STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

(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: 1/17/2022 JS / The following deficiencies resulted from the Recertification Survey, Facility Reported Incidents #100317, #100388, and #100502, and Complaint #100464 conducted December 13, 2021 to January 6, 2022. Facility Reported Incidents #100317-I and #100388-I were substantiated. Complaint #100464-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	PLAN OF CORRECTION Accura Healthcare of Pleasantville denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	1/17/2022
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, and policy reviews the facility failed to provide residents with quarterly financial statements for 3 of 13 resident's reviewed	F 568	In continuing compliance with F568, Accounting and Records of Personal Funds, Accura Healthcare of Pleasantville corrected the deficiency by printing Quarterly statements for resident #9, #12, #43 and all like residents and/or resident representatives with a trust account on 1/11/2022. To correct the deficiency and to ensure the problem does not recur, the Business Office Manager was educated on 1/11/2022 by the Regional VP of Operations on the process for issuing quarterly financial statements to residents and/or resident representatives. The Administrator and/or designee will audit quarterly statements over the next 2 quarters and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/11/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brady Allen	Regional VP of Operations	2/11/2022

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 568	Continued From page 1	F 568		

(Residents #9, #12, and #43) who had facility managed funds. The facility reported a census of 43 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 9/28/21, listed Resident #9's BIMS (Brief Interview for Mental Status Score) as 14 out of 15, indicating intact cognition.

During an interview on 12/16/21 at 1:46 p.m., Resident #9 stated she has not received a financial statement.

2. The MDS assessment dated 10/1/21, listed Resident #12's BIMS score as 13 out of 15, indicating cognitive impairment.

During an interview on 12/21/21 at 1:40 p.m., Resident #12 stated he did not remember ever receiving a quarterly bank statement.

3. The MDS assessment tool, dated 11/2/21, listed Resident #43's BIMS score as 14 out of 15, indicating intact cognition.

During an interview on 12/21/21 at 1:55 p.m., Resident #43 revealed he did not ever receive any bank statements.

During an interview with Business Office Manager on 12/15/21 at 1:55 p.m., revealed she was not sure if she had provided quarterly financial statements to residents or the Resident Representative.

During an interview with Staff A, Nurse Consultant, on 12/16/21 at 9:35 a.m., revealed

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F 568	Continued From page 2 the Business Office Manager did not send out quarterly financial statements to residents or Resident Representative on a quarterly basis. During an interview on 12/16/21 at 12:00 p.m., with Business Office Manager revealed facility document titled Trust Statement, dated 3/31/20 was the last date any quarterly Resident Trust Fund were sent to residents and Resident Representative. During an interview on 12/21/21 at 2:00 p.m., the Business Office Manager revealed she resigned from her position yesterday and stated she was not properly educated on how to perform the job. The Business Office Manager stated she was unaware she needed to perform certain duties such as provide quarterly financial statements or have money available for residents on the weekends who participate in the Resident Trust Funds. The facility lacked a Resident Trust Fund policy.	F 568		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585	In continuing compliance with F585 Grievances, Accura Healthcare of Pleasantville corrected the deficiency by Regional VP of Operations and Administrator speaking with resident #30 regarding resident's privacy concerns on 1/12/2022. Resident #30 expressed on 1/12/2022 that he no longer had any privacy concerns with his current roommate, resident #19, and did want to pursue alternative room arrangements The facility will ensure that resident #30 and like residents are provided with prompt resolution to grievances. The facility Administrator was provided education on 1/12/2022 on Accura Grievance Process by the Regional Vice President. To correct the deficiency and to ensure the problem does not recur, all staff were educated by the Administrator on 1/11/2022 or prior to the start of their next shift on the facility's grievance process. The Administrator and/or designee will audit grievances 3x/weekly x 4 week, then 2x weekly x 2 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/12/2022

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F 585	Continued From page 3 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all	F 585		

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F 585	Continued From page 4	F 585		

information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 5	F 585		

decision.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to take prompt efforts to resolve grievances for 1 of 17 residents reviewed for the right to voice grievances (Resident #30). The facility reported a census of 43 residents.

Findings include:

1. A Minimum Data Set (MDS) dated 11/9/21, documented Resident #30's diagnoses included Multiple Sclerosis (MS), depression, and presence of external hearing aide. The Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15 indicating intact cognition. Resident #30 required extensive assist of 2 staff for bed mobility, transfer and toilet use. He required extensive assist of 1 for locomotion on the unit.

A Care Plan for Resident #19 documented PT services continue and dated 6/3/21. An intervention documented that Resident #19 has a bilateral lower extremity AFO (leg brace).

2. The MDS assessment dated 10/19/21, documented Resident #19 had BIMS as 05 out of 15, indicating severely impaired cognition. Resident#19's diagnosis include a non-Alzheimer's dementia, Alzheimer's, legally blind. Resident #19 was dependent on one staff for bed mobility, transfers and toilet use.

On 12/13/21 on 3:17 PM, Resident #30 stated he told a former employee that he needed his roommate to be moved out. Resident #30 stated his roommate, Resident #19, put Resident #30's

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leg brace in the toilet. Resident #30 stated that Resident #19 had tried to sleep on top of Resident #30. Resident #30 stated that Resident #19 wanders all night long around Resident #30's bed. Resident #30 stated he asked the Nursing Home Administrator (NHA), if he could move across the hall. Resident #30 stated that Resident #19 had pulled on his wheelchair and Resident #30 had to holler out to get help because Resident #19 had drug Resident #30 around in his w/c. Resient #30 reported that he told administration and staff that they better be looking in the room for Resident #19 as Resident #30 was tired of babysitting him.

On 12/16/21 at 11:26 AM, the NHA stated the only request that he had for a room change was that gentleman over there with the goatee (pointed at Resident #30). The NHA stated Resident #30's roommate was blind and they discussed moving Resident #19 but PT did not feel that it was a good idea as Resident #19 was blind. The NHA stated they just discussed moving Resident #30 to a different room and that is what they were going to do. They discussed it in a daily Quality Assurance (QA) meeting on Monday because that's when the resident said something to the NHA. The NHA stated that he was told Resident #30 has a history of making these requests and changing his mind. He stated the Staff J, Assistant Director of Nursing (ADON) would be able to speak to this resident's history. The NHA stated he has no documentation of discussions with resident, QA team, or therapy.

12/16/21 11:35 AM Staff J, ADON, stated she knew that Resident #30 used to live with another resident who liked to have the light off and liked to sit in the dark. She stated that Resident #30

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F 585	Continued From page 7 requested a room change. The ADON stated that #30 then moved in with another resident who passed away. Then Resident #19 was moved in with Resident #30. The ADON stated that Resident #30 doesn't like it because Resident #19 will mess with resident' #30's stuff like on his way to the bathroom or Resident #19 would get up out of bed. Resident #30 wanted Resident #19 to move. The ADON stated they decided they could not move Resident #19. She stated QA and therapy decided that we can't move Resident #19 probably about a month ago. ADON stated she did not remember any other interventions put into place. The ADON knew that Resident #19 was on hourly checks for a while because he had gotten out of bed and hit his head during the night, so they put him on hourly checks. The ADON stated no interventions that she knows of were put into place to help prevent Resident #19 from going over to Resident #30's side of the room. The ADON stated that staff thought it had gotten better. She stated that there was nothing recent that Resident #30 had complained about. She stated that Resident #19 did put Resident #30's AFO in the toilet approximately 3 weeks prior. The ADON stated that Resident #30 was not usually in his room except at night. The ADOON remembered hearing that Resident #19 went over to Resident #30's bed and tried to get into it. She stated that Resident #19 forgets where he is and that he was a wanderer. She stated that Resident #19 was not walking as well as he was. ADON stated she has no documentation of discussions with QA, Resident, or therapy regarding Resident #30's concerns or requests.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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F 623	Continued From page 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. §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	F 623	In continuing compliance with F623, notice requirements before transfer/discharge, Accura Healthcare of Pleasantville corrected the deficiency by notifying the Ombudsman of resident #21, #26, #30, and all like residents, discharges from October and November 2021 on 1/11/2022. To correct the deficiency and to ensure the problem does not recur, the Administrator was educated on 1/11/2022 by the Regional VP of Operations on process for monthly notification to the Ombudsman of resident discharges. The Administrator and/or designee will audit notification to the Ombudsman on a monthly basis x 3 months and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/11/2022

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F 623	Continued From page 9 (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; (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.	F 623		

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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:
Based on clinical record review, and staff interviews the facility failed to notify the Office of State Long Term Care Ombudsman of admissions, discharges, and hospitalizations for October 2021 and November 2021 for 3 of 3 residents reviewed (Resident # 21, #26 and #30) for required notifications. The facility reported a census of 43.

Findings include:

1. The document titled Census List for Resident #21 included 10/8/21 transferred out to hospital and on 10/11/21 transferred in from the hospital. On 10/12/21 discharged and readmission on 10/18/21.

During an interview on 12/16/21 at 11:46 AM with Staff A Nurse Consultant explained the facility did not do the ombudsmen notification in October or November.

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F 623	Continued From page 11 During a subsequent interview on 12/16/21 at 12:23 PM Staff A acknowledged the facility did not have an Ombudsman notification policy, they just follow the regulations. 2. An MDS dated 10/6/21, documented Resident #26 was discharged to a hospital for an acute visit. A MDS dated 10/12/21, showed Resident #26 reentered the facility after an acute hospital stay. 3. A MDS dated 10/31/21, documented Resident #39 was discharged to a hospital for an acute visit. A MDS dated 11/4/21, showed Resident #39 reentered the facility after an acute hospital stay. On 12/16/21 at 12:33 PM, Staff A, Nurse Consultant, gave a copy of the newly done ombudsman lists for October and November of this year. She stated they had not been done but now they should be current. She stated the Administrator had did the new ones on that day.	F 623	In continuing compliance with F 637 Comprehensive Assessment After Significant Change, Accura Healthcare of Pleasantville corrected the deficiency by having the MDS Coordinator complete a significant change status assessment on resident #39. The facility audited resident #39 and all like residents to ensure a significant change was completed as necessary by 1/17/2022.	1/17/2022
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 637	To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was educated on 1/12/2022 by the Clinical Nurse Specialist on following RAI guidelines regarding significant change MDS's. The DON and/or designee will audit 24-hour summaries daily for significant change in status that would require a significant change MDS Monday through Friday x 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete a comprehensive assessment after a significant change for 1 of 14 residents sampled (Resident #39) for assessments. The facility reported a census of 43 residents.

Findings include:

A Minimum Data Set (MDS) assessment dated 10/31/21, documented Resident #39 discharged to the hospital.

A MDS dated 11/4/21 showed Resident #39 reentered the facility after an acute hospital stay.

The facility completed the MDS assessment for Resident #39 with section G filled out on 9/3/21 and another MDS with Section G filled out on 11/10/21. In comparing Section G of the 2 MDS assessments, the Resident declined in the MDS completed on 11/10/21 in areas of; bed mobility, transfer, walk in room, locomotion on and off unit, eating and toilet use.

On 12/14/21 at 3:21 PM,Staff D, Nurse Consultant provided the contact information for Staff E's, Contracted MDS Coordinator. Staff D reported Staff E had the responsibility for completing the resident's MDS assessments. Staff D stated the facility had not had a MDS Coordinator for quite a while and had just hired one at the time of this interview. Staff D stated they have been contracting Staff E in the

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meantime.

On 12/14/21 at 4:17 PM, Staff E, Contracted MDS Coordinator, stated she had been working at the facility for about 1 year. Staff E stated she worked on-site and remotely. Staff E had access to the Electronic Health Record and could see discharges, admissions, and pay changes. Staff E stated she opened a significant change for Resident #39 today. She stated that Resident 39 had come off of skilled care on 12/4/21 and Staff E stated she was waiting to open a Significant Change MDS to see if Resident #39 would bounce back as you have 14 days and she did not bounce back. Staff E stated she did not have to do a significant change on someone who returns to the facility if they are in skilled care. Staff E stated she sometimes does Care Plans if she can. She stated she worked with a lot of their facilities.

On 12/16/21 at 9:36 AM, Staff E reported she reported she did not have supportive documentation to provide to support that she could wait to do a significant change after a resident discharges from rehabilitation instead of return from the hospital. Staff E thought Resident #39 had returned to baseline but now realizes Resident #39 did not.

On 12/16/21 at 8:49 AM, Staff A, Nurse Consultant, stated Resident #39 should have had a significant change done after she returned from the hospital with the changes in Resident #39's abilities to do Activities of Daily Living.

On 12/16/21 03:00 PM Staff A and Staff D, Nurse Consultants stated the facility did not have Care Plan or MDS policies. They stated they follow

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F 637	Continued From page 14 CMS standards.	F 637	In continuing compliance with F 644 Coordination of PASRR and assessments, Accura Healthcare of Pleasantville corrected the deficiency by auditing resident #11, #45, and all like residents PASRR's by Clinical Nurse Specialist and resubmitting new Level 1 PASRR's on those needed by 1/17/2022. To correct the deficiency and to ensure the problem does not recur the MDS coordinator was educated on 01/12/2022 on the process of submitting medication and diagnosis changes and additions to the PASRR system by Clinical Nurse Specialist. The DON and/or designee will audit new orders Monday-Friday x 4 weeks, then 2x weekly x 2 weeks, then PRN for significant changes to level 1 PASRR's to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/17/2022
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: §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 and staff interview, the facility failed to refer 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 to the state designated authority promptly for 2 of 2 sampled (Residents #11 and #45) sampled for PASRR. The facility reported a census of 43 residents. Findings included:	F 644		

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1.The Minimum Data Set (MDS) assessment dated 9/28/21 indicated Resident #11 had a diagnosis of Major Depressive Disorder (MDD), psychotic disorder/delusional disorder, multiple sclerosis, and non-Alzheimer's dementia. The resident had a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Resident #11 is two person assist with bed mobility, transfers, toileting assistance and set up assistance of one with eating. Resident #11 received anti-depressant medication seven days per week during the lookback period.

Record review revealed Preadmission Screening and Resident Review (PASRR), dated 9/25/2014, revealed a negative level one outcome and indicated the individual does not have a major mental illness.

Clinical record review of resident #11 list of diagnosis, undated, revealed diagnosis of delusional disorders dated 11/17/14 and diagnosis of MDD dated 9/2/16.

Clinical record review indicated Resident #11 was hospitalized from 5/19/21 to 6/18/21 and anti-depressant increased on 4/16/21. The PASRR not resubmitted for further screening.

Clinical record titled Care Plan, initiated 10/11/21 revealed the resident at risk for alteration in psychosocial well-being and took anti-depressant medications related to MDD and delusional disorder. The staff directives included to administer medications as ordered, and monitor for side effect and effectiveness of the medication.

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During an interview on 12/21/21 at 11:12 a.m., with Assistant Director of Nursing (ADON), revealed it is the responsibility of the Director of Nursing (DON) to resubmit a PASRR if a resident received a new mental health diagnosis. The ADON stated she did not know how to resubmit a PASRR.

During an interview on 12/22/21 at 2:06 p.m., with Staff A, Nurse Consultant, revealed the facility DON completed facility PASRR's.

During an interview on 12/22/21 at 2:37 p.m., with Staff B, Nurse Consultant, revealed her past work experience at the facility included the role of DON. Staff B stated when DON, she did not review facility PASRR's to ensure they were accurate. Staff B stated she submitted for PASRR screening with new admissions, resident discharge, and new mental health diagnosis. Staff B stated she did not have a firm understanding on how to complete the process of PASRR. Staff B reported all facility residents should have a PASRR and she completed an audit on 12/2020 verifying all residents had a PASRR but did not audit for accuracy of PASRR's. Staff B stated it is the expectation of the facility that all major changes to resident care or diagnosis reflected with an updated PASRR. Staff B stated she did not resubmit Resident #11's PASRR when hospitalized from 5/19/21 to 6/18/21.
2. The MDS dated 9/7/21 for Resident # 45 did not identified resident to be not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition and she entered the facility on 2/28/14. The MDS document a BIMS score of 7 which indicated sever cognitive impairment and the resident exhibited other physical behaviors

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directed toward others on 1 to 3 days of the 7 -day look back period. The MDS also documented diagnoses that included: non-Alzheimer's Dementia, anxiety disorder, depression, psychotic disorder, and mood disorder and she received antipsychotic, and antidepressant 7 out of 7 days of the look back period.

Resident #45's Care Plan dated 1/27/20 included a focus area for traumatic life event with actual or potential for Post Traumatic Stress Disorder (PTSD) and directed staff to attempt non-pharmacological interventions with 1:1 visits , spontaneous activities , quite room and to observe the effectiveness, and referral to tele health services. Care Plan also included focus area dated 12/9/16 for a behavior problem such as combativeness, outbursts, calling staff foul words, cursing/yelling, resisting cares/meds/ADLs/eating, makes threats, will throw her belongings, hit others with her belongings, will throw away her belongings, and included diagnosis of anxiety, delusional disorder, dementia, depression, insomnia, mood disorder. The Care Plan included interventions to administer medications as ordered. Assess/document for side effects and effectiveness. Resident takes sertraline (antidepressant), trazadone (antidepressant) , Seroquel (antipsychotic).

The Medical Diagnosis sheet printed on 12/16/21 for Resident #45 included a diagnosis of unspecified dementia with behavior disturbances added on 7/21/16.

Resident #45's PASRR dated 12/4/13 included the individual met the criteria for having a

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diagnosis of metal illness as defined by PASRR and had major depressive disorder recurrent, anxiety disorder and moderate intellectual disability. Another evaluation is not required if you choose to transfer to another nursing facility unless your needs change significantly. PASRR included Placement decision: Nursing facility placement is sought to assist with psychiatric condition, chronic medical conditions, medication administration and assistance with self care. Diagnoses of anxiety disorder, major depressive disorder recurrent and unspecified mental retardation.

