STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. BUILDING _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF WASHINGTON	601 E POLK ST WASHINGTON, IA 52353

(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: April 5, 2022 JS/ The following deficiencies relate to the Recertification survey, investigation of Complaints #96457, #96459, #97242, #97528, #98359, #98559, #101963, #102716, and Facility Reported Incident #101852 conducted February 21, 2022 to March 9, 2022. Complaints #96457-C, #96459-C, #97242-C, #97528-C, #98359-C, #102716-C, #101963-C, and #102716-C were substantiated. Facility Reported Incident #101852-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and	F 576		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joseph A Peters | TITLE: Administrator | (X6) DATE: 4/5/22

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 576	Continued From page 1 the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on group interview, staff interview, and facility policy review, the facility failed to ensure mail was delivered on Saturdays. The facility reported a census of 39 residents. Findings include: On 2/22/22 at approximately 1:45 PM, a resident council interview was conducted with seven residents who resided at the facility. During the interview, the group attendees were queried if mail was delivered on Saturdays, and no one in the group attendees could confirm that mail was delivered on Saturdays.	F 576	The facility does and will continue to ensure that mail is delivered on Saturdays. All residents have the potential to be affected by the alleged deficient practice. Staff were educated by DON on 3/21/22 that on Saturday's housekeeping will go and get the mail and bring it to the nurse's desk and the nursing staff will deliver the mail to residents after being sorted. The Business Office Manager/ Designee will audit that mail is getting delivered on Saturdays Weekly X 4, monthly X 2 months and quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 4/5/22	

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F 576	Continued From page 2 On 2/23/22 at 12:13 PM, the Activities Director/Social Services Staff explained the Business Office Manger (BOM) typically checked the mail Monday through Friday. The Activities Director/Social Services Staff acknowledged there was not a reliable aide on the weekend, the BOM would check all the mail, would pass it to them, and they would pass it out. The Activities Director/Social Services Staff confirmed as of now there was not a process to get the mail out on Saturdays. On 3/1/22 at 3:48 PM, the Administrator was queried about residents receiving mail on Sundays. The Administrator explained that last week they had just designated housekeeping staff to deliver the mail on Saturday. On 3/2/22 at 12:11 PM, the BOM explained that they checked the mail at lunch time or after lunch on Monday through Friday when they were at the facility. The Facility Policy titled Resident Rights & Dignity Management documented that the residents may receive and send mail as they desire. They have the right to receive or send mail without the correspondence being opened unless the resident desires the facility to manage their mail.	F 576		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		

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F 578	Continued From page 3 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure consistent documentation of code status when a resident had documentation for Cardiopulmonary	F 578	The facility does and will continue to ensure that there is consistent documentation of code status when a resident has documentation for Cardiopulmonary Resuscitation (CPR) or Do Not Resuscitate (DNR) documents in their clinical record including resident #13. All residents have the potential to be affected by the alleged deficient practice. The Social Worker was educated by Administrator on 3/30/22 on advanced directives and that there should be consistent documentation of code status when a resident has documentation for Cardiopulmonary Resuscitation (CPR) or Do Not Resuscitate (DNR) advanced directives in their clinical chart. The Social Worker/Designee will audit that there are consistent documentation of advanced directives in the clinical charts Weekly X 4, monthly X 2 months and quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/30/22	

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F 578	Continued From page 4	F 578		

Resuscitation (CPR) and Do Not Resuscitate (DNR) documents both present in the clinical record for one of two resident reviewed for Advance Directives (Resident #13). The facility reported a census of 39 residents.

Findings include:

The Quarterly Minimum Data Set (MDS) assessment dated 12/20/21 revealed Resident #13 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, indicating severe cognitive impairment. Diagnoses for Resident #13 included dementia without behavioral disturbance, delusional disorders, and major depressive disorder.

The Quarterly MDS assessment dated 11/16/19 revealed the resident scored 11 out of 15 on a BIMS exam, which indicated the resident was moderately cognitively impaired.

Review of the paper chart for Resident #13, reviewed on 2/22/22 and 2/23/22, revealed the following:

A green full code sticker was present on the spine of the chart. The Admission Record present as the first page in the resident's paper chart documented DNR in the Advanced Directives section of the document.

The Admission Record printed 2/23/22 revealed Resident #13 had a guardian.

The Durable Power of Attorney for Health Care paperwork for Resident #13 dated 9/19/07 revealed the resident had appointed a Attorney-in-Fact for Health Care.

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The Guardianship paperwork dated 10/19/12 revealed the petition had been granted and the proposed guardian had been appointed. The appointed guardian was the same individual named in the Attorney-in-Fact for Health Care document.

The Iowa Physician Orders for Scope of Treatment (IPOST) form, signed 11/22/19, marked choices for CPR /Attempt Resuscitation, full treatment, and defined trial period of artificial nutrition by tube. The form documented medical decision making was directed by the patient, and the form had been signed on the Patient/Resident or Legal Surrogate for Health Care Signature as identified above line of the form.

The Physician Orders signed 2/10/22 included the following order: CPR (Order date 1/21/20).

The Nurse Practitioner Note for Resident #13 dated 7/19/21 documented, in part, [Resident #13] is currently a full code. Based on [Resident #13's] previous history of brain surgeries and the degree of his dementia, his outcome if CPR is done would result in decreased quality of life. I would recommend that his guardian consider changing the Code Status to DNR.

The Physician's Visits Note dated 7/22/2021 at 2:50 PM documented by the Director of Nursing (DON), indicated the facility received the notes from the visit and no new orders were given at the time. The nurse communicated the notes made from provider to Guardian in regards to code status. The Guardian will communicate the court's decision to the facility after submitting the paperwork to the court.

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F 578	Continued From page 6 On 2/23/22 at 9:47 AM, Staff A, Licensed Practical Nurse (LPN), was queried about code status. Staff A acknowledged that the residents' code statuses were on the outside of the residents' charts, was underneath the resident's name in the electronic health record, and the IPOST. On 2/23/22 at 12:03 PM, the Activities Director/Social Services Staff was queried about Resident #13, and acknowledged the resident had a guardian. The Activities Director/Social Services Staff said currently the resident's code status was full code, and acknowledged the Guardian should have signed the IPOST. On 2/23/22 at 12:21 PM, the Activities Director/Social Services Staff explained the resident's guardian and the resident wanted to change to a DNR, and a new IPOST would be sent. On 2/24/22 at 9:10 AM, an orange DNR sticker was observed on the outside of the resident's chart. The Face Sheet present in the front of the resident's chart documented DNR per the Advanced Directives section. The orange IPOST (signed 11/22/19) present after the face sheet marked that CPR was to be done. A copy of an IPOST (dated 2/24/22) present on the back side of the orange IPOST documented DNR/Do Not Attempt Resuscitation, limited additional interventions, and defined trial period of artificial nutrition by tube. This form documented medical decision making was directed by the Durable Power of Attorney for Health Care. Rationale for these orders marked the option for patient's known preference.	F 578		

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F 578	Continued From page 7 The FAX ORDERS note dated 2/23/22 from the Nurse Practitioner documented the resident's code status was DNR. On 2/24/22 at 3:10 PM, the DON was queried where staff were to look if they needed to know whether the resident was to have CPR performed or DNR status. The DON responded they would look at the IPOST. The DON reported it was a mistake for not taking out one of the IPOSTs. The facility provided a document titled Iowa Physician Orders for Scope of Treatment IPOST Guidance for Healthcare Providers revised on 4/23/12. The document directed that The IPOST provides documentation of the patient/resident treatment preferences which reflect the values of the patient/resident. In health care facilities, the IPOST should be the first document in the clinical record. The section titled How to Change the IPOST Document revealed, The IPOST form should be reviewed periodically and a new IPOST form completed when the patient/resident's treatment preferences change. Review may also occur when the patient/person is transferred from one care setting or care level to another, and/or routine medical appointments.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		

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F 580	Continued From page 8 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580	The facility does and will continue to ensure to notify the resident's physician and responsible person related to changes in the resident's status and notification to responsible person on any new physicians' orders including resident #3, #32, and #35. All residents have the potential to be affected by the alleged deficient practice. Nurses were educated by DON on 3/21/22 of our Change of Condition Standard and to notify the resident's physician and responsible person related to changes in the resident's status and notification to responsible person on any new physicians' orders The Director of Nursing/Designee will monitor resident orders, resident progress notes and 24-hour communication sheets for any changes in condition and new orders and the need for follow up with the resident's physician and responsible person weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of Compliance: 3/21/22	

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room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and policy review the facility failed to notify the resident's responisible person related to changes in the residents status and any new physicians' orders. In addition the facility failed to notify a resident's physician of changes for 3 out of 20 residents reviewed. (Resident #3, #32, and #35) The facility reported a resident census of 39.

