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F 000	INITIAL COMMENTS Corrected Date_____ Investigation of complaints #93454-C, #94649-C, #94931-C, #94995-C, #95000-C, #95005-C, #95067-C, and #95139-C, and self report #93816-I, and focused infection control survey completed 12/16/20 to 1/21/21 resulted in the following deficiencies. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.) The facility was found not to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Complaint #93454-C was substantiated. Self report #93816-I was not substantiated. Complaint #94649-C was substantiated. Complaint #94931-C was substantiated. Complaint #94995-C was substantiated. Complaint #95000-C was substantiated. Complaint #95005-C was substantiated. Complaint #95067-C was substantiated Complaint #95139-C was substantiated. The facility reported 33 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		

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

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure a resident's received the appropriate care to maintain or enhance his or her quality of life for 3 of 5 residents reviewed, (Resident #6, #11, and #12).	F 550		

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The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 12/5/20, Resident #6 scored 10 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident required limited assistance with activities of daily living (ADL's) including bed mobility, transfer, walking in her room, dressing, and toilet use. The resident required extensive assist with bathing.

The Medical Diagnosis record included the resident had type 2 diabetes and heart failure.

The Care Plan identified the resident had actual ADL function deficits revised 9/30/19. The interventions included the resident needed limited to extensive assist of one with toilet use, with changing pull up or briefs, pericares, and adjustment of clothing every 3-4 hours and as needed (PRN).
The resident needed extensive assist of one with bathing/showering, with encouragement to wash parts of her body that she was able, and assist with hard to reach places and lower extremities.
The resident needed supervision after set up to wash hands and face and one staff limited/extensive assist for combing hair, brushing of dentures, and oral care.
The resident needed extensive assist of one with dressing, and needed help with TED (compression) hose, socks and shoes.

The Covid-19 Observation dated 12/10/20 at 12:49 a.m. documented the resident had increased weakness and confusion. Staff

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reminded to assist with ADL's and cares.

The Progress Notes dated 12/10/20 at 3:13 p.m. documented the ambulance called per the charge nurse request due to increased respirations, low oxygen saturation, and tachycardia.
At 3:30 p.m. the resident transported via ambulance to the hospital.

A History and Physical dated 12/10/20 documented the resident presented for hypoxia. The resident looked unkempt and smelled of urine. The resident had a very significant erythematous raw wound/lesion under the left breast extending around to the side of her back.

A wound assessment dated 12/10/20 at 5:50 p.m. documented inflammation of the left lower breast that appeared wet, pink/red with a small amount milky drainage, a strong foul odor, measuring 9.75 by 3.5 inches.

The POC Response History documented on 12/10/20 the resident had last received physical help in part of the bathing activity on 11/30/20 (11 days).
The POC Response History lacked any documentation regarding assisting the resident with toilet use, dressing, or personal hygiene on 12/10/20.

During an interview on 12/28/20 at 10:59 a.m. Staff C Certified Nursing Assistant (CNA) (worked 12/10/20) stated she did not recall redness or irritation under the resident's breast. She said the resident was independent and they just reminded her to go to the bathroom, she did not need assist.

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During an interview on 12/30/20 at 10:54 a.m. the Physician Assistant stated when the resident presented to the hospital 12/10/20 she did not appear to have received personal care. The resident had a pretty significant rash under her left breast that appeared red, raw, and did not appear to have been cared for.

2) According to the MDS assessment dated 11/27/20, Resident #11 scored 11 on the BIMS indicating some cognitive impairment. The resident required limited assistance with ADL's including bed mobility, transfer, ambulation in her room, dressing, toilet use, and personal hygiene.

The Medical Diagnosis list documented the resident's diagnoses included unspecified dementia without behavioral disturbance, unspecified abnormalities of gait and mobility, and need for assistance with personal care.

The Baseline Care Plan documented the resident needed assist of 1 with transfers, physical assist of 1 person with walking, assist of 1 with toileting, set up assist with grooming/hygiene, and assist of 1 with bathing. The resident's skin integrity goal's included to maintain intact skin. Interventions included incontinent care as needed. The resident had a risk for incontinence secondary to need for ADL assistance. The resident to shower 2 times a week.

The Progress Notes dated 12/30/20 at 9:02 a.m. documented the resident had a telehealth video visit via Zoom with the Physician's Assistant (PA), and family present via telephone. The resident had redness to her left lower extremity (LLE) assessed, and the resident denied pain when

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asked. Her skin appeared red, temp normal to touch, dry and flakey. Per the PA, continue hydrophillic ointment PRN. Order received for resident to discharge from the facility to assisted living (AL). No further concerns voiced by the resident, and the family planned to transport the resident that a.m.

A POC Response History for bathing documented the resident independent 12/10/20, not available 12/14/20 and 12/28/20, otherwise not applicable.

The AL facility notes dated 12/30/20 at 2:30 p.m. documented the resident arrived with family. The resident had a very foul odor and staff took her directly to the whirlpool to clean her up. After bathing her, staff found the Registered Nurse (RN) in tears, stating the resident's skin needed immediate care and attention. Staff reported the resident had fecal matter under her breasts and up her back, citing the smell almost more than she could bear. After cleansing her, she noted large amounts of skin breakdown under her breasts. Upon assessment, noted skin from side to side completely broken down and fiery red about a 6 inch swath under both breasts. They did not attempt a bra fearing it would be too painful for the resident. The RN patted the areas dry again due to weeping, and applied cotton strips of cloth with corn starch between the breasts and skin. The resident stated she had not had a bath like that for a long time.
A late entry dated 1/5/21 at 7:30 a.m. documented on 12/30/20 the staff person took the resident immediately to the bath due to a bad odor from the resident. She observed dry, diarrhea like fecal matter on different areas of her body, on her back, upper part of her trousers. The entire skin area under her breasts appeared

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raw with yellowish green weeping and a foul odor. After soaking about 10 minutes in the tub, she had trouble cleaning it due to sensitivity. It looked like about 1 step away from bleeding. In her 11 years of care giving the staff member had never seen this degree of breakdown under breasts before. The resident told her they did not give her baths or take such good care of her.
A skin assessment dated 1/5/21 at 11 a.m. documented the resident reported feeling much better. The skin under her breasts a darker pink, but no longer open. She wore a bra for the 1st time, and denied pain.

During an interview on 1/5/21 at 4:05 p.m. the RN at the AL stated the resident arrived at the AL and due to odor immediately went to the shower. The staff who assisted her stated she had dried fecal matter caked and dried on, and her skin appeared discolored from having stool in contact with it. The resident had fiery red, painful skin under her breasts.

During an interview on 1/6/21 at 9:59 a.m. Staff D Licensed Practical Nurse (LPN) stated she worked when the resident discharged. She left with family in a good mood. She had a virtual visit (with PA) due to a reddened calf. They pulled her pant leg up and removed her socks and shoes. She did not note the resident looked dirty or had an odor. They do wear masks but they could still tell if someone had body odor. She said the resident needed a lot of cueing. Unsure if the resident refused care or refused to have laundry done. She believed the resident would receive bed baths or at least assist with personal hygiene. She did not know the resident had a skin concern under her breasts.

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During an interview on 1/7/21 at 10:35 a.m. the Director of Nursing (DON) stated she saw the resident the day she transferred to the AL. She saw her legs, feet, and abdomen. She did not see under her breasts. She said they did not do a head to toe skin assessment when discharged. The DON stated the resident did not appear unclean, disheveled or unkempt. She said her hair had not been done but they were not allowing the beautician in the building. She walked the resident to the car when she left. She said staff should document any bath including bed bath on PCC, and document if the resident refused. At 1:50 p.m. the DON stated the resident did not go anywhere on 12/14/20 or 12/28/20 that she would be unavailable for a bath.

3) According to the MDS assessment dated 11/27/20, Resident #12 was rarely or never understood. The resident required limited assistance with ADL's including bed mobility, transfer, ambulation in the room, dressing, toilet use, and personal hygiene.

The Medical Diagnosis record documented the resident's diagnoses included need for assist with personal care and altered mental status.

The current Care Plan revised 3/16/17 identified the resident had an ADL self care performance deficit. Interventions included assist of 1 with grooming and oral cares a.m. and bedtime daily.

During an interview on 1/4/21 at 4:16 p.m. the resident's family member stated the previous week she did a facetime with the resident and

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F 550	Continued From page 8 she basically had a beard. The family member said she flipped out, because the resident would be horrified. The family member stated the facility reported to her they put the resident on skilled care because she would get better care. The family member stated the resident did not get a bath from 12/8-31/20. The POC Response History documented the resident did not receive a bath between 12/16-26/20 (10 days), or between 12/26/20 and 1/6/21 (11 days). During an observation on 1/5/21/at 1:50 p.m. the resident sat in her chair in her room. She had 1/2 inch long hair growth across her chin. During an observation on 1/6/21 at 12:09 p.m. the resident continued to have hair growth across her chin. During an interview on 1/6/21 at 12:10 p.m. Staff J Registered Nurse (RN) stated it did not take long to shave someone, and they should shave with any signs of hair growth.	F 550		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the physician's orders for 3 of 3 residents reviewed, (Resident #1, #6, and	F 658		

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#7). The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 10/21/20, Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.
The resident was independent with activities of daily living (ADL's) including transfer, ambulation and personal hygiene and required extensive assist with bathing.

The resident's Medical Diagnosis record included Covid-19 and diabetes.

a) A Telephone Encounter dated 12/8/20 included orders to start Doxycycline 100 mg 2 times a day for 7 days.

The Medication Administration Record (MAR) for December 2020 documented on 12/8/20 and 12/9/20 at 8 p.m. Doxycycline not given, with the progress notes documenting the med not there from pharmacy (although marked as given 12/9/20 a.m.) The MAR documented the resident received 12 doses of the medication.

During an interview on 1/5/21 at 4 p.m. the Director of Nursing (DON) stated the resident probably did not receive 14 doses of the medication.

b) The Medication Review Report dated 10/28/20 showed the resident had an order for daily weights one time a day, and if weight increased by 2-3 pounds in a day or 5# in a week, notify the PCP (primary care provider).

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The Treatment Administration Record (TAR) for December 2020 lacked documentation of a daily weight on December 5, 6, 9, 10, 11, 12, 13, 15, or 18.

During an interview on 12/29/20 at 10:50 a.m. the resident stated she should get her weight daily before breakfast, and some days they did not even get a weight.

During an interview on 1/6/21 at 9:59 a.m. Staff D Licensed Practical Nurse (LPN) stated she did not know why the resident had some missed weights.

c) The current Care Plan revised 10/6/20 identified the resident had a diagnosis of diabetes. The interventions included diabetes medication as ordered by the doctor.

The Medication Review Report dated 10/28/20 included the order to increase the insulin Levemir to 32 units, 2 times a day (BID).

The Progress Notes dated 10/28/20 at 6:20 p.m. documented the writer asked another nurse to call the resident's Power of Attorney (POA) and update her on the new order received during a routine telehealth visit. Blood sugars were reviewed after the visit and order received to increase Levemir to 32 units.

The Progress Notes dated 10/29/20 at 9:03 p.m. documented the resident's family contacted regarding increase in Levemir from 30 units BID to 32 units BID. The family voiced understanding.

The MAR for November 2020 showed the

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resident received Levemir 30 units through the a.m. of 11/6/20, and did not have the increase to 32 units BID until the p.m. of 11/6/20.

During an interview on 1/6/21 at 9:59 a.m. Staff D Licensed Practical Nurse (LPN) stated when they increased the Levemir she asked the night nurse to notify the family and enter the new order on the MAR. For some reason she did not get it done and it delayed starting the increased dose.

d) During an interview on 12/29/20 at 10:50 a.m. the resident stated Staff D drew her blood after she ate (breakfast) a day in June and it should be fasting. When her daughter called the Administrator, he told her Staff D documented drawing it at 6 a.m.

A fax dated 6/2/20 at 10:51 a.m. notified the physician the resident had an order for a basic metabolic panel (BMP) that a.m. and questioned if okay to draw 6/3/20 before breakfast. The physician responded yes.

The Progress Notes created 6/3/20 at 12:46 p.m. documented the effective date of 6/3/20 at 6:46 a.m. BMP drawn from right antecubital (AC); blood taken to clinic, awaiting results.

A BMP lab result dated 6/3/20 documented the specimen collected at 9:22 a.m. and unknown if fasting, with the result time of 9:47 a.m.

During an interview on 1/6/21 Saff D stated she was not sure what happened. She guessed she documented later in the nurse's notes and documented the wrong time, she really could not remember.

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2) According to the MDS assessment dated 12/5/20, Resident #6 scored 10 on the BIMS indicating cognitive impairment. The resident required limited assistance with activities of daily living (ADL's) including bed mobility, transfer, walking in her room, dressing, and toilet use. The resident required extensive assist with bathing.

The resident's Medical Diagnosis record included type 2 diabetes and heart failure.

The current Care Plan revised 6/30/19 identified the resident used Oxygen therapy. Interventions included use of O2 via nasal prongs at 2-5 liters continuously.

Hospital discharge instructions dated 12/17/20 included O2 at 2-5 liters per nasal cannula continuous, titrate to keep saturations above 90%, and monitor oxygen (O2) saturations (sats) 4 times a day (QID).

The Weights and Vitals record and the MAR/TAR for December 2020 lacked documentation of QID O2 Sats.

During an interview on 1/5/21 at 4 p.m. the DON stated if QID O2 sats were not on the MAR/TAR or Weights and Vitals record, they were not done.

3) According to the MDS assessment dated 10/9/20, Resident #7 had long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfers, dressing, eating, and toilet use.

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The resident's Medical Diagnosis record included unspecified dementia without behavior disturbance.

A fax dated 12/19/20 notified the physician the resident had a wound to the right side of her buttocks. The fax questioned if they could have orders for Arginaid 2 times a day and Triad wound cream with a.m. and p.m. cares every day and discontinue when healed. The fax returned okay.

A fax dated 12/25/20 notified the physician the current treatment to the wound Triad, 2 times a day, and questioned if the physician would like to continue the treatment or change the treatment since the wound did not appear to improve. The physician responded to continue same and questioned if they had access to a wound nurse.

The Medication Administration Record for December 2020 showed staff signed off doing the treatment with Triad 12/22/20 x2, 12/23/20 x1, 12/24/20 x2, 12/25/20 x2, 12/26/20 x2, 12/27/20 x2, and 12/28/20 x1.

During an observation on 12/28/20 at 2:15 p.m. the resident laid in bed on her left side. Staff D LPN pulled the resident's incontinent pad back to reveal a round ulcer. Staff D checked and they had no Triad in the cart, and they had no Triad for the resident.