The document Order Summary Report dated 12/13/21 for Resident #45 included the following:

a. Fluoxetine 20 mg 2 tablets by mouth daily related to major depressive disorder with a start date of 11/10/21.

b. Quetiapine 100 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20.

c. Quetiapine 25 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20.

d. Quetiapine 50 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/12/20.

e. Trazadone 125 mg by mouth daily related to unspecified mood disorder, anxiety disorder, major depressive disorder with a start date of

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F 644	Continued From page 19 8/20/19. Resident #45's Medication Administration Record (MAR) for December included the following medications given daily through the review: a. Fluoxetine 20 mg 2 tablets by mouth daily related to major depressive disorder with a start date of 11/10/21. b. Quetiapine 100 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20. c. Quetiapine 25 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20. d. Quetiapine 50 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/12/20. e. Trazadone 125 mg by mouth daily related to unspecified mood disorder, anxiety disorder, major depressive disorder with a start date of 8/20/19. The Telehealth Progress Note dated 9/27/21 for Resident #45 included the following medication changes: a. Taper dose of sertraline as follows: sertraline 100 mg give 1 1/2 tablets 150 mg daily for 1 week. then 1 tablet daily for 1 week, then 1/2 tablet daily for 1 week, then discontinue.	F 644		

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F 644	Continued From page 20 b. Switch to fluoxetine and titrate as follows: fluoxetine 20 mg give 1/2 tablet = 10 mg every morning for 1 week, then 1 tablet every morning for 1 week, then 1 1/2 tablets = 30 mg for 1 week, then 2 tablets =40 mg every morning thereafter for depression / anxiety. During an interview on 12/20/21 at 9:21 AM, Staff B Registered Nurse and prior Director of Nursing acknowledged from 9/20 to 9/21 she submitted or resubmitted the PASRR's during that time. Staff B explained she would have resubmitted the PASRR for a medication change or sign/ symptom change not a dose change. Staff B further explained that Staff D Nurse Consultant looked in the system and identified the 2013 PASRR as the most current. During a follow up interview on 12/22/21 at 2:39 PM with Staff B explained during her time as the DON she did not review any PASRR to change, she knew to do new admissions or major changes. Staff B acknowledged the DON to be responsible for doing the PASRR and the DON before her also had the responsibility of the PASRR's. Prior the MDS coordinator had the responsibility, since the MDS coordinator had not been constant for a while so the responsibility changed to the DON.	F 644	In continuing compliance with F 657 Care Plan Timing and Revision, Accura Healthcare of Pleasantville corrected the deficiency by updating resident #3, # 9, #19,# 21, #39, #45 and all like residents care plans to ensure they were up to date and met each residents needs by Clinical Nurse Specialist by 1/17/2022.	1/17/2022
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	To correct the deficiency and to ensure the problem does not recur, MDS Coordinator was educated on timely revision of care plan to ensure resident needs are met on 1/12/2022 by Clinical Nurse Specialist. The DON and/or designee will audit orders and/or changes in resident condition Monday through Friday x 4 weeks then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 657	Continued From page 21 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to update the comprehensive care plan for 6 of 12 residents reviewed (Resident #3, #9, #19, #21, #39, and #45). The facility reported a census of 43 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated 9/14/21 documented Resident 3's Brief Interview for Mental Status Score (BIMS) as 10, indicating moderately impaired cognition. Resident #3 had diagnoses of Parkinson disease, non-Alzheimer's dementia, contracture of left knee/ankle. The resident required extensive	F 657		

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assist of two staff for bed mobility, transfers, and toileting, he required set up assistance with eating. Resident #3 is at high risk for skin breakdown.

The residents Comprehensive Care Plan lacked documentation of Prevalon boot (prevents sores to the heel).

Facility document titled, MDS, dated 12/20/21, lacked documentation of Prevalon boot.

Observation on 12/13/21 at 4:48 p.m. revealed Resident #3 in bed without Prevalon boot on his foot. Staff P, Certified Nurse Assistant (CNA), and Staff BB, CNA attached Hoyer sling to resident and transferred to wheelchair. Staff BB applied Prevalon boot to resident's right foot.

Observation on 12/14/21 at 9:26 a.m. revealed Resident #3 sat in wheelchair with Prevalon boot on his left foot.

Observation on 12/15/21 at 9:57 a.m. revealed Resident #3 laid in bed with Prevalon boot on his left foot.

Observation on 12/15/21 at 10:46 a.m., revealed Resident #3 sat in wheelchair while he watched T.V., Prevalon boot on his right foot.

Observation on 12/15/21 at 1:47 a.m., of Staff P, CNA, and Staff BB, CNA, transferred Resident #3 from the wheelchair to the bed. Staff P and BB attached the Hoyer sling and transferred to the bed. Prevalon boot was not on either feet.

During an interview on 12/20/21 at 12:47 p.m. with Staff S, Licensed Practical Nurse (LPN),

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revealed Resident #3 has been wearing the Prevalon boot for months. Staff S stated she is uncertain by whom or when Resident #3 received the Prevalon boot. Staff S stated, the MDS Coordinator updated the Care Plans.

During an interview on 12/20/21 at 8:40 a.m., with Staff C, CNA revealed Resident #3 wears the Prevalon boot on his left foot. Resident #3 has worn the Prevalon boot for a year. Staff C was unsure if Prevalon boot was on her pocket Kardex and did not print a copy off on 12/20/21.

During an interview on 12/21/21 at 11:06 a.m., with Assistant Director of Nursing (ADON), revealed any of the nursing staff may update the Care Plan. ADON stated Resident #3 has worn the Prevalon boot for quite a while and she is unsure why. ADON stated Resident #3 wears the Prevalon boot on the left foot.

2. The MDS assessment tool, dated 9/28/21, listed Resident #9's BIMS as 14, out of 15, indicating intact cognition. Resident #9 had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD), oxygen dependent and incontinence. Resident #9 is independent with bed mobility, transfers, and toileting; she requires set up assistance with eating. She is at risk for pressure ulcers.

Physician Order dated 9/29/21 revealed order for Intra-Dry treatment to excoriated areas daily and as needed (PRN). The order discontinued on 10/4/21; the Physician Order not updated on Resident #9's Care Plan.

Physician Order dated 10/5/21 revealed order to

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apply Betadine to abdominal wound BID. The Physician Order not updated on Resident #9's Care Plan.

Physician Order dated 10/9/21 revealed order to apply Zinc Oxide twice per day (BID) and PRN to abdominal fold. The Physician order not updated on Resident #9's Care Plan.

The Care Plan dated 10/11/21 shows the resident was at risk for impaired skin integrity related to incontinence and chronic excoriation beneath abdominal folds and under each breast. According to the care plan, the resident was to receive Intra-dry treatment to excoriated areas daily and as needed (PRN), weekly treatment documentation to include measurement of each area of skin breakdown size, type of tissue and exudate or other notable changes or observations. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to Medical Doctor (MD).

The Care Plan lacked current physician orders for assessment and treatment of belly button skin breakdown.

The clinical record lacked documentation of application of physician ordered Nystatin to macerated belly button skin on the Medication Administration Record (MAR) for date range of 10/1/21 thru 11/14/21.

Observation on 12/15/21 at 10:29 a.m., with Staff A, Nurse Consultant, revealed Resident #9's belly button macerated (when skin is in contact with moisture for too long, the skin looks lighter in color, appears white), red border, moist in appearance with 1-2 inch pieces of skin missing.

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F 657	Continued From page 25 During an interview on 12/21/21 at 11:16 a.m., with the ADON, revealed Resident #9 has a history of maceration of her belly button skin. ADON stated staff will apply Nystatin and it will clear up. ADON stated Resident #9 or the bath aide will notify the nurse, the nurse will notify Staff L, RN, who will assess. The Nystatin order had discontinued and the clinical record lacked documentation of attempts to reorder the Nystatin. 3. The MDS assessment dated 10/19/21; documented Resident #19 had BIMS as 05 out of 15, indicating severely impaired cognition. Resident#19's diagnosis include a non-Alzheimer's dementia, Alzheimer's, legally blind. Resident #19 was dependent on one staff for bed mobility, transfers and toileting. Facility document titled, HAWK-Fall Risk Assessment, dated 12/13/21, recorded Resident #19 as "very high" risk for falling. The Comprehensive Care Plan with date initiated of 6/9/21 revealed the resident was at risk for falls due to unsteady gait, history of falls, and visual deficit (legally blind). The care plan lacked staff directive of hourly checks implemented after 10/20/21 fall and interventions instructing how Resident #19 notifies staff when assistance needed. Observation on 12/13/21 at 12:00 p.m., revealed Resident #19 sat on recliner in his room, feet elevated. Call light not within reach. Observation on 12/15/21 at 10:00 a.m. of	F 657		

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Resident #19 sat in recliner with his arms outstretched and appeared to be reaching for something. Call light was out of reach.

Observation on 12/20/21 at 10:46 a.m. of Resident #19 sat in recliner with feet down. Resident #19 attempted to remove his shirt. The call light was not within reach.

Observation on 12/21/21 at 11:55 a.m. of Resident #19 sat in recliner, call light out of his reach. Staff Q, CNA, entered the room and escorted resident to dining room with unsteady gait and blind cane.
.
Observation on 12/21/21 at 3:37 p.m. of Resident #19 leaned over recliner with both feet on the floor. Call light not within reach.

During an interview on 12/21/21 at 3:48 p.m., with Staff C, CNA stated Resident #19 required assistance with ambulation, as he required both a gait belt and staff assistance of one. Staff C did not know how Resident #19 notifies staff when he needed help.

During an interview on 12/21/21 at 3:50 p.m. with Resident #30 (roommate) revealed Resident #19 is up independently often. Resident #30 stated he had never heard staff educate Resident #19 how to use the call light.

During an interview on 12/21/21 at 3:58 p.m. with Staff D, Nurse Consultant, stated the following interventions were added post-fall to Resident #19's Care Plan: Resident #19 moved to a room closer to the Nurses Station; Dysem cushion added to his recliner; Resident #30 alerts staff if Resident #19 needs assistance; and Physical

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F 657	Continued From page 27 Therapy evaluation. During an interview on 12/21/21 at 4:50 p.m., with Staff A, Nurse Consultant, revealed Resident #19 ambulated independently. During an interview on 12/20/21 with Staff D, Nurse Consultant, revealed Resident #19 self-transferred at night. Staff D stated hourly checks initiated from date range of 10/21/21-11/28/21. Staff D was unsure why the Care Plan did not reflect this change. 4. A MDS dated 12/4/21, documented diagnoses for Resident #39 included Alzheimer's disease and non-Alzheimer's disease; hip fracture; and psychotic disorder. The BIMS score for this resident was 00 out of 15, which indicated severe cognitive impairment. Resident #39 required extensive assist of 2 for transfer; walking in room and corridor; and toilet use. Findings include: A Minimum Data Set (MDS) dated 10/31/21, documented Resident #39 was discharged to a hospital for an acute visit. A MDS dated 11/4/21, showed Resident #39 reentered the facility after an acute hospital stay. The facility completed a MDS for Resident #39 with section G filled out on 9/3/21, which documented that Resident required limited assist of 1 for bed mobility, transfer, walking in room and corridor, and toilet use. The facility completed a MDS for Resident #39 with Section G filled out on 11/10/21, which	F 657		

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documented that this resident required extensive assist of 2 for bed mobility, transfer, and toilet use. It documented that the activity did not occur for walking in room and corridor.

A Care Plan for this resident has a focus area dated 1/27/20, documented that Resident #39 had a self care performance deficit related to dementia. The goal revised on 11/26/21, documented that Resident #39 would maintain her current level of function in dressing through the review date. The following interventions directed staff to:

a. ambulation needed assist of 2 with a forward wheeled walker and gaitbelt with the broad chair to follow up to 100 feet. Date initiated was 12/16/21 with a revision date of 12/20/21.

b. assist resident with hygiene and grooming. Date initiated was 12/15/21.

c. 1 person assist with repositioning in bed. Date initiated was 12/14/21.

d. 2 person assist with toileting needs. Date initiated was on 12/14/21 with a revision date of 12/20/21. Prior toileting needs that was initiated on 12/14/21 read 1 person assist with toileting needs.

e. assist of 2 for transfers and ambulation with gait belt and walker, initiated on 12/14/21.

f. full weight bearing per doctor orders. Date initiated was 12/14/21.

g. Staff to assist resident in wearng a facial mask as she tolerates when out of room. Date initated was 10/16/20 with a revision date of 11/17/20.

h. wedge pillow at all times per doctors orders. Date initiated was 12/14/21.

i. bathing showering: check nail length and trim and clean on bath day and as necessary.

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Report changes to the nurse. Date initated was 1/27/20.

j. Bathing/Showering: the resident requires assist of 1 staff for showering 2 times a week and as necessary. Date initiated 1/27/20.

k. Dressing: assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Date initiated 1/27/20.

l. Dressing: the resident needs assist of 1 to complete dressing at all times. The resident will often change clothing during day to pajamas. Please remove dirty cloting each shift. Date initated 1/27/20 and revised on 11/10/20.

m. Praise all efforts at self care. Date intiated 1/27/20.

The care plan changes above were not done upon this resident's return to the facility on 11/4/21, nor were some of the above interventions updated to reflect her needs until the middle of December.

On 12/14/21 at 4:17 PM, Staff E, Contract MDS Registered Nurse (RN), stated she had been working for the facility part time for about 1 year. Staff E stated she worked both on site and remotely. She stated she had access to the electronic health records and could see the census, discharges, admissions, and payer changes that would show if a resident was on skilled care. Staff E stated she sometimes did care plans if she could. She stated she worked with a lot of their facilities. Staff E stated the care plans should be updated quarterly and the care plans should be changed when things occurred. She stated she had not been told that she was responsible to make daily care plan changes. She stated the facility knows she cannot make

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the daily changes. Staff E added that the care plan changes should have been made though.

On 12/16/21 at 8:49 AM, Staff A Nurse Consultant, stated Resident #39anet should have had a significant change assessment done after she returned from the hospital with a change in ADLs. She should have had her care plan updated with the changes.

On 12/16/21 at 3:00 PM, Staff A and Staff D, Nurse Consultants, stated they did not have any care plan or MDS policies. They stated the facility would follow CMS standards.
5. The annual MDS dated 9/7/21 for Resident # 45 document a BIMS score of 7 which indicated sever cognitive impairment and the resident exhibited other physical behaviors directed toward others on 1 to 3 days of the 7 -day look back period. The MDS also documented diagnoses that included: non-Alzheimer's Dementia, anxiety disorder, depression, psychotic disorder, and mood disorder and she received antipsychotic, and antidepressant 7 out of 7 days of the look back period.

Resident #45's Care Plan dated 1/27/20 included a focus area for traumatic life event with actual or potential for Post Traumatic Stress Disorder (PTSD) and directed staff to attempt non-pharmacological interventions with 1:1 visits , spontaneous activities , quite room and to observe the effectiveness, and referral to tele health services. Care Plan also included focus area dated 12/9/16 for a behavior problem such as combativeness, outbursts, calling staff foul words, cursing/yelling, resisting cares/meds/ADLs/eating, makes threats, will throw her belongings, hit others with her

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belongings, will throw away her belongings, and included diagnosis of anxiety, delusional disorder, dementia, depression, insomnia, mood disorder. The Care Plan included interventions to administer medications as ordered. Assess/document for side effects and effectiveness. Resident takes sertraline (antidepressant), trazadone (antidepressant) , Seroquel (antipsychotic). The facility failed to update the care plan with the current medication changes.

The document Order Summary Report dated 12/13/21 for Resident #45 included the following:
a. Fluoxetine 20 mg 2 tablets by mouth daily related to major depressive disorder with a start date of 11/10/21.
b. Quetiapine 100 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20.
c. Quetiapine 25 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20.
d. Quetiapine 50 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/12/20.
e. Trazadone 125 mg by mouth daily related to unspecified mood disorder, anxiety disorder, major depressive disorder with a start date of 8/20/19.

Resident #45's Medication Administration Record (MAR) for December included the following medications given daily through the review: Fluoxetine 20 mg 2 tablets by mouth daily related to major depressive disorder with a start date of

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F 657	Continued From page 32 11/10/21. b. Quetiapine 100 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20. c. Quetiapine 25 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/11/20. d. Quetiapine 50 mg 1 tablet by mouth daily related to mood affective disorder, unspecified dementia with behavior disturbance and delusional disorders with a start date of 1/12/20. e. Trazadone 125 mg by mouth daily related to unspecified mood disorder, anxiety disorder, major depressive disorder with a start date of 8/20/19. The Telehealth Progress Note dated 9/27/21 for Resident #45 included the following medication changes: a. Taper dose of sertraline as follows: sertraline 100 mg give 1 1/2 tablets 150 mg daily for 1 week. then 1 tablet daily for 1 week, then 1/2 tablet daily for 1 week, then discontinue. b. Switch to fluoxetine and titrate as follows: fluoxetine 20 mg give 1/2 tablet = 10 mg every morning for 1 week, then 1 tablet every morning for 1 week, then 1 1/2 tablets = 30 mg for 1 week, then 2 tablets =40 mg every morning thereafter for depression / anxiety. During an interview on12/21/21 at 12:41 PM Staff A Nurse Consulant would expect the Care Plan to be updated and for staff to follow the Care Plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 33 §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, policy review, observation and staff interviews the facility failed to flush the Percutaneous Endoscopic Gastrostomy (PEG) tube prior to instilling medications for 1 of 1 Resident with a PEG Tube (Resident #21).The facility also failed to clarify and new orders for tube feeding times and medications before contacting the pharmacy and changing the Medication Administration Record (MAR) for 1 of 12 Resident (Resident #21). The facility reported a census of 43. Findings include: 1.The quarterly Minimum Data Set (MDS) dated 12/14/21 for Resident #21 reported moderately impairment for cognitive skills for daily decision making. The MDS included diagnoses of diabetes mellitus, aphasia, malnutrition, and depression and received tube feedings. Resident #21's Care Plan included a focus area of alteration in nutrition due to malnutrition and nothing by mouth and received artificial feedings. The care plan directed staff to check residual before administration and to keep head of bed elevated 45 degrees at all times. Resident #21 MAR dated 12/21 included the following: a. Clopidogrel Bisulfate tabled 75 mg, give via Peg tube one time a day with a start date of	F 658	In continuing compliance with F 658 services provided meet professional standards, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff "S" on 1/11/2022 by Clinical Nurse Specialist on administering medications via g-tube for resident #21 and all like residents to ensure proper medication administration process and following physician orders. To correct the deficiency and to ensure the problem does not recur nursing staff were educated on administering medications via g-tube to ensure proper medication administration process and following physician orders by 1/13/2022 by Clinical Nurse Specialist. The DON and/or designee will audit medication administration via g-tube 3x weekly x 4 weeks, then 2x weekly x 2 weeks, then PRN to ensure compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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F 658	Continued From page 34 7/23/20 b. Elevated HOB (Head of Bed)45 degrees during enteral feeding and 2 hours after. c. Famotidine tablet 20 mg, give 1 tablet by mouth one time a day with a start dateof 5/22/21 d. Hydrodhlorothiazide tablet 25 mg, give 25 mg via PEG tube one time a day with a start date of 7/23/20 e. Lisinopril tablet 10 mg, give 1 tablet via PEG tube with a start date of 11/25/21. f. Calcium-Vitamin D 600 mg- 400 units, give 1 tablet by mouth two times a day with a start date of 10/19/21. g. Gabapentin Capsule 100mg, give 100mg via PEG tube twice a day with a start date of 3/1/21. h. Patassium phosphate- sodium phosphate 250 mg-45mg-298 mg twice a day with a start date of 10/19/21. i. Mucus relief tablet 400 mg, give 1 tablet via PEG tube three times a day with a start date of 4/12/21. j. Flush PEG tube with 30 ml water before and after each medication administration with a start date of 7/23/20. Resident #21's Order Summary Report dated and signed by physician 12/13/21 included the following: a. Clopidogrel Bisulfate tabled 75 mg, give via Peg tube one time a day with a start date of 7/23/20 b. Elevated HOB (Head of Bed)45 degrees during enteral feeding and 2 hours after. c. Famotidine tablet 20 mg, give 1 tablet by mouth one time a day with a start date of 5/22/21 d. Hydrodhlorothiazide tablet 25 mg, give 25 mg via PEG tube one time a day with a start date of 7/23/20 e. Lisinopril tablet 10 mg, give 1 tablet via PEG	F 658		

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tube with a start date of 11/25/21.
f. Calcium-Vitamin D 600 mg- 400 units, give 1 tablet by mouth two times a day with a start date of 10/19/21.
g. Gabapentin Capsule 100mg, give 100mg via PEG tube twice a day with a start date of 3/1/21.
h. Patassium phosphate- sodium phosphate 250 mg-45mg-298 mg twice a day with a start date of 10/19/21.
i. Mucus relief tablet 400 mg, give 1 tablet via PEG tube three times a day with a start date of 4/12/21.
j. Flush PEG tube with 30 ml water before and after each medication administration with a start date of 7/23/20.

