STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ HEALTH CARE CENTER	2121 WEST 19TH STREET SIOUX CITY, IA 51103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 10/29/2021 A recertification survey and health survey and investigation of complaints #87932-C, #94729-C, #95027-C and #99966-C and of facility-reported incidents #94771-I and #95156-I was conducted 9/20 - 9/30/21 and resulted in the following deficiencies. Complaints #87932-C, #93933-C, #94729-C, 95027-C and # 99966-C were substantiated. Investigation of facility-reported incident #95156-I resulted in deficiency. Investigation of facility-reported incident #94771-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This plan of correction does not constitute an admission or agreement by Casa De Paz Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Casa De Paz Health Care Center's credible allegation of compliance. F550 1. DON provided psychosocial support to resident #24, #30 and #27 10/21/21. Staff member A was initially re-educated on positivity on 3/20/20 and was provided additional education regarding professionalism, dignity, and respect by the Director of Nursing on or before 10/28/21. Staff member D was re-educated regarding the facility process for patients transferring out of the facility to maintain dignity and respect of each resident.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550	2. DON interviewed interviewable residents regarding concerns with staff maintaining resident respect and dignity on 10/21/21. No concerns were identified at this time. 3. Facility staff were re-educated on 10/21/21 regarding the requirement to maintain resident dignity and respect. 4. DON or designee will complete observation/ in person audits with residents weekly for four weeks, then monthly for two months to ensure resident rights continue to be honored as required. Results will be reviewed at monthly QAPI meeting. DON is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/19/2021

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

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F 550	Continued From page 1 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 clinical record review and staff and resident interviews, the facility failed to ensure that all residents were treated with dignity and respect for two of 19 sampled residents (#24 and #27). Staff reported that when a residents were taken to the hospital by Emergency Medical Technicians (EMT) and moved to a gurney, they were moved to the foyer of the facility which does not provide privacy for the residents. The facility reported a census of 50 residents.	F 550		

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F 550	Continued From page 2	F 550		

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 8/3/21, Resident #24 had a Brief Interview for mental Status (BIMS) score of 14 out of 15, indicating intact cognitive ability.

According to the Care Plan updated on 2/3/21, Resident #24 required the use of a wheelchair related to the amputation of left lower extremity and was taking an antidepressant for depression.

In an interview on 9/21/21 at 12:44 PM, Resident #24 stated the facility had one staff member that consistently had been disrespectful and rude to her. The resident named Certified Nursing Assistant (CNA) Staff A. She added that the staff member had not been physically rough, but talked disrespectfully to her.

2. According to the MDS assessment of /6/21, Resident #27 had intact memory and cognition, as evidenced by a BIMS score of 15. The resident had diagnoses that included anemia, heart failure, hypertension, diabetes, anxiety, depression and manic depression.

In an interview on 9/21/21 at 12:19 PM, Resident # 27 stated some of the staff make snide comments to residents. Resident #27's roommate (#30) liked her bed made a certain way, she started to explain it when the CNA said, "I know how to make a bed" and then walked out. Resident #27 stated she filed a grievance form regarding the incident.

The Resident Grievance/Concern/Complain Report dated 3/16/21 documented Resident #30 reported Staff A is the worst, she sassed everyone. Resident #30 and Resident #27 stated

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F 550	Continued From page 3	F 550		

that Staff A replied that she knew how to make a bed and walked out without fixing it. Resident #30 stated it is normalized behavior from Staff A and has gone on for as long as she can remember. The investigation portion of the grievance stated the DON conducted 1:1 coaching with Staff A regarding the concerns and Staff A voiced understanding.

The Performance Evaluation Form dated 12/21/20 instructed Staff A to be mindful and sometimes she came off as abrasive in her tone.

The Employee Coaching Form Level 1 dated 3/3/20 recorded Staff A must maintain an acceptable standard of respect for residents, visitors, co-workers and supervisors. The coaching plan instructed not pushing a resident, telling him he is lazy and him peeing all over himself in the hallway. Having an attitude and telling people you have one.

The Performance Evaluation Form dated 3/20/20 recorded the DON instructed Staff A to be more positive around staff and residents. Smile more, be softer around your edges.

The Employee Coaching Form Level 1 dated 3/3/20 recorded Staff A must maintain an acceptable standard of respect for residents, visitors, co-workers and supervisors. The coaching plan instructed it is inappropriate to leave a resident and walk out on a CNA and she must maintain an acceptable standard of respect.

During interview on 9/27/21 at 11:40 the Administrator clarified the coaching documentation for 3/3/20. The CNA emotionally pushed a resident, not physically. She stated

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F 550	Continued From page 4 when there is a behavioral issue with a CNA, staff give them a verbal warning, then 3 written warnings before termination. 3. Interview on 9/28/21 at 8:25 a.m., the Director of Nursing (DON) revealed when a resident needs to go to the Emergency Room (ER) and it is an emergency the staff called 911. Otherwise the staff called the physician on-call to receive an order to send the resident to the hospital. After staff receive the order for transfer, staff call the Emergency Medical Technicians (EMTs) to come to transport the resident. The staff gets the resident ready and the EMTs do not come into the building. The staff takes the resident ' s out to the EMTs. If it is an emergency then the facility will allow the EMT to come into the building. Interview on 9/28/21 at 8:30 a.m., with Staff D, Registered Nurse (RN) revealed the residents do not wait outside by themselves and there is a staff member with them. If the resident is bedbound then staff will push the entire bed to the front foyer and wait for the EMTs to arrive. Staff D stated EMTs need to be screened for COVID-19 before staff allow the EMTs entry into the building. Staff D stated the EMTs do not need to be tested for COVID-19, but they do have to be screened. Staff D stated the bedbound residents are transferred in the front foyer onto the EMTs transport bed. Staff D concluded that anyone who enters the building must be screened. Review of the facility's Nursing Home Visitation-COVID-19, revised on 4/27/21, revealed under entry of healthcare workers and other providers of service, we note that EMS personnel do not need to be screened, so they can attend to an emergency without delay.	F 550		