Findings included:

1. Resident #35's Quarterly Minimum Data Set (MDS) dated 1/13/22 documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS documented Resident #35's diagnoses included, non-traumatic brain dysfunction, Alzheimer's disease, and psychotic disorder.

The Nurses' Note dated 2/9/22 at 7:44 a.m. documented that Resident #35 reported that she was feeling dizzy. Resident #35's vital signs included a blood pressure of 113/74, a heart rate 150, a respiratory rate of 22, a temperature of 98.0 Fahrenheit (F), and 92 percent (%) oxygen saturation. The Nurses Notes continued indicating that Resident #35 had a productive cough with greenish/yellow phlegm. Resident #35 began to cry, and state that she didn't want to go to the hospital. After Resident #35 received reassurance by the nurse that she would not be sent to the hospital, she calmed down. A message was sent to the primary care physician and the medical director.

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The Physician's Order Note dated 2/9/22 at 8:18 a.m. documented a call received in response to message sent to the physician for new orders. The provider gave new orders for hand held nebulizer treatments, a chest x-ray, lab tests, antibiotics, and to call the primary care physician if the resident got worse.

The progress notes lacked documentation that Resident #35's Responsible party received notice of the residents change in condition and of the new physician orders.

On 2/28/22 at 3:10 p.m. Staff I, Certified Medication Aide (CMA), reported that the resident was in the memory care unit, and they didn't have a good cognition (memory).

On 3/1/22 at 8:46 a.m. Staff F, Licensed Practical Nurse (LPN), reported that when a resident had a condition change the following people should receive notice of the change in condition, the doctor, the family or primary contact person, and even the Director of Nursing (DON) depending on the type of condition change.

On 3/1/22 at 9:29 a.m. the DON reported explained that she was in the process on working on communication to the families, especially after the event with Resident #35. Due to Resident #35's impaired cognition affecting her ability to make her own decisions, thus the the family should have been called about the situation.

2. The MDS assessment tool, dated 2/19/22, Resident #3's list of diagnoses included cerebrovascular accident(stroke), hemiplegia(one-sided paralysis), and chronic

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pain. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, and dressings. The resident required limited assistance of 2 staff for personal hygiene, and extensive assistance of 2 staff for toilet use. The MDS listed the resident's BIMS score as 9 out of 15, indicating moderately impaired cognition.

The resident's Weights and Vitals Summary report listed the following weights:
8/12/21 131 lbs
2/15/22 159 lbs

The weight change between the resident's 8/12/21 weight and 2/14/22 (approximately six months) weight calculated a weight gain of 21.37%.

The resident's clinical record lacked documentation of provider notification regarding the resident's weight gain.

An 8/20/21 Care Plan entry directed staff to weigh and record resident weights according to the company policy and stated the resident would maintain adequate nutritional status.

3. The MDS assessment tool, dated 1/11/22, listed diagnoses for Resident #32 that included Prader-Willi Syndrome(a genetic disorder which could cause obesity), diabetes, and weakness. The MDS stated that the resident required extensive assistance of 1 staff for personal hygiene and bathing. The resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use. The MDS listed the resident's BIMS score as 9 out of 15,

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indicating moderately impaired cognition.

The resident's Weights and Vitals Summary documented the following weights:
8/6/21 132.4 lbs
2/1/22 200 lbs

The weight change between the resident's 8/6/21 and 2/1/22 (approximately six months) calculated as 51.06%.

The Nutrition/Dietary Note dated 12/15/21 at 9:22 a.m. recorded that the resident continued to show weight gain despite attempts to reduce calories in meals.

The resident's clinical record lacked documentation of physician notification regarding the resident's weight gain.

The Care Plan Focus area revised on 11/12/21 by the Dietician documented that the resident had a significant weight gain since admission.

The undated facility policy Nutrition and Weight Management directed staff to address weight discrepancies of more than 5 pounds. The policy directed staff to notify the resident's physician of any weight change greater than 5%.

During an interview on 3/1/22 at 9:23 a.m., the DON (Director of Nursing) stated that she could not locate documentation of notification to the provider regarding Resident #3's and Resident #32's weight gain.

During an interview on 3/3/22 at 12:08 p.m., the DON stated the facility should notify the provider of a significant weight gain or loss.

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ASPIRE OF WASHINGTON	601 E POLK ST WASHINGTON, IA 52353

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F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582	The facility does and will continue to ensure that there is documentation of appeal decisions and there is a date of notification of Medicare Non-Coverage listed for residents with Medicare services ending including for resident #11 and #32. All residents have the potential to be affected by the alleged deficient practice. The Social Worker was educated by Administrator on 3/30/22 on the Financial Planning & Assistance detailed explanation of Non-Covered Instructions for Medicare and Managed Care standard and the need to ensure that there is documentation of appeal decisions and there is a date of notification of Medicare Non-Coverage listed for residents with Medicare services ending. The Social Worker/Designee will audit that there is documentation of appeal decisions and there is a date of notification of Medicare Non-Coverage listed for residents with Medicare services ending Weekly X 4, monthly X 2 months and quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/30/22	

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F 582	Continued From page 14	F 582		

deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to document appeal decisions and the date of notification of Medicare Non-Coverage for 2 of 3 residents with Medicare services ending (Residents #11 and #32). The facility reported a census of 39 residents.

Findings:

1. The facility Beneficiary Notice-Residents Discharged Within the Last Six Months documented Resident #11 discharged from a Medicare covered Part A stay on 12/18/21.

The facility's Notice of Medicare Non-Coverage indicated 12/18 as the resident's last day of service. The section regarding how to ask for an immediate appeal indicated the resident needed to make their request to Quality Improvement Organization (QIO). The form directed to call QIO. The section documented {insert QIO name and toll-free number of QIO} to appeal. The form lacked documentation of a number to call or the

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name of the QIO. The form was signed by Resident #11 but lacked a date of completion. The notification also lacked information on whether the resident wished to appeal the decision of the services ending.

2. The facility Beneficiary Notice-Residents Discharged Within the Last Six Months documented Resident #32 discharged from a Medicare covered Part A stay on 11/3/21.

The facility's Notice of Medicare Non-Coverage indicated 11/3 as the resident's last day of service. The section regarding how to ask for an immediate appeal indicated the resident needed to make their request to Quality Improvement Organization (QIO). The form directed to call QIO. The section documented {insert QIO name and toll-free number of QIO} to appeal. The form lacked documentation of a number to call or the name of the QIO. The section labeled Signature of Patient or Representative indicated verbal notice on 10/28/21.

The Advanced Beneficiary Notice of Non-coverage (ABN) dated 10/28/21 noted that if Medicare didn't pay for (D) below, the resident could have to pay. The section (D) directed max potential. The sections the reason Medicare may not pay and the estimated cost lacked documentation. The form directed to choose an option regarding if they continued to want (D). The options section lacked the selection regarding the resident's choice of options below 1. They wanted the (D) listed above. The resident could ask to be paid now, but they also want Medicare billed but understood that if Medicare didn't pay, they were responsible for the payment. I have the option to appeal by following the

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directions on the Medicare Summary Notice.
2. They wanted the (D) listed above but don't bill Medicare. They could be asked to pay as they were responsible for the payment. The resident was unable to appeal with this choice.
3. They didn't want the (D) listed above. They understood that they couldn't appeal if they chose this option.
The signature section indicate Resident #32 received verbal notice on 10/28/21.

The undated Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form CMS 10055 (2018) policy directed that failure to to use the form CMS-10055 (SNFABN) or significant alterations of the SNFABN could result in the notice being invalidated and/or the SNF being held liable for the care in question. The policy indicated under section Reason Medicare May Not Pay that the facility must give the applicable Medicare coverage guideline(s) and a brief explanation of why the beneficiary's medical needs or condition didn't meet the Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare could deny the payment. The policy directed staff to ensure the beneficiary selected one option box to indicate their wishes.