Policy updated 6/23/2020
Titled Medication Administration
Through Tube Feeding
Purpose:
to administer medications through a gastric (G) or nasogastric (NG) tub in a safe and appropriate manner.
Equipment
a. Dilatant (such as NS, distilled water or tap water) (for flushing tube before and after medication) at room temperature.
b. Syringe (syringes should be changed every 24 hours).
c. Disposable gloves
Procedure
a. Wash hands before touching formula or delivery system. Prepare surface and maintain clean technique. Wear gloves if necessary, to prevent contact with body secretions.
b. Explain procedure to resident and provide privacy.
c. Bring equipment to bedside, wash hands and put on glove.

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d. Check Tube Placement and Patency.
e. Feeding tube should be checked for placement and patency prior to beginning a feeding and after episodes of vomiting or any suctioning, by the following methods.
i. Attach syringe to the end of the tube and gently try to aspirate gastric fluid, If gastric fluid is evident, instill gastric fluid into tube.
ii. If gastric fluid is NOT evident place a stethoscope over the upper portion of the resident's stomach. Attach the syringe to the tube and insert a small amount (10 to 20 ml (CC)) of air into the tube while listening for a swooshing or gurgling sound. If you do not hear this, it indicates that the tube may not be in the stomach, in which case the Charge Nurse and or physician should be notified.
f. Prepare medication as appropriate. Use liquid form of medication whenever possible. Thick solutions can be mixed with water if necessary. Check with pharmacy to see id medication is available in liquid form and whether tablets can be crushed. If tablets can be crushed, crush finely and mix with warm water. Do not mix medications with enteral feeding formula. Also check to see if medications can be given with tube feedings or should be given on an empty stomach and tube feeding withheld for a prescribed time interval before and after medication is given.
NOTE: Antacids should not be given at the same time as some other medications, such as antibiotics, so wait 30 to 60 minutes in between.
g. Administer medication with syringe slowly and steadily. (Extent the elevation of the syringe will determine the flow rate). If more then one medication is to be administered, give each one separately and rinse the tube with 5 ml (cc) of warm water in between medications.
h. Flush tube with 20 to 30 ml (cc) of water before

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and after administering each medication. If resident is on continuous tube feeding, stop the feeding adn clear the tube by instilling the dilatant before administrating the medication.
i. If the G or NG tube is attached to suction turn off suction and clamp tube for 20 to 30 minutes after medication administration so it is absorbed.
j. Remove gloves and wash hands.
k. Document medication on the Documentation Record, Medication Administration and also record any fluid instilled if resident is on I & O

During an observation on 12/14/21 at 9:56 AM Staff B Registered Nurse (RN) observing while Staff S Licenses Practical Nurse (LPN) obtained Resident #21's Medications from the medication cart and placed the following into a medication cup.
a. K phos neutral 155.852/130 give one by mouth twice a day.
b. Copidogrel 75 mg give 1 via peg tube daily.
c. Famotidine 20 mg po qd given via peg tube.
d. Hydrochlorothiazide 25 mg give via peg tube every am.
e. Cal 600 vit d 400 by mouth daily.
f. guaifenesin 400 gm give via peg tube.
h. Lisinopril 10 mg give 1 via peg tube every am.
Staff S crushed all medications together, then entered Resident #21's room filled 10 cc of water and all medication donned gloves and opened gabapentin 100 mg give 1 via peg tube twice a day and placed into cup and stirred. Staff S added 30 milliliters (ml) of water to 2 different medication cups moved plate over to table and raised the bed and obtained a new syringe. Staff S donned gloves instilled 30 cc of air to peg tube to check for placement and then checked for residual. Staff S instilled the medications and then 30 cc of water after medication. Staff S

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F 658	Continued From page 38 failed to flush prior to giving medications. Lowered bed doffed gloves and washed hands. During an interview on 12/14/21 at 9:56 AM Staff S LPN stated she failed to flush the PEG tube prior to giving medications. 2. Resident #21's clinical record included a fax with a date and time stamp of 11/22/21 at 1:57 PM from the physician pertaining to Resident #21 order details included the following: Order date 10/19/21 for enteral feeding every day shift form 6 AM to 6 PM Glucerna 1.2 at 80 ml/hour x 12 hours continues. Using kangaroo pump total 960 ml, signed 12/22/21 and noted 11/24/21 and 12/8/21. Resident #21's Order Summary Report dated 12/13/21 included the following: a. Entral Feeding Order every night shift, Glucerna 1.2 @ 80 ml/hr for 12 hours. Kangaroo pump total 960 ml, with a start date of 12/25/2. Resident #21's MAR dated for 12/21 included the following: a. Entral Feeding Order every night shift, Glucerna 1.2 @ 80 ml/hr for 12 hours. Kangaroo pump total 960 ml, with a start date of 12/25/2. 3. Resident #21's clinical record included a fax notification to the physician that stated Resident takes potassium phosphate -sodium phosphate 250 mg -45mg-298mg tablet to dissolve in water. Could this be changed to liquid form with orders? She has a G-Tube. The physician responded ok-please ask pharmacy for liquid equivalent and dose recommendation. Signed and dated	F 658		

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12/15/21.Per Pharmacy phos-Nak Packet 280-160-250 mg dilute in warm water. The fax had been noted and MAR changed on 12/15/21 at 1:56 PM.

Resident #21's MAR dated 12/21 included the following:
a. Potassium phosphate-sodium phosphate 250 mg-45mg-298mg two times a day with a start date of 10/19/21 and discontinued date of 12/15/21.
b. Potassium phosphate-sodium phosphate 250 mg-45mg-298mg two times a day may dissolve in water with a start date of 12/15/21.
c. Phos-Nak Packed 280-160-250mg (potassium as sodium phosphate), give 1 packet via PEG tube two times a day dilute in 30 ml of water with a start date of 12/16/21.

During an interview on 12/16/21 at 10:24 AM Staff V Physician returned call stated he had received a fax from the facility yesterday about changing Resident # 21 potassium phosphate-sodium phosphate 250 mg-45mg-298 md tabled to dissolve in water BID asking if could be changed to liquid form with orders. Please give with orders she has G-tube. He confirmed he responded back ok please ask pharmacy for liquid equivalent and dose recommendations faxed back to facility. Let him know they did get pharmacy recommendation of phos-nat packed 280-160-250 mg dilute in 30 cc warm water. He stated good but had not okay that order as of yet he was out of the office and maybe it was waiting for him. He acknowledged he talked to the facility this morning 12/16/21 about a different order that had been mention to be discontinued in a progress not from Staff W physician back awhile. He stated he wanted mirtazapine to be continued

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F 658	Continued From page 40 since she has other indications. Explained the potassium phosphate-sodium phosphate 250 mg-45mg-298 md ordered by mouth since returning from the hospital back in October. He acknowledged he would expect the order to have been clarified back when Resident #21 returned from the hospital since she had a g tube. When asked about the change of feeding to overnight to day explained someone else in his office could have handled that he could not remember any conversation about the change. He also explained a couple of months ago duties at his office shifted.. During an interview on 12/21/21 at 8:45 AM Staff D Nurse Consultant when shown the order for tube feeding it was signed by doctor and noted but not changed on the MAR. Staff D did not think it was a system failure. She did explain the order should have been clarified since the original date was over a month ago but not changed in the MAR or clarified. Staff D not sure why this order was in the chart and where it came from. When asked about the last change to potassium - sodium phosphate. Stated the physician stated ok please ask pharmacy for liquid equivalent and dose recommendation. Staff D stated that the information must be faxed out for the physicians okay. When asked why the order had been changed on the mar before the physician knew about it. Staff D had no answer. The order already in the book to be noted a 2nd and 3rd time without being faxed back to physician.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 41 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure 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, staff interview, and record review, the facility failed to provide assessments and interventions on resident's skin for 1 of 12 residents reviewed (#9). The facility reported a census of 43 residents. 1. The MDS assessment tool, dated 9/28/21, listed Resident #9's BIMS as 14, out of 15, indicating intact cognition. Resident #9 had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD), oxygen (O2) dependent. Resident #9 is independent with bed mobility, transfers, and toileting; she requires set up assistance with eating. She is at risk for pressure ulcers. Observation on 12/15/21 at 10:29 a.m., with Staff A, Nurse Consultant, revealed Resident #9's belly button macerated (when skin is in contact with moisture for too long, the skin looks lighter in color, appears white), red border, moist in appearance with 1-2 inch pieces of skin missing. During an interview on 12/13/21 at 10:29 a.m., with Resident #9 stated, ointment applied on a shower day, if it is applied. During an interview on 12/13/21 at 12:00 p.m., with Resident #9 and Staff A, Nurse Consultant. Resident #9 revealed she always had skin issues	F 684	In continuing compliance with F 684 Quality of Care, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff "L" on 1/06/2022 by Clinical Nurse Specialist on appropriate assessment and intervention with report of new skin concerns, accuracy of staging/documentation, and timely assessments for resident's #9 and all like residents by 1/13/2022 by Clinical Nurse Specialist. To correct the deficiency and ensure the problem does not recur all nursing staff were educated on appropriate assessment and intervention with report of new skin concerns, accuracy of staging/documentation, and timely assessments for residents by 1/13/2022 by Clinical Nurse Specialist. In addition, all staff were educated on process of completion of shower sheets with all skin concerns by 1/13/22 or prior to start of next shift by Clinical Nurse Specialist. DON and/or designee will audit weekly skin assessments x 4 weeks, then PRN to ensure measurements are completed timely and audit treatments 3x weekly x 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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and staff do not check or monitor her skin. Resident #9 stated she had to tell staff when she had a skin issue. Resident #9 stated her abdominal skin is tender. Staff A stated Staff L, Registered Nurse (RN) will assess Resident #9's skin on Wednesday 12/19/21 when she visits the facility.

During an interview on 12/16/21 at 11:00 a.m., with Staff A, she stated the Certified Nurse Assistants (CNA) complete a bath sheet with every shower and are to notify the nurse if a resident has a new skin issue.

During an interview on 12/16/21 at 2:28 p.m., with Staff L, RN revealed, weekly skin assessments completed on all skin issues, even skin tears. Staff L stated, when the Director of Nursing (DON) left, the Minimum Data Set (MDS) Coordinator and Assistant Director of Nursing (ADON) split up the tasks.

During an interview on 12/16/21 at 2:45 p.m., with Staff Z, CNA, and stated Resident #9's belly button will appear "yeasty" at times. Staff Z will notify the nurse with new skin issues.

During an interview on 12/16/21 at 3:04 p.m., with Staff A, Nurse Consultant, stated CNA's use the bath sheet to document new areas on the resident's skin. Staff A stated the degree of maceration on Resident #9's belly button must have been present when last showered on 12/13/21.

During an interview on 12/20/21 at 3:43 p.m., with Staff AA, Licensed Practical Nurse (LPN) revealed, when Staff B, RN, had changed

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facilities she was asked to take over the task of measuring wounds. Staff B worked 1 day per week and stated she could not keep up with the task. Staff B not notified of new wounds such as a skin tear. Staff B and often a wound healed before she had a chance to assess. Risk management was supposed to assess a skin tears or any new CNA notification.

During an interview on 12/21/21 at 11:16 a.m., with the ADON, revealed Resident #9 has a history of maceration of her belly button skin. ADON stated staff will apply Nystatin and it will clear up. ADON stated Resident #9 or the bath aide will notify the nurse, the nurse will notify Staff L, RN, who will assess.
Facility document titled, Report Skin Concerns Immediately, dated 12/13/21, completed by Staff Z, CNA, revealed resident had no new skin breakdown.

The clinical record lacked documentation of application of physician ordered Nystatin to macerated belly button skin on the Medication Administration Record (MAR) for date range of 10/1/21 thru 11/14/21.

The Care Plan dated 10/11/21 shows the resident was at risk for impaired skin integrity related to incontinence and chronic excoriation beneath abdominal folds and under each breast. According to the care plan, the resident was to receive Intra-dry treatment to excoriated areas daily and as needed (PRN), weekly treatment documentation to include measurement of each area of skin breakdown size, type of tissue and exudate or other notable changes or observations. Report abnormalities, failure to heal, signs and symptoms of infection,

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F 684	Continued From page 44 maceration to Medical Doctor (MD). The clinical record lacked documentation of weekly skin assessments. The clinical record lacked MD notification of notable changes, observations, infections or maceration. The facility lacked documentation of Intra-dry daily treatment; skin was monitored, weekly documentation of skin and physician notification of maceration and infections of the skin. The Treatment Administration Record (TAR) lacked skin treatment of Intra-dry for date range of 10/1/21-12/15/21. The MAR listed the following medications for abdominal folds or wounds during the date range of 10/5/21-12/2/21: Betadine to abdominal wound BID and Zinc Oxide BID/PRN for skin treatment. The clinical record titled TAR, dated 10/1/21-10/31/21, and revealed physician order for Betadine to abdominal wound twice per day (BID). TAR documentation revealed the medication not applied five times due to resident being asleep and lacked documentation of nine doses. Physician ordered Zinc Oxide not documented as given. The clinical record titled TAR, dated 11/1/21-11/30/21, and revealed physician order for Betadine to abdominal wound twice per day (BID). TAR documentation revealed the medication not applied eleven times due to resident being asleep and lacked documentation of eight doses. Physician ordered Zinc Oxide not documented as given.	F 684		

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F 684	Continued From page 45 The clinical record titled TAR, dated 12/1/21-12/2/21, and revealed physician order for Betadine to abdominal wound twice per day (BID). TAR documentation revealed lacked documentation of three doses. Physician ordered Zinc Oxide not documented as given.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, observations and staff interviews the facility failed to properly assess 1 of 2 pressure ulcers (Resident #1) and failed to complete weekly assessments for 1 of 2 residents (Resident #26) observed with pressure ulcer injuries. The facility reported a census of 43. Findings include: 1. The annual Minimum Data Set (MDS) dated 12/7/21 reported Resident #1 had a Brief	F 686	In continuing compliance with F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff "L" on 1/6/2022 by Clinical Nurse Specialist on weekly measurements of wounds, accuracy of staging/documentation, timely assessments for resident's #1, #26, and all like residents. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on weekly measurements of wounds, accuracy of staging/documentation, timely assessments for resident by 1/13/2022 or prior to start of next shift by Clinical Nurse Specialist. The DON and/or designee will audit weekly skin measurements x 4 weeks, then PRN to ensure compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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Interview for Mental Status (BIMS) score of 4 which indicated sever cognitive impairment. The MDS document she required extensive assistance of 1 staff for bed mobility and total dependence of 2 staff for transfers and had range of motion impairment on both sides of her lower extremities. The MDS included diagnoses of heart failure, diabetes mellitus, arthritis, weakness and adult failure to thrive and had 1 stage 1 pressure injury (Intact skin with non-blanchable redness of a localized area usually over a bony prominence).

Resident #1's Care Plan dated updated 1/17/20 included focus area for risk for skin breakdown due to weakness and directed staff resident wore pressure deduction boots at all times only to be removed during transfers starting 11/11/18 and to use prevalon boots when resident is out of bed starting 11/24/21. The Care Plan also included a focus area of stage 1 pressure ulcer to left heel dated 12/8/21 and directed staff to assess wound, obtain measurements and document weekly on the alteration until healed. Notify physician if wound worsens or develops signs or symptoms of infection and follow physician instructions.

An Incident Report dated 12/24/21 at 8:57 for Resident#1 included hospice nurse brought to nurses attention of anew skin condition to her left heel. Assed left heel measured a 3 cm (centimeters) perfectly round white blanchable area. Physician notified and received new order for betadine to left heel twice a day until healed and prevolon boots while up in wheelchair.

Document titled Skin Sheet -Ulcer Assessment dated 11/24/21- 12/20/21 for Resident #1 included the following:

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F 686	Continued From page 47 11/24/21 New area pressure left heel 3 cm x 3 cm stage 1. Included descriptions Suspected Deep Tissue Injury- Purple or maroon localized area of intact skin or blood filed blister due to damage of underlying soft tissue from pressure and or shear. The area may be preceded by tissue that is painful,firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage 1 Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open ruptured serum-filled blister. 12/1/21 Follow up assessment in house acquired left heel pressure stage 1, 3 cm x 3 cm wound is white and blanchable, improvement. 12/8/21 Follow up assessment in house acquired left heel pressure stage 1, 3 cm x 3 cm wound is white and blanchable, improvement, order for betadine continues. 12/15/21 Follow up assessment in house acquired left heel pressure stage 1. 3 cm x 3 cm wound is white and blanchable, improvement, order for betadine continues. 12/20/21 Follow up assessment in house acquired left heel pressure stage 2, 3 cm x 4 cm wound is white and blanchable. Outer right edge of ulcer an open area noted with black edges, wound bed pink area 1.5 cm x 0.5 cm. wound declined and new order received to Cleanse left heel with wound cleanser, apply non sting barrier and cover with tegaderm silicone foam, change every 5 days and as needed. Resident #1's clinical record included the following orders: 11/24/21 Betadine surgical scrub solution apple to left heel typically two times a day for heal skin	F 686		

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F 686	Continued From page 48 area. 11/24/21 Prevalon boots to be on when up in wheel chair three times a day for breakdown area on left heel. 12/20/21 Cleanse left heel with wound cleanser, apply non sting barrier and cover with tegaderm silicone foam. Change every 5 days and as needed one time a day for wound healing. The document titled Skin Management Protocol updated 10/14/21 6 pages. All treatment orders included in these protocols require a physician's signature. Wound notification Standards a. Notify DON and Wound Nurse of new Skin Alteration or skin Ulcer. b. Complete Incident Report in Risk Management and Skin Sheet (non- Ulcer or Ulcer Assessment). c. All Skin Sheets non- Ulcer or Ulcer Assessment will be updated Weekly in Point Click Care (PCC) in Assessment Tab by designated Wound Nurse. d. The community will report to the physician if there is any deterioration or signs of infections observed. e. The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not actively transferring. Stage 1 Pressure Injury/Ulcer (non- Blanchable Erythema) a. Use approved positioning devices to minimize pressure to area. b. Tegaderm Silicone Foam, change every 5 days and as needed, c. Visualize area daily until healed and observe for changes.	F 686		

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d. Report to physician if area worsens.
e. Document dimensions weekly on Skin Sheet-Ulcer Assessment by designated community Wound Nurse.