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F 550	Continued From page 5 On 9/30/21 at 9:22 a.m., the DIN stated she expects residents that are bedbound to be transferred in their rooms and EMT staff is not currently being screened at this time to enter the building.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	F584 1. Resident #37 discharged from the facility on 10/20/2021. 2. Administrator or designee will complete audit of all resident inventory sheets on or before 10/29/21 to ensure all resident property is accounted for. The process for resident belongings will be reviewed by the Administrator at the next resident council meeting. 3. Staff were re-educated by DON on 10/21/21 regarding completing inventory sheets timely upon admission and as needed. Facility staff were re-educated on or before 10/28/21 regarding the process for residents bringing items from home. 4. Administrator or designee will complete audits of current inventory sheets for four weeks, then monthly for two months to ensure staff continue to complete inventory sheets as required and continue to follow the process for resident belongings as required. Results will be reviewed at monthly QAPI meeting. DON is responsible for ongoing compliance Date of compliance: 10/29/2021	10/29/2021

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F 584	Continued From page 6 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, family member and staff interviews, and facility policy review, the facility failed allow personal belongings for 1 of 19 residents (Resident #37) to be brought into the building to provide a homelike environment. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 8/25/21 for Resident #37 documented diagnoses of seizure disorder, heart failure and pulmonary hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Interview on 9/22/21 at 11:41 a.m., with Resident #37 revealed she understood her husband brought her a pair of scissors, a broken pair of glasses to take with her to the eye doctor appointment, CPAP supplies, a notebook and clothing around 9/4/21 and she has not seen them yet. Resident #37 stated the only clothing she has is what she is currently wearing and would like to have her clothing her husband brought.	F 584		

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F 584	Continued From page 7 Interview on 9/23/21 at 9:07 a.m., with Resident #37 family member revealed they have been trying to bring clothing, a notebook, CPAP supplies, and a broken pair of eyeglasses to take to the eye doctor to get fixed. Resident #37 ' s family member revealed the facility would not accept the items brought to the facility and was not given a reason as to why. Resident #37 ' s family revealed the only clothing Resident #37 has, is the clothing she wore into the facility and hospital gowns. Review of the Progress Note dated 8/18.21 at 2:30 pm revealed Resident #37 admitted to the facility. Review of the Progress Note dated 8/23/21 at 5:00 p.m., revealed the facility called Resident #37's husband to let him know that the facility is not accepting any clothing or items from home per Resident #37's request. Interview on 9/27/21 at 11:17 a.m., with the Director of Nursing (DON) revealed when someone brings personal items in from home they need to sit outside or in the front foyer for 24 hours before going into a resident's room. At 1:54 p.m., with the DON stated that residents are allowed to have clothing items even if they come from a home with confirmed bed bugs. The items would be bagged and brought to the laundry right away. Interview on 9/28/21 at 9:45 a.m. with the Admission Director revealed staff completed inventory sheets for residents on admission and Resident #37 did not have one filled out at time of admission because she came with nothing. The	F 584		

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F 584	Continued From page 8 Admission Director stated Resident #37's husband planned to bring in some clothing and a cell phone so she left the inventory sheet in Resident #37's room to be filled out. Review of Resident #37's chart revealed no inventory sheet. On 9/28/21 at 9:52 a.m. the Assistant Director of Nursing (ADON) stated residents can bring in their own items and since COVID the belongings that could not be washed are bagged for 24 hours and then they are given to the residents. If the items are washable, they are bagged and taken to the laundry to be washed and brought back to the resident. The ADON stated if the items are coming from a home with confirmed bed bugs then the resident is allowed to bring in clothing and other items but no electronics due to the risk transmission of the bugs. Interview on 9/28/21 at 10:51 a.m., with the DON revealed Resident #37 received a few outfits out of the clothing bank they have here in the facility and staff does not allow the residents to go without any personal clothing. Observation on 9/28/21 at 11:34 a.m., revealed Resident #37's room and closet were empty and had no personal items in them. Review of the facility policy titled Inventory List dated 8/15 revealed the purpose is to document the personal belongings of the resident or patient. The document revealed upon admission, identify all of the resident or patient's personal belongings indicating the quantity of those items listed. Upon completion of the form, obtain a signature guaranteeing accuracy from the resident or	F 584		

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F 584	Continued From page 9 patient or resident or patient's family or responsible party and a counter signature from a representative from the facility. The original shall be kept in the resident or patient's chart under the Admission tab. The copy is given to the resident or patient or resident or patient's representative. Update as necessary throughout the resident's or patient's stay by using the spaces provided. Interview on 9/29/21 at 9:13 a.m., with Staff F, Certified Nursing Assistant (CNA) revealed Resident #37 did not have any clothing in the COVID-19 unit and she did not have any clothing when she lived in her previous room. Staff F stated that personal items stay in the resident's room if they are transferred into the COVID-19 unit.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604	F604 1. DON immediately removed body pillow from bed of resident #22 on 9/27/21. A restraint assessment was completed on or before 10/28/21 for the use of a body pillow for resident #22 by the licensed nurse. 2. Residents were audited by the Director of Nursing/designee for use of restraints on 9/27/21, no additional concerns were identified. 3. DON re-educated clinical staff on 10/21/21 regarding the restraint prevention program. 4. DON or designee will audit residents to ensure staff continue to follow the restraint prevention program as required for four weeks, then monthly for two months. Results will be reviewed at monthly QAPI meeting. DON is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

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F 604	Continued From page 10 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews, and facility policy review, the facility failed to protect a resident from the use of physical restraint the resident could not remove on their own for one of 19 residents reviewed. (Resident #22). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/21/21 for Resident #22 documented diagnoses of hypertension, anxiety and dementia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. The resident required the assistance of two staff for bed mobility and transfers. The resident's Care Plan with a review date of 7/20/21 revealed she required the assistance of two with transfers and the assistance of one to reposition and turn in bed. Observation on 9/22/21 at 3:08 p.m. revealed a long pillow behind Resident #22's left side of her	F 604		

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F 604	Continued From page 11 back and the resident faced the wall. Observation on 9/23/21 at 12:12 p.m. revealed Resident #22 not in her bed and a long pillow laying on Resident #22's bed, approximately 3 feet long. Observation on 9/23/21 at 1:39 p.m. revealed Resident #22 laying in bed with a long pillow under the fitted sheet on the left side of the bed. Resident #22 lay facing the wall on her right hip area. Observation on 9/27/21 at 10:16 a.m. revealed a long pillow behind Resident #22's left side of the bed under the fitted sheet and Resident #22 facing the wall. Review of the facility policy Restraint Prevention dated 4/2013 revealed the facility staff strives to prevent the use of physical restraints by providing individualized care and services that promote the highest practicable level of function for each resident or patient. The procedure includes reviewing the effectiveness of interventions and goals for residents and patients with medical conditions that may increase the possibility for consideration of a physical restraint. Residents or patients may include those identified as cognitively impaired. Implement interventions to promote freedom of movement, improve functional status, and maintain safety. On 9/27/21 at 12:49 p.m. observation with the Director of Nursing (DON) revealed Resident #22 laying in her bed with a long pillow under the sheet behind the resident's left side. The DON stated that Resident #22 would not be able to remove the pillow on her own. The DON removed	F 604		