During an interview on 1/5/21 at 3:55 p.m. the DON stated Staff D LPN had checked and they did not have the Triad until last week (so did not have when staff documented doing the treatment 12/22-28/20)). She said staff should notify the physician if they did not have the ordered

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F 658	Continued From page 14 treatment to determine an alternative until they did. They should not sign off on the MAR doing the treatment (when not available). During an interview on 1/6/21 at 9:59 a.m. Staff D confirmed they did not have the resident's Triad until last week. She checked with the pharmacy and the 1st order they received for it came from her. She said the treatment should not be documented done when they did not have the treatment available.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure residents received the necessary services to maintain grooming and personal hygiene for 5 of 5 residents reviewed, (Resident #1, #4, #5, #6, and #11). The facility reported a census of 33 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated 10/21/20, Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident was independent with activities of daily living (ADL's) including transfer, ambulation and personal hygiene, and required extensive assist with bathing.	F 677		

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POC Response History's for bathing 12/11/20 through 12/29/20 showed the resident not available or not applicable. The record lacked documentation the resident received a bath, and documented response not required for hair washing.

During an interview on 12/29/20 at 10:50 a.m. the resident stated she just wanted to go back to her room, 209. She said they got better care there. She said she had not received a shower since she had been on this hall (since 12/8/20). Staff G Certified Medication Aide (in the room at the time) asked the resident if she would allow a bed bath and the hair cap to shampoo her hair. The resident responded she would. She said she had just been sitting on the toilet wiping herself off. She said she had not refused a bath or the hair cap, they had not offered it. The resident's hair appeared flat and greasy.`

2) According to the MDS assessment dated 10/9/20, Resident #4 scored 5 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with ADL's including bed mobility and bathing , and depended on staff for transfers, dressing, and toilet use.

The current Care Plan revised 1/12/16 identified the resident had a focus for self care and interventions included extensive assist of two staff with bathing. The resident would continue to be neat, clean and well groomed with staff providing extensive assist with ADL's.

POC Response History's documented the

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resident had assistance with a bath and hair washed 12/16/20. The record lacked a bath or hair care between 12/16/20 and 1/2/21.

During an observation on 12/29/20 at 1:10 p.m. the resident laid in bed and noted with greasy hair.

3) According to the MDS assessment dated 10/9/20, Resident #5 scored 00 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with ADL's including bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.

The current Care Plan revised 7/21/20 identified the resident with an ADL self care performance deficit. The interventions included the resident required extensive assist of two with transfers on and off the bath chair and one staff participation with bathing.

POC Response History's documented physical help with a bath on 12/11/20, and no other assistance documented through 1/5/21, and hair wash not done 12/11/20 with no response required between 12/11/20 and 1/5/21.

4) According to the MDS assessment dated 12/5/20, Resident #6 scored 10 on the BIMS indicating cognitive impairment. The resident required limited assistance with ADL's including bed mobility, transfer, walking in her room, dressing, and toilet use. The resident required extensive assist with bathing.

The Care Plan identified the resident had actual

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ADL function deficits revised 9/30/19. The interventions included the resident needed extensive assist of one with bathing/showering while encouraging her to wash parts of her body that she is able and assist with hard to reach places and lower extremities.

The POC Response History for bathing documented the resident received assistance with a bath 11/30/20, not available 12/7/20, refused 12/24/20, 12/28/20 and 1/7/21. No other baths were documented.

5) According to the MDS assessment dated 11/27/20, Resident #11 scored 11 on the BIMS indicating some cognitive impairment. The resident required limited assistance with ADL's including bed mobility, transfer, ambulation in room, dressing, toilet use, and personal hygiene, and bathing did not occur over the previous 7 days.

The Baseline Care Plan documented the resident needed assist of 1 with transfers, physical assist of 1 person with walking, assist of 1 with toileting, set up assist with grooming/hygiene, assist of 1 with bathing. The resident's skin integrity goal to maintain intact skin. Interventions included incontinent care as needed. The resident had a risk for incontinence secondary to need for ADL assistance. The resident to shower 2 times a week.

A POC Response History for bathing documented the resident independent 12/10/20, not available 12/14/20 and 12/28/20, otherwise not applicable. The POC Response History for hair washing from 12/14/20 to 12/28/20 documented response not

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required.

The Progress Notes dated 12/30/20 at 9:02 a.m. documented order received for resident to discharge from the facility to assisted living (AL). No further concerns voiced by the resident, and the family planned to transport the resident that a.m.

During an interview on 1/5/21 at 4:05 p.m. The Registered Nurse (RN) at the Assisted Living (AL) facility stated the resident arrived at the AL and due to odor immediately went to the shower. The staff who assisted her stated she had dried fecal matter caked and dried on, and her skin appeared discolored from having stool in contact with it. The resident had fiery red, painful skin under her breasts.

During an interview on 1/7/21 at 10:35 a.m. the Director of Nursing (DON) stated she saw the resident the day she transferred to the AL. She saw her legs, feet, and abdomen. She did not see under her breasts. She said they did not do a head to toe skin assessment when discharged. The DON stated the resident did not appear unclean, disheveled or unkempt. She said her hair had not been done but they were not allowing the beautician in the building. She walked the resident to the car when she left. She said staff should document any bath including bed bath on PCC, and document if the resident refused. At 1:50 p.m. the DON stated the resident did not go anywhere on 12/14/20 or 12/28/20 that she would be unavailable for a bath.

During an interview on 12/28/20 at 11:03 a.m. Staff C Certified Nursing Assistant (CNA) stated they had not had an issue lately with staffing.

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F 677	Continued From page 19 She thought the nurses may have worked short, but they seemed to do okay with CNA's. They were not doing showers due to the outbreak, but they offered bedbaths and documented in PCC. During an interview on 12/28/20 at 11:13 a.m. Staff G Certified Medication Aide (CMA) stated they had not worked short the past month. She said they offered residents bed baths and did their hair with a shampoo cap. She had not worked the floor lately so she had not been doing them. During an interview on 11/28/20 at 11:41 a.m. Staff A CNA stated she had not thought they had staffing issues lately, but some staff did not provide the necessary care. She said one CNA would say she had done care when she had not. Staff A felt terrible when residents were not cared for like they should be. She said she personally marked NA for bath on PCC because she thought it was for showers. She knew others who did not give them. During an interview on 12/28/20 at 12:34 p.m. Staff B LPN stated she could not say if they had worked short lately, but she had concerns about care provided by some staff. She said one CNA did not provide the care appropriate for the residents.	F 677		
F 684 SS=L	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

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that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview the facility failed to provide adequate assessment and timely intervention for a change in condition for 6 of 7 residents reviewed, (Resident #2, #4, #5, #6, #7, and #8). Resident #2 with Covid-19 lacked adequate assessment with a change in condition including difficulty breathing, decreased intake, low oxygen (O2) saturations (sats). Sent to the Emergency Department (ED)/Emergency room (ER) in severe acute distress, tachycardic, tachypneic, and extremely dehydrated. Resident #4 with a history of urosepsis had elevated temperatures (T), with orders to monitor VS closely, had only T documented the day before hospitalization with acute kidney failure, hypernatremia (likely due to volume depletion) hyperkalemia and sepsis. Resident #5 with a blood sugar of 51, given insulin,and documented refusal of breakfast with no follow up until blood sugar checked before lunch registered 35. Sent to hospital for treatment of hypoglycemia. Resident #6 with Covid-19 lacked adequate assessment and increased assistance with activities of daily living (ADL's). Resident hospitalized with Covid-19, questionable early pneumonia, sepsis, acute kidney injury likely secondary to dehydration/sepsis, and left breast wound/rash. Resident #7 had a change in condition with poor intakes and vital signs (VS) not within normal limits (WNL). A fax to the physician with no response and no follow up until the following day. The resident hospitalized with acute kidney injury

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and hypernatremia likely due to severe dehydration. Resident #8 admitted with wounds to the lower legs and feet with no assessment of the areas, seen by the wound nurse with recommendations not in the clinical record, and no treatment of the areas. Resident hospitalized with infection of diabetic foot ulcers. The facility reported a census of 33 residents.

A determination was made that the facility's noncompliance with one or more requirements of participation placed all residents in the facility in immediate jeopardy, beginning on 11/13/20. On 1/4/21 at 3:15 pm, the Administrator was notified of the immediate jeopardy at F684, Assessment/Intervention and was given the IJ Template.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 10/21/20, Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.
The resident was independent with ADL's including bed mobility, walking in the corridor, and eating, and required supervision with transfer, ambulation in her room, dressing, toilet use, and personal hygiene.

The resident's Medical Diagnosis record included Covid-19, unspecified atrial fibrillation, and a history of myocardial infarction.

The Progress Notes dated 12/8/20 at 12:16 p.m. documented the resident's emergency contact notified of the resident's positive Covid status.

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The Care Plan initiated 12/8/20 and revised 12/13/20 identified the resident tested positive for Covid-19. The interventions included oxygen (O2) as needed, offer fluids as needed (PRN), respiratory assessments every shift, and vital signs every shift. Report any vital signs outside parameters to the physician or nurse practitioner (NP).

The Assessments page showed the resident had:
a. no assessments documented 12/7/20 or 12/8/20,
b. 2 Covid assessments 12/9/20 12:42 a.m. and 12:28 p.m.
c. 1 Covid assessment 12/10/20 at 12:38 a.m.
d. 1 Covid assessment 12/11/20 at 2:21 a.m. and 1 SN assessment at 11:35 p.m.
e. 1 Covid assessment 12/12/20 at 2:39 p.m.
f. 1 SN assessment 12/13/20 at 10:54 p.m. and 1 Covid assessment at 11:35 p.m.

The Covid-19 and the Nursing Daily Skilled Assessment (SN) assessments did not include VS.

The weights/vitals record lacked documentation:
a. Between 12/3/20 and 12/14/20 for blood pressure.
b. Between 11/26/20 and 12/14/20 for pulse.
c. Between 12/3/20 and 12/14/20 for respirations.
d. Between 12/3/20 and 12/14/20 for temp.
e. Between 11/26/20 and 12/14/20 for O2 sats.

The Progress Notes dated 12/13/20 at 3:57 p.m. documented the resident complained of shortness of breath and appeared fatigued. Order faxed to the provider requesting to titrate O2 to to keep sats greater than 90%.

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The clinical record lacked the fax with order for O2.

A Nursing Daily Skilled Assessment dated 12/13/20 at 10:54 p.m. documented the resident ate less than 25% of the evening meal, appetite and fluid intake fair. The resident had a non-productive cough, labored breathing, irregular breathing rhythm, and faint course bilateral lung sounds. The resident received skilled level of care due to positive Covid-19 results 12/8/20. The resident had faint course lung sounds to the upper lobes with a non-productive cough. The resident denied chest pain/shortness of breath, with O2 sat 94% on O2 at 2 liters/per nasal cannula (L/NC).

A Covid-19 Observation dated 12/13/20 at 11:35 p.m. (41 minutes after the skilled assessment) documented the resident had a non-productive cough, labored breathing, and shortness of breath. The observation documented the lung sounds clear.

The clinical record lacked a Covid-19 assessment or Nursing Daily Skilled Assessment 12/14/20.

The Progress Notes dated 12/14/20 at 9:34 p.m. documented the resident drowsy with increased lethargy while administering medications. Speech low and slow to respond and said she felt so confused, and didn't know what was wrong with her. The resident had faint coarse lung sounds to the upper lobes with VS, temperature (T) 97.8, blood pressure (BP) 110/6, pulse (P) 133, respirations (R) 22, and O2 sat 77% on room air. The resident denied chest pain. As needed (PRN) oxygen administered, and call

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placed to the on call provider for further recommendations.

An EInteract SBAR summary for providers dated 12/14/20 at 9:50 p.m. documented a change in condition including abnormal vital signs, altered mental status, and shortness of breath.
At the time of evaluation the resident's BP 110/62, P 133, R 20, T 97.6, and O2 sat 73 %.
The resident had altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse), and increased confusion. The resident needed more assistance with ADL's, had general weakness, and decreased mobility. She had shortness of breath, labored or rapid breathing, abnormal lung sounds, and a resting pulse greater then 100. The on-call provider ordered to increase O2/NC, administer duoneb (breathing treatments) every 4 hours PRN and push fluids.

The Progress Notes dated 12/14/20 at 9:54 p.m. documented a call received back from the on call provider/physician and update given on the resident's health status. The physician wanted to avoid sending the resident out to the ED and manage symptoms at the facility. New orders received for duonebs every 4 hours PRN, push fluids, continue to monitor, and call back if symptoms worsen. The family updated on the resident's status, and agreed with provider recommendations/orders.

The Progress Notes dated 12/14/20 at 10:17 p.m. documented PRN neb treatment administered per provider order with O2 at 94% on 3 L/NC on recheck. Two staff assisted the resident to the bathroom and back to bed. The resident drank 12 ounces of Gatorade and swallowed without difficulty, staff to monitor.

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The clinical record lacked documentation of additional fluids offered through the shift.

The Treatment Administration Record (TAR) documented the resident received a nebulizer treatment at 3 a.m. on 12/15/20. The residents O2 sat 88%, (with no documentation of liters of O2 administered), pulse 112, and respirations 20.

The clinical record lacked documentation of the O2 sat registering above 88% after the 3 a.m. neb treatment, how much O2 delivered with this low reading, or any additional check of VS.

The Progress Notes dated 12/15/20 at 7:56 a.m. documented a call placed to the resident's physician office for follow-up on health status, speaking with the Registered Nurse (RN) and update given. The RN stated she would update the physician and call back with recommendations.

The Progress Notes dated 12/15/20 at 8:48 a.m. documented a call received from the RN at the clinic. The physician directed sending the resident to the Emergency Department (ED) for possible Bamlanivimab (BAM/monoclonal antibody) infusion and further evaluation.

The Progress Notes dated 12/15/20 at 9:06 a.m. documented the resident left the facility in a wheel chair (w/c) via facility driver to the ED.

A History and Physical dated 12/15/20 documented the resident presented with shortness of breath, hypoxia, and increased confusion. The resident tested positive for Covid on 12/8/20. She remained asymptomatic for

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some time then declined in the last few days. The nursing home staff reported increased confusion, weakness and shortness of breath. They put her on 5 liters (of O2) and were unable to maintain her oxygen saturations. Upon arrival the resident was tachycardic (rapid heart rate), tachypneic (abnormally rapid breathing), dehydrated, and very confused. The resident appeared in severe acute distress, looked acutely ill, and appeared extremely dehydrated. The posterior pharynx appeared pink, and the mouth/tongue/lips were extremely dry with cracking of the lips. They discussed with the family the critical nature of the resident's condition. The resident's diagnoses included Covid-19, right sided pneumonia, sepsis, acute kidney injury on chronic kidney disease likely due to dehydration and Covid.