Stage 2 Pressure injury/Ulcer(Partial Thickness Skin Loss) Involving Epidermis and or Dermis
a. Gently remove dressing if present.
b. Cleanse with soap and water.
c. Gently pat area dry.
d. For areas other then buttock (minimal to moderate drainage);
1. If base of wound is pink/red, Use appropriate anatomical shape dressing for heels and sacral:
i. Non-Purulent: cover with tegaderm Silicone Foam.
i.i Purulent (Infected): infected utilize KerraCal AG (Antimicrobial Gelling Fiber) as primary dressing.
iii. Avoid tape to skin as much as possible.
iv. Change every 5 days and as needed.
2. For Under a dressing use Cavilon No- Sting barrier to prevent adherence.
3. Cover with dry dressing.
f. Visualize daily and observe for improvement, deterioration, or sings of infection.
g. Report to physician id deterioration or signs of infection are observed for possible need of antibiotic or wound consult.
h .Document dimensions weekly on Skin Sheet -Ulcer Assessment by designated community Wound Nurse.
Raised Fluid Filled Blister(blood or clear fluid)
a. Gently remove dressing if present.
b. Cleanse with soap and water
c. Gently pat area dry, using caution to keep skin intact.
d. Apple Adaptic Touch One dressing to area.
e. Cover Adaptic Touch One dressing with DPD.
f. Avoid tape to skin as much as possible.

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g. Visualize area daily and observe for any signs of infection.
h. Change Adaptic Touch One dressing weekly or until healed.
i. Report to physician if signs of infecting are observed.
j. report to physician if area worsens of signs of invention are observed.
k. Document dimensions weekly on Skin Sheet-Non- Ulcer Assessment by designated community Wound Nurse.

Resident #1's Progress notes from 11/24/21 until 12/20/21 lacked documentation of any changes to her left heel.

An observation on 12/15/21 at 11:16 AM during the dressing change with Staff N Certified Medication Aide/Certified Nursing assistant (CMA/CNA) assisting Staff L Registered Nurse (RN). Staff L brought a plate with betadine swabs, barrier sheet, gloves and hand sanitizer to Resident #1's room. Staff L placed paper towel on the table and placed plate on top. Resident in bed on right side with blue boots on. Staff L removed blue boot off left foot. Both CMA and RN washed hands and donned gloves. Staff N placed the barrier sheet under Resident # 1 foot while she held up residents leg. Staff L put betadine on starting on the inside to outside, doffed gloves and used hand sanitizer. Staff N placed the blue boot back on. Both staff doffed gloves and washed hands. Area to left heel appeared open in the center.

An observation on 12/20/21 at 11:15 AM with Staff L RN looked at the heel today appeared the same as 12/15/21. Staff L stated it had a scab on it and she would have to notify the physician and

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family about the change. Agree area appeared open. Resident had blue boots on in bed.

During an interview on 12/20/21 at 11:21 AM with Staff N CMA/CNA explained she did not he whole heel. She explained the last time when doing a treatment it looked like a carpet burn not sure how long ago. Staff N stated the area not oozing or anything.

During an interview on 12/20/21 at 1:01 PM with Staff O Hospice Case Manager stated she observed the left heel on Tuesday 12/14/21 and it looked like an intact blister dark area covered in betadine. Stated they had not contacted her as of yet today to update her.

During an interview on 12/21/21 at 12:08 PM with Staff N CMA/CNA acknowledged she worked 12/6, 12/7 and 12/13 and the area on Resident # 1 heel looked like a carpet burn. Staff M explained when she helped Staff L on 12/15/21 it looked better.

During an interview on 12/21/21 at 12:24 PM with Staff A Nurse Consultant explained she would expect the CNA's to notify the nurse of a new skin area found or change. She did find a protocol and will provide it.

2. An MDS dated 11/1/21, documented that Resident #26 had a pressure ulcer.

On 12/16/21 at 12:07 PM, Staff J, Assistant Director Of Nursing (ADON) provided Skin Ulcer Assessment Sheets. Resident #26's wound was not monitored/assessed weekly after it was identified on 10/19/21 as a Stage 1. The next assessment was done on 11/5/21. The ADON

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stated she thought it was pretty good that there was only one missing due to all of the transitions that had happened.

Skin Sheet Ulcer Assessment Sheets for Resident #26 and provided by the facility showed the following:

On 10/19/21, a new area Stage 1 pressure ulcer was identified.
On 11/5/21, the area was documented as a stage 2 pressure ulcer and the MD was notified.
On 11/10/21, an assessment was done.
On 11/17/21, an assessment was done.
On 11/24/21, an assessment was done.
On 12/1/21, an assessment was done.
On 12/8/21, an assessment was done.
On 12/15/21, an assessment was done.

On 12/16/21 at 2:28 PM, Staff L, Registered Nurse (RN), wound nurse, stated they do weekly assessments on all of our skin issues, even skin tears and they especially do weekly skin assessments on pressure ulcers. When asked why one week would have been missed, Staff L stated that it would have been after Staff B, the former Director of Nursing left, the MDS and Staff J, ADON split up the tasks. Staff AA, the MDS nurse took over the ulcers, then Staff AA left. Staff L stated she didn't know much about that transition but it was her guess it was the reason a weekly assessment was missed.

On 12/20/21 at 3:43 PM, Staff AA, Licensed Practical Nurse (LPN), former MDS nurse, stated when Staff B moved to another facility, they wanted someone to take over measuring skin. Staff AA stated she only worked one day a week and would measure the wounds the one day that

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F 686	Continued From page 53 she did work. She stated that it got to where she wouldn't measure the wounds anymore because it got to where she couldn't keep up. Staff AA didn't know who had new wounds. She stated in the running log there was a guy who had ulcers on his toes from venous insufficiency. He was our biggest one. But if someone was to get a skin tear, she wouldn't get notified. Staff AA stated she would find out 2 weeks later that their skin tear was healed. She stated there was supposed to be a risk management done each time there was a skin area-skin tear, wound, or ulcer. Staff AA stated she wasn't being notified. Staff AA stated a risk management should have been done so they could have determined how it happened and then have it measured every week to monitor the area for healing. Staff AA stated that she would not stage a pressure. On 12/16/21 at 12:23 p.m., Staff A, Nurse Consultant, stated they do not have a pressure ulcer policy, they just follow the state regulations.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide adequate supervision to prevent accidents for 4 of 4	F 689	Past noncompliance: no plan ofcorrection required.	

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residents reviewed for smoking, falls and elopement (Residents #9, #22, #26 and #29). The facility failed to assess resident for Resident #9 and #22 for safe smoking, allowed Resident #9 to carry smoking material on her person, allowed Resident #9 to smoke unsupervised, and allowed resident #9 and #22 to smoke in an unsafe environment. The facility failed to utilize a gait belt and front wheeled walker during ambulation for 1 of 3 residents reviewed for falls (Resident #26) which resulted in a femur fracture. The facility failed to provide adequate door alarm system to mitigate Resident #29's elopement. The door alarm contained modes to be set, one of which prevented the alarms from being activated at all times. On 10/14/21 at 1:30 a.m., Resident #29 eloped out the front door. At 2:40 a.m., staff found Resident #29 outside on the ground. This resulted in Immediate Jeopardy to the residents' health and safety. The facility identified 8 residents who demonstrated independent mobility and wandered on 10/14/21. Resident #29 was not one of the 8 residents identified by the facility. The facility reported a census of 43.

Findings include:

1. SMOKING

The MDS assessment tool, dated 9/28/21, listed Resident #9's BIMS as 14, out of 15, indicating intact cognition. Resident #9 had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD), oxygen dependent and incontinence. Resident #9 is independent with bed mobility, transfers, and toileting; she requires set up assistance with eating. She is at risk for pressure ulcers.

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F 689	Continued From page 55 Clinical Record review of Care Plan, dated 10/11/21, revealed Resident #9, smokes on scheduled staff supervised smoke breaks and will go outside unsupervised to smoke. The Care Plan failed to address resident safety for independently smoking and the possessions of cigarettes and lighter quarterly and annually. Facility policy titled, Safe Smoking Policy, with the following dates of 12/28/12, 1/7/13, 8/7/14, 10/29/14, and 2/3/15 indicate Resident #9 is able to smoke independently. The policies failed to document Resident #9 cigarettes and lighter kept in her possession. During an interview on 12/13/21 at 11:00 a.m., with Resident #9 revealed, she is able to smoke outside independently anytime and does not follow the posted smoking breaks the other residents follow. During an observation on 12/15/21 at 10:13 a.m., Resident #9 demonstrated a cigarette case with four cigarettes and lighter in her possession. Resident #9 stated she was unsure if she signed a facility smoking consent or not. During an observation on 12/15/21 at 10:30 a.m., Resident #9 exited the facility to the courtyard covered in leaves. A pile of leaves by the door was approximately 2 feet in depth and within the cigarette butts receptacle. Resident #9 stated the leaves have been present for the past 1-2 years. During an interview on 12/21/21 at 11:13 a.m., with Assistant Director of Nursing (ADON) revealed Resident #9 may keep her cigarettes	F 689		

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and lighter with her, documented on her smoking assessment. ADON stated Resident #9 might smoke at any time. ADON stated she did not know who was responsible to pick up leaves.
2. SMOKING

The annual MDS dated 10/19/21 for Resident #22 reported a BIMS score of 7 which indicated sever cognitive impairment. The MDS documented diagnoses of non- Alzheimer's Dementia, asthma, chronic obstructive pulmonary disease or chronic lung disease and nicotine dependence (cigarettes). The MDS failed to document resident as a current tobacco user.

Resident #22's Care Plan dated 11/16/20 included focus area of ADL (Activities of Daily Living) self-care deficit and potential respiratory abnormalities related to nicotine dependence. Included interventions for smoker and go out for routine smoking times with supervision from staff and cigarettes and lighter are stored with the nursing staff. The Care Plan also included an area of confusion due to dementia, amnesia, symbolic dysfunction and mild cognitive impairment and directed staff to monitor behavior and redirect as needed.

The last documented Smoking Assessment dated 7/28/21 for Resident #22 included she had a cognitive loss, she smoked 2-5 times a day, she needed supervision and could not light her own cigarette and the facility stored her cigarettes and lighter. The facility failed to update the Smoking Assessment with the annual MDS.

Observations revealed on 12/13/21 at 3:16 PM Resident #22 standing in the lobby to go outside

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to smoke. At 3:29 PM staff took residents out to smoke. Resident # 22 sitting in a chair spaced out 1 resident with apron on it. Staff have a lock box with the cigarettes in it. Area full of leaves by the fence and within feet of the red smoking receptacle.

Observation on 12/14/21 at 9:42 AM, revealed the smoking area had fallen leaves swept off the patio area but piled up along the fence only about 3 feet from the red receptacle.

During an interview on 12/27/21 at 1:44 PM with Staff A, Nurse Consultant, thought maintenance would be responsible for keeping the leaves out of the smoking area.

During an interview on 12/27/21at 2:03 PM Staff G Maintenance stated he thought he was responsible for making sure the leaves were out of the smoking courtyard. He stated he had not moved any leaves for some time.

The undated Resident Smoking Policy included the following:

a. Smoking inside the facility is expressly prohibited.

b. This policy applies to cigarettes, cigars, pipes and/or any other materials that requires fire. This also includes electronic or vapor cigarettes.

c. A smoking evaluation with care plan interventions addressing safety issues must be completed upon admission quarterly, annually and for a change in condition assessments.

d. A copy of this policy must be completed and

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signed by the resident and or the resident representative upon admission, and as needed which confirms understanding of the smoking policy and schedule.

e. Following the completion of the smoking evaluation and acknowledgement of the policy, residents will be allowed to smoke in the designated smoking area with the supervision of a family member or other representative. No resident is authorized to smoke independently, they must be supervised by staff, family or another representative. When staff are providing supervision, smoking will only occur at times designated by the facility.

f. The designated smoking area is the resident courtyard.

g. All tobacco products including smoking tobacco, matches, lighters or other smoking paraphernalia will be kept by family members, or maintained by facility staff stored in a secure location. Residents may not sore smoking materials or supplies on person, in their belongings, or in their room, the reside twill be reevaluated and may not be allowed to continue smoking privilege id deemed unsafe. The facility will provide lighters to be used so residents do not need to purchase lighters. Residents are responsible to purchase all other smoking materials.

h. Oxygen is prohibited in smoking areas for the safety of residents.

i. Administrative/Clinical staff may also deny resident s the privilege to smoke for any other safety concerns such as inclement weather.

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j. At any time this it is deemed unsafe for the resident to be smoking, even with the use of interventions, he/she will not be allowed to do so.

4. ELOPEMENT

A MDS dated 10/10/21, documented diagnoses for Resident #29 included cancer, stroke, and non-Alzheimer's dementia. A BIMS score of 5 out of 15 indicated that resident had severe cognitive impairment. Limited assist of 1 was required for transfers, walking in room and corridor, and locomotion on and off the unit.

A Witnessed Fall Report dated 10/14/21 documented that Resident #29 got up from the dining room table and walked to the front door and went outside. The CNA followed resident outside and tried to get him to come back inside. The resident refused and kept walking, stepped off the side of the concrete on to the grass where he fell, landing on his buttocks. CNA called for help via walkie and nurse went out to assess the resident. No hip rotation, no visible injuries. Resident denied pain or discomfort. After assessment completed, writer and CNA helped resident to stand up to his walker. Resident was able to walk with walker without reports of any discomfort. His range of motion was within normal limits. The resident was upset at staff for making him come back inside because he wanted to "leave in his car".

An Elopement Risk Assessment dated 8/19/21 at 1:44 PM, scored resident at a 0 which indicated low risk for elopement.

An Elopement Risk Assessment dated 10/14/21

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at 9:45 AM, scored resident at a 3 which indicated high risk for elopement.

A Focus area in Resident 29's care plan, documented that this resident was an elopement risk related to an actual elopement on 10/14/21. The goal was that the resident would not leave facility unattended through the review date. Interventions included this resident wore a Wanderguard, to check placement and function of Wanderguard as ordered, and medication review by the primary care provider.

A Progress Note dated 10/14/21 at 2:27 AM, labelled this entry as a behavior note and documented that a staff CNA reported that the resident got up from the table and walked to the front door and went outside. The CNA followed the resident outside and tried to get him to come back inside. The resident refused and kept walking, stepped off the side of the concrete on to the grass where he fell, landing on his buttocks. The CNA called for help via a walkie and the nurse went out to assess the resident. No hip rotation, no visible injuries. Resident denied pain or discomfort. After the assessment was completed the writer and the CNA helped the resident to stand up to his walker. The resident was able to walk with walker without reports of any discomfort. Range of motion was within normal limits. The resident was upset with staff for making him come back inside because he wanted to "leave in his car." Fax was sent out to primary care provider and the Assistant Director of Nursing and administrator were aware.

Progress Note dated 10/14/21 at 10:25 AM, documented that a Wander Guard was placed on resident's right ankle without any problems. This

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resident was friendly and compliant at the time.

A Progress Note dated 10/14/21 at 10:30 AM, documented that a call was placed to this resident's daughter. She was made aware of the resident exiting the building and fell outside of the building. The resident was redirected into the building with staff assist and a FWW, without injury. No concerns voiced regarding resident exiting the building and fall.

A Progress Note dated 10/15/2021 at 8:47, documented that resident's daughter returned a call to the facility and discussion was held regarding moving Resident #29 to the CCDI unit for elopement concerns per order from the primary care provider. The daughter was in agreement and voiced no concerns.

A Progress Note dated 10/15/21 at 11:17 PM, documented that a call was placed to resident's daughter for further discussion regarding resident moving to the CCDI unit. Orders were received to discontinue resident transfer to CCDI unit after the Interdisciplinary Team reviewed. Resident's daughter was in agreement.

On 12/13/21 at 1:26 PM, an observation revealed the CCDI (Chronic Confusion and Dementing Illness) unit door alarm sounded after the door was opened and before the door shut. Keypad on both sides of the door. The code was put in prior to the door being opened.

On 12/14/21 at 3:30 PM, observation of exit doors revealed the following:

a. A door alarm with an added pull string alarm was at the front door. Both Staff A and Staff D,

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stated the door alarm sounds differently for the WanderGuard then it does for people without a WanderGuard. The front door did not sound with the WanderGuard. Both the door and the pull alarm sounded but not a different sound for the WanderGuard.

b. Checked doors at the end of the open unit hallways (north and south doors). Both sounded when opened. Both required a key code to disarm the alarm.

c. Door to courtyard from the open unit was not locked nor did it alarm. The courtyard is enclosed. They leave the door unlocked year round.

d. There was a door to a separate courtyard from the common area in the CCDI unit. This door was locked and would not open without entering a code. The code is written above the door. The door took some maneuvering by staff to get it to open after the code was put in. This courtyard was enclosed and paddle locks were noted on the gates. The fence is approximately 7 foot tall around both courtyards.

e. The exit door down the resident room hallway on the CCDI unit sounded when opened. There was also a keypad on this door.

f. There is a staff entrance door from the back parking lot. This required a code and will set off an alarm if door opened without the code. Staff D had a WanderGuard bracelet with her when checking the doors and this door sounded differently when the WanderGuard was close to the door.

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On 12/15/21 at 10:45 AM, Staff G, Maintenance Assistant, stated he was employed for 4 or 5 months. Staff G stated he was responsible for doing the checks on alarms, magnetic door locks, entries, exits, and the electric lock door in the infirmary. Staff G stated he had not had any issues with doors. He stated the doors had been getting a little old and finicky. Staff G stated they just went and replaced the alarms on the main door and the 2 North and South doors.

A Work History Report printed on 10/14/21 at 8:51 PM, and provided by Staff G, showed the doors were check on 10/12/21 by Staff G.

A Logbook Documentation, documented that on 10/12/21, Staff G tested the operation of doors and locks. The checks took 45 minutes.

On 12/15/21 at 10:53 AM, Staff D stated the former NHA (Staff CC) had told Staff D that the front door alarm was set on the wrong setting. It was set to sound on day shift but not night shift.

On 12/15/21 at 3:04 PM, voice message left for Staff CC, requested a call back.

On 12/16/21 at 1:54 PM, Staff GG, CNA, stated she was working on the locked unit that night, so she was not working with Resident #29 but she heard about the incident. Staff GG stated there was only 1 CNA on the unlocked unit and that was Staff HH, CNA. Staff AA, Licensed Practical Nurse (LPN) was the nurse covering both units that night. Staff GG stated that Resident #29 had not tried to exit before when she had worked with him but she could see that he would do that, as at that time Resident #29 would walk up and down the hall. Staff GG stated she no longer works at

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the facility. Staff GG stated she had left the facility about 3 months prior to this interview. Staff GG stated there were a couple of resident who wore Wander guard in the front open unit. Staff GG was asked if she had heard an alarm go off that night, she was in the back (locked unit/CCDI) and didn't hear anything. She stated that there is usually an alarm that goes off and that was weird because there was not an alarm going off. The first story she heard was nobody knew how he got out there and the second story was that Staff HH had gone out there with the Resident #29. Staff GG stated the day before she had heard the front door alarm sound. She was working on second shift on that day, so it was working then. She did not know if someone messed with the alarm or not.

12/16/21 at 3:08 p.m., Staff II, Stanley Technical Support (contracted), stated he was contacted by the facility as the facility had an elopement for a resident who was not wearing a tag. He stated a tag is a Wanderguard device. The alarm at the facility was set on day mode. Staff II stated that the day mode does not refer to the time of day or a shift nor does the night mode. Staff II stated that when an alarm is set on day mode it will only sound when a resident with a tag opens the door. He stated if a resident not wearing a tag opened the door, when it was set on day mode, the alarm would not sound. Staff II stated he remotely changed the alarm from day mode to night mode. He stated when the system is set on night mode the alarm will sound every time the door is open without a code being entered no matter if a tag is worn or not. He stated that staff, visitors or residents with or without a tag would cause the alarm to sound if the door is opened without the code being punched in prior to opening the door.