The undated policy labeled Form Instructions Advanced Beneficiary Notice of Non-Coverage (ABN) OMB Approval Number: 0938-0566 instructed for the Body Blank (D): the notification must list the specific name of the items or services that could be not covered. The policy directed that Blank (E): reason Medicare may not pay must explain in a beneficiary friendly

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F 582	Continued From page 17 language, why the services might not be covered by Medicare. The policy indicated that section Blank (F) estimated coverage must complete the column under Blank (F) to ensure the beneficiary had all available information to make an informed decision about whether or not to obtain potentially noncovered services. The notification must make a good faith effort to insert a reasonable estimate for all of the items or services provided under section Blank (D). The section labeled Signature Box regarding Blank (I) Signature: indicated that the beneficiary (or representative) must sign the notice to indicate that they have received notice and understood its contents. The Blank (J) Date: directed that the beneficiary (or representative) must write the date they signed the ABN. If the beneficiary has a physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the person giving the notification. During an interview on 3/2/22 at 10:04 a.m., the Social Services Director stated she was not aware she needed to ask residents that discharged from skilled services if they wished to appeal. She explained that she informed the residents of the discharge within two days of the date of discharge.	F 582		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625		

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F 625	Continued From page 18 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical records review, staff interviews, facility policies, and the facility's Admission Agreement, the facility failed to provide 3 of 4 residents with a bed-hold option upon transfer to a hospital. (Residents #16, #18, and #26). The facility reported a resident census of 39. Findings include: 1. Resident #16's Quarterly Minimum Data Set (MDS) dated 1/26/22 documented a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. The MDS documented Resident #16's diagnoses included stroke with left-sided weakness, kidney disease, and heart disease.	F 625	The facility does and will continue to ensure that written information related to their Bed-Hold Policy Before/Upon Transfer will be completed prior to a resident's transfer to a hospital is completed for all residents, including resident #16, #18 and #26. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff were educated by DON on 3/21/22 our Bed Hold Policy policy and procedure regarding Notice of Bed Hold Policy Before/Upon Transfer to the hospital. The DON/Designee will review and audit transfers and proper documentation of Bed Hold policy weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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The Nurse Note dated 12/14/21 at 8:37 a.m. documented a phone call from the hospital that the resident would be at the hospital for a couple of more days for the administration of intravenous antibiotics.

The Admission Summary dated 12/20/21 at 1:19 p.m. recorded that the resident had returned from the hospital.

The Nurse Note dated 1/8/22 at 5:22 p.m. documented that the ambulance service picked up the resident to transport him to the hospital.

The Nurse Note dated 1/17/2022 at 1:20 p.m. documented that the resident had returned to the facility.

The residents record lacked documentation of a bed hold offerred or completed for the hospitalization dates of 1/8/22 and 12/24/21.

On 02/28/22 at 1:22 p.m. Staff A, Licensed Practical Nurse (LPN), reported that the bed hold forms were in the file cabinet at the nurses station. Staff A explained that they should be sent out with each hospitalization with the resident..

On 2/28/22 at 2:00 p.m. the Director of Nursing reported that they could not find the bed-holds for the Residents #16, #18, #26, and #41.

The undated Resident Admission Agreement documented under the Facility Obligations and Rights section included a section labeled Bed-hold Policy. The Bed-hold Policy indicated that upon request, the facility should hold a resident's bed when the resident was away from

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F 625	Continued From page 20	F 625		

the facility for medical leave or on therapeutic leave as long as the applicable bed-hold fee was paid. The Resident would be notified if bed-hold charges will be assessed, and must consent in writing to the additional charge.

The Facility Bed Hold policy dated 3/3/20 documented that all residents/responsible parties should receive a copy of the state specific bed hold policy and bed hold authorization form upon admission. In the case of an emergency transfer, the resident or their responsible party is provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. The bed hold authorization form must be completed and signed by the resident/responsible party to be valid.

2. Resident #18's MDS assessment tool, dated 12/25/21, listed diagnoses that included heart failure, diabetes mellitus, and morbid (severe) obesity due to excess calories. The MDS instructed that the resident required limited assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. Resident #18's most recent admission/entry or reentry to the facility was on 10/26/21. Resident #18 returned to the facility from an acute hospital stay.

The Admission Record printed 3/3/22 showed Resident #18's most recent hospital stay as 10/21/22 until 10//26/22.

The resident's clinical record lacked documentation the facility provided a copy of the

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bed-hold policy for the above transfer.

3. The MDS assessment tool, dated 1/1/22, listed diagnoses for Resident #26 included: Diabetes mellitus, respiratory failure, and weakness. MDS stated the resident required extensive assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, and personal hygiene. Bathing did not occur in the assessment period. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, which indicated cognitively intact. The most recent admission/entry or reentry into the facility was documented as 8/11/21. The resident readmitted to the facility from an acute hospital.

The Admission Record dated 3/8/22 indicated the resident's most recent hospital stay as 8/7/21 until 8/11/21.

The Hospital updates note dated 8/7/21 at 10:54 PM documented that the resident transferred to the hospital.

The Admission Summary note dated 8/11/21 at 3:17 PM indicated the resident readmitted to the facility.

The Health Status Note dated 11/7/21 at 9:50 AM recorded that the nurse got an order to send Resident #26 to the hospital.

The Admission Summary dated 11/17/21 at 2:40 PM reported that Resident #26 returned to the facility from the hospital.

The resident's clinical record lacked documentation the facility provided the resident or

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F 625	Continued From page 22 the resident's representative a copy of the bed-hold policy for the above 2 transfers. The facility policy dated 3/3/2020, titled Bed Hold indicated the facility would provide residents with bed hold information upon hospital transfer.	F 625		
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 reviews, staff interviews, and facility policy review, the facility failed to resubmit a new Preadmission Screening and Resident Review (PASARR) form following the addition of new medical diagnoses for one of one resident reviewed for PASARR (Resident #13). The facility reported a census of 39 residents.	F 644	The facility does and will continue to ensure that the facility will resubmit a new Preadmission Screening and Resident Review (PASARR) for following the addition of new medical diagnoses including for resident #13. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator was educated by DON on 3/31/22 on our policy for resubmitting a new Preadmission Screening and Resident Review (PASARR) following the addition of new medical diagnoses. The MDS Coordinator/Designee will review and audit residents DX for the need of a new PASARR weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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F 644	Continued From page 23	F 644		

Findings include:

The Quarterly Minimum Data Set (MDS) assessment dated 12/20/21 revealed Resident #13 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, indicating severe cognitive impairment. The diagnoses for Resident #13 included delusional disorders, major depressive disorder, and dementia without behavioral disturbance.

The Notice of Negative Level I (one) Screen Outcome from Ascend, mailing date 10/2/14, documented no further Level 1 screening is required unless you are known to have or are suspected of having a major mental illness or developmental disability and exhibit a significant change in treatment needs. Per the section of the form titled Mental Illness, it had been documented Resident #13 did not have any of the following Major Mental Illnesses: Schizophrenia, Schizoaffective Disorder, Major Depression, Psychotic/Delusional Disorder, Bipolar Disorder (manic depression), or Paranoid Disorder. Psychotropic medications documented on the form included Citalopram for Depressive Disorder and Risperidone for Dementia/Neurocognitive Disorder.

On 2/23/22, review of active diagnoses included delusional disorder (added 4/19/18) and major depressive disorder (added 4/21/14).