During an interview on 12/28/20 at 11:08 a.m. Staff G Certified Medication Aide (CMA) stated she worked with the resident the last couple of days before she went to the hospital, and she was not drinking. She got weaker and weaker and not looking like herself, or responding like usual. She could not swallow all her pills the day she transferred, spitting some of them back out. She said she had to pee, but couldn't. Her lips were very dry and had a bluish tint. Staff G swabbed her mouth with a toothette. She really was not able to take in orally.

During an interview on 12/18/20 at 11:32 a.m. Staff D Licensed Practical Nurse (LPN) stated when she called the on-call physician he said the hospital was really slammed and wanted them to manage the resident's symptoms at the facility. She told him the resident's symptoms and he ordered nebulizer treatments and to push fluids.

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She gave the resident 12 ounces (360 cc's) of Gatorade around that time, and she thought the CNA's gave her another 12 ounces overnight. Staff D stated the resident showed a big decline the evening before she transferred.

During an interview on 12/28/20 at 3:34 p.m. Staff H CNA stated all they gave the resident through the night was Gatorade, about 1/2 of a 12 ounce bottle (180 cc's). The resident's lips were very dry and she applied chapstick That night shift she appeared very sick and very confused. She thought they had her O2 up to 5 liters to try and get her sats up.

During an interview on 12/30/20 at 10:54 a.m. the Physician Assistant stated the resident was absolutely critical when she came to the ED. She did not know if she would make it 2 hours. She said the resident had extreme dehydration, the dryest she had ever seen. She said there was not a specific standard for pushing fluids, but they would do a 1000 cc bolus of intravenous fluids in an hour. She would say they should drink 5 to 8 cups of fluid over a few hours (1200-1920 cc's). Eighteen ounces (540 cc's) over the night would not be adequate to rehydrate. It was her professional opinion if the resident had received care sooner it may have changed the outcome (the resident died).

During an interview on 1/4/21 at 8:37 a.m. the Physician (on call the evening before hospitalized) stated he did not recall specific details regarding the reports on the resident the night before she hospitalized. He said if they were unable to keep her sats above 90% with the neb treatments and increased O2 he would expect the facility to call him back. He believed a

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person needed about 60 ounces of fluid per day, so 540 cc's would not be adequate to combat dehydration He said if the resident had treatment earlier it could have potentially changed the outcome.

During an interview on 12/28/20 at 1:15 p.m. Staff D LPN and Infection Preventionist stated she and the DON were the only one's that had not tested positive for Covid-19, and they worked a lot. She saw assessments were not done as planned,

2) According to the MDS assessment dated 10/9/20, Resident #4 scored 5 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with ADL's including bed mobility, and depended on staff for transfers, dressing, and toilet use.

The Care Plan initiated 11/11/20 identified the resident had a diagnosis of urinary tract infection (UTI). The interventions included checking on her frequently and offering fluids every time passing by her room.

The Progress Notes dated 11/9/20 at 9:13 a.m. documented staff reported increased lethargy with confusion, decreased appetite, and fluid intake. The resident had T 100.9, BP 146/82, P 131, R 17, and O2 sat of 97% on room air. The power of attorney (POA) called and updated and concerned about resident's history of chronic UTI's and requesting a urinalysis (UA) checked for possible UTI. Fax sent to primary care provider (PCP), awaiting response.

A fax dated 11/9/20 at 10:36 a.m. notified the physician the resident had increased lethargy, slow to respond, lungs clear, and denied

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shortness of breath or chest pain. The resident had T 100.9, BP 146/82, P 131, R 18, and O2 sat 95%. The family requested a UA and reflex due to resident's history of chronic UTI's. The physician responded with orders for UA with reflex and complete blood count (CBC). The fax timestamp showed 11/9/20 at 1:45 p.m. The order not noted until 11/11/12 at 4:22 p.m.

The Progress Notes dated 11/10/20 at 2:31 a.m. documented the resident had a fever x 1 during the day. On med rounds T 98.9. At the time T 100.2, with red cheeks. The resident very thirsty, drinking 600 cc's water, and a cool, moist washcloth applied to her forehead.

The Progress Notes dated 11/10/20 at 6:02 p.m. documented contacting the physician via phone due to increased fever and other signs and symptoms (s/sx) of UTI (orange/red colored urine.) Telephone orders received to start Tylenol every 4 hours, Ibuprofen every 6 hours, and Rocephin (antibiotic) tonight and tomorrow night. At 8 p.m. Rocephin 1 gram (gm) given intramuscularly (IM) in the left buttock.

The Progress Notes dated 11/11/20 at 2:01 a.m. documented the resident's T 100.5. Tylenol 650 mg oral (po) given and resident drank 2, 8 oz glasses of Pedialyte. At 3:10 a.m. the resident's T 101.4 and 2, 8 oz glasses of Pediialyte given. Would recheck temp and offer more fluids.

An order dated 11/11/20 directed the need for a UA reflux to culture, and CBC today. The resident should get another gram of Rocephin today and tomorrow. Also starting oral antibiotics, Bactrim DS 2 times a day for 7 days. Please closely monitor her vital signs and mental state

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and update them appropriately.

The Progress Notes dated 11/11/20 at 10:27 a.m. documented the physician called and did telephone order for CBC draw and UA with reflex. Labs drawn from right hand without complication. At 10:46 a.m. new orders received for 1 gm Rocephin 11/11 and 11/12 and start oral antibiotics. Bactrim DS 800-160 mg 1 tab 2 times a day (BID) x 7 Days. Closely monitor vital signs and mental state. At 2:34 p.m. the resident continued on antibiotics for possible UTI, afebrile and no s/sx of adverse effects.

The Progress Notes dated 11/12/20 at 5:19 a.m. documented the resident had low grade temps through the night; 8 p.m. 100.1, received scheduled Tylenol, 11:45 p.m. 99.1, and 3 a.m. 98.9. The resident drank Pedialyte through the night, lips continued dry, oral cares preformed, and rested in bed.

The clinical record lacked documentation of other vital signs 11/12/20.

The Progress Notes dated 11/13/20 at 9:14 a.m. documented an EInteract SBAR Summary for Providers. The situation included abnormal vital signs, BP 50/40, P 111, R 24,
T 97.5, and O2 sat 71 % on room air. The resident exhibited altered level of consciousness, general weakness, swallowing difficulty, labored or rapid breathing, resting pulse greater than 100. The PCP responded with the following feedback to transfer to the Emergency Department (ED) via ambulance. At 10:05 a.m. the resident sent to the ED due to a change in condition.

A History and Physical dated 11/13/20

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documented severe sepsis suspected with evidence of organ dysfunction. The problem list included acute kidney failure, hypernatremia, likely due to volume depletion, hyperkalemia, and sepsis. The resident presented from the nursing home for decline in condition. The resident had an O2 sat of 71% on room air. The resident had a white blood count of 19.3, with the reference range 4.5-11.

During an interview on 12/30/20 at 10:54 a.m. the Physician Assistant stated the physician on-call 11/9/20 received report the resident more confused, lethargic and he ordered a CBC and UA. She saw the fax. She had call on 11/10/20 and the facility called her. She assumed they had obtained the CBC and UA so she started antibiotics and scheduled Tylenol and Ibuprofen. On 11/11/20 she discovered they had not obtained the CBC or the UA. She wrote orders for close monitoring of the resident including vital signs. She said checking vital signs 1 time each 12 hour shift would not be adequate. She said because the UA and CBC were not completed 11/9/20, there was a delay in determining the appropriate antibiotic and the resident became septic quickly.

During an interview on 1/4/21 at 10:09 a.m. Staff F LPN stated she recalled when she received a fax from 11/9/20 on 11/11/20. She said they had something wrong with the fax machine and they were not coming through. The provider wrote new orders that day and they were completed 11/11/20. She did not know why someone did not follow up 11/10/20 when the fax did not return.

3) According to the MDS assessment dated

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10/9/20, Resident #5 scored 00 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with ADL's including bed mobility, transfer, dressing, toilet use and personal hygiene.

The resident's Medical Diagnosis record included diabetes.

The current Care Plan revised 7/21/20 identified the resident with insulin dependent diabetes mellitus. The interventions included administering diabetes medication as ordered by the doctor, monitoring/documenting for side effects and effectiveness.

The Medication Administration Record (MAR) for December 2020 documented the resident had a blood sugars of:
a. 63 on 12/5/20 at 7:30 a.m. and the resident's insulin held.
b. 88 on 12/6/20 at 7:30 a.m. and the resident's insulin held.
c. 89 on 12/8/20 at 7:30 a.m. and the resident's insulin held.
d. 63 on 12/10/20 at 7:30 a.m. and the resident's insulin held.
e. 77 on 12/11/20 at 7:30 a.m. and the resident's insulin held.
The clinical record lacked documentation of notifying the physician of the resident's blood sugars or holding his insulin.
f. 51 on 12/13/20 at 7:30 a.m. and the resident's insulin given.

The POC Response History for percentage of meal eaten documented the resident refused the morning meal on 12/13/20.

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The Progress Notes dated 12/13/20 at 12:26 p.m. documented upon performing noon accucheck, the resident's blood sugar registered at 35 and PRN Glucagon given. Additional accucheck read 37. The ambulance paged for emergent transfer to the hospital, and notification of the transfer. The resident transferred to the stretcher with extensive assist, and transferred to the hospital.

The Emergency Room Visit Notes dated 12/13/20 documented the resident presented with hypoglycemia. The facility reported the resident did not receive sliding scale insulin this a.m. with breakfast, but did receive 18 units of scheduled regular fast acting insulin. The blood sugar before insulin 51. Upon recheck the blood sugar was 37, and glucagon given. They rechecked the blood sugar with no improvement. He became somewhat agitated and unresponsive so they transferred him to the ED. Upon arrival the resident somewhat unresponsive but able to follow commands, and somewhat agitated during the exam. They were able to start an IV and gave dextrose infusion and the blood sugar improved. They did a CT of the head due the agitation and altered mental status. Over the course of the ER visit he became more alert and responsive and felt to be stable for discharge back to the home.

A hospital Patient Visit Information page documented the resident seen for hypoglycemia, diabetic insulin reaction. Orders for change of evening Lantus to 35 units that evening and call the PCP to manage further during illness in the a.m., and holding scheduled Novolog while resident not eating well. Ok to continue sliding scale. If blood sugar under 100 hold insulin and and notify PCP.

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The Progress Notes dated 12/13/20 at 3:30 p.m. documented the resident returned via ambulance and transferred from the stretcher to bed with extensive assist. The resident had and IV present to right (R) antecubital from the hospital. Orders received to change evening Lantus to 35 unites tonight. Hold scheduled Novolog until follow-up with PCP. Okay to continue sliding scale insulin. Hold insulin if blood sugar less than 100. The responsible party and PCP notified, and fax sent out to provider to set up telehealth appointment on 12/14/20.

During an interview on 12/28/20 at 11:10 a.m. Staff G CMA stated when she did a blood sugar check she reported right away before the nurse gave the resident's insulin. She said if a resident had a blood sugar less than 90 she would give them a glass of milk or orange juice.

During an interview on 12/28/20 at 11:24 a.m. Staff D LPN stated she would expect the CNA's to let her know if a resident did not eat. She said she would notify the physician before giving insulin if the blood sugar below 90. She did not know how the other nurses would handle it.

During an interview on 1/4/20 at 2:15 p.m. the Director of Nursing (DON) stated she gave the resident his a.m. dose of insulin. She said the CNA's reported he had eaten breakfast. She did not know they had documented a refusal.

During subsequent interview on 1/5/20 at 3:40 p.m. the DON stated they would normally notify the physician of a low blood sugar and/or holding the insulin.

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During an interview on 1/6/21 at 12:25 p.m. the Family Nurse Practitioner (FNP) stated the resident found unresponsive and given Glucogan per the DON. The resident's blood sugar result low at breakfast and they held the sliding scale insulin, but gave the regular (scheduled) insulin. She said they should be holding insulin with a blood sugar that low.

4) According to the MDS assessment dated 12/5/20, Resident #6 scored 10 on the BIMS indicating cognitive impairment. The resident required limited assistance with activities of daily living (ADL's) including bed mobility, transfer, walking in her room, dressing, and toilet use. The resident required extensive assist with bathing.

The current Care Plan initiated 7/15/20 identified the resident had a reddened area of skin under breasts bilaterally. The interventions included application of topical powders per physician orders.

The Care Plan initiated 12/8/20 and revised 12/13/20 identified the resident presumptive positive/or having tested positive for COVID-19. The interventions included maintaining droplet isolation, O2 PRN, offer fluids PRN, respiratory assessment completed every shift, VS every shift. Report any vital signs outside parameters to physician or NP.

The Care Plan identified the resident had actual ADL function deficits revised 9/30/19. The interventions included the resident needed limited to extensive assist of one with toilet use, with changing pull up or briefs, pericares, and adjustment of clothing every 3-4 hours and PRN.

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The resident needed extensive assist of one with bathing/showering. The resident needed supervision after set up to wash hands and face and one staff l limited/extensive assist for combing hair, brushing of dentures and oral care. The resident needed extensive assist of one with dressing.

The Progress Notes dated 12/8/20 at 1:11 p.m. documented the resident had scattered wheezes noted through out bilaterally. The resident notified of testing positive for Covid-19.

A fax dated 12/8/20 asked the physician if the resident could be skilled due to Covid. The physician responded okay to continue skilled care.

A census record showed the resident's primary payor Medicare A (for skilled care) starting 12/8/20 and ending 12/31/20.

The Clinical Assessment record lacked any skilled nursing assessments between 12/8/20 and 12/10/20. The record documented only 5 skilled nursing assessments in the 23 day period.

The Clinical Assessment record showed the resident had no Covid-19 Observation completed 12/8/20, and 1 assessment completed 12/9/20.

The Covid-19 Observation dated 12/10/20 at 12:49 a.m. documented the resident had no signs or symptoms of Covid, the resident tested positive 12/8/20. The resident had crackles in the lung bases, increased weakness and confusion. Staff reminded to assist with ADL's and cares.

The Treatment Administration Record (TAR) for

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December 2020 included O2 at 4 liters per nasal cannula checked off a.m. and p.m. The record did not document O2 sats with the use of O2.

The clinical record lacked documentation of further assessment or VS before the resident transferred to the hospital.

The BP Summary showed no BP's recorded between 12/3/20 and 12/19/20.
The T summary showed no T's recorded between 12/3/20 and 12/18/20.
The O2 sats Summary showed no O2 sat's recorded between 11/25/20 and 12/18/20.
The P Summary showed no P's recorded between 11/25/20 and 12/19/20.
The R Summary showed no R's recorded between 12/3/20 and 12/19/20.

A POC Response History for documenting fluids in cc's showed the resident drank 240 cc's on 12/8/20, refused 12/9/20, and nothing documented on 12/10/20.