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F 689	Continued From page 65 Staff II remotely changed the mode from day to night. The facility provided an email to Staff CC from Stanley Technical Support dated 10/14/21 at 1:59 PM which documented that this was a ticket update notification from Stanley systems. The ticket is closed. Should we mistakenly closed the ticket you can simply reply to this email with your comment or call us. On 12/20/21 at 3:27 PM, Staff AA, LPN- Staff GG stated she was having behaviors on the CCDI unit. Staff AA went down there and when Staff AA was coming back up the hallway from the unit, Staff HH had locked himself outside with Resident #29. Staff HH went outside to get Resident #29, and went out the front door and the doors lock behind him and they could not get back inside. Staff AA went outside and Resident #29 had fallen into the grass near the building. Staff AA assumed this resident fell because he was on different ground as he would have walked off of the cement. Staff AA helped get this resident up. The way Staff AA understood it was that Resident #29 walked out with Staff HH and that's when this resident fell. Staff AA stated that Staff HH was hard to understand. Staff AA stated that later it came out that Staff HH had watched Resident #29 go out the doors, but Staff HH was not with this resident when this resident went out the front door. Staff AA stated that it had been so long since she had heard the alarm. She stated they do not have a lot of people trying to get out the doors. Staff AA believed housekeeping checks the doors daily. Staff AA stated she was told there were issues with the doors before this incident happened. Staff AA stated the issue was the doors were not alarming if a resident was	F 689		

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near the door or pushed the door open they. Staff AA stated the only doors that should make noise are the inside doors with Wanderguard . She stated the doors should alarm no matter what. Staff AA had heard administration knew about the doors not working but she did not believe that. Staff AA thought it was one of those deals that they would work part of the time and the part time that the doors alarmed would have been when family would come in and they would screen them before they could get through the interior doors. Staff AA stated if family would try to come in, it would set the door alarm off. Staff AA mainly worked day shift and then she worked night shift. Staff AA stated that is when she heard Resident #29 would wander some at night and she observed Resident #29 wandering. Staff AA stated one reason she had have chosen to not work PRN anymore is because Staff HH should never work alone. He was a good worker. They told me they would never put Staff HH alone up front, then that night happened. Staff AA stated she has not been back there since. Staff AA stated that at nights the nurse may have to go back to the CCDI and that would leave one CNA out there alone. She stated it was too much responsibility. Staff AA stated there were approximately 35 residents up front. She stated only resident that she dealt with that wandered at night was Resident #29. She stated she wanted to put Resident #29 in the back (CCDI) prior to him going out the front door. Staff AA stated she got an order for him to transfer to the back. Staff AA stated she was told you really can't move him to the back because it could agitate him more and could cause aggression in the back. Staff AA stated she did not remember it being cold or anything outside that night. Staff AA supposed it was maybe jacket weather.

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On 12/20/21 at 6:16 PM, Staff CC, former NHA, stated she remembered the incident but did not have access to her notes. The NHA stated she remembered in the beginning of the day, getting a message that Staff AA had left for her. The message had said that Staff HH had gone out the door with Resident #29. Staff CC stated that she then got to the facility and notified Staff D. Staff CC stated then Staff AA sent text messages and said the door alarm wasn't working. Staff D found Staff HH's witness statement on the copy machine around 11:30 AM-noon. The witness statement looked like Staff HH didn't see the resident go out the front door. Staff CC believed it was within 15-30 minutes from the time Staff HH last saw this resident to the time Staff HH found this resident. Staff CC believed that Staff HH had searched the building twice. Staff CC and Staff D immediately went over to the door. Staff CC stated that sure enough the alarm was not working. Staff CC stated the alarm wasn't working from the time that Staff HH discovered it until Staff CC read Staff AA's text around noon. Staff CC stated they put Resident #29 on checks and an assessment was done. Staff CC stated they reached out to Stanley who called back within a few hours. Staff CC immediately reset the door. It was on day mode and not night mode. Staff CC stated there was a difference about the day mode and night mode. Staff CC stated she set it on the night mode where it has a red button/light on it. Staff CC said their resource center had them call Stanley to be sure the alarm was functioning at that time. Staff CC stated she made a decision at the time to change the code because before it was a 3 digit code to open the door and the code that goes to night code was a 4 digit code with only one number off between the

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2 codes. Staff CC talked with Stanley and Staff II checked and saw the alarm was working as designed. Staff CC could not change the 4 digit code per Stanley but could change the 3 digit code, so she changed it to 3 completely different numbers. Staff CC stated that her intuitive thinking took me there. Staff CC thought someone accidentally hit the 4th number, changing it from night mode to day mode. Staff CC stated the day mode activates WanderGuard. If it's in night mode it goes off anytime anyone opens it inside and out. There is a 3 digit code you can touch to shut off the alarm to get in and out of the door. The day/night code had 1 number difference otherwise 3 numbers were chronologically the same, if she was remembering correctly. Staff CC stated it should be on day mode for the WanderGuard to work, but the facility had always kept the front door on night mode. Staff CC stated the door would have been on day mode when the resident eloped. The resident did not wear/was not care planned for a WanderGuard device at the time of the elopement. Staff CC stated she did not like the design. If the color is red on the alarm, that means it will always alarm when the door is opened (night mode). It won't detect a WanderGuard. It will just sound whether a resident or non-resident is wearing a WanderGuard or not. She stated the code is on the inside of the staff entrance (a different door), up high. This door is on day mode but is locked so a code is required to go through the door at any time and will alarm if the door is opened and the code wasn't punched in first. The day mode and night mode do not correlate to the time of day.

1/04/22 at 8:28 AM, Staff CC stated she submitted an email report to DIA initially within 24

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hours for the elopement.

On 12/21/21 at 10:02 PM, Staff HH stated Resident #29 sometimes came out of his room to hang out in the dining room. Staff HH stated Resident 29 would get up and sometimes sit in the couch or chair in the common area. Staff HH stated he did not have good peripheral vision. Staff HH got up to start rounds and Resident #29 was at one of the tables and he was walking toward the door and Staff HH thought he was going to one of the seating areas where Resident #29 sometimes sits. Staff HH was charting when Resident #29 was walking toward the seating. Staff HH stated it was about 1:30 or 2:00 AM. Staff HH wrote a little report so that should be more accurate. Staff HH was sitting at a table behind this resident when this resident walked toward the couch. Staff HH didn't even think Resident #29 would go out the door. Staff HH stated Resident #29 had never tried to go outside or never said he was going to go outside. Staff HH stated that Resident #29 was not exit seeking. Staff HH was charting and Resident #29 was out of Staff HH's line of sight. Staff HH stated that he was going to start his rounds but then intuition kicked in and he thought he'd better check on Resident #29. Staff HH stated Resident #29 was not over in either seating area. Staff HH stated he checked the halls and Resident #29's room and other resident's rooms and could not find Resident #29. Staff HH stated he did that twice. Staff HH stated he then walked outside to see if he had gone out there. Staff HH had his walkie with him. Staff HH stated that Resident #29 had walked down the side of the building and Staff HH found Resident #29 sitting on the grass. Staff HH stated he thought this resident was trying to stand up. Staff HH stated he tried the

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walkie a couple of times, but it must have been out of reach. Staff HH then tried to go inside but the door was locked. Staff HH stated he used his cell phone to call the facility and Staff AA answered the phone. Staff HH stated that Staff AA came out and she made sure the door was not going to lock on them. Staff HH stated that they both walked out and assessed Resident #29. Staff HH stated Resident #29 was rubbing his right knee a little bit and this resident's knee was slightly red. Staff HH then stated there might have been some redness. Staff HH stated they helped Resident #29 to stand up. Staff HH and Staff AA then walked Resident #29 inside and Resident #29 did say something about his car. Staff HH stated they told Resident #29 his daughter was taking care of his car, she had taken it to the shop and Resident #29 calmed down. Staff HH stated Resident #29 was just slightly agitated about his car and Resident #29 wasn't hurt. Staff HH stated that Resident #29 had never asked about his car before. Staff HH stated that he and Staff AA then realized the door alarm didn't work. Staff HH stated he and Staff AA took Resident #29 back to bed and he was totally fine the rest of the night. Staff HH stated that Resident #29 said he wasn't hurting. Staff HH stated he made sure Resident was still in bed as he kept peeking in there at this resident. Staff HH stated this resident fell where the concrete ended, where all the chairs are at when you turn right when you go out the front door. Staff HH stated this resident did not fall down the hill. Staff HH stated there is a little hill out there. Staff HH believed the nurse at least checked on the alarm to see why it didn't go off. Staff HH had asked her to check to make sure that he just didn't hear it go off. Staff HH was later told that he should have had the nurse initiate the search and not

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him. Staff HH stated he only started looking for Resident #29 because the nurse was in the back in the unit. Staff HH stated he understood why he should have had the nurse initiate the search as he had locked himself out. Staff HH stated he was hard of hearing. Staff HH stated it was just Staff AA, himself and then whoever was in the Lodge (CCDI) the night this resident went outside. Staff HH stated that back then he was normally working with just one nurse and then a CNA was in the back. He stated that now they normally have 2 CNAs. Staff HH the alarm has been working since then. A resident pushed on the door when she was wandering around and the alarm sounded. Staff HH stated he heard it. Staff HH stated that Resident #29 and another resident are up at nights. Staff HH stated that the weather was mild outside that night. He stated it wasn't like freezing, it wasn't cold because he would have grabbed a coat prior to going outside. Staff HH stated it was about 15 minutes from when he last saw Resident #29 walking toward the front seating area to when he found him outside.

An Investigation Questions form documented the date/time of the incident was 10/14/21 at 1:30 PM, and documented that Staff CC and Staff D interviewed Staff GG. Staff GG had not heard anything about the incident until after the shift. What Staff GG heard was Staff AA had told her that while she was busy, Resident #29 was outside with Staff HH. Staff GG stated she did hear Staff HH paging, saying something like repeating Staff AA's name and saying best friend or buddy? He did not indicate an emergency. Staff GG was in the lodge (CCDI) unit doing rounds. She did not assist with the incident as at the time she did not know what was going on.

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Staff GG asked if Staff HH followed Resident #29 out the door, that wouldn't be an elopement, would it? Staff GG stated she had heard that Staff HH had followed the resident out the door. Staff B signed the form on 10/14/21 at 2:02 PM. Staff CC signed the form at 10/14/21 at 4:02 PM.

An Investigation Questions form documented the date/time of the incident was 10/14/21 at 2:27 PM, and documented that Staff CC and Staff D interviewed Staff AA. Staff AA stated that Staff HH stated that a resident went out the front door. Staff HH stated he was "right on his tail" and Staff HH tried to get resident back into the building, resident was difficult to redirect and fell with his walker. Staff CC documented that Staff HH called the facility from outside the front door had been and that she did not witness the incident. Staff AA stated she walked to the front of the building from the CCDI unit and the phone was ringing. Staff HH was on the phone stating that he was out front of building with resident and they were locked out. Staff AA had been on the CCDI unit putting away medications from pharmacy delivery. Staff AA assisted resident back into the facility after identified there were no injuries. Staff AA completed a head to toe assessment and took vital signs. Staff AA notified Staff CC and the Assistant Director of Nursing of the incident and door alarm not sounding. Staff AA sent a fax to the primary care provider. Staff AA reported that Staff HH had told her that the resident got up from a recliner chair and went to the door. Staff B signed the form on 10/14/21 at 3:45 PM. Staff CC signed the form on 10/14/21.

An Investigation Questions form documented the date and time of the incident was 10/14/21 at 1:30 AM, and documented that Staff B and Staff

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CC were the interviewers. Staff HH reported that he did not hear anything but noticed that Resident #29 had got up from the table and walked away. Staff HH thought the resident was going to sit on one of the couches and when he checked on the resident, the resident wasn't there. Staff HH reported he searched every room twice and went out the front door to look as he did not hear an alarm. When Staff HH checked outside he saw Resident #29 on the ground. Staff HH reported it to the charge nurse. Staff B and Staff CC did not sign or date the form.

An email from the State Climatologist of Iowa and dated 12/21/21 at 9:29 AM, documented the weather in that area on 10/14/21 at 2:40 AM, was as follows:

Temperature: 54 degrees Fahrenheit
Relative humidity: 62%
Winds out of the WSW at 6 mph
Overcast skies
No precipitation detected
No wind chill temperature

A Resident with Wander Guard list provided by the facility during the survey named the following residents to have Wander Guard devices and the date they were placed:

a. On 10/9/21, Resident #12.

b. On 4/30/21, Resident #41.

c. On 1014/21, Resident #29.

The facility provided a list of 8 residents who demonstrated independent mobility and wandered on 10/14/21.

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F 689	Continued From page 74 On 10/14/21, the facility implemented the following: a. A secondary alarm to the front door. b. Changed the door code to prevent staff from being able to change the door modes and ensure it remains active at all times. c. All staffreceived education on missing resident process and process for non-functioning door alarms. d. An audit of all exit doors and door alarms to ensure proper function. e. An elopement drill conducted with all staff on shift. f. Plan to continue elopement drills once a week to ensure compliance for 4 weeks and then monthly. g. All residents reviewed for elopement risk and appropriate interventions put into place. h. Facility to audit for proper functioning door alarms every shift for 14 days and then daily to ensure continued compliance. The State Agency informed the facility of the Immediate Jeopardy on December 21, 2021 at 4:45 p.m. The facility removed the immediate jeopardy on October 14, 2021, prior to this survey. Compliance was verified during the survey. The removal resulted in past noncompliance.	F 689		

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F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on clinical record review, competency review, policy review, observations and staff interviews the facility failed to follow physician orders regarding enteral feeding via Percutaneous Endoscopic Gastrostomy (PEG) tube and Head of Bed (HOB) being elevated for 1 of 1 residents reviewed for PEG tube (Resident #21). The facility reported a census of 43. Findings include: The quarterly Minimum Data Set (MDS) dated 12/14/21 for Resident #21 reported moderately	F 693	In continuing compliance with F 693 Tube Feeding Mgmt/Restor Eating Skills, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff "S" on 1/11/2022 by Clinical Nurse Specialist on proper tube feeding management and Head of Bed elevation for resident # 21 and all like residents. To correct the deficiency and to ensure the problem does not recur, nursing staff were educated by 1/13/2022 by Clinical Nurse Specialist on following physician orders regarding enteral feeding by PEG tube and HOB being elevated per physician's order. The DON and/or designee will audit administering medications via g-tube and HOB positioning 3x weekly x 4 weeks, then 2x/weekly x 2 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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impairment for cognitive skills for daily decision making. The MDS included diagnoses of diabetes mellitus, aphasia, malnutrition, and depression and received tube feedings.

Resident #21's Care Plan included a focus area of alteration in nutrition due to malnutrition and nothing by mouth and received artificial feedings. The care plan directed staff to check residual before administration and to keep head of bed elevated 45 degrees at all times.

Resident #21's clinical record included a fax with a date and time stamp of 11/22/21 at 1:57 PM from the physician pertaining to Resident #21 order details included the following:
Order date 10/19/21 for enteral feeding every day shift form 6 AM to 6 PM Glucerna 1.2 at 80 ml/hour x 12 hours continues. Using kangaroo pump total 960 ml, signed 12/22/21 and noted 11/24/21 and 12/8/21.

Resident #21's clinical record included a fax notification to the physician that stated Resident takes potassium phosphate -sodium phosphate 250 mg -45mg-298mg tablet to dissolve in water. Could this be changed to liquid form with orders? She has a G-Tube. The physician responded ok-please ask pharmacy for liquid equivalent and dose recommendation. Signed and dated 12/15/21.Per Pharmacy phos-Nak Packet 280-160-250 mg dilute in warm water. The fax had been noted and MAR changed on 12/15/21 at 1:56 PM.

Resident #21's Order Summary Report dated 12/13/21 included the following:

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F 693	Continued From page 77 a. Enteral Feeding Order every night shift, Glucerna 1.2 @ 80 ml/hr for 12 hours. Kangaroo pump total 960 ml, with a start date of 10/25/21. b. Elevate Head of Bed (HOB) 45 degrees during enteral feeding and for 2 hours after feeding completion. Every day shift with a start date of 10/18/21. c. Check gastric residual before feeding administration if more than 100 ml hold feeding and notify physician, with a start date of 10/19/21. d. Check gastric residual volume every 4 hours during tube feeding and as needed, with a start date of 10/19/21. e. Flush PEG tube with 150 ml of water before and after tube feeding twice a day, with a start date of 10/25/21. f. Flush PEG tube with 30 ml of water before and after each medication administration, with a start date of 7/23/20. g. May administer medications together via PEG tube with 30 ml of water each medication pass, with a start date of 6/3/21. h. Check placement of PEG tube with each use, with a start date of 7/22/20. Resident #21's MAR dated for 12/21 included the following: a. Enteral Feeding Order every night shift, Glucerna 1.2 @ 80 ml/hr for 12 hours. Kangaroo pump total 960 ml, with a start date of 10/25/21.	F 693		

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F 693	Continued From page 78 b. Elevate Head of Bed (HOB) 45 degrees during enteral feeding and for 2 hours after feeding completion. Every day shift with a start date of 10/18/21. c. Check gastric residual before feeding administration if more than 100 ml hold feeding and notify physician, with a start date of 10/19/21. d. Check gastric residual volume every 4 hours during tube feeding and as needed, with a start date of 10/19/21. e. Flush PEG tube with 150 ml of water before and after tube feeding twice a day, with a start date of 10/25/21. f. Flush PEG tube with 30 ml of water before and after each medication administration, with a start date of 7/23/20. g. May administer medications together via PEG tube with 30 ml of water each medication pass, with a start date of 6/3/21. h. Check placement of PEG tube with each use, with a start date of 7/22/20. i. Potassium phosphate-sodium phosphate 250 mg-45mg-298mg two times a day with a start date of 10/19/21 and discontinued date of 12/15/21. j. Potassium phosphate-sodium phosphate 250 mg-45mg-298mg two times a day may dissolve in water with a start date of 12/15/21. k.Phos-Nak Packed 280-160-250mg (potassium	F 693		

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as sodium phosphate), give 1 packet via PEG tube two times a day dilute in 30 ml of water with a start date of 12/16/21

Resident #21's clinical record contained a document titled Enteral Feeding Flowsheet dated for October, 21(most current flowsheet in the record). The flowsheet contained the formula type and directions for rate and water flushes and to elevate the HOB up to 45 degrees during and for 2 hours after feeding.

The document titled Competency for Enteral Feeding updated 5/11/21 included the following:

a. Verify physicians order.

b. Prepare the feeding as directed by orders.

c. Gather equipment.

d. Explain procedure to resident.

e. Provide privacy

f. Wash hands and put on gloves.

g. Attach 60 cc syringe to enteral tube.

h. With 60 cc syringe attached to enteral tube, clamp enteral tubing and fill syringe with ordered water flush, unclamp and allow to free flow.

