observe R17 closely for signs of pain, administer pain medication, and work cooperatively with the hospice team to ensure the resident's, spiritual, emotional, intellectual, physical, and social needs were met. The care plan lacked specific information related to the hospice provider, services and equipment or medications that would be provided, and when to notify the hospice provider.

The "Hospice Order" dated 09/18/24, documented R17's hospice provider, and

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diagnoses of CHF and fractures. R17 had her neck brace, and the hospice provider would provide pull-ups, a skilled nurse weekly, and a nurse aide two times a week. The orders included medications covered under R17's hospice benefit.

The "Progress Note" dated 09/11/24 at 01:13 PM, documented R17's primary care practitioner asked staff to "Please discuss comfort care and or hospice with R17's family" and the charge nurse was to address R17's power of attorney about changes.

The "Progress Note" dated 09/12/24 at 02:15 PM, documented the facility nurse spoke with R17's family and spouse about hospice care. The hospice social worker was in to meet with the family.

The "Progress Note" dated 09/12/24 at 05:29 PM, documented the hospice nurse called to relay that as of 09/12/24, R17 was admitted to hospice.

Upon review, R17's clinical record lacked evidence of the hospice assessment findings and hospice nurse visit notes.

On 11/18/24 at 02:20 PM, observation revealed R17 sat in a recliner in her room with a family member next to her. R17 reported she was doing okay. R17 had the footrest elevated and a small, rolled blanket to the back of her neck.

On 11/19/24 at 11:37 AM, Certified Nurse Aide (CNA) N reported staff received information from the charge nurse when a resident was receiving hospice services. CNA N stated the hospice provider would usually provide incontinent

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products, a wheelchair, and oxygen. CNA N stated the shower list had when a hospice aide would bathe the resident.

On 11/19/24 at 03:31 PM, Licensed Nurse (LN) G reported the facility did not have a hospice book or chart for R17. LN G reported the facility staff signed the hospice staff's tablets confirming the hospice staff visit and that the hospice nurse and facility nurse verbally discussed the resident's condition. LN G was unable to find the hospice nurse documentation of assessments or ongoing collaboration in R17's EMR. LN G reported the hospice plan of care was sent to the facility via email every six months with the recertification of hospice services.

On 11/20/24 at 10:33 AM, Administrative Nurse D verified the hospice provider should send notes from all visits made which should be scanned into the EMR. Administrative Nurse D reported the hospice provider had a change in computerized record keeping and was unaware the hospice provider had not been sending the information from the visits until recently. Administrative Nurse D said the facility had not followed up on receiving information from the hospice provider.

The facility "Hospice Agreement" dated 05/15/2018, last signed 5/1/20 by both parties documented that the nursing facility and hospice shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving facility and Hospice services. Each clinical record shall completely and accurately document all services provided to and events concerning (including evaluations, treatments, progress notes, and physician orders of each) hospice patient. The

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F 849	Continued From page 20 nursing facility and hospice provider shall each retain the records and the records shall be readily accessible and organized to facilitate retrieval by either party. The facility failed to collaborate care and services with R17's hospice provider, which placed R17 at risk of impaired end-of-life care.	F 849		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct	F 851		

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F 851	Continued From page 21 care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility had a census of 21 residents. Based on record review and interview the facility failed to submit complete and accurate staffing information through Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.	F 851		

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F 851	Continued From page 22 Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid Service (CMS) for Fiscal Year (YR) 2023 Quarter (Q) 4 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days (five). A review of the facility's licensed nurse timesheet data for the dates listed on the PBJ revealed a licensed nurse was on duty 24 hours a day seven days a week. On 11/18/24 at 12:26 PM, Administrative Staff A reported the discrepancy may be related to the submission of licensed nurse break hours and this had been adjusted to capture all the hours licensed nurses worked. Administrative Staff D stated the facility had nurse coverage 24 hours a day. The facility's undated "Mandatory Submission of Uniform Format Staffing Information (PBJ)" policy documented the facility would electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 23 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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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 21 residents. Based on interviews and record review, the facility failed to implement a water management plan to mitigate risks for Legionella (a bacterium spread through the 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). The facility failed to maintain an antibiotic tracking system and did not review its infection control policies annually. This deficient

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practice placed the 21 residents of the facility at risk for infection.

Findings included:

- The facility printed out a log that included resident names, locations, and prescriptions. The prescriptions were dated from 9/30/22 to 10/02/24. The log revealed eight prescriptions for antibiotics in 2024 but indicated the infection being treated was unknown. The log lacked documentation of onset, symptoms, or cultures.

The facility's "Infection Control" policy was last reviewed on 07/01/21 and
the facility's "Vaccine" policy was 02/13/23.

The facility had "Appendix A for Identifying Buildings at Increased Risk" which indicated the facility should have a water management program for the hot and cold-water distribution system.

On 11/19/24 at 01:55 PM, Administrative Staff A verified the facility had not reviewed the infection control policies annually, and that it had been a couple of years since they did. Administrative Staff A verified the facility had not followed through with setting up a water management program to address Legionella risk.

On 11/20/24 at 09:55 AM, Administrative Staff D, the certified Infection Preventionist, verified the facility had not tracked infections and did not have an ongoing monitoring process in place. She stated the staff discussed any current infections during the Quality Assessment and Assurance meetings.

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On 11/20/24 at 09:55 AM, Administrative Staff E stated she checked for patterns if more than one infection was going on at a time.

The facility's "Antibiotic Stewardship" policy, dated 07/15/2021, stated the center would discuss antibiotic use and resistance data. Compliance with antibiotic use algorithms and results of provider feedback during QAPI. The policy stated the Infection Preventionist would monitor antibiotic stewardship activities through a review of provider orders, clinical documentation, and pharmacy and lab reports. The ICP would track antibiotic use and resistance patterns, provide education as needed, and alert the facility if certain antibiotic-resistant organisms were identified. The policy stated the facility would implement a standard assessment and communication tool for residents suspected of having an infection SBAR. The facility would monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Monitor if cultures were obtained before antibiotics were initiated and if antibiotics changed during the course of treatment.

The facility's Infection Control Policy dated 07/01/2021, stated the facility would 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.

The facility's Legionella Risk Management policy stated the facility would ensure appropriate precautions for the control of Legionella bacteria were identified through a Legionella risk

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F 880	Continued From page 27 assessment process and appropriate control measures implemented to ensure, as reasonably practicable, the health, safety, and welfare of residents. The minimum standards to be met included: Legionella risk assessments, a description of the building water system, and an identification of where Legionella could grow and spread. An action plan for preventing or controlling the risk. Implementation, management, monitoring, and recording of precautions. The facility failed to implement a water management plan to mitigate risk for Legionella and failed to maintain an antibiotic tracking system and review infection control policies at least annually. This placed the 21 residents of the facility at increased risk for infection.	F 880		