The Progress Notes dated 12/10/20 at 3:13 p.m. documented the ambulance called per the charge nurse request due to increased R's, low O2 sat, and tachycardia. At 3:30 p.m. the resident transported via ambulance to the hospital. At 6:02 p.m. received update from the hospital. The resident would be admitted.

A History and Physical dated 12/10/20 documented the resident presented for hypoxia. Per report from the nursing home the resident received 5 liters of O2 and unable to get her sats above 88%. The resident tested positive for Covid on 12/6/20. The resident looked unkempt and smelled of urine. The resident had a very

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significant erythematous raw wound/lesion under the left breast extending around to the side of her back. See nursing documentation for size. The resident's assessment included Covid-19 with questionable early pneumonia, sepsis, acute kidney injury likely secondary to dehydration/sepsis, and left breast wound/rash.

A wound assessment dated 12/10/20 at 5:50 p.m. documented inflammation of the left lower breast that appeared wet, pink/red with a small amount milky drainage, with a strong foul odor, measuring 9.75 by 3.5 inches.

The POC Response History documented the resident had last received physical help in part of the bathing activity on 11/30/20.

The POC Response History lacked any documentation regarding assist with toilet use, dressing, or personal hygiene on 12/10/20.

During an interview on 12/28/20 at 10:59 a.m. Staff C CNA (worked 12/10/20) stated she did not recall redness or irritation under the resident's breast. She said the resident was independent and they just reminded her to go to the bathroom, she did not need assist.

During an interview on 12/28/20 Staff G CMA stated the resident had redness under her breasts off and on and they had a powder they could use when she needed it, but she had not applied it for awhile.

During an interview on 12/28/20 at 11:17 a.m. Staff D LPN stated the resident had some powder they used when the resident got sore under her breasts, but was not aware she had an issue the

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day she transferred to the hospital. She did not know of any reddened areas now.

During an interview on 12/29/20 at 10:20 a.m. Staff D stated not aware of any redness under the resident's breasts.

During an observation on 12/29/20 at 10:30 a.m. when assisting the resident with toileting, Staff G CMA and Staff D LPN checked under the resident's breasts and noted redness under the right breast, and a diffuse red, raw area under the left abdominal fold.

During an interview on 12/30/20 at 10:54 a.m. the Physician Assistant stated when the resident presented to the hospital 12/10/20 she did not appear to have received personal care. The resident had a pretty significant rash under her left breast that appeared red, raw, and did not appear to have been cared for. They saw she had a powder for under her breasts but did not know if it had been applied. She asked the nurse to measure the area, it looked painful. She said residents with Covid needed monitoring more frequently due to the potential for decline and dehydration. She thought they assessed and took vital signs every shift, which were 12 hours, but probably not adequate.

5) According to the MDS assessment dated 10/9/20, Resident #7 had long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfers, dressing, eating, and toilet use.

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The resident's Medical Diagnosis record included unspecified dementia without behavioral disturbance.

The Progress Notes dated 11/25/20 at 3:26 p.m. documented the resident had been very lethargic during the shift, did not eat meals well, and had poor intake for fluids.

A fax dated 11/25/20 at 2:25 p.m. notified the physician the resident had been very lethargic and ate poorly at breakfast and lunch, refusing meals with little to drink. The fax circled to please respond ASAP. The resident had BP 173/118, P 128, O2 sat 94, T 98, and R 18.

The clinical record lacked follow up the vital signs not within normal limits or assessment of the resident until the following day.

The Weights and Vitals record showed the resident had no recorded O2 sat, T, BP or P between the time staff sent the fax to the physician and the following morning.

The Progress Notes dated 11/26/20 at 10:31 a.m. documented the resident continued with lethargy and at times unresponsive. The resident had not eaten or drank in 24 hours, except small sips. The resident VS, BP 171/104, P 138, O2 sat 90. T 9.0, and R 24. Placed a call to the physician with new orders to transfer to the hospital. A Rapid Covid test administered and came back negative. The ambulance transferred at 10:28 a.m.

The Progress Notes dated 11/26/20 at 6:18 p.m. documented the resident admitted to the hospital with a diagnosis of hypernatremia, and no idea on

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length of stay.

The History and Physical dated 11/26/20 documented the resident had acute kidney injury, dehydration, moderate, hypernatremia, and altered mental status. The discharge summary included the nursing home reported the resident had not been drinking, with no reports of nausea, vomiting, or diarrhea. No other causes of hypernatremia identified. Labs were obtained and resident found to have acute kidney injury and hypernatremia with a sodium of 165, likely due to severe dehydration. The discharge instructions included to please assure resident drank adequate amounts of fluid and monitor urine output.

During an interview on 12/28/20 at 11:41 a.m. Staff A CNA stated the day before the resident went to the hospital, she was very lethargic. The resident would not eat but drank some. The resident would not open her eyes. Staff A stated the resident had days when she was tired but this went beyond that.

During an interview on 12/28/20 at 12:34 p.m. Staff B LPN stated on 11/25/20 she recorded the resident's vital signs, taken earlier by someone else, in the electronic health record. She did let the charge nurse know the vital signs were not WNL. She said they were to take VS every shift. They had 2, 12 hour shifts, so 2 times a day. She said if VS were not WNL they should be rechecked. She had not assessed the resident that day, but would expect the overnight shift would assess the resident due to a change in condition.

During an interview on 1/4/21 at 10:09 a.m. Staff

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F LPN stated she did not specifically recall the event, but she would expect if a resident had a change in condition like the resident did, they would follow up.

During an interview on 1/6/21 at 12:25 p.m. the Family Nurse Practitioner (FNP) stated the resident arrived in the ED basically unresponsive, and severely dehydrated, with acute kidney injury and hypernatremia due to the dehydration. After rehydrating her in the hospital they were able to keep her hydrated with staff assist with eating and drinking.

6) According to the MDS assessment dated 11/20/20, Resident #8 was rarely or never understood, but had no long or short term memory problems and modified independence for daily decision making. The resident required extensive assistance with ADL's including bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had other open lesions on the foot.

The resident's Medical Diagnosis record included Covid-19, UTI, and diabetes.

The Baseline Care Plan dated 11/13/20 documented other wound identified, treatments per physician's order.

A Nursing daily Skilled Assessment dated 11/14/20 at 2:35 p.m. included the resident had wounds on the bilateral lower extremities. The clinical record lacked an assessment of the wounds.

The Progress Notes dated 11/25/20 at 5:59 p.m.

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documented a fax sent to the provider regarding the presence of 15 sores/wounds on the resident's left lower extremity (LLE), and 21 sores/wounds on the right lower extremity (RLE) along with edema 5+ on the right foot, and a bloody sore on right foot big toe. The sores were all in various stages of healing, believed to be the result of the combination of venous stasis ulcers, arterial ulcers, and pressure areas with diabetic neuropathy. Staff completed application of honey and mepilex to the 7 open sores while leaving the others open to air (OTA), as they appeared to be healing. They requested provider to give an adequate treatment or see the patient.

The clinical record lacked a fax to the physician 11/25/20 regarding orders for wound treatment.

A fax dated 11/27/20 asked the physician if they could have permission for the resident to see the wound nurse. The fax returned with a yes answer.

The Progress Notes dated 11/27/20 at 7:41 p.m. documented a fax returned from the provider for permission to see the wound nurse. The wound nurse contacted and appointment set up for 12/1/20 with the wound nurse.

The clinical record lacked an evaluation of the resident's wounds by the wound nurse.

The Order Summary Report signed 12/8/20 directed to continue wound care for the bilateral lower extremities and feet (no wound care identified).

The Progress Notes dated 12/8/20 at 11:31 a.m. documented a late entry, orders included

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continuing wound care for bilateral lower extremities (BLE).

A Nursing Daily Skilled Assessment dated 12/9/20 at 1:03 p.m. documented the resident had wounds present to the BLE.

The clinical record lacked assessment or a treatment for the resident's wounds.

The Progress Notes dated 12/15/20 at 6 a.m. documented the resident had increased lethargy. She made eye contact but did not respond verbally to staff. A bilingual CNA made several attempts to communicate, but the resident still did not give a verbal response. The resident did not void on the overnight shift. The resident started Bactrim DS on 12/12/20 for UTI. The resident indicated no pain; T 97.8, BP 141/64, P 78, R 16, and O2 sat 98% on room air. Fax sent to primary care provider (PCP) with update and requesting recommendations.

The Progress Notes dated 12/15/20 at 1 p.m. documented the resident unresponsive when the physical therapist went to work with her. This nurse found the resident in the recliner with eyes closed, and body completely limp. The resident did open her eyes, but unable to follow basic commands, and had no motor control. VS stable with T 97.5, P 88, R 18, BP 113/78, and O2 sat 97%. They made the decision to transfer to the ED.

A History and Physical dated 12/15/20 documented the resident presented after being found unresponsive. Nursing staff reported they last checked on her either yesterday or this a.m. and was normal. They had been treating her her

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for UTI. On arrival the resident appeared dazed and not responding well. The resident had the right 3rd and 4th toes with open wounds, purulent drainage, surrounding erythema and edema. She also had scattered open wounds and scabs on the bilateral lower extremities. The assessment included a diabetic foot ulcer, right 3rd and 4th digit, with closed fracture of the right 4th phalynx. Plan for antibiotics, with pharmacy to dose. Obtained wound culture, local wound care, and x-rays read as 4th digit fracture. Consider ortho consult for foot, UTI, type 2 diabetes, episode of hypoglycemia which improved with an amp of D50 (glucose), confusion and weakness improved since arrival, likely related to hypoglycemia, acute illness.

A Wound culture collected 12/15/20 documented the final results showed 3 organisms identified:
Eschericia coli- ESBL (extended spectrum beta lactamase) light growth,
Staphylococcus Aureus- MRSA (Methecillin Resistant Staphylococcus aureus) moderate growth,
Enterococcus Faecalis moderate growth.

During an interview on 12/28/20 at 11:03 a.m. Staff C CNA stated the day before the resident went to the hospital she needed 1 assist to transfer, and could walk with assist. The day she transferred, it took 2 to transfer and she required assist with eating. She said the resident admitted to the facility with wounds to her legs and feet. She didn't know if they were treating them, but they put lotion on them. She didn't recall if they were draining.

During an interview on 12/28/20 at 11:18 a.m. Staff D LPN stated she worked overnight, then

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until noon the day the resident transferred to the hospital. She said the resident appeared lethargic, but was never real peppy. She called the physician's office right away that a.m. to ask them to address the fax, and then called again later. She thought the fax returned with orders for labs and another UA. Staff D stated the resident had scabs on her feet when she admitted to the facility and they applied stock lotion to them. She said she lotioned the resident's legs and feet that a.m. She said the resident did not complain of pain.

During an interview on 12/28/20 at 12:50 p.m. Staff E Registered Nurse (RN) stated the 1st time she saw the resident's legs and feet she had no dressings on and some of the wounds were seeping, so she needed dressings. She sent a fax to the resident's physician but she did not hear back that shift, and she did not work again for about 2 weeks. When she did work again there were no orders on the MAR/TAR for a treatment or dressing, so she did not check her feet and legs. She said the day she saw the wounds she applied dressings to 7 open areas. She said Staff F LPN thought the honey and Mepilex dressing would be the best thing to do.

During an interview on 1/4/21 at 10:09 a.m. Staff F stated she recalled using Mepilex on the resident's legs and feet. She requested a wound consult for the wounds on her toes and up her leg. She recalled the wound nurse saw the resident and 2 others. She had some orders on the note. She had to pass some of the days orders off to the night nurse. She was later told she needed to send the recommendations to the physician to sign off. She said the note disappeared and she did not know what

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happened to it.

During an interview on 12/30/20 at 10:54 the Physician Assistant stated she saw the resident on a virtual visit (12/8/20) and she was a new patient to them. The resident's wounds were brought up (during that visit), and she thought they were being treated. When the resident presented to the ER the toes were definitely infected, with purulent drainage and odor. She said the podiatrist treated as Osteomyelitis (inflammation of bone usually due to infection). She said the infection of the wounds contributed to the resident's overall decline. She was unsure about the toe fracture but the family had mentioned a fall prior to the hospitalization.

During an interview on 12/31/20 at 1:23 p.m. the Wound Nurse stated she saw the resident (12/1/20) and did an evaluation of the bilateral lower extremities. She wrote progress notes and recommendations for treatment on a paper record. She did not have a copy.

The immediate jeopardy was removed on 1/4/21 after the surveyor verified implementation of a removal plan. The removal plan included staff education of processes and expectations of consistent resident assessment and documentation, including weekly wound assessment and assessing residents adequately to identify and manage symptoms including verification of current treatments. Covid-19 documentation of assessment at least TID approx. 6-8 hours apart and to include temp. and oxygen sats. Change of condition assessment to include full vital signs at least BID. All blood sugar check orders need to include parameters and if results are outside parameters, physician

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F 684	Continued From page 48 notification and follow up is required. The scope and severity was lowered to an "F".	F 684		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure a resident maintained acceptable parameters of nutrition status, for 2 of 4 residents reviewed (Resident #13 and #12), and proper hydration (Resident #13). The facility reported a census of 33 residents. Resident #13 returned from the hospital 12/30/20. The record lacked skilled nursing (SN) assessments between 12/30/20 and 1/4/21. The 1/4/21 assessment revealed the resident needed	F 692		

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limited assistance with ADL's. and then totally dependent on 1/6/21 indicating a change of condition. The assessments documented poor food and fluid intake with no new interventions identified to increase consumption. The resident could not wear dentures and had no evaluation to determine if the resident needed a mechanically altered diet. When the assessments documented the need for total staff assistance with eating the eating record documented no more than supervision provided. The resident showed a 9.5% significant weight loss with no family or physician notification and no interventions identified until the family called the physician's office with concerns. The resident presented to the emergency room (ER) severely dehydrated.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 10/21/20, Resident #13 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.
The resident was independent with activities of daily living (ADL's) including transfer, ambulation and eating.

A Hospital Discharge Summary dated 12/30/20 documented Resident #13's discharge condition stable. Diagnoses included acute pulmonary embolus (PE), supraventricular tachycardia (SVT), pneumonia, cancer, metastatic to bone, and acute hypoxemia respiratory failure. On the day of discharge the resident sat up in the chair eating breakfast. The resident tolerated oral intake and fluids with some encouragement. He initially did not have dentures so started a mechanical soft diet because he could not chew adequately. He was awake, alert, and oriented.

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The resident's oral mucosa appeared pink and moist without dentures. His tongue had a normal appearance without lesions, no buccal (cheek) nodules or lesions noted. The resident alert and oriented to person, place, and time with normal speech.