The Medication Administration policy updated 6/23/2020 directed staff to administer medications through a gastric (G) or nasogastric (NG) tub in a safe and appropriate manner as follows:

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a. Dilatant (such as NS, distilled water or tap water) (for flushing tube before and after medication) at room temperature.

b. Syringe (syringes should be changed every 24 hours).

c. Disposable gloves

Procedure:

a. Wash hands before touching formula or delivery system. Prepare surface and maintain clean technique. Wear gloves if necessary, to prevent contact with body secretions.

b. Explain procedure to resident and provide privacy.

c. Bring equipment to bedside, wash hands and put on glove.

d. Check Tube Placement and Patency.

e. Feeding tube should be checked for placement and patency prior to beginning a feeding and after episodes of vomiting or any suctioning, by the following methods.

i. Attach syringe to the end of the tube and gently try to aspirate gastric fluid, If gastric fluid is evident, instill gastric fluid into tube.

ii. If gastric fluid is NOT evident place a stethoscope over the upper portion of the resident's stomach. Attach the syringe to the tube and insert a small amount (10 to 20 ml (CC)) of air into the tube while listening for a swooshing or gurgling sound. If you do not hear this, it indicates

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that the tube may not be in the stomach, in which case the Charge Nurse and or physician should be notified.

f. Prepare medication as appropriate. Use liquid form of medication whenever possible. Thick solutions can be mixed with water if necessary. Check with pharmacy to see id medication is available in liquid form and whether tablets can be crushed. If tablets can be crushed, crush finely and mix with warm water. Do not mix medications with enteral feeding formula. Also check to see if medications can be given with tube feedings or should be given on an empty stomach and tube feeding withheld for a prescribed time interval before and after medication is given.
NOTE: Antacids should not be given at the same time as some other medications, such as antibiotics, so wait 30 to 60 minutes in between.

g. Administer medication with syringe slowly and steadily. (Extent the elevation of the syringe will determine the flow rate). If more then one medication is to be administered, give each one separately and rinse the tube with 5 ml (cc) of warm water in between medications.

h. Flush tube with 20 to 30 ml (cc) of water before and after administering each medication. If resident is on continuous tube feeding, stop the feeding and clear the tube by instilling the dilatant before administrating the medication.

i. If the G or NG tube is attached to suction turn off suction and clamp tube for 20 to 30 minutes after medication administration so it is absorbed.

j. Remove gloves and wash hands.

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F 693	Continued From page 82 k. Document medication on the Documentation Record, Medication Administration and also record any fluid instilled if resident is on I & O During an observation on 12/14/21 at 8:00 AM Staff B Registered Nurse (RN) observing Staff S Practical Nurse (LPN) entered Resident #21's room with feeding pump sounding. Her HOB not to red line Staff S raised the bed up. The HOB approximant bed 9 to 12 inched below the red lines on the bed. The sign on the wall states to elevate the HOB up to the red line during feeding and 2 hours after feeding. Staff S disconnected the feeding tube instilled air and listened for placement and then checked for residual. Staff S then flushed the peg tube with 150 cc of water, and discarded the feeding and water bags along with tubing (that was not dated). Discarded the graduate dated 12/12/21 lowered the bed back down. Staff S raised HOB up to red line. The red line is in line with the mattress. Resident slid way down in the bed. Her head approximant 18 inched above the bend in the bed. Her head approximately about 24 inched from the top of the mattress. During an observation on 12/15/21 at 10:11 AM Staff B RN observing Staff L RN knocked on Resident #21's door and let Res know what she was going to do washed hands placed plate with medications on to barrier along with gloves and hand sanitizer and donned gloves. Residents HOB up and her head about 24 inched form the top. Staff L after instilling medications rinsed off syringe and doffed gloves washed hand. Mattress at the red line. During an observation at 12/20/21 at 5:52 PM Staff X RN entered Resident #21's room to administer medications and start her tube	F 693		

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feeding. HOB elevated the mattress is at the red line.

During an observation on 12/21/21 at 9:13 AM Staff D Nurse Consultant measured Resident #21's bed using an protractor the bed frame is at 45 degrees and the mattress is at 30 degrees and Resident # 21 is up higher then observed for days. Staff D explained that is where the Staff R Speech Therapist explained the red lines measured 45 degrees at the mattress. The sign in the room stated to Elevate the HOB to red line during feeding and 2 hours after feeding. The sign in the room is unclear.

During an observation on 12/21/21 at 12:12 PM Staff D Nurse Consultant measured bed at the red lines and mattress measured 36 degrees and resident about 24 inched down from the top of the bed.

During an observation on 12/22/21 at 9:37 AM Sign on Resident #21's wall stated Keep Head of Bed elevated at least 45 degrees during feeding and after feeding until 9 AM. May lower HOB during cares. If during cares at night notify nurse to pause feeding first, along with a picture to raise the bed frame to the red tape. HOB at 45 Degrees.

During an interview on 12/16/21 at 12:12 Staff D Nurse Consultant stated she could not find a tube feeding order just the conversation with Staff W Physician about the changes.

During an interview on 12/20/21 at 9:39 AM Staff W Physician stated her intentions were to have Resident #21's tube feeding during the day. Her blood sugars were all over the place and she had

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insomnia. Why would you disturb her sleep and also they had more nurses during the day to better assist with Resident #21's needs.

During an interview on 12/20/21 at 10:38 AM with Staff R Speech Therapist acknowledged she put the lines on the bed with red tape it should be the mattress surface at the red line since the mattress could change.

During an interview on 12/20/21 at 10:19 AM Staff D Nurse Consultant explained she talked with Staff W Physician about the change for Resident #21 to work with therapy. Staff D stated it would take too long to complete the tube feedings. Staff D looked at the red tape marks and thought therapy put the lines on the bed and the note on the wall.

During an interview on 12/16/21 at 10:24 AM Staff V Physician returned call stated he had received a fax from the facility yesterday about changing Resident # 21 potassium phosphate-sodium phosphate 250 mg-45mg-298 md tabled to dissolve in water BID asking if could be changed to liquid form with orders. Please give with orders she has G-tube. He confirmed he responded back ok please ask pharmacy for liquid equivalent and dose recommendations faxed back to facility. Let him know they did get pharmacy recommendation of phos-nat packed 280-160-250 mg dilute in 30 cc warm water. He stated good but had not okay that order as of yet he was out of the office and maybe it was waiting for him. He acknowledged he talked to the facility this morning 12/16/21 about a different order that had been mention to be discontinued in a progress not from Staff W physician back awhile. He stated he wanted mirtazapine to be continued

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since she has other indications. Explained the potassium phosphate-sodium phosphate 250 mg-45mg-298 md ordered by mouth since returning from the hospital back in October. He acknowledged he would expect the order to have been clarified back when Resident #21 returned from the hospital since she had a g tube. When asked about the change of feeding to overnight to day explained someone else in his office could have handled that he could not remember any conversation about the change. He also explained a couple of months ago duties at his office shifted.

During an interview on 12/21/21 at 8:45 AM Staff D Nurse Consultant when shown the order for tube feeding it was signed by doctor and noted but not changed on the MAR. Staff D did not think it was a system failure. She did explain the order should have been clarified since the original date was over a month ago but not changed in the MAR or clarified. Staff D not sure why this order was in the chart and where it came from. When asked about the last change to potassium - sodium phosphate. Stated Staff V physician stated ok please ask pharmacy for liquid equivalent and dose recommendation. Staff D stated that the information must be faxed out for the physicians okay. When asked why the order had been changed on the mar before the physician knew about it. Staff D had no answer. The order already in the book to be noted a 2nd and 3rd time without being faxed back to physician.

During an interview on 12/21/21 at 3:12 PM with Staff D Nurse Consultant and Staff B RN had a new sign printed for Resident # 21 room waiting

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F 693	Continued From page 86 for approval from the physician before hanging it up. They both stated had talked with therapy about the sign on the wall. Therapy agreed the sign miss leading and needed changed. During an interview on 12/30/21 at 10:00 AM Staff Y RN stated the feeding flow sheets should be in Resident # 21 chart she would ask Staff K Corporate Administrator. During an interview on 12/30/21 at 10:09 AM Staff K Corporate Administrator explained according to Staff RN stated the flow sheets should be in the chart. Staff K explained staff had signed off on the MAR but not completing a flow sheet consistently. During an interview on 12/30/21 at 10:53 AM Staff K Corporate Administrator explained did not have a separate feeding tube police but they had the protocol for the feeding tube competency for enteral Feeding and everyone should be following. Staff K explained he did not think they had a separate policy for feeding with a pump.	F 693	In continuing compliance with F 695 Respiratory/Tracheostomy Care and Suctioning, Accura Healthcare of Pleasantville corrected the deficiency by changing resident #9, #15, and all like resident's oxygen tubing on 12/14/2021 by Clinical Nurse Specialist. All residents' oxygen orders were reviewed on 1/12/2022 by Clinical Nurse Specialist to ensure orders to change tubing weekly are in place. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on the process of changing residents' oxygen and nebulizer tubing per physician orders by 1/13/2022 by the Clinical Nurse Specialist. The DON and/or designee will audit oxygen tubing weekly x 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		

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F 695	Continued From page 87	F 695		

Based on observations, record review, and interview, the facility failed to date oxygen tubing for two of two residents reviewed on oxygen (Resident #9 and #15). The facility reported a census of 43 residents.

1.) The MDS assessment tool, dated 9/28/21, listed Resident #9's BIMS as 14, out of 15, indicating intact cognition. Resident #9 had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD), oxygen (O2) dependent. Resident #9 is independent with bed mobility, transfers, and toileting; she requires set up assistance with eating. She is at risk for pressure ulcers.

Observation of Resident #9 on 12/15/21 at 10:07 a.m. sitting in wheelchair at her computer with O2 on at 3L/NC. O2 tubing without date last changed, nebulizer tubing marked with date of 9/9/21 as last changed. Resident #9 stated she did not know when the nebulizer tubing last cleaned or tubing changed.

Observation of Resident #9 on 12/21/21 at 11:20 a.m. revealed Assistant Director of Nursing (ADON) changed oxygen (O2) tubing and dated. ADON stated O2 tubing is changed every Wednesday, staff document on electronic medical record (EMR).

Facility document titled Treatment Administration Record (TAR), dated 12/1/21-12/31/21 revealed:
a.) Change O2 tubing and sanitize O2 concentrator every week on Wednesday and change nebulizer set up and sanitize nebulizer machine every Wednesday.
b.) Documentation revealed the O2 and nebulizer tubing not changed 12/1/21

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F 695	Continued From page 88 Facility document titled TAR, dated 11/1/21-11/30/21 revealed: a.) Change O2 tubing and sanitize O2 concentrator every week on Wednesday and change nebulizer set up and sanitize nebulizer machine every Wednesday. b.) Documentation revealed the O2 and nebulizer tubing not changed 11/3/21 Facility document titled TAR, dated 9/1/21-9/30/21 revealed: a.) Change O2 tubing and sanitize O2 concentrator every week on Wednesday and change nebulizer set up and sanitize nebulizer machine every Wednesday. b.) Documentation revealed the O2 and nebulizer tubing not changed 9/22/21 During an interview on 12/13/21at 11:00 a.m., with Resident #9 revealed, her O2 is at 3 liters (L)/nasal cannula (NC) continuously via O2 concentrator. Oxygen tubing is not dated and resident #9 did not know when it was last changed. During an interview on 12/14/at 1:00 p.m., with Staff A, Licensed Practical Nurse (LPN), revealed, she is unsure how often O2 tubing is to be changed on residents wearing O2. During an interview on 12/14/21 at 1:39 p.m., with Staff A, Nurse Consultant revealed, the facility does not have an oxygen policy and the staff follow standards of care. She stated, "I think they change the tubing every 10 days or so." 2.) The quarterly MDS assessment tool, dated 10/12/21, listed Resident # 15's BIMS as 15 out	F 695		

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of 15, indicating intact cognition. Resident # 15 had a diagnosis of asthma or COPD, obstructive sleep apnea, and heart failure. He is oxygen dependent. Resident #15 is independent with bed mobility, transfers, toileting, and set up assistance with eating.

During an observation and interview on 12/13/21 at 10:05 a.m., with resident #15 while he sat at his bedside wearing O2 at 1.5L/NC via O2 concentrator. The O2 tubing not dated and resident #15 stated the staff forget to change it.

Observation on 12/14/21 at 11:45 a.m. revealed resident #15 sat at his bedside eating lunch. O2 was at 1.5.L/NC. O2 tubing not dated.

Observation on 12/15/21 at 9:26 a.m., resident #15 sat at his bedside coloring. O2 tubing dated 12/15/21.

Facility document titled, Care Plan, dated 10/25/21 revealed:
a.) Resident has oxygen therapy related to COPD. O2 via NC at 0.5L/NC
b.) Change tubing to oxygen weekly along with sanitize oxygen concentrator. Every day shift every Thursday. The facility lacked documentation of weekly O2 tubing change.

Facility document titled, TAR, dated 12/1/21-12/31/21, and lacked instruction and documentation of O2 tubing change.

Facility document titled, Physician Order, dated 7/23/21, revealed, change tubing to oxygen weekly along with sanitize oxygen concentrator. The facility lacked documentation of weekly O2 tubing change.

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F 695	Continued From page 90 During an interview on 12/14/at 1:00 p.m., with Staff A, Licensed Practical Nurse (LPN), revealed, she is unsure how often O2 tubing is to be changed on residents wearing O2. During an interview on 12/14/21 at 1:39 p.m., with Staff A, Nurse Consultant revealed, the facility does not have an oxygen policy and the staff follow standards of care. She stated, "I think they change the tubing every 10 days or so."	F 695		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	In continuing compliance with F732, Posted Nurse Staffing Information, Accura Healthcare of Pleasantville corrected the deficiency by educating the ED by the Regional VP of Operations on nurse staff posting requirements on 1/11/2022. To correct the deficiency and to ensure the problem does not recur, all nurses were educated by the Regional VP of Operations by 1/12/2022 on the process for updating and posting the daily staffing sheet. The Administrator and/or designee will audit daily staffing sheet for 4 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/12/2022

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F 732	Continued From page 91 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to update the staff working for 4 out of the 6 days of the survey. The facility reported a census of 43. Findings include: The daily staffing sheets provided by the facility the included the documents titled Daily Staffing Reports for 12/12/21, 12/18/21 and 12/20/21. The following observations revealed: a. On 12/13/21 04:05 PM, staffing posted by the nurses station with the date of 12/12/21. b. On 12/14/21 11:59 AM, staffing posted by the nurses station with the date of 12/12/21. c. On 12/15/21 08:49 AM, staffing posted by the nurses station with the date of 12/12/21. d. On 12/16/21 08:16 AM, staffing posted by the nursed station with the date of 12/12/21.	F 732		

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F 732	Continued From page 92 During an interview on 12/21/21 at 12:53 PM with Staff G License Practical Nurse (LPN) explained the night shift nurse changed the daily posting. During an interview on 12/21/21 at 1:08 PM with Staff A and Staff D Nurse Consultants, Staff D acknowledged the office manager would have the daily staff postings. Staff A stated they would print the midnight census and change the staff posting and give them both to the office manager. During an interview on 12/21/21 at 1:09 PM Staff I Business Office Manager explained she only found 12/12/21, 12/18/21 and 12/20/21 and stated she would asked the Administrator if he received them. During a subsequent interview on 12/21/21 at 2:06 PM Staff I acknowledged no on provided her the daily staff postings for the 12/12, 12/14, 12/15, 12/16 or 12/17.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	In continuing compliance with F 755 Pharmacy Services/Procedures/Pharmacist/Records, Accura Healthcare of Pleasantville corrected the deficiency by ensuring resident #21 and all like resident's tube feeding orders have been clarified to be administered via the correct route by 1/4/2022 by Clinical Nurse Specialist. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on ensuring proper route of medication administration as well as following and clarification of physician orders by 1/13/2022 by Clinical Nurse Specialist. DON and/or designee will audit g-tube medication administration 3x/weekly x 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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F 755	Continued From page 93 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, observation, physician interview and staff interview the facility failed to clarify medication orders to give via a Percutaneous Endoscopic Gastrostomy (PEG) tube instead of by mouth for 1 of 1 residents sampled for pharmacy services (Resident #21). The facility reported a census of 43. Findings include: The quarterly Minimum Data Set (MDS) dated 12/14/21 for Resident #21 reported moderately impairment for cognitive skills for daily decision making. The MDS included diagnoses of diabetes mellitus, aphasia, malnutrition, and depression and received tube feedings. Resident #21's Care Plan included a focus area of alteration in nutrition due to malnutrition and	F 755		

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nothing by mouth and received artificial feedings. The care plan directed staff to check residual before administration and to keep head of bed elevated 45 degrees at all times.

The December Medication administration Record (MAR) for Resident #21 included the following medications:

a. Famotidine Tablet 20 milligrams (mg) Give 1 tablet by mouth one time a day for heartburn with a start date of 5/22/21.

b. Calcium-Vitamin D tablet 600-400 mg-unit, Give 1 tablet by mouth two times a day related to age related osteoporosis with a start date of 10/19/21.

c. Potassium phosphate-sodium phosphate 250 mg- 45mg-298mg two times a day with a start date of 10/19/21.

The Order Summary Report dated 12/13/21 for Resident #21 include the following:

a. Potassium phosphate-sodium phosphate 250 mg- 45mg-298mg two times a day with a start date of 10/19/21.

b. Calcium-Vitamin D tablet 600-400 mg-unit, Give 1 tablet by mouth two times a day related to age related osteoporosis with a start date of 10/19/21.

c. Famotidine Tablet 20 milligrams (mg) Give 1 tablet by mouth one time a day for heartburn with a start date of 5/22/21.

Resident #21's Clinical Record included a fax

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notification to the physician that stated Resident takes potassium phosphate -sodium phosphate 250 mg -45mg-298mg tablet to dissolve in water. Could this be changed to liquid form with orders? She has a G-Tube. The physician responded ok- please ask pharmacy for liquid equivalent and dose recommendation. Signed and dated 12/15/21. Per Pharmacy phos-Nak Packet 280-160-250 mg dilute in warm water. The fax had been noted and MAR changed on 12/15/21 at 1:56 PM.

The undated Medication Administration Procedures directed the staff to:

a. Note any allergies or contraindications the resident may have prior to drug administration.

b. Check expiration date on package/container.

c. Read medication label three (3) times before pouring.

d. Identify resident before administrating medication.

e. Provide privacy for resident if appropriate.

f. Medication cart is to be keep locked at all times unless in use and within nurse's sight.

g. Cleanse hands before handling medication and before contact with resident.

h. Explain to resident the type of medication being administered.

i. Obtain and record any vital sign as necessary

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prior to medication administration.

j. After administration, return the cart and document administration in Medication Administration Record (MAR) or Treatment Administration Record(TAR).

k. If Resident refuses the medication, document refusal on MAR of TAR.

l. Observe for medication actions/reactions and record on the PRN effectiveness on EMAR note when appropriate.

m. Once removed from the package or container, unused doses should be disposed of according to facility policy.

During an observation on 12/14/21 at 9:56 AM Staff B Registered Nurse (RN) observing while Staff S Licenses Practical Nurse (LPN) obtained Resident #21's Medications from the medication cart and placed the following into a medication cup:

a. K phos neutral 155.852/130 give one by mouth twice a day.

b. Copidogrel 75 mg give 1 via peg tube daily.

c. Famotidine 20 mg po qd given via peg tube.

d. Hydrochlorothiazide 25 mg give via peg tube every am.

e. Cal 600 vit d 400 by mouth daily.

f. Guaifenesin 400 gm give via peg tube.