The Physician Orders signed 2/10/22 included Buspirone 10 mg (milligrams) four times a day for anxiety, Divaloprex Sodium ER 250 mg one tablet by mouth one time a day related to delusional disorder, and Divaloprex Sodium ER 500 mg one tablet by mouth in the afternoon related to

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F 644	Continued From page 24 delusional disorder. On 2/28/22 at approximately 12:40 PM, the Director of Nursing (DON) provided Resident #13's PASARR dated 10/2/14, and confirmed this was the most recent assessment. On 3/1/22 at 9:42 AM, the MDS Coordinator was queried about their involvement in PASARRs. The MDS Coordinator was notified of Resident #13 having had new psychiatric diagnoses added, and the MDS Coordinator acknowledged that typically in that situation a new PASARR would be filed. On 3/1/22 at 3:27 PM, the DON was queried about PASARR assessments related to a resident with a new psychiatric diagnosis. The DON acknowledged that the facility would need to resubmit a new PASARR with the new diagnosis. The facility provided an undate PASRR Change of Condition and BIMS Calculation power point, which documented the following per the Change of Condition related to the PASRR section: The following are specific circumstances and situations that must be considered as a change in condition for resident with mental illness a. A New psychiatric diagnosis with an exacerbated condition.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		

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F 655	Continued From page 25 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review,	F 655	The facility does and will continue to ensure and complete and/or provide the resident or the resident's representative a baseline care plan within 48 hours of admission including for resident #4 and #41. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator was educated by DON on 3/31/22 on our RAI – Care Planning Policy and Procedure and the need to complete and/or provide the resident or the resident's representative a baseline care plan within 48 hours of admission. The MDS Coordinator/Designee will review and audit new resident admissions for a base line care plan to be done within 48 hours of admission weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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resident interview, and staff interview, the facility failed to complete and/or provide the resident or the resident's representative a baseline care plan within 48 hours of admission for 2 of 20 residents reviewed (Residents #4 and #41). The facility reported a census of 39 residents.

Findings:

1. The MDS (Minimum Data Set) assessment tool, dated 11/29/21, listed diagnoses for Resident #4 included thyroid disorder, hypertension (high blood pressure), and depression. The MDS stated the resident was independent with her ADLs (Activities of Daily Living) and listed her BIMS (Brief Interview for Mental Status) score as 13 out of 15, indicating intact cognition. The MDS listed the resident's admission date as 11/16/21.

During an interview on 2/21/22 at 12:16 p.m., Resident #4 stated she didn't have a care conference since her admission to the facility.

The resident's Baseline Care Plan lacked a signature in the section titled "Resident" or "Representative" to indicate staff provided the resident with the Care Plan.

The August 2021 policy "RAI/Care Planning" directed staff to develop an interim baseline Care Plan within 48 hours of admission and to communicate the plan with the resident and their family.

During an interview on 3/3/22 at 12:08 p.m., the DON (Director of Nursing) stated that the floor nurses should go over the Baseline Care Plan with new residents.

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F 655	Continued From page 27 During an interview on 3/3/22 at 2:47 p.m., the MDS Coordinator stated that when Resident #4 admitted, she was out of the facility. 2. The Admission Record printed on 3/3/22 for Resident #41 listed an 11/24/21 admission date, and a 12/8/21 discharge date. The Admission Record documented Resident #41's diagnoses included conduct disorder, unspecified; unspecified open wound, left foot; and diabetes mellitus with hyperglycemia. The clinical record lacked documentation of a baseline care plan.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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F 656	Continued From page 28 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed implement a person centered care plan for 1 of 5 residents reviewed for medications (Resident #19). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set assessment dated 12/26/21, listed diagnoses for Resident #19 included non-Alzheimer's dementia, muscle weakness, and hyperglycemia. The MDS stated the resident required limited assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 7 out of 15, indicating	F 656	The facility does and will continue to ensure and implement a person-centered care plan for medications including for resident #19. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator was educated by DON on 3/31/22 on our RAI – Care Planning Policy and Procedure and the need to implement a person-centered care plan for medications. The MDS Coordinator/Designee will review and audit resident orders for the need to implement a person-centered care plan for medications weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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F 656	Continued From page 29 severely impaired cognition and stated the resident received insulin. 11/1/21 Order Details reports listed orders for Basaglar KwikPen (insulin pen) Solution Pen-injector 22 units at bed time and an order for Novolog (insulin) 8 units before meals. The Care Plan lacked documentation the resident received insulin and lacked side effects related to insulin for staff to monitor. The RAI/Care Planning Management policy dated August 2021, stated the care plan would be a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and would include individual needs and care requirements. During an interview on 3/03/22 at 2:47 p.m. the Minimum Data Set Coordinator stated the Care Plan should include insulin.	F 656		
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 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.	F 657		

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F 657	Continued From page 30 (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 observation, interview, and record review, and facility policy review the facility failed to ensure care conferences were completed quarterly and failed to ensure care plans addressed current resident status for use of a pommel cushion, catheter, updated fall interventions, skin prevention interventions, and current elopement interventions for ten of ten residents reviewed for care plan revision and care conferences (Resident #9, #10, #15, #16, #17, #18, #21, #26, #36, and #40). The facility reported a census of 39 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated 12/8/21 revealed Resident #9 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact. Diagnoses for Resident #9 included paranoid schizophrenia and type two diabetes mellitus with diabetic chronic kidney disease.	F 657	The facility does and will continue to ensure care conferences are completed quarterly and will ensure care plans address current resident status for use of cushions, catheters, fall interventions, skin prevention interventions and elopement interventions including for resident #9, #10, #15, #16, #17, #18, #21, #26, #36 and #40. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator was educated by DON on 3/31/22 on our RAI – Care Planning Policy and Procedure and the need to ensure care conferences are completed quarterly and will ensure care plans address current resident status for use of cushions, catheters, fall interventions, skin prevention interventions and elopement interventions. The MDS Coordinator/Designee will review and audit residents on that care conferences are completed quarterly and ensure care plans address current resident status for use of cushions, catheters, fall interventions, skin prevention interventions and elopement interventions weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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The most recent Care Conference Note in Resident #9's electronic clinical record was dated 3/24/21.

On 2/28/22 at approximately 1:09 PM, the Minimum Data Set (MDS) Coordinator provided care plan conference summary notes for multiple residents, which included Resident #9. Care Plan Conference Summary Forms were provided for 4/25/18 and 8/28/19 for Resident #9. At 1:09 PM, the MDS Coordinator acknowledged what she provided was all she could find.

On 3/01/22 at 9:28 AM, the MDS Coordinator explained they had started MDS at the facility around October or November 2021, and had been off until November 19. The MDS Coordinator explained they did not start having Care Plan Conferences until the end of December 2021/January 2022.

2. The MDS assessment dated 12/9/21 revealed Resident #10 scored 00 out of 15 on a BIMS exam, which indicated the resident was severely cognitively impaired. Diagnoses included dementia without behavioral disturbance and muscle weakness.

On 2/22/22 at 10:31 AM, Resident #10 was observed to be transferred via hoyer lift from the wheelchair to the their bed, incontinence care was performed, and the resident was then transferred via hoyer lift back into the wheelchair. Observation revealed Resident #10 had a pommel cushion in their wheelchair.

Physician Orders and the Care Plan did not address use of a pommel cushion for Resident

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#10.

On 2/28/22 at 1:47 PM, Staff E, Scheduler/Certified Medication Aide (CMA) was queried about a cushion for Resident #10. Staff E explained the resident did have a cushion with the "thing" in the middle because he would slide out. Staff E further explained she hadn't worked with the resident for a little bit.

On 3/01/22 at 9:34 AM, the MDS Coordinator was queried about Resident #10's pommel cushion and if it should have been on the Care Plan, and explained they were not sure if it should be. Observation of Resident #10 with the MDS Coordinator upon conclusion of the interview revealed Resident #10 was seated in their wheelchair in the common area by the nursing station, and had a blue pommel cushion present in their chair.

On 3/01/22 at 3:19 PM, the Director of Nursing (DON) was queried about the pommel cushion for Resident #10. The DON explained the resident had the cushion from hospice. When queried if it should be care planned, the DON responded they could add it.

3. The MDS assessment dated 1/14/22 revealed Resident #36 scored 8 out of 15 on a BIMS exam, which indicated the resident was severely cognitively impaired. The assessment documented the resident had an indwelling catheter. Diagnoses for Resident #36 included, in part, alcohol dependence with alcohol-induced persisting dementia, and benign prostatic hyperplasia with lower urinary tract symptoms.

The signed Physician Orders dated 2/10/22

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included the following order, dated 12/19/21: Insert 18fr (french) catheter for bladder distention and inability to urinate.

On 2/28/22, the Care Plan for Resident #36 did not address use of an indwelling catheter.

On 2/21/22 at approximately 1:27 PM, Resident #36 was observed in the doorway of another resident's room with catheter tubing observed to stretch upwards towards the middle section of the room door.