The Care Plan identified the resident had a nutritional problem or potential nutritional problem initated on 1/29/20 and revised on 2/12/20. The interventions included:
a. Monitoring/documenting/reporting to the physician as needed (PRN) for signs and symptoms (s/sx) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearing concerned during meals.
b. Monitoring/recording/reporting to the physician PRN s/sx of malnutrition: emaciation (abnormally thin or weak), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain weights as ordered and per facility policy.
c. Providing, serving diet as ordered: regular with regular textures and thin liquids. Monitoring intake and recording every meal.
d. Registered Dietitian to evaluate and make diet change recommendations PRN.

The Care Plan identified the resident had oral/dental health problems and wore dentures related to poor oral hygiene. The interventions included providing mouth care as per ADL personal hygiene, initiated 2/6/20.

The Progress Notes dated 12/30/20 at 12:26 p.m. documented the resident readmitted to the facility at 10:30 a.m. via transportation service in a wheelchair (w/c), status post hospitalization from

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12/28-12/30/20 for acute bilateral (bilat) PE, acute left lower extremity (LLE) deep vein thrombosis (DVT), SVT and pneumonia. The resident appeared drowsy, lethargic, slow to respond; needed extensive assist of 2 with transferring from the w/c to the recliner. Bilateral lungs sound diminished and exertion noted during transfer. Vital signs (VS) Temperature (T) 97.0, blood pressure (BP) 112/85, pulse (P) 91, respirations (R) 18- Oxygen (O2) saturation (sat) 91% an 3 liters/per nasal cannula (L/NC).

A Weights and Vitals record showed the resident weighed 186.8 pounds on 11/16/20, with no other weights until 12/30/20 at 169 pounds, a loss of 17.8 pounds or 9.5% in 6 weeks, a significant loss.

The clinical record lacked notification of the resident's physician or family of the significant weight loss, evaluation by the dietician, or interventions to maintain or gain weight.

The Progress Notes dated 1/2/21 at 8:47 p.m. documented the resident rested in bed, he had very little energy, it took everything he had in him to take his medications with sips of water. He seemed very short of breath, lung sounds diminished bilateral, and O2 on at 4 L/NC, with sat of 93%.

The Progress Notes dated 1/3/21 at 6:08 a.m. documented the certified nursing assistant's (CNA's) reported the resident had taken himself to the bathroom without assistance. The CNA's reminded him to use the call light for help.

The Progress Notes dated 1/3/21 at 10:19 p.m. documented the resident continued very weak,

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took his bedtime (HS) meds with sips of water, and that alone tired him out.

A Nursing Daily Skilled Assessment dated 1/4/2021 5:17 p.m. documented the resident ambulatory with unsteady gait, needing some help with transferring. The resident needed limited assistance with bed mobility, transfer, dressing, and toilet use, and independent with eating. The resident's appetite and fluid intake were poor. The resident drowsy, and had a regular breathing pattern with the head of the bed elevated and O2 use. He was tired, at times difficult to arouse, and completely incontinent at the time. Lung sounds were diminished throughout. The bowel sounds were overactive with diarrhea.

The Progress Notes dated 1/4/21 at 8:47 p.m. documented the resident rested in bed. VS were T 98.1, P 68, R 18, BP 121/81. The resident had no complaints, with O2 at 5 L/NC with sat of 93%. Order faxed out to provider to hold scheduled metoprolol due to earlier blood pressure of 89/50.

A POC Response History for the percentage of the meal eaten documented;
a. On 1/4/21 the resident refused times 3.
b. On 1/5/21 the resident ate 0-25% 1 time with no other documentation.
c. On 1/6/21 the resident ate 50-75% 1 time and refused 2 times.
d. On 1/7/21 the resident refused 2 times and not available 1 time.

A POC Response History for eating support provided documented:
a. On 1/4/21 the resident refused times 3.
b. On 1/5/20 the resident provided set up only 1

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time with no other documentation.
c. On 1/6/20 the resident provided set up only 2 times and refused 1 time.
d. On 1/7/21 the resident refused 1 time, provided no setup or physical help from staff 1 time and not available 1 time.

A POC Response History for eating self performance documented:
a. On 1/4/21 the resident refused.
b. On 1/5/21 the resident independent 1 time with no other documentation.
c. On 1/6/21 the resident provided supervision 2 times and refused 1 time.
d. On 1/7/21 the resident independent 1 time, refused 1 time and not available 1 time.

A POC Response History for fluids offered documented fluids offered 3 times 1/4/21, 2 times 1/5/21, 2 times 1/6/21, and 2 times 1/7/21. The record lacked documentation of the amount of fluids the resident consumed.

The POC Response History's for morning, afternoon, and HS snacks offered between 1/4/21 through 1/7/21 documented no or not applicable to offering the resident snacks.

A Nursing Daily Skilled Assessment 1/5/2021 at 3:18 a.m. documented the resident ambulated with a walker with assist x1 to ambulate from the bed to the bathroom. The resident needed extensive assist with bed mobility, transfer, dressing, eating, and toilet use. The resident had poor appetite and fluid intake. The resident appeared lethargic, drowsy, continued confused, speech low, unclear, not answering questions appropriately. The resident short of breath, irregular breathing rhythm, distress, oxygen use,

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lungs diminished; labored breathing noted with ambulation. The resident had a loss of liquids/solids from mouth when eating or drinking, and holding food in his mouth/cheeks or residual food in mouth after meals.

The Progress Notes dated 1/5/21 at 11:02 a.m. documented the resident had a scheduled hospital follow up. The resident had no concerns. The resident's family member had many concerns. The family concerned the resident not himself, had not been able to clearly speak, answer questions, eat, drink, etc... The nursing home brought up concerns regarding the resident's labile BP, with most readings in the 90's - systolic, and 40-50's - diastolic. The resident had not been able to participate in Occupational therapy (OT)/Physical therapy (PT), the BP dropped to around 70/40, with each attempt. He had been attempting to participate in Speech Therapy (ST), but had difficulty staying awake, or feeling too weak/fatigued to participate. The resident had not been able to put in his dentures, since discharge, as a result of his mouth being very sore, with sores around his lips, and an inability to keep his mouth open to put them in, and immediate gagging that took place each time he attempted to put them in. This nurse attempted to help him put his dentures in, but he immediately was crying out in pain, and severely gagging, without emesis. The family stated understanding that this may not happen, but stated he believed the resident's speaking, cognition, and ability to swallow, would improve if he began to use his dentures. The Provider had no comment. Other concerns brought forth by the nursing home, included, the resident had extreme confusion, not able to swallow medications, on O2 at 5 L/NC that only maintained him at 90% or

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less, slurred his words, expressed discomfort with being extremely warm, despite no temperature, inability to get comfortable, fidgeting, and overall discomfort. The resident's family on the phone while doing telehealth appointment with the provider, via tablet. All concerns were addressed with the provider. The provider discussed all concerns with family. The family expressed concern that the resident's BP medication made him dizzy, for the last 6 years, and asked that it be adjusted, as he believed it caused resident's fatigue. The provider changed metoprolol tartrate order from 12.5 mg orally (PO) 2 times a day (BID) to 12.5 mg PO HS with desire to readdress at next appointment, or if a change took place. The provider discussed recent diagnoses post-hospitalization, and clarified the resident on a blood thinner, Eliquis, with no need for PT/INR, and on an antibiotic for pneumonia, which finished on 12/30/20. She saw no further need to continue the resident on antibiotic, but did order a CBC, to confirm the infection had resolved. The provider had no concerns regarding the resident's current oxygenation needs, stating that those levels were expected post-hospitalization for COVID. She educated the resident's family on what took place after the virus, expected fatigue/confusion, etc..., and stated not concerned with his current status, unless it worsened. She stated that it may take 6 or more months to resolve. The resident's son stated understanding. She said that she would review his lab results and update orders, as necessary, and then the nursing home could update him, but that she would not know anymore until those labs were completed. The family had many concerns, related to the resident's recent injections, prior to the resident's hospitalization. He was concerned that the injections may have caused his increased

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fatigue. The provider stated she could not say, she did not have copies of those records. Information given to the provider, with phone number, to contact the physician who administered the injections, in order to get updated records. The information provided by the family. The family addressed concerns related to the resident's inability to do activities, get out of bed, eat, and drink. The resident unable to answer questions or have a dialogue, throughout the telehealth visit. The provider re-educated on post-hospitalization weakness, generalized malaise, and how all of those are common post-hospitalization, but especially when a resident suffered from all the resident suffered from. The family stated understanding. The resident was a full code, prior to this conversation. The nursing home requested the nurse have conversation with provider and family, to discuss his code status. A full and thorough conversation with both provider and son, with nurse stating what would take place without a code, and provider restating. The family decided to change the resident to a do not resuscitate (DNR), as he did not want CPR performed, did not want him to be intubated, and did not want a feeding tube, etc..., but did still want oxygen. The provider and nurse reassured him they considered considered comfort care, which would all still be provided. The family stated understanding. Orders were then restated and ensured to be correct. The provider also called back to speak to this nurse, to ensure correctness. All orders were entered into the system, and faxed for signature. The family notified of the changes during the conversation with no further concerns.

A Nursing Daily Skilled Assessment dated 1/5/21

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at 5:48 p.m. documented the resident used the w/c due to weakness, and limited assist with bed mobility, dressing, and eating, and extensive assistance with transfer and toilet use. The resident fed this evening due to weakness. Appetite and fluid intake poor. The resident appeared alert, with labored breathing, shortness of breath, and irregular breathing rhythm. Lung sounds with diminished-crackles at bilat posterior bases. The resident tired and at times difficult to arouse. Lung sounds diminished throughout with crackles noted. O2 administered at 5 L/NC with O2 sat 90%, and hypotensive.

The Progress Notes dated 1/5/21 at 8:08 p.m. documented the resident stated he didn't have the strength to take the medication.

The Progress Notes dated 1/6/2021 at 2:55 a.m. documented the resident continued in a weakened physical state, and refused HS meds due to not having the strength to stay in a sitting position. The resident used ancillary muscles with his breathing, and became SOB with any exertion. Lung Sounds were very diminished bilat, O2 on at 5 L/NC, with sat of 91%., skin pale, warm and dry.

A Nursing Daily Skilled Assessment dated 1/6/21 at 4:20 p.m. documented the resident dependent for bed mobility, dressing and eating, non ambulatory and transfer did not occur. Bowel sounds were present with diarrhea. The resident had weight loss and appetite and fluid intake poor. The resident's skin color pale and cyanotic. He had shortness of breath, labored breathing, distress, the head of the bed elevated, and he used O2. The resident continued on skilled nursing care and therapy services. The resident

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alert and oriented x1, not able to make wants or needs known, restless with O2 sat of 89% on 5 L/NC.

The Progress Notes dated 1/7/21 at 1:55 a.m. documented the resident continued in a weakened state, so exhausted that he struggled to take sips of water, and refused his medications. The resident removed his O2, staff reapplied when they did rounds. He had pale, warm, dry skin, lung sounds diminished, with poor exchange noted, and no cough.

The Progress Notes dated 1/7/21 at 11:51 a.m. documented a fax received back regarding labs from 1/5/21. The PA noted good; no further recommendations/comments received; also new order received to start calazime cream daily and as needed to coccyx for reddened areas; and okay to hold scheduled metoprolol dose at HS on 1/5/21 for BP of 89/65. The family called and updated on labs, new orders, and current health status today.

The Progress Notes dated 1/7/21 at 12:34 p.m. documented receipt of a fax for resident to have Certified Nursing Assistant (CNA) assistance with all meals and snacks, and for resident to have boost (nutritional) supplement 2 times a day (BID). The family informed of the new order.

The Progress Notes dated 1/7/21 at 1 p.m. documented a call placed to the Physician's Assistant (PA) regarding the resident's health status; mottling to knees not present a few hours ago, along with rapid, labored breathing, and the resident remained in bed all shift. Informed the PA the resident's condition had not improved since retuning to the facility. Vital signs at 9:49 a.m. T

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98.0, BP 139/84, P 121, R 18, O2 sat 95% on O2 at 5 L/NC.

A History and Physical dated 1/8/21 documented the resident presented to the emergency department (ED) via ambulance from the health center with complaints of abnormal vital signs initially reporting blood pressure 63/35 and on repeat 110/65. They were unable to get an O2 sat per the report and he transferred to the ED for deconditioning, per request of the family, according to the staff at the health center. Of note the resident recently discharged from the hospital 12/30/20 post Covid, pneumonia, PE with heart strain and DVT. Upon discharge from the hospital 12/30/20 the patient awake, alert, and able to converse with staff. The resident could feed himself a pureed diet because he did not have dentures at the time of admission, and he could take oral fluids. The family confirmed after discharge from the hospital they were able to talk to him and his spouse a number of times and in good condition. It was unclear when the resident's condition changed. Family stated they had not been able to visit with them via facetime the past couple of days. Upon arrival to the ED the resident in poor physical condition and only able to respond occasionally to touch. His tongue quite dry and sandpaper like with cracked scabbed lips. His skin pale, cool to touch, and mottled on arrival, and his extremities were bluish in color, and he appeared severely dehydrated. Labs included a white count of 13.9, sodium significantly elevated at 153, chloride elevated at 120, BUN 66, creatinine 2.2, GFR 29, and lactic acid elevated at 3.8. The resident went into SVT with a heart rate in the 140's however remained hypotensive at 87/68 so at the time did not treat. The family had concerns regarding the resident's

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weight, and recent intakes reporting when talking to the resident and spouse, reported giving him a chicken breast and vegetables that he could not cut and he required some assistance with eating and no assistance from staff provided. The FNP discussed the case with a physician who agreed the resident was severely dehydrated likely from not getting oral intake for the previous couple of days. The FNP called the facility for an intake and output (I&O) log but none obtained. The plan included admission to observation for correction of hypernatremia with D5W (5% dextrose in water). The resident's sodium improved however his liver function tests (LFT's) significantly elevated from previous, and the white blood count (WBC) elevated. They would admit to acute care for further monitoring and intravenous (IV) antibiotics. The resident struggled and unable to tolerate oral (PO) intake. The resident made nothing by mouth (NPO) and speech consult placed. The oral mucosa appeared pink and dry with sand paper like tongue, with deep cracks.

During an interview on 1/8/21 at 9:41 a.m. The Family Nurse Practitioner (FNP) stated the resident presented from the facility 1/7/21 severely dehydrated. He had been hospitalized and returned to the health center 12/30/20. The facility called the resident's provider and received orders to transfer to the Emergency Department (ED). They called for the ambulance, but did not call a report to the hospital. Hospital staff called the health center and they said the resident transferred due to the resident deconditioning per the family request. The resident presented unresponsive. His tongue was so dry it had cracks/craters, and his lips were dry and cracked. She said they also asked the health center for intake and outputs which they never received.