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F 755	Continued From page 97 h. Lisinopril 10 mg give 1 via peg tube every am. Staff S crushed all medications together, then entered Resident #21's room filled 10 cc of water and all medication donned gloves and opened gabapentin 100 mg give 1 via peg tube twice a day and placed into cup and stirred. Staff S added 30 milliliters (ml) of water to 2 different medication cups moved plate over to table and raised the bed and obtained a new syringe. Staff S donned gloves instilled 30 cc of air to peg tube to check for placement and then checked for residual. Staff S instilled the medications and then 30 cc of water after medication. Staff S failed to flush prior to giving medications. Lowered bed doffed gloves and washed hands. During an observation on 12/15/21 at 10:11 AM Staff B RN observing while Staff L RN obtained Resident #21's Medications from the medication cart and placed the following into a medication cups: a. K phos neutral 155.852/130 give one by mouth twice a day, in cup by self. b. Copidogrel 75 mg give 1 via peg tube daily. c. Famotidine 20 mg po qd given via peg tube. d. Hydrochlorothiazide 25 mg give via peg tube every am. e. Cal 600 vit d 400 by mouth daily. f. Guaifenesin 400 gm give via peg tube. h. Lisinopril 10 mg give 1 via peg tube every am.	F 755		

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ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

(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 755	Continued From page 98	F 755		

Staff L used hand sanitizer and donned gloves crushed medications together and opened Gabapentin 100 mg 1 via peg twice a day capsule and placed with the crushed medication. Staff L added water to the K phos neutral, doffed gloves and used hand sanitizer. Staff L knocked on Resident #21's door and let her know what she was going to do. Staff L washed hands placed plate with medications onto barrier along with gloves and hand sanitizer and donned gloves. Resident's head of bed elevated with her head about 24 inched form the top. Staff L placed all the medications in 1 cup with 10 cc of water, then filled cup with tap water. Had new syringe dated 12/15/21 Left room to get cups knocked entered room washed hands and donned gloves. Staff L poured 30 cc of water into 2 medication cups, added water to medication to equal 30 cc doffed gloves used hand sanitizer donned gloves. Staff L instilled air to check placement wiped stethoscope off with alcohol swabs doffed gloves used hand sanitizer. Staff L donned gloves, instilled 30 cc water, then medication, then 30 cc water into PEG tube. Staff L rinsed off syringe and placed on paper towel. Doffed gloves and washed hands.

During an interview on 12/16/21 at 9:03 AM Staff T Certified Medication Aide (CMA) explained she thought the facility had a medication book and thought it to be in a drawer at the nurses station, unable to find the medication book.

During an interview on 12/16/21 at 9:18 AM Staff B RN Prior DON acknowledged all staff know to call pharmacy if they have a question about a drug or any questions.

During an interview on 12/16/21 at 9:20 AM Staff

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H LPN acknowledged the facility did not have a drug book. She explained if she would have a question she would google it.

During an interview on 12/16/21 at 9:38 AM, Staff U, Pharmacy Tech, acknowledged the order for K- Phose Neutral 155/852/130 1 by mouth a new order started on 10/20/21. Staff U explained the facility did not clarify order until yesterday 12/15/21 when the facility called with questions. The medication could be given via peg tube if placed in 4 to 6 ounces of water for 2 to 5 minutes if any particles left crush stir and administer via peg tube.

During an interview on 12/16/21 at 10:24 AM, Staff V, Physician, returned call stated he had received a fax from the facility yesterday about changing Resident # 21 potassium phosphate-sodium phosphate 250 mg-45mg-298 md tabled to dissolve in water BID asking if could be changed to liquid form with orders. Please give with orders she has G-tube. He confirmed he responded back ok please ask pharmacy for liquid equivalent and dose recommendations faxed back to facility. Let him know they did get pharmacy recommendation of phos-nat packed 280-160-250 mg dilute in 30 cc warm water. He stated good but had not okay that order as of yet he was out of the office and maybe it was waiting for him. He acknowledged he talked to the facility this morning 12/16/21 about a different order that had been mention to be discontinued in a progress not from Staff W physician back awhile. He stated he wanted mirtazapine to be continued since she has other indications. Explained the potassium phosphate-sodium phosphate 250 mg-45mg-298 md ordered by mouth since returning from the hospital back in October. He

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F 755	Continued From page 100 acknowledged he would expect the order to have been clarified back when Resident #21 returned from the hospital since she had a g tube. When asked about the change of feeding to overnight to day explained someone else in his office could have handled that he could not remember any conversation about the change. He also explained a couple of months ago duties at his office shifted. During an interview on 12/21/21 at 8:45 AM, Staff D, Nurse Consultant, when shown the order for tube feeding it was signed by doctor and noted but not changed on the MAR. Staff D did not think it was a system failure. She did explain the order should have been clarified since the original date was over a month ago but not changed in the MAR or clarified. Staff D not sure why this order was in the chart and where it came from. When asked about the last change to potassium - sodium phosphate. Stated Staff V physician stated ok please ask pharmacy for liquid equivalent and dose recommendation. Staff D stated that the information must be faxed out for the physicians okay. When asked why the order had been changed on the mar before the physician knew about it. Staff D had no answer. The order already in the book to be noted a 2nd and 3rd time without being faxed back to physician.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759	In continuing compliance with F 759 Free of medication error rates 5 percent or more, Accura Healthcare of Pleasantville corrected the deficiency by educating staff "S" on ensuring residents have an order to administer medications via g-tube per the appropriate route for resident # 21 and all like residents on 1/11/2022 by Clinical Nurse Specialist. To correct the deficiency and to ensure the problem does not recur, all nurses were educated by 1/13/2022 on the process of administering medications via g-tube ensuring appropriate route is ordered by the Clinical Nurse Specialist. The DON and/or designee will audit g-tube medication administration 3x/weekly for 4 weeks, then 2x/weekly x 2 weeks, then PRN to ensure compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	1/13/2022

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, observations and interview the facility failed to clarify medication orders to be given by mouth when given by Percutaneous Endoscopic Gastrostomy (PEG) tube. The facility gave 6 medications in error out of 35 opportunities for a medication error rate of 17.14%. The 4 medications were given via PEG tube while the order stated by mouth, 2 medications given via PEG tube while the order did not contain a route and the medication card stated by mouth two times a day. The facility reported a census of 43.

Findings Included:

The December Medication administration Record (MAR) for Resident #21 included the following medications:
a. Famotidine Tablet 20 milligrams (mg) Give 1 tablet by mouth one time a day for heartburn with a start date of 5/22/21.
b. Calcium-Vitamin D tablet 600-400 mg-unit, Give 1 tablet by mouth two times a day related to age related osteoporosis with a start date of 10/19/21.
c. Potassium phosphate-sodium phosphate 250 mg- 45mg-298mg two times a day with a start date of 10/19/21.

The Order Summary Report dated 12/13/21 for Resident #21 include the following:
a. Potassium phosphate-sodium phosphate 250 mg- 45mg-298mg two times a day with a start date of 10/19/21.
b. Calcium-Vitamin D tablet 600-400 mg-unit, Give 1 tablet by mouth two times a day related to age related osteoporosis with a start date of

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F 759	Continued From page 102 10/19/21. c. Famotidine Tablet 20 milligrams (mg) Give 1 tablet by mouth one time a day for heartburn with a start date of 5/22/21. Policy updated 6/23/2020 titled Medication Administration Through Tube Feeding Purpose: to administer medications through a gastric (G) or nasogastric (NG) tub in a safe and appropriate manner. Equipment a. Dilatant (such as NS, distilled water or tap water) (for flushing tube before and after medication) at room temperature. b. Syringe (syringes should be changed every 24 hours). c. Disposable gloves Procedure a. Wash hands before touching formula or delivery system. Prepare surface and maintain clean technique. Wear gloves if necessary, to prevent contact with body secretions. b. Explain procedure to resident and provide privacy. c. Bring equipment to bedside, wash hands and put on glove. d. Check Tube Placement and Patency. e. Feeding tube should be checked for placement and patency prior to beginning a feeding and after episodes of vomiting or any suctioning, by the following methods. i. Attach syringe to the end of the tube and gently try to aspirate gastric fluid, If gastric fluid is evident, instill gastric fluid into tube. ii. If gastric fluid is NOT evident place a stethoscope over the upper portion of the	F 759		

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resident's stomach. Attach the syringe to the tube and insert a small amount (10 to 20 ml (CC)) of air into the tube while listening for a swooshing or gurgling sound. If you do not hear this, it indicates that the tube may not be in the stomach, in which case the Charge Nurse and or physician should be notified.
f. Prepare medication as appropriate. Use liquid form of medication whenever possible. Thick solutions can be mixed with water if necessary. Check with pharmacy to see id medication is available in liquid form and whether tablets can be crushed. If tablets can be crushed, crush finely and mix with warm water. Do not mix medications with enteral feeding formula. Also check to see if medications can be given with tube feedings or should be given on an empty stomach and tube feeding withheld for a prescribed time interval before and after medication is given.
NOTE: Antacids should not be given at the same time as some other medications, such as antibiotics, so wait 30 to 60 minutes in between.
g. Administer medication with syringe slowly and steadily. (Extent the elevation of the syringe will determine the flow rate). If more then one medication is to be administered, give each one separately and rinse the tube with 5 ml (cc) of warm water in between medications.
h. Flush tube with 20 to 30 ml (cc) of water before and after administering each medication. If resident is on continuous tube feeding, stop the feeding adn clear the tube by instilling the dilatant before administrating the medication.
i. If the G or NG tube is attached to suction turn off suction and clamp tube for 20 to 30 minutes after medication administration so theit is absorbed.
j. Remove gloves and wash hands.
k. Document medication on the Documentation

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Record, Medication Administration and also record any fluid instilled if resident is on I & O

undated document titled
Medication Administration Procedures:
General Procedures to follow for all medications:
a. Note any allergies or contraindications the resident may have prior to drug administration.
b. Check expiration date on package/container.
c. Read medication label three (3) times before pouring.
d. Identify resident before administrating medication.
e. Provide privacy for resident if appropriate.
f. Medication cart is to be keep locked at all times unless in use and within nurse's sight.
g. Cleanse hands before handling medication and before contact with resident.
h. Explain to resident the type of medication being administered.
i. Obtain and record any vital sign as necessary prior to medication administration.
j. After administration, return the cart and document administration in Medication Administration Record (MAR) or Treatment Administration Record(TAR).
k. If Resident refuses the medication, document refusal on MAR of TAR.
l. Observe for medication actions/reactions and record on the PRN effectiveness on EMAR note when appropriate.
m. Once removed from the package or container, unused doses should be disposed of according to facility policy.

During an observation on 12/14/21 at 9:56 AM Staff B Registered Nurse (RN) observing while Staff S Licenses Practical Nurse (LPN) obtained Resident #21's Medications from the medication

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cart and placed the following into a medication cup.
a. K phos neutral 155.852/130 give one by mouth twice a day.
b. Copidogrel 75 mg give 1 via peg tube daily.
c. Famotidine 20 mg po qd given via peg tube.
d. Hydrochlorothiazide 25 mg give via peg tube every am.
e. Cal 600 vit d 400 by mouth daily.
f. guaifenesin 400 gm give via peg tube.
h. Lisinopril 10 mg give 1 via peg tube every am.
Staff S crushed all medications together, then entered Resident #21's room filled 10 cc of water and all medication donned gloves and opened gabapentin 100 mg give 1 via peg tube twice a day and placed into cup and stirred. Staff S added 30 milliliters (ml) of water to 2 different medication cups
moved plate over to table and raised the bed and obtained a new syringe. Staff S donned gloves instilled 30 cc of air to peg tube to check for placement and then checked for residual. Staff S instilled the medications and then 30 cc of water after medication. Staff S failed to flush prior to giving medications. Lowered bed doffed gloves and washed hands.

During an observation on 12/15/21 at 10:11 AM Staff B RN observing while Staff L RN obtained Resident #21's Medications from the medication cart and placed the following into a medication cups.
a. K phos neutral 155.852/130 give one by mouth twice a day , in cup by self.
b. Copidogrel 75 mg give 1 via peg tube daily.
c. Famotidine 20 mg po qd given via peg tube.
d. Hydrochlorothiazide 25 mg give via peg tube every am.
e. Cal 600 vit d 400 by mouth daily.

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f. guaifenesin 400 gm give via peg tube.
h. Lisinopril 10 mg give 1 via peg tube every am.
Staff L used hand sanitizer and donned gloves crushed medications together and opened Gabapentin 100 mg 1 via peg twice a day capsule and placed with the crushed medication. Staff L added water to the K phos neutral, doffed gloves and used hand sanitizer. Staff L knocked on Resident #21's door and let her know what she was going to do. Staff L washed hands placed plate with medications onto barrier along with gloves and hand sanitizer and donned gloves. Resident's head of bed elevated with her head about 24 inched form the top. Staff L placed all the medications in 1 cup with 10 cc of water, then filled cup with tap water. Had new syringe dated 12/15/21 Left room to get cups knocked entered room washed hands and donned gloves. Staff L poured 30 cc of water into 2 medication cups, added water to medication to equal 30 cc doffed gloves used hand sanitizer donned gloves. Staff L instilled air to check placement wiped stethoscope off with alcohol swabs doffed gloves used hand sanitizer. Staff L donned gloves, instilled 30 cc water, then medication, then 30 cc water into PEG tube. Staff L rinsed off syringe and placed on paper towel. Doffed gloves and washed hands.

During an interview on 12/16/21 at 9:03 AM Staff T Certified Medication Aide (CMA) explained she thought the facility had a medication book and thought it to be in a drawer at the nurses station, unable to find the medication book.

During an interview on 12/16/21 at 9:18 AM Staff B RN Prior DON acknowledged all staff know to call pharmacy if they have a question about a drug or any questions.

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F 759	Continued From page 107 During an interview on 12/16/21 at 9:20 AM Staff H LPN acknowledged the facility did not have a drug book. She explained if she would have a question she would google it. During an interview on 12/16/21 at 9:38 AM with Staff U facility Pharmacy Teck acknowledged the order for K- Phose Neutral 155/852/130 1 by mouth a new order started on 10/20/21. Staff U explained the facility did not clarify order until yesterday 12/15/21 when the facility called with questions. The medication could be given via peg tube if placed in 4 to 6 ounces of water for 2 to 5 minutes if any particles left crush stir and administer via peg tube.	F 759		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure the daily nutritional needs of 4 out of 4 residents (Residents # 16, #34, #37, and #41) was offered. The facility pureed food for 4 residents who required a pureed diet. The facility pureed 4 servings for the 4 residents for lunch and served the 4 residents but had portions of the pureed food left over in the steam table revealing that these 4 residents did not receive the planned nutritional needs for lunch on that day. The	F 800	In continuing compliance with F800, Provided Diet Meets Needs of Each Resident, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff JJ by the Dietary Manager on 12/15/2021, on proper puree process to ensure accurate portions for residents #16, #34, #37, #41, and all like residents. To correct the deficiency and to ensure the problem does not recur. All cooks were educated by the Dietary Manager by 1/12/2022 on the process for pureeing foods. The Dietary Manager and/or designee will audit the pureed food process twice weekly for 4 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/12/2022

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facility reported a census of 43.

Findings include:

On 12/15/21 at 11:06 AM, Staff JJ, Cook, stated she works at another facility, had never worked in this facility before and she came from the other facility as the cook did not show up that morning.

On 12/15/21 at 11:22 AM, Staff JJ started to puree food. Staff JJ took 4 fruit turnovers and placed them in the robo coupe (food processor). Staff JJ added milk from the refridgerator and added some hot water from the coffee maker spout. She then put the blended turnovers into a small stainless steel container. Staff JJ did not measure the amount of blended food prior to putting it into the container. Staff JJ then scooped 4 gray slotted spoonfuls of peas into the robo coupe. Staff JJ stated she believed the slotted spoon was 4 ounces (oz). Staff JJ was unable to find the measurement on the spoon itself. Staff KK, Dietary Manager (DM), concurred that it was 4 ounces. Staff JJ then put a little bit of hot water in it, blended and poured pureed peas in container. Staff JJ did not measure the blended amount prior to pouring the peas into the container. Staff KK stated that Staff JJ should have used the pea liquid instead of hot water. Staff JJ concurred that she had only used hot water. Staff JJ then took 4 scoops of ham and added ham juice and hot water, placed into the robo coup. She did not measure the pureed ham prior to pouring it into a stainless steel container.

On 12/15/21 at 11:55 AM, Staff JJ poured hot water into a portion of the pureed food for Resident #34 (who has an order of puree liquid for her diet consistency) that had been scooped

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into nosey cups (cups that have a cut out at the top of cup). Staff KK told Staff JJ that she was to add juice from the ham into the cups with ham and peas instead of the hot water. Staff JJ also got took out of the refrigerator bread and butter that she said she had pureed earlier. Staff JJ stated she used 4 pieces of bread and added butter and milk.

On 12/15/21 at 1:30 PM, Staff JJ used a 1 blue scoop full for the pureed peas and ham servings, and 1 yellow scoop full for the pureed servings of fruit pastry and bread and butter. At this time all residents were served. Staff JJ measured the pureed food left. There was 1 blue scoop of ham, 1 blue scoop of peas, and 2 yellow scoops left of the pureed fruit pastry and 2 yellow scoops left of the pureed bread and butter. Staff KK stated that the residents did not receive the amount that they should have received. Staff KK stated that the 4 residents that have the pureed diets received 3 ounces instead of 4 ounces of both the ham and the peas, and they served ½ of the portion that they should have gotten of the bread and butter and of the fruit pastry. The DM (Staff KK) stated it was not acceptable. Staff KK then showed Staff JJ the chart on how to determine scoop size for pureed foods after pureeing the foods and before placing them into the stainless steel containers. Staff JJ stated she had never used the chart before or measured the pureed food before.

On 1/06/22 at 1:57 PM, Staff MM, RDLD (Registered Dietitian and Licensed Dieitian), stated there should not have been any food left over if the cook started out with 4 servings. She should have evaluated her final scoop size prior to serving. She should have measured the

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ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

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F 800	Continued From page 110 pureed food first and then divided it out. An Week 2 Wednesday menu for 2021-2022, documented the following for the noon meal: a. 4 ounces of cola glazed ham steak b. 4 ounces peas c. 1 each bread with margarine d. 1 each fruit turnover	F 800		
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. (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 observation, department cleaning schedule review and interviews, the facility failed to ensure food was stored and handled in a safe and sanitary manner. The facility had dented and outdated cans stored in a room with filthy floors. Milk was stored in a cooler without a	F 812	In continuing compliance with F812, Food Procurement,Store/Prepare/Serve-Sanitary, Accura Healthcare of Pleasantville corrected the deficiency by removing all dented and outdated cans in storage room on 12/13/2021; cleaned floors in storage room on 12/13/2021; thermometer was placed in cooler on 12/13/2021 by dietary manager. Staff JJ, KK, and LL were provided education by 1/12/2022 by dietary manager on kitchen infection control processes, routine cleaning schedules, and process for receiving dented cans. To correct the deficiency and to ensure the problem does not recur, all kitchen staff were educated by the Dietary Manager by 1/12/2022 on kitchen infection control processes, routine cleaning expectations, and the process for receiving dented cans. The Administrator and/or designee will audit infection control practices when preparing food and storage of cans 3x/weekly for 4 weeks, then 2x/weekly for 2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/12/2022

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F 812	Continued From page 111	F 812		

thermometer. Food was handled by kitchen staff without using gloves or using gloves after touching non food items first. Food was transported to residents rooms without being covered. The facility reported a census of 43.