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F 604	Continued From page 12 the pillow from under the sheet and behind the resident and immediately educated staff.	F 604		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file review, staff interview, and facility policy review, the facility failed to ensure all employees had an Iowa Criminal Background check and Dependent Adult/Child Abuse Registry check completed prior to working in the facility for one of five employees reviewed (Staff A). The facility reported a census of 50 residents. Findings include: The personnel file for Staff A, Certified Nursing Assistant (CNA) recorded a start date of 10/30/19. The file lacked documentation of the Iowa Criminal Background Check and dependent adult/child abuse registry check prior to hire. The facility completed a criminal background check and dependent adult and child abuse registry check on 2/27/20.	F 607	F607 1. Staff A has a completed criminal background check and dependent adult and child abuse registry check dated 2/27/20. 2. Audit completed by Business Office Mangers to identify any other staff missing mandatory criminal background checks and/or adult and child abuse registry check by 10/20/2021. 3. Administrator and/or designee will educate Business Office Manager on regulations requiring mandatory criminal background checks and/or adult and child abuse registry check by 10/20/2021. 4. Administrator and/or designee will audit each new hire's chart prior to start date weekly for 4 weeks and monthly for 2 months to ensure criminal background checks and/or adult and child abuse registry continues be completed prior to start date as required. The Administrator and/or designee will report findings of these audits to facility Quality Assurance and Performance Improvement Program (QAPI) monthly for 3 months for review and recommendations as needed. The administrator is responsible for monitoring and follow up. Date of Compliance: 10/20/2021	10/20/2021

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	165174	A. BUILDING _____ B. WING _____	09/30/2021

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F 607	Continued From page 13 Review of facility policy titled Background checks with a date of 7/1/15 revealed direction that background checks will be made in compliance with all federal and state requirements. Types of Background checks included county, statewide or alternative criminal searches. Review of facility policy titled Abuse Prevention Program and Reporting Policy with a revision date of 4/17 revealed the facility will screen all potential employees prior to hire for a history of abuse, neglect, or mistreating residents or patients, exploitation and or misappropriation of resident property during the hiring process. On 9/27/21 at 12:45 p.m., an interview with the Administrator revealed she expected background checks to be completed prior to hire.	F 607		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623	F623 1. Social Services designee will notify the Long Term Care Ombudsman on or before 10/27/21 of resident #46's transfer to emergency department on 6/17/21. 2. The last 30 days of transfers was audited by the Administrator on 10/21/21 to determine if other residents discharges were reported to the Long Term Care Ombudsman as required. Concerns identified were addressed at time of identification. 3. The Social Services designee will be re-educated by the Administrator on or before 10/27/21 on the requirement to notify the Long Term Care Ombudsman of resident discharges from the facility. 4. Audits will be completed weekly for four weeks, then monthly for two months by the Administrator/designee to validate notification to the Long Term Care Ombudsman are sent as required. Results of audits will be brought to the QAPI meeting monthly for three months for review. The Administrator is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

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F 623	Continued From page 14 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 15 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 16 Based on clinical record review, staff interview, and facility policy review, the facility failed to notify the Long Term Care (LTC) Ombudsman of transfer to the hospital for one of three residents reviewed who required transfer (Resident #46). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/22/21 recorded Resident #46 re-admitted to the facility on 6/22/21 from the hospital. The MDS dated 6/29/21 identified the resident with diagnoses that included heart failure, hypertension, coronary artery disease, dementia and anemia. The Progress Note date 6/17/21 at 6:03 a.m. recorded Resident #46 as in the Emergency Department and he would be admitted to the hospital. The Progress Note dated 6/22/21 at 2:33 p.m. documented the resident returned to the facility from the hospital. The facility notifications to the LTC (Long Term Care) Ombudsman lacked documentation of Resident #46 leaving the facility for hospitalization and return. Review of the resident's clinical record also revealed no documentation of notice to the LTC Ombudsman of his transfer to the hospital. Review of the facility policy titled CMS Issues Clarification of Notice Requirements to Long-Term care Ombudsman when Resident is Transferred or Discharged from Long-Term Care Facility- Review of Practices, Policies and	F 623		

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F 623	Continued From page 17 Procedures Required dated 7/24/17 revealed the facility must also send a copy of the notice to a representative of the Office of the State LTC Ombudsman. Sending a copy of the notice to a representative of the Ombudsman ensured the Ombudsman is aware of facility practices and activities related to transfers and discharges, providing added protection to residents. During interview on 9/27/21 at 12:47 p.m., the Administrator stated she is doing LTC Ombudsman notifications as the facility did not have a current social worker. The Administrator stated she sent the report at the end each month and if a resident went to the hospital then it should be on the report.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625	F625 1. The bed hold policy will be sent to residents #40 representative on or before 10/27/21 by the Social Services designee regarding resident's transfer to the emergency room on 9/12/21. 2. The last 30 days of transfers was audited by the Administrator on 10/21/21 to determine if other residents' representatives received a bed hold policy. Concerns identified were addressed at time of identification. 3. The Social Services designee and licensed nursing staff will be re-educated by the Administrator on or before 10/27/21 on the importance of supplying a bed hold policy to residents' representatives when they are transferred from the facility. 4. Audits will be completed weekly for four weeks, then monthly for two months by the Administrator or designee to validate bed hold policies are sent as required. Results of audits will be brought to the QAPI meeting monthly for three months for review. The Administrator is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

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F 625	Continued From page 18 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility policy review, the facility failed to provide bed hold notices to one of three residents and/or the resident's representative when a resident transferred out of the facility (Resident # 40). The facility reported a census of 50 residents. Findings include: The Progress Note dated 9/12/21 at 7:55 a.m. documented Resident #40 transported to the hospital for evaluation and treatment. The Progress Note of 9/17/21 at 11:28 a.m. recorded Resident #40 returned to the facility from the hospital. Resident #40's clinical record lacked documentation that staff provided a bed hold notice to the resident or their representative on or within 24 hours of the transfer to the hospital. Review of facility policy titled Bed Hold Requirement and Notification, revised 12/15, revealed the resident or patient and a family member or responsible party shall be given notice of the bed hold option at the time of	F 625		