On 3/01/22 at 9:34 AM, the MDS Coordinator was queried if Resident #36 had a Care Plan for a catheter, and explained they did not see it and it would be on there today.

On 3/01/22 at 3:19 PM, the DON was queried about the catheter not having been addressed on the resident's Care Plan, and explained that had been updated.

Incident Reports for Resident #36 revealed the resident had fallen in the resident room and/or resident bathroom on 3/25/21, 5/22/21, 11/23/21, 12/15/21, 12/17/21, 2/10/22, and 2/16/22.

On 2/28/22 at 2:21 PM, the DON was queried about the falls process at the facility. The DON explained if a resident fell, then the nurse would come in and do the assessment, and would take vitals before moving them. If they were in pain at all the resident would not be moved until they had talked to the doctor to see what they wanted to do. Then, they would get them up safely, call the family, and notify the proper people. Neuros would be done if it was unwitnessed. The DON was queried about incident reports, and explained

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this was done by the nurse. They would do risk management, and a progress note would be completed. The DON was queried as to the process if there were witnesses, and explained if they witnessed a fall they would need to put them in as a witness. The DON would review the report, help with the new fall intervention, and the DON, Administrator, and the nurse would sign it. The DON was queried where the new intervention would be located, and explained it went on the notes section. The DON acknowledged it had not printed on the incident report. The DON acknowledged the new intervention would go on the care plan.

The DON was queried about the Care Plan for Resident #26, as the most recent fall interventions were observed to be dated in 2021. Additional information was requested at this time.

On 3/01/22 at 9:38 AM, the MDS Coordinator was queried about the Care Plan for falls for Resident #36. The MDS Coordinator explained she had gone into the resident's Care Plan yesterday and she did not know what happened, it was fixed now, and she did not know why the interventions were not on there. Then, the MDS Coordinator said some of the interventions had been present but the dates had not been there.

The Care Plan dated 3/25/21 documented, I have the potential risk for falls r/t (related to) my alcohol induced dementia. Interventions included the following:

The following interventions documented a created date of 2/28/22:

a. 11/23/21 FI: 1st shift to check on resident prior

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to end of shift to anticipate needs
b. 12/15/21 FI: resident moved to 400 hall for increased supervision
c. 12/17/21 FI: PT/OT eval and treat
d. 2/10/22 FI: assess needs Q 2 hours
e. 2/16/22 FI: If resident is awake do not lay down in bed.

Additional interventions included the following:

a. (created date 3/26/21, revised 6/10/21) 3/25/21- signage posted in room and on call light to cue resident to ask for assistance.
b. (created date 3/25/21, revised 6/10/21) 3/25/21-CNAs to use body pillow for positioning and comfort when I am getting ready for bed.
c. (created date 5/24/21, revised 6/10/21) 5/22/21-CNAs to ensure resident has shoes on at all times when out of bed.
d. (created date 3/25/21) Anticipate and meet The resident's needs.
e. (created date 3/25/21) Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.
f. (created date 3/25/21) Follow facility fall protocol.
g. (created 3/25/21) Pt evaluate and treat as ordered or PRN (as needed).

The Facility Policy tiled RAI (Resident Assessment Instrument) Planning Management dated August 2021 documented, THE CARE PLAN The Comprehensive Care Plan is completed within seven (7) days after the MDS is completed (at no time will this time frame exceed 21 days), and reviewed quarterly thereafter. If modifications, deletions, additions are necessary,

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changes would be made at the time of occurrence.....Care Conferences are held after the MDS is completed but before the care plan is due for all new admissions. Conferences are also held quarterly and annually with each review. In addition, care plan reviews are conducted when a resident has a change of condition.
4. The MDS assessment dated 12/25/21, listed diagnoses for Resident #18 included: heart failure, Diabetes mellitus, and morbid (severe) obesity due to excess calories. MDS stated the resident required limited assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, personal hygiene, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 14 out of 15, which indicated cognitively intact.

During an interview on 02/22/22 at 02:43 PM the resident stated the facility did not invite her to care conference and she did not attend.

The resident ' s clinical record lacked documentation of care conferences since 8/5/21.

5. The MDS assessment dated 12/26/21, listed diagnoses for Resident #17 included: heart failure, Diabetes mellitus, and morbid (severe) obesity due to excess calories. MDS stated the resident required extensive assistance of 2 plus staff for bed mobility, transfers, toilet use, and personal hygiene. Extensive assistance of one staff for dressing, and totally dependent for bathing. Walking did not occur during this assessment period The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, which indicated cognitively intact.

During an interview on 02/22/22 at 02:43 PM the

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resident stated the facility did not invite her to the care conference and she did not attend.

The resident ' s clinical record lacked documentation of care conferences since 6/18/21.

6. The MDS assessment dated 1/1/22, listed diagnoses for Resident #26 included: Diabetes mellitus, respiratory failure, and weakness. MDS stated the resident required extensive assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, and personal hygiene. Bathing did not occur in the assessment period. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 15 out of 15, which indicated cognitively intact.

During an interview on 02/22/22 at 02:43 PM the resident stated the facility did not invite her to a care conference and she did not attend.

The resident ' s clinical record lacked documentation of care conferences between 4/1/21 and 1/13/22.

A facility policy titled RAI/Care Planning Management dated August 2021 stated care conference attendees are the Interdisciplinary (ID team), resident, and family/responsible party, and other staff who have vital information to share about the residents being reviewed. The policy stated care conferences are held quarterly, annually, and when there is a change in condition.

On 02/28/22 01:13 PM the MDS Coordinator Registered Nurse (RN) stated the facility had no further documentation of care conferences.

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7. The MDS assessment dated 1/20/22, listed diagnoses for Resident #40 included cerebral infarct due to unspecified occlusion or stenosis of unspecified cerebral artery, non-Alzheimer's dementia, and morbid (severe) obesity due to excess calories. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 4 out of 15, which indicated a severe cognitive impairment.

The Care Plan stated the resident was at increased risk for wandering and potential elopement, with an intervention for the use of a wanderguard dated 6/8/21.

On 12/29/21 at 9:54am the facility received a physician order to check for proper functioning for wanderguard on every shift two times daily. The reason for this order stated system not working properly.

During an interview on 03/03/22 at 11:39 AM the Director of Nursing (DON) stated if a resident safety device is not operational she expected the care plan to be immediately updated. The DON stated that the facility became aware that the Wanderguard system was not operational on 12/29/21. She stated the resident current care plan should be updated.

8. The MDS assessment dated 9/22/21, listed diagnoses for Resident #15 included non-Alzheimer's dementia, paranoid schizophrenia, and anxiety. The MDS stated the resident required supervision and setup assistance for eating, limited assistance of 1 staff

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for bed mobility, transfers, walking, and toilet use, and extensive assistance of 1 staff for dressing, personal hygiene, and bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 10 out of 15, indicating moderately impaired cognition.

The Care Plan listed the following entries:
5/5/21 The resident was an elopement risk and wandered aimlessly. Distract the resident from wandering by offering diversions such as activities, food, conversation, television, and books. The resident wore a wanderguard(a device worn which alerted if a resident attempted to exit the facility).

A 12/3/21 Nursing Note stated the resident was awake all night and came up to the desk with her coat on and asked to use the phone to "get out of this place".

A 12/5/21 Nursing Note stated the resident stated she needed to go home and see her children and told staff they couldn't keep her there.

A 12/12/21 1:00 p.m. Nursing Note stated kitchen staff related that the resident stood outside the front door rang the doorbell at approximately 10:00 a.m. Staff redirected the resident and she returned inside the building.

According to the National Weather Service, the high temperature for Washington, Iowa on 12/12/21 was 43 degrees Fahrenheit (https://www.weather.gov/wrh/Climate?wfo=dvn).

The December 2021 Treatment Record stated the resident had a wanderguard and directed staff to check it for proper function and placement

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every shift. The Treatment Record included staff initials until 12/29/21 to indicate completion of the task.

A 12/29/21 Physician's Order directed staff to discontinue the resident's wanderguard as the system was not working.

The Care Plan lacked any further interventions to prevent the resident from eloping after 5/5/21. The Care Plan continued to include a wanderguard as an intervention even though the system had not functioned since at least May of 2021.

The Care Plan lacked any updates following the resident's elopement on 12/12/21.