Findings include:

On 12/13/21 at 11:05 AM, an initial kitchen tour was conducted with Staff LL, Cook. The dry storage room floor was sticky. Staff LL stated the night crew was supposed to clean the floor. The kitchen floor was dirty and there was rust and questionable mold under them sink. Staff Z believed it was rust. In the dietary room across the hall from the kitchen, the rug in front of a stand up fridge and freezer was filthy. Staff LL concurred that it was filthy. One large can cream style corn was dented and was pulled off of the rack for disposal by Staff LL. Staff LL stated she sits dented cans aside than her boss can take a look before throwing away. The milk fridge did not have a thermometer in it. Staff LL verified this. She stated that the delivery man had just put milk in the milk cooler. She stated when he came and took the crates he must have taken the thermometer. A can of chunk light tuna had an expiration date of 9/30/21 and a can of corn had an expiration date of 11/11/21. Staff LL verified they were past date and removed them.

12/14/21 02:16 PM Staff KK, Dietary Manager (DM), concurred that the floors in the kitchen and the dry storage rooms were dirty. She agreed that the rug in front of the fridge and freezer in the dry storage room still was dirty. She stated she'll probably have to wash parts of it by hand. Staff KK concurred the meals were served late on that day. Stated it's because they (the nursing staff)

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F 812	Continued From page 112	F 812		

were not helping them. She didn't know if it was because DIA was in the facility as it normally was not normally like that. Dietary Manager confirmed the 2 cans were dented from yesterday and should have not been accepted and returned to Martin Brothers at the time they received.. She concurred the dates were outdated at 9/30/21 and 11/11/21.

On 12/15/21 at 12:55 p.m., Staff KK prepared a sandwich. She put floves on then touched bun package and cheese package and scissors. Staff KK then touched the ham, cheese and buns to make the sandwich. The sandwich was served to a resident.

An observation at the same time as above, revealed meal trays were going out to rooms without the fruit bars being covered. Staff KK concurred that the fruit bars should have been covered.

On 12/15/21 at 1:29 p.m., Staff JJ, Cook, made toast for a resident. She grabbed the bread out of the bag and placed in the toaster, then took the toast out of the toaster, buttered it, cut it in half and served it to a resident. The cook did not use gloves throughout this observation.

On 12/15/21 at 1:30 p.m., Staff KK stated she should not have touched food items with gloves that she had touched non food items with. Staff LL stated she have worn gloves when touching the bread/toast. Staff KK agreed that Staff LL should have wore gloves when touching the bread/toast.

On 12/13/21 at 1:50 PM, Staff NN, Environmental Services Supervisor, stated they do not clean the

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F 812	Continued From page 113 kitchen. Staff NN stated that her department basically cleaned the resident rooms, the bathrooms, shower rooms, common areas (kitchen does common area after supper). Staff NN stated her department did not clean the kitchen or the room across the hall. Staff NN stated she knew the kitchen was supposed to clean the kitchen and dry storage but she was not sure who does it. An undated Weekly Cleaning Schedule, directed kitchen staff that om Sunday PM shift they were to deep clean floors. The facility did not provide policy/procedure for food handling/glove use.	F 812		
F 839 SS=F	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 record review and staff interviews the facility failed to conducted a license verification check prior to hire for 1 of 2 licensed staff reviewed for professional license verification (Staff M). The facility reported a census of 43. Findings include:	F 839	In continuing compliance with F839, Staff Qualifications, Accura Healthcare of Pleasantville corrected the deficiency by completing a license verification on Staff M on 12/20/2021 by business office manager. Audit of all other licensed staff was completed on 12/202/2021 by business office manager. To correct the deficiency and to ensure the problem does not recur, the Business Office Manager was educated on 1/11/2022 by the Regional VP of Operations on the process for verifying nurse licenses prior to their employment. The Administrator and/or designee will audit license verification for newly hired staff prior to their start date for 4 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/11/2022

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F 839	Continued From page 114 The untitled document which listed staff names, hire date, position and if terminated or current employed included the name of Staff M License Practical Nurse with a hire date of 6/2/20. The document titled Quick Confirm License Verification Report dated 12/20/21 included the license verification for Staff M. During an interview on 12/20/21 at 3:17 PM, Staff I Business Office Manager acknowledged the facility just ran the verification for Staff M's license. Staff I explained Staff M hired 6/2/20 and termed 11/14/21 Staff M had been on leave and unable to return to work.	F 839		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 868	In continuing compliance with F868, QAA Committee, Accura Healthcare of Pleasantville corrected the deficiency by education of the Administrator by the Regional VP of Operations to ensure continued compliance with the QAA requirements on 1/11/2022. A quarterly QAA meeting was held with all required individuals on 1/24/2022. To correct the deficiency and to ensure the problem does not recur, the DON and ED were educated on 1/11/2022 by the Regional VP of Operations on the process for quarterly QA meetings and ensuring all required members are present. The Regional VP of Operations and/or designee will audit quarterly for one year to ensure compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/11/2022

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F 868	Continued From page 115 facility failed to ensure the Quality Assessment and Assurance committee (QA) was attended by the required members to include: 1) the Nursing Home Administer (NHA) or representative; 2) Director of Nursing (DON); 3) the Medical Director (MD) or representative and 4) two other members of the facility's staff present on a minimum of a quarterly basis. The facility reported a census of 43. Findings include: The Quality Assurance Committee Meeting Sign In sheets provided by the facility since their recertification survey on 9/5/2019 between the dates of 01/2020 and 12/2021. The following dates did not have the required members attend the meeting: a. 5/18/21 lacked Director of Nursing (DON) signature and member of the facility b. 12/20/21 lacked DON signature Facility document titled, Quality Assurance Program, dated 10/21/21, revealed: a. Quality Assurance Committee will meet quarterly b. Quality Assurance identifies areas of strengths and weaknesses within our own systems and services offered. Will be accomplished through the consistent monitoring and evaluation of services, programs, and resident quality of care indicators. These evaluations will be completed with the goal of addressing and improving the quality of services being provided for residents and their families.	F 868		

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F 868	Continued From page 116 c. Recommended representatives to be utilized within the Quality Assurance Committee: A. Executive Director, DON, Food Services Director, Social Services Coordinator, Laundry Supervisor, Housekeeping Supervisor, Activities Director, Medical Director, Clinic Supervisor, Pharmacist, Medical Records, Business Office, Minimum Data Set (MDS) Coordinator An interview on 1/6/21 at 9:30 a.m. with VP revealed the facility follows QAPI guidelines and do not have a QAPI policy. VP to email guidelines to this surveyor. An email dated 1/6/21 at 12:55 p.m., and sent to the Vice President of Operations (VP), posed the question why the DON did not attend the QAPI meetings of 5/8/21 and 12/20/21. An email dated 1/6/21 at 1:21 p.m., and sent from the VP, replied to the above question that he does not know why the DON and an additional staff member was not in attendance on 5/8/21 and why the DON was not in attendance on 12/20/21 QAPI meetings.	F 868	In continuing compliance with F880, Infection Prevention and Control, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff "H" on proper hand hygiene and gloving with wound care for resident #23 and all like residents on 1/12/2022 by Clinical Nurse Specialist. On 1/6/2021, education and communication was posted for all staff on reminders of the screening in and out processes by the Clinical Nurse Specialist. To correct the deficiency and to ensure the problem does not recur, all nurses were educated by the Clinical Nurse Specialist by 1/12/2022 on proper hand washing and glove use during wound care to ensure compliance with infection prevention and control measures. All staff were educated on the process for screening in and out of the facility by the Administrator by 1/11/2022 or prior to the start of their next shift. The Administrator and/or designee will audit screening logs daily Monday through Friday x 4weeks and then PRN to ensure continued compliance with the screening process. The DON and/or designee will audit infection control processes during wound care and hand hygiene 3x/ weekly for 4 week, then 2x/weekly x 2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/12/2022
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 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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F 880	Continued From page 117	F 880		

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.
(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

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F 880	Continued From page 118 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 review of facility policies, observation, and staff interview, the facility failed to screen employees 30 times before entering the facility at the start of their shift by another staff member, in a manner that would reduce possible exposure of COVID-19 to their residents. The facility failed to provide follow up with staff regarding to omission of screening documentation and positive signs or symptoms of COVID-19 on the screening log 20 times to employees, both between the dates of 10/19/21 to 11/15/21. The facility failed to follow infection control practices during wound care in regards to donning and doffing gloves and hand hygiene for 1 of 14 residents reviewed (Resident #23). The facility reported a census of 43 residents. Findings include: Review of facility policy titled, COVID-19 Employee Screening Log, dated between	F 880		

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F 880	Continued From page 119 10/19/21-11/15/21 revealed the following: a. Two logs undated b. 10/19/21, staff member documented "yes" to cough, sore throat, and other symptoms. Facility lacked follow up documentation. A staff member failed to provide initial temperature prior to entering the facility. A third staff member lacked documentation screened by another staff member. c. 10/20/21, three staff members lacked documentation screened by another staff member. d. 10/20/21, staff member failed to complete screening prior to start of work and documentation screened by another staff member. The facility lacked follow up documentation. e. 10/23/21, staff member lacked documentation screened by anther staff member. f. 10/24/21, two staff members lacked documentation screened by another staff member. The facility lacked follow up documentation. g. 10/28/21, staff member documented "yes" to cough, facility lacked follow up documentation. A second staff member lacked documentation screened by another staff member. The facility lacked follow up documentation. h. 10/29/21, staff member lacked documentation screened by another staff member. The facility lacked follow up documentation.	F 880		

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F 880	Continued From page 120 i. 10/30/21, staff member documented "yes" to cough. The facility lacked follow up documentation. j. 11/1/21, staff member failed to complete screening questions or screened by another staff member. The facility lacked follow up documentation. k. 11/2/21, staff member failed to complete screening questions. The facility lacked follow up documentation. l. 11/3/21, staff member failed to complete screening questions or screened by another staff member. The facility lacked follow up documentation. Five additional staff members lacked documentation screened by another staff member. The facility lacked follow up documentation. m. 11/4/21, three staff member lacked documentation screened by another staff member. The facility lacked follow up documentation. n. 11/5/21, two staff member lacked documentation screened by another staff member. The facility lacked follow up documentation. o. 11/7/21, staff member lacked documentation screened by another staff member. The facility lacked follow up documentation. p. 11/8/21, three staff members failed to complete screening questions. The facility lacked follow up documentation. Two additional staff member	F 880		

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F 880	Continued From page 121	F 880		

lacked documentation screened by another staff member. The facility lacked follow up documentation.

q. 11/10/21 staff member lacked documentation screened by another staff member. The facility lacked follow up documentation.

r. 11/11/21 five staff members failed to complete screening questions. The facility lacked follow up documentation.

s. 11/12/21 three staff members failed to complete screening questions. The facility lacked follow up documentation. One additional staff member lacked documentation screened by another staff member.

t. 11/13/21 staff member lacked documentation screened by another staff member. The facility lacked follow up documentation.

u. 11/15/21, staff member failed to complete screening questions or screened by another staff member. The facility lacked follow up documentation.

v. 11/16/21 staff member failed to complete screening questions. The facility lacked follow up documentation. One addition staff member lacked documentation screened by another staff member. The facility lacked follow up documentation.

Facility lacked policy on infection surveillance.

Facility document titled, Corona Virus (COVID-19) Positive Test Procedure, undated,

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F 880	Continued From page 122 lacked infection surveillance documentation. Facility document titled, Infection Control & Prevention Protocol, undated, revealed, Provide surveillance and monitoring to: a. Minimize exposure to potential source of infection b. Uses appropriate hand hygiene prior to and after all procedures c. Use of Personal Protective Equipment (PPE) when indicated d. Collect data and evaluate for trends Facility lacked employee tracking and monitoring of COVID-19 signs and symptoms data for trends. During an observation on 12/20/21 at 7:20 a.m., this surveyor entered the back entrance, no staff present, used walkie-talkie to ask to screen in and waited for response 5 minutes. This surveyor opened unlocked door and waved Staff D, Nurse Consultant down. She then screened this surveyor into the facility. During an interview on 12/14/21 at 1:45 p.m., with Assistant Director of Nursing (ADON), revealed she not completed her Infection Preventionist (IP) training. ADON stated she collects and reviews Employee Screening Log for blanks or 'yes' at the end of the day. ADON stated she has too much to do and has difficulty completing the task. ADON stated all staff enter through back entrance, perform a temperature check, screen for symptoms. If staff have any symptoms, staff	F 880		

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	165324	A. BUILDING _____ B. WING _____	01/06/2022

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F 880	Continued From page 123	F 880		

cannot screen themselves. No one person designated to perform screening, all able to screening each other.

During an interview on 12/21/21 at 11:23 a.m., with ADON, revealed staff instructed to use walkie-talkie if no one is present to screen staff. Staff are to perform temperature check, if answeryes to any screening question they would be tested for COVID and sent home. ADON stated she gathered screening logs and reviewed in the morning. ADON stated she got overwhelmed and logs not checked.

2. An MDS dated 11/1/21, documented that Resident #26 had a pressure ulcer.

A Doctor's Order for Resident #26 with a start date of 11/5/21, directed staff to apply betadine soaked gauze to left heel then wrap BID two times a day.

An observation on 12/16/21 at 02:07 PM, revealed Staff H, Licensed Practical Nurse (LPN), performed a wound treatment on Resident #26's pressure ulcer located on her left heel. Staff H poured betadine into a cup. Staff H laid down a barrier of paper towels down on the tray table and placed Kerlix tape on top of the paper towels. Staff H then raised the bed and removed Resident #26's Prevelon boot. Staff H had placed tape on paper towels. She then placed betadine and gauze on small paper plate. She set gloves on another paper plate. Tore tape off before beginning the treatment and dated one piece of tape with her initials. Prior to treatment she had placed a paper barrier under resident's heel. She floated the left foot by placing a pillow tucked under lower left leg. She then donned gloves and removed kerlix/tape bandage. Staff H

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F 880	Continued From page 124	F 880		

poured sterile water on over wound on foot and cleansed the area. Staff H then threw gloves away and put on new gloves. Staff H took 2x2's soaked with betadine out of the cup with betadine. Placed on heel then wrapped with kerlix and taped. She then threw the barrier away and placed Prevelon boot back on. With gloves still on, Staff H placed pillow back under leg and situated this resident's covers. Staff H then removed her gloves, poured sterile water out, and placed bottle in trash. Staff H then washed and dried her hands and lowered this resident's bed. Staff H, LPN stated she should have removed her gloves and sanitized her hands after removing the soiled dressing. Staff H also reported she should have sanitized her hands when she removed her gloves after cleaning the wound and then she should have reapplied new gloves after cleaning the wound and applying the new dressing.

Staff B prior Director of Nursing observed the wound treatment and concurred that the LPN should have performed hand hygiene.

A Hand Hygiene policy dated 6/21/21, directed staff that they should always perform hand hygiene before donning and after removing gloves, and after handling contaminated items and equipment, such as dressings, and secretions and excretions from residents.

A Using Gloves policy dated /21/21, directed staff that gloves should be worn when touching excretions, secretions, body fluids, blood, muscous membranes or non intact skin. Gloves should be worn when handling potentially contaminated items.

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F 909 F 909 SS=D	Continued From page 125 Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, facility document review, and staff interviews, the facility failed to conduct regular inspection of side rails as part of a regular maintenance program for 1 of 12 residents (Resident #11). The facility reported a census of 43 at time of the survey. 1. The Minimum Data Set (MDS) assessment dated 9/28/21, documented Resident #11 had BIMS (Brief Interview for Mental Status Score) as 11 out of 15, indicating moderately impaired. Resident#11 diagnosis include a neurogenic bladder, stroke, non-Alzheimer's dementia, Multiple Sclerosis, and depression. Resident #11 was dependent on staff for bed mobility, transfers and toileting. Observation on 12/13/21 at 10:53 a.m. of Resident #11 in bed and watching television, call light attached to bed. Side rail x2, in up position and laid inward toward the mattress. This surveyor assessed for bed rail security, both rails attached to bed were loose and moved inward approximately 6 inches. Observation on 12/14/21 at 10:00 a.m. of	F 909 F 909	In continuing compliance with F909, Resident Bed, Accura Healthcare of Pleasantville corrected the deficiency by educating the Administrator by the Regional VP of Operations on 1/11/2022. on the bed rail requirements for resident #11 and all like residents. An audit of all bed rails was complete on 12/28/2021 by DON and all were in compliance. To correct the deficiency and to ensure the problem does not recur, the Administrator was educated on 1/11/2022 by the Regional VP of Operations on regular inspection of side rails to ensure compliance with side rail requirements. The Administrator and/or designee will audit side rails weekly x 4 weeks and then PRN to ensure compliance. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	1/11/2022

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Resident #11 in bed awake, call light out of reach, both side rails in up position. Resident # 11 stated she required assistance with a bedpan.

Observation on 12/15/21 at 2:45 p.m. of Resident #11 in bed asleep, call light clipped to bed sheet, both side rails in up position.

Facility document titled HAWK-Fall Risk Assessment, dated 9/28/21 scored resident #11 as a high fall risk.

Facility document titled Maintenance book, undated, did not list Resident #11's side rails as being loose.

Facility document titled, TELS Reports, dated 12/15/21, revealed lack of documentation to provide routine maintenance to resident side rails.

Clinical Record review of document titled, Side Rail Use Assessment, dated 10/1/21, revealed Resident #11 had bilateral half side rails in place and side rails indicated to provide safety. The document lacked documentation of any maintenance schedule, if attached securely, or any identified issues with the side rails.

During an interview on 12/15/21 at 11:00 a.m., with Staff J, Assistant Director of Nursing (ADON) revealed she assessed resident need for the initial side rail placement. The resident assessed quarterly for ongoing need of side rails. Documentation completed in the electronic medical record (EMR). Staff J stated maintenance handle issues with side rails. Staff J stated the staff will write maintenance issues in the red Maintenance book kept at the Nurses station and the maintenance workers will fix

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F 909	Continued From page 127 problem. During an interview on 12/15/21 at 11:24 a.m., with Staff G, Maintenance Assistant, revealed side rails purchased with facility beds to ensure proper fit and avoid gaps associated with entrapment. Staff G stated the TELS system generate maintenance to provide on side rails every month, which include check if side rails are loose. Staff G was unsure when he last provided maintenance to Resident #11's side rails. During an interview on 12/15/21 at 12:00 p.m., with Staff G Maintenance Assistant, revealed TELS system unable to generate maintenance log from prior month. During an interview on 12/16/21 at 9:57 a.m., with Staff A, Nurse Consultant, and Staff Q, Certified Nurse Assistant (CNA), revealed they were unaware of Resident #11's side rails were loose. Staff Q, stated staff are to write in the red Maintenance book or to verbally notify Staff Q.	F 909		