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F 625	Continued From page 19 hospitalization or therapeutic leave. The procedure directed the following actions: 1. Complete the Bed Hold Form prior to transferring resident or patient to the hospital. Note: In cases of an emergency transfer, written notification must be provided within twenty-four hours of transfer. 2. Complete the Bed Hold From prior to the resident or patient leaving the facility for a therapeutic leave. 3. Provide a copy of the Bed Hold Form to the resident or patient and place a copy in the medical record. 4. Make every attempt to get the form signed by the resident or responsible party. If phone contact is the only option, have two staff members sign the form and document the decision. Make a note in the medical record. An interview on 9/27/21 at 10:03 a.m. with the Administrator revealed the bed hold was not done since Resident #40 is on Medicaid and the facility has to hold the bed for 10 days. On 9/27/21 at 1:57 p.m., the Director of Nursing (DON) stated that Resident #40 did not have a bed hold and it was missed.	F 625	F644 1. New PASRR updated by Administrator on or before 10/28/21 for resident #27 to include the change in mental health diagnosis. 2. Social Services Director/designee completed an audit of residents with psychiatric diagnosis on or before 10/28/21 to verify that PASSR Level 2 is current. 3. Social Services Director/Designee re-educated by the Administrator on 10/21/21 regarding PASSR Level 2 requirements including when a resident receives a new psychiatric diagnosis, it will be reviewed by the IDT team to address if PASSR Level 2 needs to be requested/updated. 4. Social Services Director/Designee to audit new psychiatric diagnosis weekly for 4 weeks, then monthly for 2 months to ensure PASSR requirements continue to be completed and implemented as required. Results of audits will be brought to the QAPI meeting monthly for three months for review. The Administrator is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		

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F 644	Continued From page 20 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, the facility failed to submit a follow-up Preadmission Screening and Resident Review (PASRR) for one of two residents (#57) reviewed who had a change in mental health diagnoses. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 12/10/20 for Resident #27 documented diagnoses of depression and bipolar disorder. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. Review of the PASRR dated 11/12/18 informed no further Level 1 screening is required unless the resident was known to have or suspected of having a major mental illness or and an intellectual or developmental disability and exhibit a significant change in treatment. The resident's Psychological Services Progress Note dated 2/19/19 recorded a major mental	F 644		

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F 644	Continued From page 21 illness (MMI) diagnosis of major depressive disorder. A Psychotherapy Progress Note dated 2/19/19 recorded a MMI diagnosis of moderate bipolar disorder. The resident's Care Plan documented a focus area for behavioral problems related to bipolar disorder and depression initiated on 8/12/21. The document titled Admission Process (undated) instructed that a new PASRR may also be submitted if there is a significant change in the resident. In an interview on 9/29/21 at 11:30 AM, the Administrator confirmed the PASRR should have been resubmitted for Resident #27's major depression and bipolar disorder. The Administrator acknowledged this may have led to the lack of services and treatment of both major mental illnesses.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645	F645 1. Resident #22 PASSR updated on or before 10/28/21 by Administrator to include diagnosis of Bipolar Disorder. 2. The Administrator or designee will audit all PASSR's in facility on or before 10/29/2021 to determine if mental health conditions and current mental health medications are listed on the PASSR. Concerns identified will be addressed at the time of identification. 3. On 10/21/2021, the Regional Nurse Consultant re-educated nursing staff and Social Services designee on the requirement of having mental health conditions and medications on the PASSR. 4. Audits will be completed weekly for 4 weeks, then monthly for 2 months by the SSD and/or designee to validate PASSR's reflect current mental health conditions and current mental health medications. Results of audits will be brought to the QAPI meeting monthly for three months for review. The Administrator is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

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F 645	Continued From page 22 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing	F 645		

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F 645	Continued From page 23 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to completed a follow-up and resubmit to ASCEND for reevaluation according to the Preadmission Screening and Resident Review (PASRR) for one of two residents reviewed (Resident #22). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/21/21 for Resident #22 documented diagnoses of hypertension, anxiety and dementia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive impairment. Review of the PASRR dated 1/21/21 completed prior to admission revealed Resident #22 with an outcome of no level II required- No Serious Mental Illness (SMI) or intellectual disability (ID). Level I screen indicates that a PASRR disability is not present because of the following reason: no evidence of a PASRR condition of an intellectual or developmental disability or a serious	F 645		

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F 645	Continued From page 24 behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. Resident #22's MDS assessment of 1/28/21 contained an active diagnosis of bipolar disorder. Resident #22's chart lacked a follow-up and resubmission of a PASRR with the diagnosis of bipolar disorder. Interview on 9/27/21 at 12:48 p.m., with the Director of Nursing (DON) revealed if there was a diagnoses of bipolar disorder on the MDS, then there should be one on the PASRR that was completed. The DON stated the expectation of a new PASRR to be completed and the facility would be completing a new PASRR for Resident #22.	F 645	F658 1. Resident #00 was discharged from the facility on 6/11/2021. Resident #37 was discharged from the facility on 10/20/21. Resident #34 was discharged from the facility on 9/22/2021. 2. An audit of medication availability was completed on or before 10/28/21 by the Director of Nursing/designee to validate prescribed medications are available per the physicians' order. An audit of required appointments was completed by the Director of Nursing/designee on or before 10/28/21 to validate residents with orders for follow up appointments have them scheduled per physician order. An audit of residents with daily weights was completed by the Director of Nursing on or before 10/28/21 to ensure supplemental documentation is in place. Concerns identified were addressed at the time of identification. 3. Nursing staff was re-educated on 10/21/21 by the DON regarding the requirement to provide professional services with attention to ensuring appointments are scheduled per physician orders, supplemental documentation is in place for residents with orders for daily weights, and medications are available per physicians' orders.	
F 658 SS=D	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 clinical record review, observation and staff, clinic personnel and pharmacist interviews and facility policy review, facility staff failed to ensure professional standards of care for three of 16 residents reviewed. The facility failed to provide scheduled medications for Residents #37 and #34, and failed to arrange a follow up appointment for Resident #00 after surgery and measure the resident's daily weights as ordered.	F 658		