A list provided to the survey team by the DON(Director of Nursing) on 2/24/22, listed 8 cognitively impaired, independently mobile residents including Resident #15.

The facility policy "Elopement Management", dated 2021, stated after an elopement, the facility would conduct a full investigation of how the elopement happened and where the process failed. The policy directed staff to develop an individualized elopement risk/mood/behavior plan.

During an interview on 2/23/22 at 10:49 a.m., Staff A, Licensed Practical Nurse, stated she worked the day the resident left the building. She stated the resident went out the front door and did a "U-turn" and came right back in. She stated she saw the resident approximately 30 minutes before.

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During an interview on 2/23/22 at 4:44 p.m., Staff N, Dietary Aide, stated he was in the kitchen and heard the doorbell ring and was "flabbergasted" the resident was outside ringing the doorbell. He stated he had not heard the alarm. He stated when he let the resident in, the rug was not stuck in the door and there was no key in the door.

During an interview on 2/23/22 at 12:00 p.m., Staff M, Housekeeping Supervisor, stated she was in the kitchen and Staff N Dietary Aide told her he let the resident into the building. She stated after he told her this she went to the front door because she wondered how the resident got out. The surveyor accompanied Staff M to the front door so she could explain what she observed. Staff M stated after the resident came back in the lights on the door were green and not red to indicate the door was locked. She stated she had to go and get the key to lock it because it was totally unlocked. She stated someone turned it off and she had to turn it back on.

During a follow-up interview on 2/23/22 at 4:08 p.m., Staff M stated when she checked the door on the day of the elopement when it was unlocked, there was no key in the door and the rug was not stuck in the door.

During an interview on 2/23/22 at 2:57 p.m., the Maintenance Director stated after the elopement, he checked the door and it worked fine. He stated there were no problems with the sensor.

During an interview on 2/23/22 at 3:09 p.m., the Administrator stated after the elopement, the door worked fine. He stated he didn't believe staff could have turned the alarm off because the key would need to be in the door. He stated he

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thought possibly the rug was stuck in the door and that was why it did not alarm. He stated the facility's wanderguard system had not worked since May of 2021 when the facility owners switched. After the interview, the surveyor and the Administrator attempted to remove the key from the door while it was in an unlocked state and it was impossible to remove.

During an observation on 2/23/22 at 4:03 p.m. the Administrator put the code into the front door pad, opened the door, placed the rug between the door and the threshold to prevent the door from closing and the alarm did not go off.

During a observation on 2/24/22 at 3:40 p.m. the front door had an additional alarm system on it. In order to leave the facility, staff had to enter codes into 2 keypads or an alarm sounded.

During an interview on 2/28/22 at 7:45 a.m., the Administrator stated the rug at the front door had been there since the new company took over in May of 2021.

During an interview on 3/8/21 at 11:31 a.m., the Director of Nursing stated elopement interventions was something they should care plan.

During an interview on 2/28/22 at 12:55 p.m., the Minimum Data Set Coordinator stated she had a hard time locating care conferences prior to her time at the facility.
9. The MDS dated 12/23/21 for Resident#21 documented that the resident had scored a 13 out of 15 for the brief interview for mental status, which indicated intact cognitive skills for daily decision making. The MDS documented that the

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resident required none or just set up assistance of staff for activities of daily living.

The Care Plan dated 10/1/20 identified a focus area as follows; the potential risk of psychosocial well-being problem related to a depression diagnosis. The care plan directed the staff with the following interventions; Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears as needed. Provide opportunities for the resident and family to participate in care.

During the resident group interview on 2/22/22 at 1:45 p.m. Resident#21 reported that she did not get invited to her care conference meetings.

The Care Conference Notes provided by the facility included the dates 3/18/21. The Care Conference Note lacked the documentation that the resident had attended the care conference meeting.

The Care Conferences Noted in the electronic health record included the dates 3/18/21 and 6/24/21.

On 03/02/22 at 2:58 p.m. the MDS coordinator reported that she had not been able to find any other care plan conference notes or attendance records for the residents care conferences.

10. The MDS assessment dated 1/26/22 documented that Resident#16 had scored a 9 out of 15 for the brief interview for mental status, which indicated moderate impairment for cognitive decision making skills. The MDS documented that the resident had diagnoses including stroke with left sided weakness, kidney

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F 657	Continued From page 44 disease, and heart disease. Observation on 02/21/22 at 2:08 p.m. revealed the resident sitting in a wheelchair with heel protectors on both feet. Observation on 02/23/22 at 9:03 a.m. revealed the resident transferred from the his wheelchair to his bed. The bed had an inflated air mattress, Prevalon boots on both his feet, and a cushion in his wheelchair seat. Observation on 02/24/22 at 1:49 p.m. revealed the resident resting in bed with air mattress inflated, and Prevalon boots on both lower extremities. The residents Care Plan with the next review date of 5/23/22 documented the initiation of the following on 2/28/22 by the MDS Coordinator; Prevlon boots on at all times, and air mattress on the bed, but lacked the direction for staff to make sure wheelchair cushion had been in place.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to administer medications as directed and/or in a timely manner for 4 of 20 residents sampled for medication administration (Residents #10, #13,	F 658		

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F 658	Continued From page 45 #36, #40). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/9/21, listed diagnoses for Resident #10 included Alzheimer's disease, non-Alzheimer's dementia, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for eating, extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition. The February 2022 Medication Record listed an order for Trazodone (an antidepressant and sedative) 50milligrams (mg) 1.5 tabs at bedtime for insomnia. The entry for 2/26/21 had Staff K,Certified Medication Aide, initials to indicate she administered the medication. A review of Staff K's Timesheet revealed Staff K clocked out of her shift on 2/26/21 at 4:45 p.m. During an interview on 3/1/22 at 12:42 p.m., Staff O, Dietary Aide, stated a staff member came into the kitchen on 2/26/22 and he thought it was Staff K. He stated she could not get Resident #10 to take his medication and he observed her take the lid of the resident's pureed goulash and add medication to it. He stated Staff K then took a piece of paper and wrote the resident's name on it and taped it to the resident's food. He thought this was around 3:40 p.m. Staff K then placed the food back in the warmer for around an hour and stated Staff H CNA(Certified Nursing	F 658	The facility does and will continue to ensure to administer medications as directed and/or in a timely manner including for resident #10, #13, #36 and #40. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Medication Administration and Physician Services Policy and Procedures and the need to administer medications as directed and/ or in a timely manner. The DON/Designee will review and audit resident orders and MARS/TARS to make sure that medications are administered as directed and/or in a timely manner weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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Assistant) retrieved the food later and the resident ate around 5:00 p.m. or 5:30 p.m.

During an interview on 3/1/22 at 10:25 a.m., Staff H stated on 2/26/22 Staff K informed her and other CNAs that there was medication in Resident #10s food. She stated Resident #10's food had a label on it and she(Staff H) fed him the food and he ate about 70% of the total food on his plate including spaghetti, squash, and apple juice. Staff H stated she was not comfortable with this and she reported it to the Dietary Manager.

During an interview on 3/1/22 at 3:51 p.m., Staff P, Certified Nurse Aide, stated she worked on 2/26/22 and Staff K stated she planned to place the resident's medication into his food but she stated she did not know if she actually carried this out. She stated Staff K was not present in the facility during the evening meal.

During an interview on 3/1/22 at 1:10 p.m., the Dietary Manager stated staff informed him that Staff K placed medications in food and left it in the kitchen. He stated he informed the Administrator of this.

During an interview on 3/1/22 at 3:40 p.m., the Administrator stated the facility suspended Staff K pending their investigation. He stated his understanding of the situation was that Staff K was having trouble getting the resident to take his medications so she went in the kitchen and added his crushed Trazodone to his pureed spaghetti. He stated he started retraining regarding the incident.

During an interview on 3/2/22 at 3:18 p.m., the

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Administrator stated he verified Staff H fed the resident his food and did not believe that Staff K was in the building at that time.

The August 2021 facility policy "Medication Administration Guidelines" directed staff to administer medications 1 hour before or 1 hour after the scheduled time.

The undated Schedule of Medication Administration Times documented revealed medication adminstration times of 7:00 a.m., 11:00 a.m., 4:00 p.m., 7:00 p.m., and 9:00 p.m.