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She consulted with the e-hospitalist who felt due to the resident's condition and labs he probably had not had adequate intake for 2-3 days. The resident appeared pale, cool, and mottled. The FNP stated when last in the hospital the resident received food he could eat. He could not chew because he did not wear his dentures. His family reported the resident shared a room at the health center with his spouse. She reported they brought him food he could not eat. She said when the health center called the ambulance they told them the resident was in the same condition they sent him back from the hospital in. The FNP stated that was not true, when he discharged he was eating and drinking.

During an interview on 1/8/21 at 12:32 p.m. Staff J Registered Nurse (RN) stated she worked the previous 2 days. She said when the resident transferred he was unresponsive, had retractions with breathing, and the family requested he be sent to the ED. She said Staff D Licensed Practical Nurse (LPN) checked on the resident, saw mottling, and basically panicked. She said this was a change in condition from the day before. Staff D called the family and told them she thought he was dying. They had 3 options, they could opt for comfort care, come to visit him, or have him transferred to the hospital. They opted for transfer. Staff D called the resident's provider and the ambulance and told them he was in the same condition he returned from the hospital, which was not true, he did not present this way the day before. Staff J did feel the resident was dehydrated. She said the family had called the resident's provider with concerns the staff were not assisting the resident with food and fluid intake and the provider faxed 1/7/21 to assist with all meals and snacks. Staff J stated the

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resident had been refusing meals and she notified the family, but had not documented it. She knew the dentures caused the resident pain. She said he could put milk on his corn flaked until they were soft enough to eat. She said they served him a regular diet, not a mechanical soft. He could eat soft foods like mashed potatoes. Staff J stated 1/6/21 the resident sat up in the chair and appeared alert, but had been more confused. Staff J stated the resident would take a cup of water with med pass. She said CNA's didn't think he got enough, but was drinking. Staff J stated she did not see an order for I&O's, but they did not require an order to monitor a resident's I&O.

During an interview on 1/12/21 at 8:23 a.m. the resident's family member stated the resident had been in the hospital and they got him up in the chair and eating. He went back to the facility and he went backwards. They brought the resident food, but he could not feed himself. The last day or 2 (prior to hospital 1/7/21) the facility told them the resident was not eating. The family assumed he had a weight loss, but they were not informed by the facility of the weight loss. Staff D called him 1/7/21 and said the resident not in good shape and they would need to make a decision, and they decided to send him to the hospital. The family member stated the hospital got the resident hydrated, sitting up, and they were treating his mouth.

During an interview on 1/12/21 at 10:30 a.m. another family member stated the resident lost a lot of ground after having Covid-19. He had a 2 day stay at the hospital (12/28-30/20) then readmitted (to the hospital) 1/7/21. The facility reported the resident not doing well. They were

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not aware how far down the resident had gone. The family member stated he had very labored breathing (when she saw him in the hospital). After they hydrated him he could carry on a conversation and did better,

A typed note signed by the Speech Therapist documented on 1/2/21 she went to the room to administer the BIMS. The resident laid in bed trying to remove O2 and she adjusted and encouraged him to leave it on. The resident requested water and she offered him water present in the room, but he wanted cold ice water. She administered the BIMS which took approximately 5 minutes, then went to the kitchen to get ice water. She returned to the room and assisted him with drinking. He declined to sit up in bed or move to the recliner, but allowed her to elevate the head of the bed minimally while drinking. He took several drinks through the straw with no swallowing difficulty appreciated. She offered him a fruit cup while awaiting breakfast but he declined and stated he was not hungry. When finished drinking she exited the room with no concerns regarding swallowing for thin liquids. CNA's reported the resident with no appetite since returning from the hospital, but denied coughing, difficulty chewing, or complaints of difficult swallowing. On 1/6/21 she was notified the residents spouse assisted him with meals. She spoke with the charge nurse and requested that a CNA assist the resident with lunch because it probably was not appropriate for the spouse to assist given his weakness. The Charge Nurse immediately notified CNA's to start assisting the resident with meals. The CNA reported it did not increase PO intake and the resident accepted only a few bites before declining further bites (amount eaten record documented the resident

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ate 51-75%). The CNA again stated no appetite and denied difficulty chewing or swallowing. On 1/7/21 nursing staff alerted her of orders received to assist the resident with all meals and snacks and begin Boost supplement. She discussed results of ongoing assessment that she had completed with the charge nurse and said they could request orders for ST to eval and treat swallowing due to family with continued concerns.

During an interview on 1/13/21 at 8:33 a.m. the ST stated someone received an e-mail from the resident's family that his spouse had been feeding him. She talked with Staff D and she said they had heard that. The ST informed Staff D she did not think it appropriate due the resident not wanting to get up, and weakness. She did not know which CNA assisted the resident at the noon meal on 1/6/21, but they told her he only took a few bites. She had discussed with the DON about accuracy of charting. She didn't know if anyone contacted the dietician about the resident.

During an interview on 1/13/21 at 11:10 a.m. the Physician's Assistant stated she did not think she knew of the weight loss or she probably would have put the resident on supplements. She said the facility did express concerns with intakes during the telehealth visit. She would expect staff to monitor for dehydration. She did not necessarily expect I&O's. She thought the family had called the clinic 1/7/21 with concerns so she ordered CNA's to assist with all meals and a supplement to help increase his nutrition (the resident transferred to the hospital that day).

The facility policy for Hydration revised 4/2013 documented the facility staff strived to reduce the

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risk of fluid imbalance by preventing, managing, stabilizing, and reversing dehydration and promoting resident care practices to improve hydration. They would implement individualized interventions based on the resident needs and goals, which promoted fluid intake to maintain sufficient hydration for the resident.

2) According to the MDS assessment dated 11/27/20, Resident #12 was rarely or never understood. The resident required limited assistance with ADL's including bed mobility, transfer, ambulation in the room, dressing, toilet use, and personal hygiene.

The current Care Plan identified the the resident at risk for alterations in nutritional status, revised 2/5/20. The interventions included providing diet the doctor ordered: regular with mechanical soft textures and thin liquids, and weighing per facility protocol, documenting significant changes, and reporting significant changes the dietician.

The quarterly Dietician Progress Note dated 7/29/20 at 11:38 a.m. documented the resident's weight 113#, down 3% in 30 days and down 6% in 180 days, which were not significant weight changes. Note weight loss trend. Body Mass Index (BMI) 22.1 so weight okay at the time. She consumed a regular diet and fed self with supervision 25-75%. Would continue with plans and monitor ongoing.

The weight record documented the resident weighed 113.2# on 7/1/20 and 102# on 11/16/20, an 11.2#, and .0989 (10%) weight loss in less than 6 months.
The weight record documented the resident

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weighed 113.2# on 7/1/20 and 97.6# on 1/5/2021 a 15.6#, and 13.8% weight loss in 6 months. The record documented the residents ideal body weight range 123-149#.

The clinical record lacked any additional assessment by the dietician, notification of the physician or family, or interventions related to significant weight loss.

The facility policy for Nutritional Status-Unintended Weight Loss Management revised 4/2013 documented facility staff would strive to improve the resident's weight by identifying risk factors associated with weight loss and determining appropriate individualized interventions. Efforts would be made to manage, stabilize, and reverse the risk factors whenever possible. The facility would work with the resident, and family/responsible party to identify and respect goals and choices related to end of life decisions. The dietician would be notified when an additional nutritional assessment was required. The procedure included review for risk factors associated with unintended weight loss which may include but are not limited to chewing and swallowing problems, dehydration, dry mouth, edentulous (lacking teeth), ill fitting dentures, medications, mouth pain, and dependence for eating.
Report weight loss of 5% in 1 month, 7.5% in 3 months, and 10% in 6 months to the immediate supervisor. Notify the dietician and physician of weight loss. Document and implement changes to physician's orders as indicated.
They would develop and implement individualized interventions to prevent/reduce the risk of unintended weight loss, which may include, but not limited to providing and encouraging intake of

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F 692	Continued From page 67 between meal snacks, providing high calorie supplementation with medication pass if ordered, providing assistance and encouragement during meal times, and reevaluating food preferences, especially with change in condition. They would communicate to care giving team and provide education as needed, weigh the resident at least weekly and record, and evaluate effectiveness of interventions and resident progress towards goals.	F 692		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure residents were free of any significant medication errors for 2 of 5 residents reviewed, (Resident #6 and #15) which resulted in immediate jeopardy to resident health and safety. Resident #6 received antidiabetic medications and the facility failed to provide adequate monitoring of the resident's meal intakes resulting in hypoglycemia, and while struggling to stabilize the residents blood sugars administered additional antidiabetic medication. The resident transferred to the hospital with a seriously low blood sugar requiring 4 hours to stabilize. Resident #15 admitted to the facility with orders for numerous medications, including an oral antidiabetic and insulin. The facility failed to acquire the medications and the resident required transfer to the hospital with high blood sugar. The facility reported a census of 33 residents.	F 760		

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A determination was made that the facility's noncompliance with one or more requirements of participation placed all residents in the facility in immediate jeopardy, beginning January 11, 2021. On 1/14/21 at 12:45 pm, the Administrator was notified of the immediate jeopardy at F760, Significant Medication Error.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 12/5/20, Resident #6 scored 10 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident required limited assistance with activities of daily living (ADL's) including bed mobility, transfer, walking in her room, dressing, and toilet use. The resident required extensive assist with bathing.

The Medical Diagnosis record included the resident had type 2 diabetes and heart failure.

The current Care Plan identified the resident had expected weight loss related to poor food intake initiated 07/23/20. The goals included the resident would consume 50% of two or three meals per day. The interventions included encouraging healthy food choices and monitoring and recording food intake at each meal.

The Care Plan identified the resident had diabetes, revised 6/30/19. The goals included the resident would be free from any signs/symptoms (s/sx) of hyper/hypoglycemia. The interventions included diabetes medication as ordered by doctor, and monitoring/documenting for side effects and effectiveness. Dietary consult for nutritional regimen and ongoing monitoring.

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Encourage the resident to practice good general health practices: lose weight if overweight, stop smoking, compliance with dietary restrictions, compliance with treatment regimen, adequate sleep and exercise, good hygiene and oral care. Monitoring/documenting/reporting to MD as needed (PRN) s/sx of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.

The Medication Administration Record (MAR) for January 2021 documented the residents daily blood sugar on 1/11/21 at 8 a.m. at 84. The MAR showed the resident received Glipizide (antidiabetic) 5 mg at 7:30 a.m. and Metformin (antidiabetic) 1000 mg at 8 a.m. for type 2 diabetes.

The POC Response History for percentage of meal eaten documented only one intake on 1/11/21 at 9:39 p.m. The history lacked entries for the a.m. or noon meals.

The POC Response History for morning snacks lacked an entry of offering the resident a snack the morning of 1/11/21.

The Progress Notes dated 1/11/21 at 1:36 p.m. documented a Certified Nursing Assistant (CNA) notified the Nurse the resident did not act right. The nurse approached the resident and she would not respond verbally but did lift her head and look at staff. Her legs and arms where shaking. The nurse gave her a whole glass of orange juice and Gluctose per physician order. The resident's provider called, and the on call physician updated with her current condition and treatments/med received. The physician wanted

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follow up on condition and blood sugar. If blood sugar remained low wanted the nurse to contact them immediately. Gluctose 15 Gel 40% given for blood sugar of 43. At 2:41 p.m. after the Gluctose, the resident ate her taco from lunch and drank a glass of cranberry juice. Her blood sugar, rechecked 15 minutes after the Gluctose went back down to 77. A Provider already on the phone doing telehealth round visits, agreed to look in on the resident. She stated to continue to monitor blood sugars and to give her healthy carbohydrates to raise the blood sugar back up. She stated it would take a little time to get her back up, but if she continuously dropped to contact them again for further orders. The resident ate a pack of peanut butter crackers and a glass of milk.

A telehealth visit dated 1/11/21 documented just prior to the visit the resident had a hypoglycemic event with blood sugar of 42. Staff gave the resident orange juice, and she remained somewhat confused. Nursing staff did repeat her blood sugar and it remained low at 74. They would give the resident a glass of milk and toast with peanut butter, and check her blood sugar in one hour. The telehealth visit started at 2:45 p.m. and ended at 2:50 p.m.

The Progress Notes dated 1/11/21 at 3:52 p.m. documented the resident seen by the provider via telehealth for routine visit. The resident appeared alert, and made jokes with the provider when asked questions. The resident voiced complaints of occasional loose stools. The medication and orders were reviewed by the provider and she educated the resident on side effects of Metformin with order updated in MAR to administer Metformin with food (a.m. and p.m.

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meal) per provider request. No further orders or changes received. At 4:46 p.m. documented the daily weight not completed because the resident physically unable, very weak, low blood sugar.

The MAR for January 2021 showed on 1/11/21 the resident received Metformin 1000 mg at 4:03 p.m. (not with a meal) and Glipizide 2.5 mg at 4:03 p.m.

The clinical record lacked specific times they checked the blood sugars after the telehealth visit, including if they rechecked the blood sugar prior to administering the antidiabetic medications.

The Progress Notes dated 1/11/21/at 5:25 p.m. documented they tested the resident again about a half hour after eating the snacks, with blood sugar of 98. An hour later back down to 77. They offered her a peanut butter sandwich and another glass of milk. Staff checked back and she would not eat her sandwich because she was too damn full to eat anymore. She had another blood sugar of 69. They contacted the physician and she requested med list. She would call back with orders after review. At 6:11 p.m. the physician called and said to admit if blood sugar did not stay elevated, for one time only 1/11/21. At 7:09 p.m. the resident had a blood sugar of 73, and given chocolate ice cream. At 6:55 p.m. the physician called for an update, she said to hold the oral anti diabetic medications for tonight and tomorrow and to send the resident to the hospital if she can not maintain a blood sugar above 70. At 8 p.m. the resident had a blood sugar of 71. They took 2 ham sandwiches and a large glass of chocolate milk to the resident. She refused to eat the sandwiches, but did take the chocolate milk.

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At 9:21 p.m. sent a fax requesting parameters on blood sugars and to hold oral anti diabetic medications if blood sugar low. At 9:33 p.m. the resident ate 2 pieces of toast with peanut butter and cinnamon/sugar, and blood sugar rechecked at 75. At 11:36 p.m. the resident's blood sugar checked at 56. The resident told she would go to the hospital. At 11:44 p.m. staff called for the ambulance. At 11:48 p.m. the resident with no s/s of hypoglycemia, transported to the ED per ambulance.

The Progress Noted dated 1/12/21 at 3:59 a.m. documented the hospital called and the resident would transfer back. They gave the resident 5% dextrose in normal saline (D5NS) 3 times and she ate peanut butter sandwiches for them, and her blood sugar at 100.
At 4:23 a.m. the ambulance crew brought the resident back, with her last blood sugar at the ER 97. They gave a peanut butter sandwich and milk prior to discharge. The ER doctor recommended checking with the provider prior to giving oral in a.m. if blood sugar lower than normal.