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F 658	Continued From page 25 The facility reported a census of 50 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 4/12/21, Resident #00 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognitive ability. The MDS documented the resident required the assistance of two for toilet use and personal hygiene. According to the MDS, Resident #00 had diagnoses that included congestive heart failure (CHF), acute respiratory failure, acute kidney failure, encephalopathy, chronic kidney disease, chronic obstructive pulmonary disease and type 2 diabetes. According to Resident 00's History and Physical report dated 5/17/21 at 2:56 PM, Resident #00 presented to the emergency room with severe pain in the left calf and was found to have a large intramuscular hematoma. The resident underwent left lower extremity posterior lateral subcutaneous hematoma evacuation. A venous Doppler ultrasound of her left lower extremity showed evidence of deep vein thrombosis (DVT). a. The Hospital Discharge Orders dated 5/21/21 at 11:16 AM by the orthopedic surgeon requested that a follow up appointment be arranged 3-5 days after the resident's surgery and that the dressing on her leg remain intact until the clinic visit. The facility clinical record for Resident #00 lacked any documentation of a follow up appointment. A Nursing Note dated 5/30/21 at 10:21 AM #00 transferred to the emergency room with necrotic tissue at the surgical site. On 9/28/21 at 4:10 a nurse for the orthopedic	F 658	4. Audits will be completed weekly for four weeks, then monthly for two months by the DON or designee ensuring professional standards are being followed; appointments are being scheduled timely, medications are being sent for refill timely and supplement documentation is added where needed. Results of audits will be brought to the QAPI meeting monthly for three months for review. The DON is responsible for ongoing compliance. Date of compliance: 10/29/2021	

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F 658	Continued From page 26 surgeon said that the doctor relayed a message that he expected a follow up appointment with him within a week after the surgery and that he wanted the dressing change to be done in his clinic. He said that they did not get a call for a clinic appointment and unfortunately, the resident readmitted to the hospital before he could see her again. The orthopedic surgeon said that he did not feel that the necrosis was caused by a delay in dressing change. b. The Hospital Discharge Orders dated 5/21/21 at 11:16 AM also instructed facility staff weigh Resident #00 daily and document the measurement. Notify her PCP (Primary Care Provider) with a weight gain of 3 pounds in one day or 5 pounds in one week. The resident's clinical record lacked daily weights for Resident #00. According to the vitals documentation in the record, on 5/14/21 the resident's weight measured 190 pounds and on 5/27/21, her weight measured 202.8 pounds. On 5/30/21 at 10:21 AM, Resident #00 transferred to the emergency room with foul smelling wound. The Hospital Admission Report of 5/30/21 recorded her weight at 205 pounds. The resident's Hospital Report dated 6/21/21 indicated she admitted on 6/11/21 with acute and chronic respiratory failure and passed away on 6/21/21 at the hospital. The death certificate indicated that primary cause of death was acute hypoxic respiratory failure. On 9/28/21 at 8:33 AM, the Assistant Director of Nursing (ADON) stated that resident appointments were usually arranged by the secretary, and the admitting nurse would	F 658		

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communicate any orders for appointments to the secretary. She said that over the last year the secretary position had been vacant so in that case, it would have been the responsibility of the nurses to make the appointments. The ADON said that when the order for daily weights is entered correctly into the electronic chart there should be an area to document the weight. She acknowledged that the MAR for #00 included a daily check box only and not the box for entering the weight.

2. The MDS assessment of 4/12/21 identified Resident #34 with a BIMS score of 15 out of 15. The MDS recorded Resident #34 had diagnoses that included intracerebral hemorrhage, high blood pressure, hemiplegia/hemiparesis, seizures and type II diabetes. Resident #4 required the assistance of two for transfers, dressing and toilet use. The assessment documented Resident #34 experienced almost constant pain and received scheduled and as needed (prn) pain medications.

The Care Plan for Resident #34, dated 8/23/21, included a focus area of pain related to hemiparesis and it directed staff to monitor for pain and to try different interventions to help relieve the resident's pain.

On 8/13/21 at 5:00, the resident's PCP ordered Lyrica (for pain) 75 mg (milligrams) twice a day and ordered the medication to be discontinued on 8/19/21. On 8/19/21 at 5:00 PM, the PCP ordered Lyrica 100 mg twice a day.

Resident #34's 9/21 Medication Administration Record (MAR) recorded one missed dose of the Lyrica on 9/19 and two missed doses on 9/20. The resident's Nursing Notes recorded the

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following information:

a. 8/19/21 at 4:55 PM - Order clarified by pharmacy, gave 75 mg already.
b. 9/19/21 at 5:51 PM - Waiting to receive from the pharmacy.
c. 9/20/21 at 8:24 AM - Medication not available.
d. 9/20/21 at 4:53 PM - Medication not available, pharmacy contacted.

On 9/27/21 at 11:44 AM, the Director of Nursing (DON) stated when a narcotic medication is running low, the nurses are expected to look ahead and anticipate that an order is needed 4 - 7 days before it runs out. She said that it can take some time to fax the doctor for an order and get an electronic prescription sent to the pharmacy. The DON acknowledged that running out of narcotic medications had been a problem. Sometimes they can call the on-call doctor but that person may hesitate to prescribe a narcotic for a resident that is not their patient.

3. The MDS assessment dated 8/25/21 for Resident #37 documented diagnoses that included seizure disorder, heart failure, pulmonary hypertension, depression and muscle wasting and atrophy. The assessment documented Resident #37 had a BIMS score of 15. The MDS documented she experienced frequent pain and received scheduled and prn pain medications.

During interview on 9/22/21 at 11:41 a.m., Resident #37 reported she missed her Lyrica on Saturday (9/18/21), Sunday (9/19/21) and Monday (9/20/21). Resident #37 felt she was having withdrawal symptoms from not receiving

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the medication. Resident #37 described feeling shaky, on edge and just not feeling well. Resident #37 stated since restarting the medication she has been feeling better.

Resident #37's 9/21 MAR directed administration of Lyrica (pregabalin) 150 mg by mouth twice a day for nerve pain. The MAR recorded the following information:

a. 9/18/21 AM dosage of pregabalin 150 mg signed off with a 9 which indicated other/see nurses notes
b. 9/18/21 PM dosage of pregabalin 150 mg signed off with a 9.
c. 9/19/21 AM dosage of pregabalin 150mg signed off with a 9.
d. 9/19/21 PM dosage of pregabalin 150 mg signed off with a 9.
e. 9/20/21 AM dosage of pregabalin 150 mg signed off with a 9.
f. 9/20/21 PM dosage of pregabalin 150 mg signed off with a 9.