During an interview on 3/3/22 at 12:08 p.m., the Director of Nursing (DON) stated staff should administer medications in the window of one hour before or after the scheduled time.

During an interview on 3/8/22 at 11:31 a.m., the DON stated 4:45 p.m. was too early to administer bedtime medications.

2. The MDS assessment dated 1/14/22 listed diagnoses for Resident #36 included alcohol dependence with alcohol-induced persisting dementia; benign prostatic hyperplasia with lower urinary tract symptoms; other specified persistent mood disorders. The MDS stated the resident required limited assistance of 1 staff for bed mobility, walking, dressing, and extensive assistance of 1 staff for transfers, toilet use, and personal hygiene, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 8 out of 15, which indicated a moderate cognitive impairment.

A 2/11/22 physician visit note listed an order for Cipro 500 mg twice daily for five days for a urinary tract infection (UTI). A copy of the faxed

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order to the facility had a notation to indicate the facility faxed the order to the pharmacy on 2/11/22.

The February 2022 Medication Administration Record (MAR) noted a 2/11/22 Cipro order. The MAR revealed the medication started on 2/13/22 . The resident ' s paper and electronic chart lacked documentation of attempts to notify the pharmacy the facility did not receive the medication and to the provider and family of the delay in the start of the medication.

Prior to 3/1/22, per record review the care plan lacked documentation to monitor the resident for signs and symptoms of a UTI.

3. The MDS assessment dated 1/20/22, listed diagnoses for Resident #40 included cerebral infarct due to unspecified occlusion or stenosis(narrowing) of unspecified cerebral artery, non-Alzheimer's dementia, and morbid (severe) obesity due to excess calories. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and bathing. The MDS listed the resident's BIMS score as 4 out of 15, which indicated a severe cognitive impairment.

On 02/22/22 at 11:54 AM a record review revealed a physician's order on 12/9/21 for a one time UA (urinalysis) with C&S (culture and sensitivity meaning if bacteria was seen under microscope to do a culture to identify bacteria present and then test to determine best antibiotics).

On 12/13/22 the laboratory reported the cause of

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the UTI as Escherichia coli (a bacteria). The date and time of the reported results was 12/13/21 at 10:00 am. The resident progress notes lacked documentation or communication of this information.

A 12/15/2021 1:43 PM Physician Order directed staff to start Macrobid-active 1 capsule by mouth two times a day for UTI for 10 days.

A 12/16/22 progress note stated the facility did not receive the Macrobid. The facility lacked documentation of communication with pharmacy, provider, resident and family of the delay in the initiation of the medication.

The December 2021 Medication Administration Record (MAR) stated Macrobid 100 mg 1 capsule BID (twice daily) for 10 days with an order date of 12/15/21. Per the MAR the medication started on 12/17/21.

4. The MDS assessment dated 12/2021, listed diagnoses for Resident #13 included Alzheimer's dementia with late onset; unspecified mood (affective disorder), and generalized muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, transfers, personal hygiene and bathing. The resident required extensive assistance of 2 plus staff for walking, dressing and toileting. The MDS listed the resident BIMS score as 00 out of 15, indicating severely impaired cognition.

A record review on 2/24/21 at 1:19 PM revealed a Progress Note dated 1/3/22 entered by the Director of Nursing (DON). The note stated: Visit today with Advanced Registered Nurse Practitioner (ARNP) via telemedicine. The

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resident expressed that he had been anxious lately and that his mood had been fair. Denies being depressed or sad. Order to get a Depakote level and add Buspar and discontinue citalopram. Follow up for 3 weeks. This note was struck out on 1/9/22 by the DON with a stated reason for the wrong chart.

A Pharmacy Consultation report dated 1/18/22 stated the resident Progress Notes stated to discontinue celexa and start buspar on 1/3/22, but not reflected in the pharmacy orders. The pharmacy recommendation requested clarification.

A 1/19/22 email from the Advanced Registered Nurse Practitioner (ARNP) stated she noticed the resident did not have the order change from 1/3/22 in Electronic Health Record and she resent the order.

A 1/19/22 order directed staff to decrease Citalopram (antidepressant) to 10 mg PO (by mouth) for 7 days, then discontinue; and buspirone (anti-anxiety) 5 mg PO QID (four times daily) for 7 days, then increase to 10 mg PO QID.

A Progress Note entered on 1/19/22 at 9:22 AM directed an order change for citalopram; and at 9:34 AM directed an order for buspirone. A third progress note at 9:38AM stated the orders received from ARNP, and faxed to the pharmacy.

On 02/24/22 at 03:14 PM the DON stated a nurse took notes for the telehealth appointment and the provider faxed the orders. The DON stated the facility did not receive the 1/3/22 buspirone order. She stated she realized this the same day the provider emailed on 1/19/22.

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F 658	Continued From page 51 On 2/24/2022 at 3:30 PM record review revealed the January and February 2022 Medication Administration Record (MAR) lacked the new order for buspirone. On 2/24/2022 at 3:45 PM the surveyor asked the DON to clarify the order. A 2/24/2022 at 4:03 PM Progress Note stated the facility did not initiate the buspirone. An ARNP order directed staff to discontinue buspirone on 2/25/22 at 9:16 AM On 2/28/22 at 12:40 PM the DON stated the provider discontinued the Buspirone order on 2/25/2021 after the survey team brought it to the facility's attention. The facility policy titled Physician Services, dated August 2021, stated a licensed nurse between the hours of 12:00 midnight and 6:00 AM would review all physicians' verbal and/or telephone orders daily. The nurse should indicate if the orders were accurate and implemented. On 3/3/22 at 11:39 AM the DON stated when the facility received an order the expectation was the medication is started within 12 to 24 hours. The DON added the medication would start sooner if the facility had it in the ekit (emergency medication kit). Whether the medication was in the ekit or not, the expectation was the nurses should fax and call the pharmacy right away to verify receipt of fax and state the order is STAT (needed immediately). The DON stated she had a lot of pharmacy delivery issues. The DON added if the facility did not receive the new order	F 658		

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F 658	Continued From page 52 within 12 to 24 hours the nurse should call the pharmacy to inform them the facility did not receive the medication, and required it immediately. The nurse should update the provider, resident and family of the delay.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out complete perineal cleansing for 1 of 6 incontinent residents reviewed (Resident #40). The facility reported a census of 39. Findings: 1. The MDS(Minimum Data Set) assessment tool, dated 1/20/22, listed diagnoses for Resident #40 included cerebral infarct due to unspecified occlusion or stenosis of unspecified cerebral artery, non-Alzheimer's dementia, and morbid (severe) obesity due to excess calories. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 4 out of 15, which indicated a severe cognitive impairment Observation on 02/24/22 at 09:02 AM of Staff T Certified Nursing Assistant (CNA) and Staff L	F 677	The facility does and will continue to ensure to carry out complete perineal cleansing for incontinent residents including for resident #40. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Perineal Care Standard and proper perineal care after a resident has been incontinent. The DON/Designee will review and audit perineal care weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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CNA assisted the resident with incontinence care. The resident went to the bathroom to have an incontinence brief changed. Staff L and Staff T removed residents' pants and brief in the bathroom. The resident ' s pants were wet, and the brief was observed to be heavily saturated with urine and a large smear of stool. Staff L wiped the rectal area four times front to back. Staff L did not cleanse the frontal peri area, inguinal folds,or inner thighs. The resident did not refuse cares during the observation.

Per the Care Plan entry dated xxx (CP) stated the resident had bladder incontinence, and directed staff to check the resident for toileting and incontinent care needs.

A 12/13/21 lab report stated the resident had an Urinary Tract Infection (UTI) caused by . Escherichia coli (a bacteria that is found in stool)

The facility policy titled Perineal Care Standard dated August 2021 stated the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition. The policy directed the staff to cleanse the perineal area including in between the thighs, labia's, uretheral and vaginal openings.

During staff interview on 3/3/22 at 11:39 AM the Director of Nursing (DON) stated when a resident has a heavily saturated incontinence brief she expects proper peri care with washcloths and soap will be completed. The DON explained that proper peri care includes cleansing the residents groin, private parts, buttocks and abdominal areas.