The Emergency Room Visit Notes dated 1/12/21 documented the resident presented to the ER with a low blood sugar of 23. The nursing home reported they had been fighting a low blood sugar with her most of the day. The blood sugar low at 43, and they gave her chocolate milk and other high sugar foods to keep it elevated.

During an interview on 1/13/21 at 1:44 p.m. the ED physician stated the resident presented to the ER 1/11/21 with a low blood sugar. He said the resident had antidiabetic medication in the a.m. and at some point her blood sugar registered 43. They administered her antidiabetic medications in

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the afternoon. Her blood sugar dropped to 23. It took 4 hours to stabilize her blood sugar in the ED. He said antidiabetic medications should be held when trying to stabilize a low blood sugar.

During an interview on 1/13/21 at 2:56 p.m. Staff E Registered Nurse (RN) stated she worked 1/11/21 and knew the resident had an issue with a low blood sugar, but Staff F Licensed Practical Nurse (LPN) handled it. Staff E thought the resident did not eat breakfast or lunch.

During an interview on 1/13/21 at 3:19 p.m. Staff F stated on 1/11/21 a CNA mentioned the resident not responding. She went to her room to check on her and she did not respond per usual. When she went to the resident's room, her lunch tray had not been touched. The CNA stated the resident was sleeping when she took the lunch tray in to her. Staff F told the CNA when they served a meal they needed to wake her and assist if needed. She found out then, the resident did not eat breakfast either. She said no one reported this to her. She said she told the CNA's they needed to report if a resident did not eat, so they could offer them something else. She stated the CNA's needed more training. Staff F gave Gluctose and the resident did eat what she had on her lunch tray. She said she talked to the provider several times. They had not discussed holding the p.m. antidiabetic medications, and by the time they did they had already been administered. When Staff F left, the resident's blood sugar registered 70. She reported to the oncoming nurse what transpired and they had an order to transfer to the ED if the blood sugars remained low.

During an interview on 1/17/21 at 7:05 p.m. Staff

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M RN stated they were monitoring the resident's blood sugar frequently and seemed they gave her food constantly. She said the provider called and ordered to hold the antidiabetic medication. Staff M stated she did not give the resident the Metformin at bedtime. She did not realize they had changed the administration time to 5 p.m. and the resident had already received both the Metformin and the Glipizide. She said she sent the resident to the hospital around 12 a.m. and she returned around 4:30 a.m. with a last blood sugar at 100 after receiving intravenous dextrose and giving her more food.

The facility medication reference Nursing 2018 Drug Handbook documented Metformin an antidiabetic and brand names included Glucophage. The Administration included giving with meals. The adverse reactins included hypoglycemia which could be life threatening. The contraindications and cautions included to use cautiously in elderly, debilitated, or malnourished patients because if increased risk of hypoglycemia. Glyburide an antidiabetic in the sulfonylureas class had adverse reactions including hypoglycema which could be life threatening. To use cautiously in debilitated, malnourished, or elderly patients.

HIGHLIGHTS OF PRESCRIBING INFORMATION and full prescribing information for GLUCOPHAGE (metformin hydrochloride) tablets for oral use included inform patients that hypoglycemia may occur when the medication was coadministered with oral sulfonylureas and insulin. Explain to patients receiving concomitant therapy the risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development.

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Metformin rarely caused hypoglycemia (low blood sugar) by themselves. However, hypoglycemia could happen if they did not eat enough, drank alcohol, or took other medicines to lower blood sugar.

GLUCOTROl (glipizide) TABLETS For Oral Use (at www.access.fda.gov), documented glipizide was an oral blood-glucose-lowering drug of the sulfonylurea class.
All sulfonylurea drugs were capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions were important to avoid hypoglycemic episodes. Elderly, debilitated or malnourished patients, and those with adrenal or pituitary insufficiency, were particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly. Hypoglycemia was more likely to occur when caloric intake was deficient, after severe or prolonged exercise, when alcohol was ingested, or when more than one glucose-lowering drug was used.

According to the American Diabetes Association any sulfonylurea or meglitinide can cause blood glucose levels to drop too low (hypoglycemia). Metformin or the glitazones rarely cause hypoglycemia unless taken with insulin stimulators (sulfonylureas or repaglinide) or insulin injections.

2) The Progress Notes dated 1/11/21 at 5:08 p.m. documented Resident #15 arrived at the facility at 10 a.m. with family transport. Diagnoses included congestive heart failure (CHF) exacerbation, diabetes type 2, hyponatremia, dementia (chronic), generalized weakness, dysphagia, and

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myocardial infarction (heart attack). The resident's chest expansion symmetrical with difficulty taking deep breaths, The resident's lung sounds clear to auscultation and diminished bilaterally, medications per orders tab.

The Progress Notes dated 1/11/21 at 5:29 p.m. documented the nurse spoke to the Hospital regarding resident 12 times. Prior to 11 a.m., they did not have orders ready, despite the fact that resident arrived at facility at 10 a.m.. Orders did not arrive until 12 p.m. and did not include an order for therapy or skilled services or dietary instructions. Orders returned for skilled services. Each time the nurse spoke to the hospital, they said they would call back, get orders, etc..., but did not get proper, necessary paperwork to this nurse, until 12 p.m., and, at that point, orders were still not complete, waiting official diet order. Per nursing report from the hospital, initiated a mechanical soft diet with ground meats, and faxed for clarification to provider.

The Progress Notes dated 1/11/21 at 5:48 p.m. documented the resident's report from the hospital included the resident came from Assisted Living for elevated troponin, with CHF exacerbation, a urinary tract infection (UTI) with completion of antibiotics while hospitalized. The resident a type II diabetic previously took Metformin and Januvia. During hospitalization, discussed it may be best to switch her over to insulin, based on the the resident hospitalized with a blood glucose of 500. The resident arrived with no oral antidiabetic medications, only insulin.

The Nursing Admission Data Collection dated 1/11/21 at 2:47 p.m. documented the resident had orders for insulin. The most recent hospitalization

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took place as a result of the resident's blood glucose climbing from 450-500, without consulting the provider or taking to hospital.

The Progress Notes dated 1/11/21 at 8:05 p.m. documented a Covid test completed, with negative result. At 9:57 p.m. the resident's medications were not delivered from the pharmacy.

The MAR/TAR lacked a blood sugar check on 1/11/21, with no reference whether sliding scale insulin needed.

The MAR documented a blood sugar on 1/12/21 at 7:30 a.m. of 268, indicating the need for 9 units of sliding scale insulin, not administered.

The Progress Notes dated 1/12/21 at 07:29 a.m. documented;
a. Miglitol Tablet 100 MG, for type 2 diabetes with meals, not administered because they did not have them at the facility.
b. At 10:15 a.m. Humalog KwikPen Solution Pen-injector per sliding scale
if 60 - 150 = 0 No insulin;
201 - 250 = 6;
251 - 300 = 9;
301 - 350 = 12;
351 and above call provider. Insulin not administered because meds not available, had not arrived yet.
c. At 10:16 a.m. Lantus SoloStar Solution Pen-injector, 15 unit subcutaneously one time a day not administered, med unavailable, had not arrived yet.

The Progress Notes dated 1/12/21 at 11:16 a.m. documented the resident did not receive Miglitol

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Tablet 100 MG for type 2 diabetes with meals.

The Progress Notes dated 1/12/21 at 11:25 a.m. documented notification of the blood glucose and would monitor.

The MAR documented a blood sugar on 1/12/21 at 12 p.m. of 594.

An EInteract Change in Condition Evaluation dated 1/12/21 at 11:59 a.m. documented the resident had a sudden change in level of consciousness or responsiveness, lethargic, not answering, blood sugar over 600.

The Progress Notes dated 1/12/21 at 11:43 a.m. documented the resident had a very high blood sugar reading this noon. It would not even read, just said high. She had no insulin available at the time at the facility. Staff called the physician and gave vital signs. The physician wanted her to go to the emergency room (ER). The POA called and updated, he wanted her to go out to the ER as well. The Ambulance arrived at 11:43 a.m. for transfer to the ER. At 5:10 p.m. the hospital called with an update. The resident admitting overnight for hyperglycemia.

The Emergency Room Visit Notes dated 1/12/21 documented the resident arrived by ambulance with a high blood sugar. The nursing home stated they were unable to get any of the resident's medications yesterday or this a.m. and at noon blood sugar read high. The resident presented after the nursing home reported blood glucose too high to register on a blood sugar check. The resident recently hospitalized for MI, CHF and uncontrolled diabetes. The resident discharged the previous day to the nursing home.

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Reportedly, the family sent the resident to the nursing home with her insulins, however per the family, the nursing home would not take them. The nursing home did not receive any of the resident's medications from their pharmacy. The resident complained of fatigue but no other symptoms. The initial point of care blood glucose 524. The complete metabolic panel (CMP) showed 540. The resident received 16 units of Humalog and sugars checked periodically approximately every 30 minutes with a steady trend down, with a bedside glucose at 6:37 p.m. of 177. Medical decision making included lack of appropriate insulins for her diabetes appeared to be cause of hyperglycemia, with sugars steadily going down. Worsening CHF in the setting of reported no medications since discharge, apnea (cessation of breathing for a time)/agonal breathing (gasping when struggling to breath). Would admit resident for continued cardiac and sugar monitoring.

During an interview on 1/13/21 at 1:44 p.m. the resident's Physician stated the resident discharged from the hospital 1/11/21 to the facility. The resident had orders for insulin to manage her diabetes because she had elevated blood sugars. He said they called with a report of her medications, and they were aware she had insulin orders. The resident's family member took the insulin from the hospital so they could use it at the facility, but the facility told them they would obtain insulin. On 1/12/21 around 11:30 a.m. the facility reported the resident's blood sugar read HHH indicating high. The resident transferred to the hospital with blood sugar of 533. The physician thought she might die. He said she became completely unresponsive and had apnea spells. When they called the nursing

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home they found out they had not given insulin 1/11/21 or 1/12/21. Initially they said they were not given orders for insulin, then said they did not have the insulin.

During an interview on 1/13/21 at 2:56 p.m. Staff E Registered Nurse (RN) stated she and Staff F worked 1/11/21 and were very busy. Staff E admitted the resident, while Staff F managed the floor. She said she had to talk to the hospital multiple times to get the orders and the final orders received around 2:30 -3 p.m. She was directed to send the medication orders to a certain pharmacy. She said she called them 1st then faxed the med orders twice to assure they went through. She left about 6:45 p.m. They did not have the resident's insulin. She said if the insulin did not arrive she would have called another pharmacy for stat doses if not available in the emergency kit. She said they asked for help multiple times that day and not 1 of the office nurses helped them. She said they had 2 nurses and 2 med aides but had a lot going on and needed help.

During an interview on 1/17/21 at 7:05 p.m. Staff M RN stated they did not receive the resident's meds 1/11/21. The pharmacy did not deliver them. She said the meds did not arrive until the following evening after the resident had already transferred to the hospital. She would have to check if they had insulin in the e-kit. She said on 1/11/21 she spent a great deal of time with another resident, so she had a Certified Medication (CMA) pass some of the meds. She said the resident did not have medications, and they had not set up an accucheck box so the blood sugars were not checked. She said a family member called and asked about the

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resident 1/11/21 she told them she did good. She did not tell the family member they had not received the resident's meds. Staff M stated they had issues getting medications from the pharmacy timely.

During an interview on 1/13/21 at 3:19 p.m. Staff F stated she didn't know they did not check the resident's blood sugar the afternoon/eve of 1/11/21, until the next morning. She said they had no insulin for the resident. They did check the blood sugar in the a.m. and would have given sliding scale insulin if she had it available. She said when she called the pharmacy, they said they did not receive the orders. She said they had no insulin in the e-kit. She said they asked for help from office nurses 1/11/21 but did not get help. She said she had ordered from the pharmacy before with a delay in the receipt of medications.

During an interview on 1/14/21 at 9:13 a.m. the Hospital Director of Nursing stated the physician changed some of the orders after the resident left the hospital. They called the facility and faxed the changes to the facility. The facility did not notify them they did not have the resident's medication. She said they gave insulin pens with the resident's name on them to the family for use at the facility. The resident's family member told her the staff at the nursing home said they could not use them.

During an interview on 1/14/21 at 8:13 a.m. the resident's family member stated they decided to have the resident go to the the facility for 24/7 nursing care. The resident would need blood sugars monitored and insulin administered. The family member stated the resident walked out of

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the hospital to the van for transfer to the nursing home. She took 2 insulin pens with her mother's name on them, but they gave them back, and said they could not use them. She called the home the evening of 1/11/21 and asked how the resident was doing. The person on the phone said good. They did not tell her they did not have the resident's medications including the insulin. The family member stated they were not aware they had not received her insulin or medications until they went to the ER around noon on 1/12/21. When she questioned why her mother did not receive her medications staff at the nursing home stated the pharmacy told them they did not receive the orders. In the ER the resident had periods where she became unresponsive and stopped breathing, and they told them they should notify (other) family to say their good bye's. The family member stated when another family member called the facility about it's poor ratings (prior to going to the facility), the DON assured them they would take good care of the resident.

b. The MAR for January 2021 included Lasix Tablet 40 MG (Furosemide) 2 tablet by mouth two times a day related to heart failure, with order date 1/11/21 not given the eve of 1/11/21 or the a.m. of 1/12/21.

The Progress Notes dated 1/12/21 at 7:34 a.m. documented Lasix Tablet 40 mg 2 tablet by mouth two times a day not administered, did not have them at the facility at that time.

During an interview on 1/20/21 at 1:55 p.m. the ED physician stated the resident arrived very lethargic. She had not received any insulin since she discharged. He said she also had not

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F 760	Continued From page 83 received 2 doses of her lasix for heart failure and her BNP went up 1000 points since the previous day (indicator of congestive heart failure), but she did not seem fluid overloaded. The immediate jeopardy was removed on 1/14/21 after the surveyor verified implementation of a removal plan. The plan included education provided to nursing staff related to alerting the nurse when a diabetic resident does not eat a meal, initiatng documentation to communicate any resident changes or concerns. Licensed nurses educated related to completion on noting physician orders, notifying pharmacy of medications ordered and assuring if they are not received timely other methods are used to assure residents receive medications as ordered. The scope and severity was lowered to a "D".	F 760		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to confirm nursing licensure for 1 of 5 staff reviewed (Staff J). The facility reported a census of 33 residents. Findings include:	F 839		

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F 839	Continued From page 84 A Personnel File Checklist documented Staff J Registered Nurse (RN) hired on 8/12/20. The checklist lacked a check for professional license verification (print from website). The personnel file lacked Staff J's nursing license, or verification of licensure from a website. During an interview on 1/7/21 at 1:00 p.m. the Business Office Manager stated she ran Staff J's license verification after asked about it. Staff J's multi state nursing license verified 1/7/21 at 11:55 a.m. The facility policy for Employee Credentials dated 7/1/15 documented all staff requiring licensure or certification would have current license or other authorization to practice in the state in which they work. The scope included all employees in licensed and certified positions including RN's. The procedure included the individual's current license/certification verification prior to employment including verification with the appropriate licensing board/registry.	F 839		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to maintain a complete and accurate record for 2 of 3 residents reviewed, (Resident #2 and #8). The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment dated 10/21/20, Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.
The resident was independent with activities of daily living (ADL's) including bed mobility, walking in the corridor, and eating, and required supervision with transfer, ambulation in her room, dressing, toilet use, and personal hygiene.