Review of Resident #37's Progress Notes revealed no entries regarding the Pregabalin capsule 150mg administered on 9/18/21, 9/19/21 and 9/20/21.

Interview on 9/22/21 at 01:24 p.m., with Staff C, Licensed Practical Nurse (LPN) revealed an issue at the pharmacy regarding getting a script for the resident's medication and the medication was refilled on Tuesday (9/21/21) and Staff C gave the resident the AM dosage on Tuesday morning. Staff C stated the medication had to be reordered by pulling off the label and sending it to the pharmacy.

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F 658	Continued From page 30 Interview on 9/22/21 at 1:45 p.m. with the facility's Pharmacist revealed the facility received 60 capsules of pregabalin 150 mg on 8/18/21 and 60 capsules of pregabalin 150 mg on 9/20/21. The Pharmacist stated the facility requested a refill on 9/18/21 and the pharmacy tried to fill the medication and could not as the prescriber was not a Medicaid provider. The pharmacy called the facility and talked to Staff D, Registered Nurse (RN) to find out where to send the script to as they were unable to fill the medication, the script needed to go to Resident #37's provider and Staff D gave the ok to deal with the script on Monday (9/20/21). The Pharmacist stated the facility led them to believe that the Resident #37 was not out of her medication due to the ok to deal with the script on Monday. The Pharmacist stated that pharmacy staff could have paged a physician or received a telephone order to ensure Resident #37 did not go without her medication. The Pharmacist also stated if pregabalin capsules are going to be discontinued, the medication should be tapered down over a minimum of one week per the medication's instructions. If a resident or patient is stable on pregabalin capsules the resident or patients should avoid abrupt discontinuation due to possible withdrawal symptoms that could include insomnia, nausea, headache, anxiety, diarrhea, and hyperhidrosis (abnormally excessive sweating involving the extremities, underarms, and face, usually unrelated to body temperature or exercise) as well as others. The Pharmacist verified that pregabalin capsules are not stored in the facility's emergency medication kit. On 9/22/21 at 3:10 p.m. Staff D stated when she worked on 9/18/21, she called the about the resident's missing medications and pharmacy	F 658		

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F 658	Continued From page 31 staff informed her they sent the script to the wrong physician. Staff D directed the pharmacy to the correct physician. Staff D stated Resident #37 told her on 9/19/21 that she did not feel well. Resident #37 couldn't pinpoint what was wrong just not well. Resident #37 told Staff D she felt super-duper tired. Staff D stated the facility emergency medication kit did not contain pregabalin capsules and if it had the nurse would have given the resident the medication. Interview on 9/27/21 at 11:42 a.m., with the DON revealed the procedure for refills would be to refill the medication 4 to 7 days before the medication is to run out. Nursing staff should monitor this and are expected to make sure that the medication is being reordered on a timely basis. There are sometimes issues with getting refills from the pharmacy and a backup plan would include calling the on-call doctor and having them prescribed, but the on-call physician will not always fill medications for the primary care doctor either. Review of undated pharmacy guidelines revealed under refills to be sure to reorder 3-5 days before the medication runs out. One may use an electronic system to reorder the prescriptions for faster service and immediate feedback. If you reorder after the cutoff time, the medication will be delivered the following day. For controlled substance orders, controlled substances can only be sent upon valid script from a prescriber or a verbal order from a prescriber or agent of the prescriber. The Deliveries for Medication Reorders document, dated 2017, instructed to allow 72 hours for routine refills and allow 5-7 days for	F 658		

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F 658	Continued From page 32 controlled refills. As always, if a refill is needed sooner, just call the pharmacy and speak to a pharmacy representative. The Medication Re-ordering Electronic via eRefill, fax or phone instructions, dated 2017, instructed things to remember when ordering: reorder medications with a 3-5 days supply remaining, pull the sticker and place it on the reorder record for refill and reconcile the delivery of medication with the reorder record. The Order Process for STAT (immediate) and Missed Cut-off Times, dated 2017, directed that for STAT orders, write STAT on the order sheet, fax the order to the pharmacy, call the pharmacy and let them know the time the resident needs the medication. Interview on 9/28/21 at 10:28 a.m., with the DON revealed pharmacy staff would not have called the on-call doctor and would not have been able to get a script on the weekend. The DON stated Resident #37 should not have gone without the medication.	F 658	F690 1. A complete assessment was done by a licensed nurse on 9/28/21 on resident #42, no signs or symptoms of infection were noted. 2. DON audited all residents with catheters on 9/28/21 for signs and symptoms of infection, no concerns were identified.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690	3. Nursing staff were re-educated/in-serviced by the DON on female/male catheter care on 9/29/21 and 9/30/21. 4. Observational audits will be completed weekly for four weeks, then monthly for two months by the DON or designee ensuring proper catheter care is being completed. Results of audits will be brought to the QAPI meeting monthly for three months for review. The DON is responsible for ongoing compliance. Date of compliance: 10/29/2021	10/29/2021

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F 690	Continued From page 33 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, facility staff failed to provide complete catheter care for one of four residents reviewed (Resident #42). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated 8/27/21 for Resident #42 documented diagnoses that included heart failure, Parkinson's disease, and neurogenic bladder (condition in which problems with the nervous system affect the	F 690		

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bladder and urination). The resident required the assistance of one with toilet use and personal hygiene. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

Review of the Care Plan edited on 9/4/21 revealed Resident #42 required an indwelling urinary catheter related to a neurogenic bladder.

Observation on 9/21/21 at 10:41 a.m., revealed Staff B, Certified Nursing Assistant (CNA) entered the room and asked Resident #42 if she could do catheter care. Resident #42 agreed. Staff B took two paper towels and laid them on the bedside table, then took two unopened alcohol swab packages and laid them on top of the paper towels on the bedside table. Staff B performed hand hygiene and applied gloves. Staff B assisted Resident #42 to a standing position to pull down his pants and his brief. Staff B opened an alcohol swab and took one swab and wiped from the resident's urethral opening down the catheter tubing and then discarded the alcohol swab into the trash. Staff B then took another alcohol swab and wiped from the urethral opening down the catheter tubing and then discarded the alcohol swab into the trash. Staff B then assisted Resident #42 to remove a soiled brief, applied a new brief and assisted Resident #42 to pull the brief and pants up.