The Progress Notes dated 12/13/20 at 3:57 p.m. documented the resident complained of

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shortness of breath and appeared fatigued. Order faxed to provider requesting to titrate oxygen (O2) to to keep saturations (sat) greater than 90%.

A Nursing Daily Skilled Assessment dated 12/13/20 at 10:54 p.m. documented the resident with O2 sat 94% on O2 at 2 liters/per nasal cannula.

The clinical record lacked the fax with the order for O2.

During an interview on 1/5/21 at 4 p.m. the Director of Nursing (DON) stated they were unable to locate the fax with the O2 order.

2) According to the Minimum Data Set (MDS) assessment dated 11/20/20, Resident #8 had no long and short term memory problems and modified independence for daily decision making. The resident required extensive assistance with activities of daily living including bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had other open lesions on the foot.

The Baseline Care Plan dated 11/13/20 documented other wound identified, treatments per physician's order.

A Nursing daily Skilled Assessment dated 11/14/20 at 2:35 p.m. included the resident had wounds on the bilateral lower extremities. The clinical record lacked an assessment of the wounds.

The Progress Notes dated 11/25/20 at 5:59 p.m. documented a fax sent to the provider regarding

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the presence of 15 sores/wounds on the resident's left lower extremity (LLE), and 21 sores/wounds on the right lower extremity (RLE) along with edema 5+ on the right foot, and a bloody sore on right foot big toe. Sores all in various stages of healing, believed to be the result of the combination of venous stasis ulcers, arterial ulcers, and pressure areas with diabetic neuropathy. Completed application of honey and mepilex to the 7 open sores while leaving the others open to air (OTA), as they appeared to be healing. They requested the provider give an adequate treatment or see the patient.

The clinical record lacked a fax to the physician 11/25/20 regarding orders for wound treatment.

A fax dated 11/27/20 asked the physician if they could have permission for the resident to see the wound nurse. The fax returned with a yes answer.

The Progress Notes dated 11/27/20 at 7:41 p.m. documented a fax returned from the provider for permission to see the wound nurse. Wound nurse contacted and appointment set up for 12/1/20 with the wound nurse.

The clinical record lacked an evaluation of the resident's wounds by the wound nurse.

The Order Summary Report signed 12/8/20 directed to continue wound care for bilateral lower extremities and feet.

The Progress Notes dated 12/8/20 at 11:31 a.m. documented a late entry, orders included continuing wound care for bilateral lower extremities (BLE).

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F 842	Continued From page 89 The clinical record lacked a treatment for the resident's wounds. During an interview on 12/28/20 at 12:50 p.m. Staff E Registered Nurse (RN) stated the 1st time she saw the resident's legs and feet she had no dressings on and some of the wounds were seeping, so she needed dressings. She sent a fax to the resident's physician but she did not hear back that shift, and she did not work again for about 2 weeks. When she did work again there were no orders on the MAR/TAR for a treatment or dressing, so she did not check her feet and legs. She said the day she saw the wounds she applied dressings to 7 open areas. She said Staff F LPN thought the honey and Mepilex dressing would be the best thing to do. During an interview on 12/31/20 at 1:23 p.m. the Wound Nurse stated she saw the resident (12/1/20) and did an evaluation of the bilateral lower extremities. She wrote progress notes and recommendations for treatment on a paper record. She did not have a copy. During an interview on 1/5/21 at 4 p.m. the DON stated they were unable to locate the wound assessment or the fax to the physician regarding the wounds.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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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 §483.70(e) and following accepted national standards;

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

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(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:
Based on observation, record review, and staff interview, the facility failed to increase assessments of ill residents with Covid-19 to at least 3 times a day for 2 of 3 residents reviewed (Resident#2, and #6,) to provide appropriate infection control measures for 1 resident with a catheter (Resident #4) during the monitoring of a blood sugar for 1 resident (Resident #14), failed to use appropriate infection control protocols when exiting Covid units, and failed to complete TB testing for 4 of 5 newly hired staff (Staff C, Staff J, Staff N, and Staff O). The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS)

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assessment dated 10/21/20, Resident #2 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.
The resident was independent with activities of daily living (ADL's) including bed mobility, walking in the corridor, and eating, and required supervision with transfer, ambulation in her room, dressing, toilet use, and personal hygiene.

The resident's Medical Diagnosis record included Covid-19, unspecified atrial fibrillation, and a history of myocardial infarction.

The Progress Notes dated 12/8/20 at 12:16 p.m. documented the resident's emergency contact notified of the resident's positive Covid status.

The Care Plan initiated 12/8/20 and revised 12/13/20 identified the resident tested positive for Covid-19. The interventions included oxygen (O2) as needed, offer fluids as needed, respiratory assessments every shift, and vital signs every shift. Report any vital signs outside parameters to the doctor or nurse practitioner.

The Assessments page showed the resident had:
a. no assessments documented 12/7/20 or 12/8/20,
b. 2 Covid assessments 12/9/20 12:42 a.m. and 12:28 p.m.
c. 1 Covid assessment 12/10/20 at 12:38 a.m.
d. 1 Covid assessment 12/11/20 at 2:21 a.m. and 1 SN assessment at 11:35 p.m.
e. 1 Covid assessment 12/12/20 at 2:39 p.m.
f. 1 SN assessment 12/13/20 at 10:54 p.m. and 1 Covid assessment at 10:35 p.m.

The Covid-19 and Nursing Daily Skilled Assessment (SN) assessments lacked vital

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signs.

The Weights/Vitals record lacked documentation:
a. Between 12/3/20 and 12/14/20 for blood pressure.
b. Between 11/26/20 and 12/14/20 for pulse.
c. Between 12/3/20 and 12/14/20 for respirations.
d. Between 12/3/20 and 12/14/20 for temp.
e. Between 11/26/20 and 12/14/20 for O2 sats.

The clinical record lacked a Covid-19 assessment or Skilled Nursing Assessment 12/14/20.

During an interview on 12/28/20 at 1:15 p.m. Staff D Infection Preventionist stated she and the DON were the only one's that had not tested positive for Covid-19, and they worked a lot. She saw assessments were not done as planned,

2) According to the MDS assessment dated 12/5/20, Resident #6 scored 10 on the BIMS indicating cognitive impairment. The resident required limited assistance with ADL's including bed mobility, transfer, walking in her room,dressing, and toilet use. The resident required extensive assist with bathing.

The Care Plan initiated 12/8/20 and revised 12/13/20 identified the resident presumptive positive/or having tested positive for COVID-19. The interventions included maintaining droplet isolation, oxygen (O2) as needed (PRN), offer fluids PRN, respiratory assessment completed every shift, vital signs (VS) every shift. Report any VS outside parameters to physician or nurse practitioner (NP).

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The Progress Notes dated 12/8/20 at 1:11 p.m. documented the resident had scattered wheezes noted through out bilaterally. The resident notified of testing positive for Covid-19.

A fax dated 12/8/20 asked the physician if the resident could be skilled due to Covid. The physician responded okay to continue skilled care.

A census record showed the resident's primary payor Medicare A (for skilled care) starting 12/8/20 and ending 12/31/20.

The Clinical Assessment record lacked any skilled nursing assessments between 12/8/20 and 12/10/20.

The Clinical Assessment record showed the resident had no Covid-19 Observation completed 12/8/20, and 1 assessment completed 12/9/20.

The Covid-19 Observation dated 12/10/20 at 12:49 a.m. documented the resident had no signs or symptoms of Covid, the resident tested positive 12/8/20. The resident had crackles in the lung bases, increased weakness and confusion. Staff reminded to assist with ADL's and cares.

The Treatment Administration Record (TAR) for December 2020 included O2 at 4 liters per nasal cannula checked off a.m. and p.m. The record did not document O2 sats with the use of O2.

The BP Summary showed no BP's recorded between 12/3/20 and 12/19/20.
The T summary showed no T's recorded between 12/3/20 and 12/18/20.
The O2 sats Summary showed no O2 sat's

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recorded between 11/25/20 and 12/18/20.
The P Summary showed no P's recorded between 11/25/20 and 12/19/20.
The R Summary showed no R's recorded between 12/3/20 and 12/19/20.

The clinical record lacked documentation of further assessment or VS before the resident transferred to the hospital 12/10/20 at 3:13 p.m.

The CDC memo Preparing for COVID-19 in Nursing Homes updated Nov. 20, 2020 included increasing the monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.

3) According to the MDS assessment dated 10/9/20, Resident #4 scored 5 on the BIMS indicating severe cognitive impairment. The resident required extensive assistance with ADL's including bed mobility, and depended on staff for transfers, dressing, and toilet use.

The current Care Plan identified the resident with alteration in elimination related to frequently incontinent of bowel, and suprapubic catheter, with a history of urinary tract infection (UTI). The interventions included monitoring catheter patency, keeping tubing free of kinks, and keeping drainage bag below bladder level, and providing peri/cath care each shift and with each incontinent episode and as needed (PRN). Be alert to any discoloration, redness, swelling, open areas, drainage or signs and symptoms of infection and report to the physician as needed.

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During an observation on 12/29/20 at 1:10 p.m. Staff C Certified Nursing Assistant (CNA) placed a barrier on the floor and sat a graduate on the barrier. Staff C wore gloves and dropped an alcohol prep package on the floor. Staff C picked the packet up off the floor and opened the catheter drain wearing the same gloves, opened the packet and wiped the drain wearing the contaminated gloves. While the catheter drained into the graduate Staff C steadied herself with her left hand on the floor. She then handled the the drain port wearing the same gloves, wiping the port with another alcohol wipe and replacing the drain.

During an interview on 1/6/21 at 10:15 a.m. Staff D Licensed Practical Nurse (LPN), Infection Preventionist stated staff were aware of the procedure to empty catheter bags including use of clean gloves. If they touched a contaminated item or surface, they should change gloves with hand hygiene.

4) During an observation on 1/5/21 at 10:44 a.m. Staff L housekeeping removed her gown and gloves and exited the 300 hall without cleaning her shield or changing her mask. She went to the linen closet and obtained a pillow and bed spread. She reentered the 300 hall with no hand hygiene, dropped the gown on the floor before picking it up and putting it on. While walking down the hall she held the bedspread up against the the gown that had been on the floor. At 10:50 a.m. Staff L wheeled the cart and vacuum up the hall. Staff L removed gown and gloves and did hand hygiene. She pulled the housekeeping cart out of the clean area and then the vacuum. Staff L did not change her mask or cleanse her shield. She wheeled the cart and vacuum down the hall

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toward the kitchen without wiping them down for disinfection.

After an initial entrance of the facility on 12/16/20 Staff D reviewed the protocol for Covid units (hall 100 and 300). Full personal protective equipment (PPE) needed to enter the unit. When leaving the unit remove PPE, go to clean area don a new mask and disinfect shield or goggles.

5) A Medical Diagnosis record documented Resident #14's diagnoses included type 2 diabetes.

The resident's Physician Orders included accu-cheks (blood sugar checks) before meals and at HS.

During an observation on 1/5/20 at 11:17 a.m. Staff I Certified Medication Aide (CMA) performed a accu-chek on Resident #14. Staff I removed a container with supplies for checking blood sugars from the med cart with the resident's name on it. She went to the resident's room and sat the container directly on the bed side table with no barrier. She removed the blood glucose monitor and sat it on the table with no barrier. After testing the resident's blood sugar, she put the glucometer back in the container with the clean supplies without disinfecting it. She took the container and sat it on top of the med cart without disinfecting it, opened the med cart and placed it in the top drawer.

During an interview on 1/6/21 at 10:32 a.m. Staff D stated she expected a barrier before placing anything from the med cart on a resident's table, and disinfection of the glucose monitor after use to check a blood sugar.

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The facility policy for Blood Glucose testing originating 1/13 included placing a barrier on surface prior to placing glucometer/supplies, and disinfection of the blood glucose monitor after each use with 1:10 dilution of sodium hypochlorite (bleach) unless the manufacturer recommendations said otherwise.

6) The facility policy Tuberculosis: Prevention and Management Tuberculin Skin Test (TST), documented the facility would administer the 2-step baseline TST intradermally using the mantoux technique by injecting 0.1 ml of 5TU purified protein derivative (PPD) solution to all newly hired employees for early detection and thus prevention of the spread of Mycobacterium tuberculosis. They would read the TST by measuring the amount of induration (hardness) at the site of injection between 48 to 72 hours (after administration). They would record the results on the TST record for employees, and complete the 2nd step, as indicated, within 7-21 days, if the 1st step was negative.

a. A Personnel File Checklist documented Staff C CNA hired 6/17/20. The checklist lacked a check mark by TB test (2-step) or chest x-ray (to be placed in employee medical file after review).

A Tuberculin Skin Test form documented Staff C had a TST on 6/3/20 at 12:20 p.m. The form lacked results or date read, and lacked a 2nd test

b. A Personnel File Checklist documented Staff J Registered Nurse (RN) hired 8/12/20. The checklist lacked a check mark by TB test (2-step) or chest x-ray (to be placed in employee medical

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file after review).

The personnel file lacked a TST form.

c. A Personnel File Checklist documented Staff N Maintenance hired 9/8/20. The checklist had a check by TB test (2-step) or chest x-ray (to be placed in employee medical file after review).

An Employee, health care worker (HCW), Volunteer Tuberculin Skin Test/chest x-ray (CXR) log documented Staff N had a TST test 9/3/20. The log lacked the results of or date read, and a 2nd test.

d. A Personnel File Checklist documented Staff O dietary hired 10/30/20. The checklist lacked a check of TB test (2-step) or chest x-ray (to be placed in employee medical file after review).

A Tuberculin Skin Test form documented Staff O had a TST on 11/11/20. The form lacked results or date read, and lacked a 2nd test.

During an interview in 1/7/21 at 12:50 p.m. the Director of Nursing stated staff should have a 2-step when hired.

During an interview in 1/7/21 at 1 p.m. the Business Office Manager stated TB tests on those staff with a sheet not read, and 2nd test not administered. Staff J did not have record of a TB test.