Review of facility policy titled Catheter Care, dated 1/13, revealed the purpose of the policy is to provide safe and proper care of a resident or patient with an indwelling catheter by evaluation elimination status, minimizing risk of bladder infection, and maintaining skin integrity. The procedure directed the following actions:

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F 690	Continued From page 35 Step #8 - Cleanse the entire perineal area with soap and water or perineal wash, unless otherwise ordered. a. Female- separate labia and cleanse from center to thigh and front to back b. Male- cleanse from urethra outward; retract foreskin of uncircumcised male, cleanse, and replace foreskin. An interview on 9/28/21 at 10:43 a.m. with the Director of Nursing (DON) revealed she expected staff to do perineum care with catheter care and staff should not be doing catheter care with an alcohol swab.	F 690		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of	F 801	F801 1. A certified dietary manager was hired by the Administrator on or before 10/29/21 in a consultant role. 2. An audit of dietary staff qualifications was completed on or before 10/29/21 by the Administrator. 3. The Regional Vice President re-educated the Administrator on or before 10/29/21 regarding the requirement to employ qualified dietary staff. 4. The Administrator or designee will audit dietary staffing weekly for 4 weeks, then monthly for 2 months to ensure the facility continues to employ qualified dietary staff as required. Results of these audits will be taken to the QA meeting monthly for 3 months for review and recommendations as needed. Administrator is responsible for monitoring and follow up. Date of compliance: 10/29/2021	10/29/2021

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F 801	Continued From page 36 a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food	F 801		

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	165174	A. BUILDING _____ B. WING _____	09/30/2021

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F 801	Continued From page 37 service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on on staff interviews and review of the facility's job description and professional references, the facility failed to employ a qualified person to serve as the Dietary Manager in the absence of a full-time dietitian. The following would be qualified persons; certified dietary manager, certified food service manager; or has similar national certification for food service management and safety from a national certifying body, an associates or higher degree in food service management, hospitality, or restaurant management from an accredited institution or higher learning. The facility reported a census of 50 residents. Findings include: In an interview on 9/20/21 at 2:22 PM, the Administrator stated the facility's Dietary Manager (DM) lacked Dietary Manager certification. In an interview on 9/20/21 at 2:25 PM, the DM stated he was enrolled in the certification course and stated he would bring in the paperwork. On 9/22/21 at 11:25 AM, the DM stated he could not get the records as he did not have the password	F 801		

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F 801	Continued From page 38 to the website. In an interview on 9/28/21 at 11:14 AM, the DM he planned to get the certification transcripts faxed to the facility today. When asked if he had finished all the required classes, the DM responded no. The DM stated he worked as the DM since 11/19. The DM acknowledged he lacked the proper certification requirements of a Dietary Manager and stated he could not finish classes due to his workload. On 9/29/21 at 10:44 AM, when asked if her expectation would be the DM is certified, the Administrator responded yes. The Job Description, Dietary Services Supervisor document, dated 1/13, instructed the DM should be a graduate of an accredited course in dietetic training approved by the American Dietetic Association. The 2017 Food & Drug Administration (FDA) Food Code 2-102.12 included the Certified Food Protection Manager or the person in charge shall be a Certified Food Protection Manager who has shown proficiency of required information through passing a test that is part of an accredited program.	F 801	F812 1. The plate of goulash, uncovered desserts, open can of pudding, box of cream of wheat, bag of crispy onions, tomatoes, sausage, and oranges were discarded on 9/20/2021 by the dietary manager. The residents snack cart and juice cart was cleaned and sanitized on 9/20/2021 by dietary staff. The microwave oven and steam table were cleaned and sanitized on 9/20/2021 by dietary staff. The floor was mopped and deep cleaned on 9/21/2021 by Dietary Manager. Cleaning logs were reinitiated on 9/21/2021 by the dietary manager. 2. The Administrator completed kitchen sanitation rounds on or before 10/29/21 with corrections implemented at the time of identification. 3. Dietary Manager, aides and cooks were re-educated by Administrator on kitchen cleanliness on 10/21/2021.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812	4. The Administrator will audit the kitchen 3 times weekly for 4weeks, then weekly for 8 weeks to ensure the kitchen continues to be clean and sanitary as required. Results of these audits will be presented to the QAPI Committee meeting monthly for 3 months for review and recommendation as needed. Administrator is responsible for monitoring and follow-up Date of compliance: 10/29/2021	10/29/2021

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F 812	Continued From page 39 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to store food in a manner that prevented the chance of foodborne illness. The facility also failed to keep equipment sanitary and clean. The facility reported a census of 50. Findings include: An initial kitchen tour conduct on 9/20/21 at 2:25 PM revealed the following areas of concern: a. A partially consumed plate of goulash found in the kitchen area. b. Desserts found to be uncovered in the double door refrigerator. c. An open can of pudding with a tin foil cover. d. The residents' snack cart and juice cart with dried liquid and food debris. e. The microwave oven and steam table with splattered food, dried liquid and a variety of food particles. f. The kitchen floor covered in a sticky residue and crushed food particles.	F 812		

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F 812	Continued From page 40 g. A box of Cream of Wheat and a bag of Crispy Onions found to be unsealed and unlabeled. h. The walk-in refrigerator contained tomatoes and oranges with mold and a ring of sausage found to be unsealed and unlabeled. During the initial kitchen tour on 9/20/21 at 2:25 PM, the Dietary Manager (DM) agreed that employees should not be eating in the kitchen and immediately discarded the plate of goulash. The DM acknowledged open food should be sealed and labeled. He agreed food stored in an open can could pose a food hazard. He reported the residents did not consume any of the pudding after the can was stored in the refrigerator and he did not know how the can got there; storing food in a can is not the facility's normal practice. The DM agreed the microwave, food carts and steam table should be sanitary. The DM acknowledged the refrigerator should not contain produce with mold after which he immediately discarded the tomatoes and oranges. During the tour the DM stated that some of the cleaning logs were moldy from a leak, but he would see what he could get. In an interview 9/21/21 at 2:34 PM the DM stated the log book ran off. The DM did not know what happened to it and he started a new clipboard system on 9/21/21. The document titled Food Labeling Reference Guide instructed when a food item is opened and not completely used, write the open date on the food container. The document titled Cleaning & Sanitizing directed that the food and dish carts are maintained in a clean and sanitary condition. In an interview on 9/30/21 at 11:22 AM, the Administrator stated she would expect the kitchen	F 812		

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F 812	Continued From page 41 surfaces, floors and appliances to be sanitary and clean from debris. She expected open food to be sealed, labeled and discarded when needed. The Administrator stated cleaning logs should be available and up to date.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable 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;	F 880	F880 1. Staff C was re-educated by DON on 9/29/2021 to use hand sanitizer/wash hands prior to performing any patient care. Resident #42 was assessed for any signs or symptoms of infection by DON on 9/28/2021. Staff B was re-educated by the Director of Nursing on or before 10/28/21 regarding the requirements of infection control, including hand hygiene and glove use during the provision of catheter care. The ceiling tile above the washing machine was replaced by the maintenance director on or before 10/28/21. 2. Observational audit completed of facility nursing staff regarding hand hygiene, glove use and infection control practice by DON on 9/28/2021. DON audited residents with catheters on 9/28/21 for signs and symptoms of infection, no concerns were identified. An observational audit of ceiling tile integrity was completed by the Administrator on or before 10/28/21 with corrections implemented as identified. 3. DON or designee will re-educate facility staff on infection control practices related to hand hygiene, glove use, and catheter care. Staff members will watch the video Clean Hands and Keep Covid-19 Out on YouTube. This will be completed by 10/28/21. The administrator re-educated the maintenance director on or before 10/28/21 regarding the requirement to maintain ceiling tiles.	

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F 880	Continued From page 42 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and facility policy review, facility staff failed to perform hand hygiene and/or change their gloves when indicated during	F 880	4. DON or designee will audit hand washing with glove use for compliance weekly for four weeks, then monthly for two months. Results of audits will be brought to the QAPI meeting monthly for three months for review. The DON and the Administrator are responsible for ongoing compliance. Date of compliance: 10/29/2021	

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F 880	Continued From page 43 medication pass and resident cares of one of three residents reviewed (#42). Additionally, observation revealed the facility's laundry area with damaged and loose ceiling tiles directly above resident laundry machines. The facility reported a census of 50 residents. Findings: 1. A random observation on 9/21/21 at 9:20 AM revealed Staff C, LPN (Licensed Practical Nurse) reached down the inside of her shirt until her elbow was at the collar of her shirt for approximately 20 seconds, removed her arm, re-arranged her name tag, and placed her hands into her pockets. She then proceeded to touch items on the medication cart without performing hand hygiene. When asked if she should wash her hands, Staff C responded yes. In an interview on 9/29/21 at 11:35 AM, the Administrator stated all facility staff should use a private area to adjust their clothing or otherwise, they should have washed their hands. 2. The Minimum Data Set (MDS) assessment dated 8/27/21 for Resident #42 documented diagnoses that included heart failure, Parkinson's disease, and neurogenic bladder (condition in which problems with the nervous system affect the bladder and urination). The resident required the assistance of one with toilet use and personal hygiene. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the Care Plan edited on 9/4/21 revealed Resident #42 required an indwelling urinary catheter related to a neurogenic bladder.	F 880		

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F 880	Continued From page 44 Observation on 9/21/21 at 10:41 a.m., revealed Staff B, Certified Nursing Assistant (CNA) entered the room and asked Resident #42 if Staff B she could do catheter care; the resident agreed. Staff B took two paper towels and laid them on the bedside table, then took two unopened alcohol swab packages and laid them on top of the paper towels on the bedside table. Staff B performed hand hygiene and applied gloves. Staff B assisted Resident #42 to a standing position to pull down his pants and his brief. Staff B then opened an alcohol swab and took one swab and wiped from the urethra opening down the catheter tubing then discarded the alcohol swab into the trash. Staff B then took another alcohol swab and wiped from the urethra opening down the catheter tubing then discarded the alcohol swab into the trash. Staff B removed her gloves and without performing hand hygiene, applied new gloves and assisted Resident #42 to remove a soiled brief. Staff B then, without changing her gloves or performing hand hygiene, applied a new brief and assisted Resident #42 to pull up his brief and pants. Staff B removed her gloves and without performing hand hygiene, took a paper towel and laid it on the floor, applied gloves and placed a plastic graduate on top of the paper towel. Staff B used an alcohol swab to wipe the opening of the catheter drainage opening. Staff B emptied the urine into the graduate, closed the opening and cleaned it with a clean alcohol swab. Staff B emptied the graduate into the toilet. Without rinsing the graduate out, Staff B then placed the graduate on top of a cabinet in the bathroom by the toilet. Staff B then removed her gloves and performed hand hygiene. Review of facility policy titled Handwashing, dated	F 880		

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F 880	Continued From page 45 3/20, revealed the facility will follow the Center for Disease Control (CDC) Guidelines for handwashing. Handwashing is the single most important procedure for preventing nosocomial infections. Hands must be washed after the following, including, but not limited to: contact with blood or body fluids, contact with residents or patients, initiating a clean procedure and removal of gloves. Review of facility policy titled Infection Control Two-Tier Transmission Based Precaution: Standard Precautions, dated 3/15, revealed first tier standard precautions will be utilized on all residents or patients. The procedure for hand washing instructed to wash hands after touching the following whether or not gloves are worn include body fluids: contaminated items, excretions, and secretions. The policy instructed to wash hands promptly after gloves are removed, as indicated to avoid transfer of microorganisms to other residents or patients or environments and between tasks and procedures on the same resident or patent to prevent cross-contamination of different body sites. Apply clean gloves before touching mucous membranes or non-intact skin. Change gloves between tasks and procedures on the same resident or patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surface, and before going to another resident or patient. Wash hands promptly to avoid transfer of microorganisms to other residents or patients or the environment. The facility policy also instructed that resident and patient care equipment to bag or cover used resident or patient care equipment soiled with	F 880		

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F 880	Continued From page 46 blood, body fluids, secretions, and excretions to prevent skin and mucous membrane exposures, contamination of clothing, or transfer of microorganisms to other residents or patients or environment. An interview on 9/28/21 at 10:43 a.m., with the Director of Nursing (DON) revealed she expected staff to wash their hands before and after gloving and to change their gloves if going from clean to soiled as needed through any procedure. 3. Observation on 9/29/21 at 9:05 AM revealed a ceiling tile just above a washing machine with significant water damage. The tile was bowing with the weight of water, stained and appeared close to falling down. Staff E, Laundry stated the facility used the washing machine for resident personal items and these were in that wash machine. Interview with the Maintenance Manager at the time revealed the damage came from condensation from the air conditioner because some areas of the duct work were not insulated. He stated he had been aware of the damage and planned to get it corrected soon.	F 880		