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F 684	Continued From page 54	F 684	The facility does and will continue to ensure that there is prompt follow up and monitoring upon resident change of condition; weekly skin assessments are completed; there is prompt and thorough assess/monitor of non-pressure skin wounds and qualified staff will administer medications including for resident #10, #35, #36 and #192. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Medication Administration Standard, Skin Standard and Change of Condition Incident Reporting Standard as well as prompt follow up and monitoring upon resident change of condition; weekly skin assessments are completed; there is prompt and thorough assess/monitor of non-pressure skin wounds and qualified staff will administer medications. The DON/Designee will review and audit nursing 24 hour sheets, progress notes, skin sheets and qualified staff for prompt follow up and monitoring upon resident change of condition; weekly skin assessments are completed; there is prompt and thorough assess/monitor of non-pressure skin wounds and qualified staff will administer medications weekly X 4 weeks, monthly X 2 months and then quarterly X 3.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure 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, interview, and record review the facility failed to ensure prompt follow up and monitoring upon resident change of condition; failed to ensure weekly skin assessments were completed; failed to promptly and thoroughly assess/monitor a non-pressure skin wound; and failed to ensure medications were administered by staff who were qualified to do so for four of twenty-two residents reviewed for quality of care (Resident #10, Resident #35, Resident #36, and Resident #192). The facility reported a census of 39 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated 12/9/21 revealed Resident #10 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was severely cognitively impaired. Diagnoses for Resident #10 included dementia without behavioral disturbance and muscle weakness. The Care Plan last revised 8/16/19 documented, I			

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F 684	Continued From page 55 have the potential for skin breakdown r/t (related to) incontinence. The Care Plan did not address frequency of skin assessments. On 2/22/22, review of skin assessments in Resident #10's electronic health record (EHR) revealed the last assessment had been completed on 1/13/22. On 2/23/22 at 9:47 AM, Staff A, Licensed Practical Nurse (LPN) explained the CNAs (Certified Nursing Assistants) came and got her for showers, and there was a skin assessment sheet that was given to her after every shower. Per Staff A, there was a shower book that they put the skin sheets in after she had signed them. Also, Staff A acknowledged there were weekly electronic skin assessments. On 2/28/22, the Skin Assessment dated 2/27/22 was observed in the resident's electronic assessments. Skin assessments were not observed in the electronic record between 1/13/22 and 2/27/22. On 2/28/22 at 1:12 PM, Staff A, Licensed Practical Nurse (LPN) was queried about electronic skin assessments. Staff A explained electronic skin assessments were done by anyone who got the shower sheet, and they were supposed to do them before the end of the CNA shift. Staff A acknowledged they typically happened more often than weekly. Staff A was queried if there was any reason someone would not be getting electronic skin assessments, and responded no. On 3/01/22 at 3:14 PM, the Director of Nursing (DON) was queried about electronic Skin	F 684	Continued From page 55 All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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Assessments, and explained usually they were done on shower days. The DON further explained they were required once a week.

2. The Quarterly MDS assessment dated 1/14/22 revealed Resident #36 scored 8 out of 15 on a BIMS exam, which indicated the resident was severely cognitively impaired. The assessment documented the resident had an indwelling catheter. Diagnoses for Resident #36 included, in part, alcohol dependence with alcohol-induced persisting dementia, and benign prostatic hyperplasia with lower urinary tract symptoms.

The Care Plan dated 3/30/21 documented, I have the potential risk of impaired skin integrity r/t (related to) occasional incontinence. The Care Plan did not address frequency of skin assessments.

On 3/2/22, review of weekly skin assessments in Resident #36's electronic health record revealed the last assessment had been completed on 2/15/22.

The following was also reviewed for Resident #36:

The signed Physician Orders dated 2/10/22 included the following order, dated 12/19/21: Insert 18fr (french) catheter for bladder distention and inability to urinate.

The Nurses Note dated 12/19/2021 at 2:26 PM documented, Called Dr. [Name Redacted] regarding resident's not voiding all day this day. Received order from Dr. [Name Redacted] to insert 18fr (french) foley catheter.

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The Skin Assessment dated 12/19/21 revealed skin was clear and intact.

The Nurse Note dated 12/20/2021 at 12:10 PM documented, Noted that resident had pulled out foley catheter this am with bulb inflated; informed Dr. [Name Redacted] of occurrence and new order noted to use leg bag with foley catheter; went to re insert foley catheter and noted frank blood around meatus and in pullup; re inserted 18fr foley catheter per sterile technique and noted immediate return of very bloody urine into leg bag; 150cc (cubic centimeters) out at this time; inflated balloon with sterile water; resident tolerated procedure without difficulties; attached leg bag; will continue to monitor.

The Nursing Note dated 12/24/2021 at 7:09 AM documented, over night nurse reported that resident had pulled his leg bag off last night so she put a regular bag on his Foley. Foley was intact at that time but blood was all over and there was no output in the foley bag all night. Resident had a shower early this am due to this and having a large bm all over. CNA (Certified Nursing Assistant) reported to this writer that went she went into resident's room to get him up this am resident's foley was laying on the floor with blood all over it. This writer went to resident's room and found resident's foley with bag attached laying on the floor with blood clots on it. Balloon intact and deflated. No output was in the bag other than a few drops of blood in the tubing. Resident states he doesn't know what happened and denies any pain or discomfort at this time. This writer placed new foley 18F/5cc without issue. Resident had no pain or discomfort during placement. Foley had immediate blood tinted urine return. No clots present at this time. CNA educated on the

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importance of making sure resident has a leg strap in place for foley and how to use it. Resident encouraged to leave foley alone. CNA educated on the importance of leaving resident's pants on while laying down to help keep resident from accidentally pulling on foley.

The Nurse Note dated 12/25/2021 at 10:03 AM documented, Resident continues to have very bloody urine this day; has left catheter in place thus far this shift.

The Nurse Practitioner Note dated 12/27/21 for Resident #36 documented, in part, He has an indwelling catheter but over the last week has pulled it out twice. His skin is currently intact.

Skin Assessments dated 12/29/21, 1/1/22, 1/7/22, 1/15/22, 1/17/22 documented Resident #36's skin was clear and intact.

The Nurse Note authored by Staff A, Licensed Practical Nurse (LPN) dated 1/21/2022 at 3:12 PM documented, Resident due for foley catheter change this day; deflated balloon from existing foley catheter and removed without difficulties; Re inserted 18fr (18 french) foley catheter per sterile technique and inflated balloon with 8cc sterile water; resident tolerated procedure without difficulties; did note that meatus on underside of penis is substantially torn; no noted bleeding from this area during foley insertion; will continue to monitor.

The Skin Assessment dated 1/21/22, 1/25/22 and 2/11/22 also documented the resident's skin was clear and intact.

The late entry Shower Note dated 2/1/2022 at

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3:01 PM documented, Resident received shower this day, tolerated well. No new skin concerns at this time.

On 2/28/22 at 9:46 AM, Staff B, Certified Nursing Assistant (CNA) and Staff D, CNA, were observed to provide cares to Resident #36. Resident #36 was observed in bed, and catheter tubing was observed to the right side of the resident's bed which went to a dignity bag. At 9:50 AM, Staff B stated,"His split all the way". Resident #36 was observed to have an indwelling catheter which exited on the underside of the shaft of the penis, approximately one inch down the shaft of the penis.

On 2/22/22 at 10:06 AM, Staff B explained the area had been present since the staff member had been at the facility on January 17.

On 2/28/22 at 10:08 AM, Staff D explained the area had been there for awhile. Staff D explained they were an agency staff member who had worked on and off at the facility for six months, and acknowledged the area had been present before Staff B had started.

On 2/28/22 at 1:15 PM, Staff A, LPN, was queried about the resident's wound. Staff A explained they had come back from a few days off and a CNA had asked her to look at the area so she did. Staff A was queried which CNA had shared the information, and was unable to recall. Per Staff A, when she saw it the first time it did not look fresh, and further explained it looked like it could have been at least a day old. Staff A acknowledged scant blood had been present. Staff A explained they thought they charted it and would have passed on the information in report.

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Staff A was queried if they had notified the doctor, and stated that the Nurse Practitioner (NP) was aware of it as Staff A had told them herself when she changed the resident's foley.

On 2/28/22 at 1:39 PM, Staff E, Scheduler/Certified Medication Aide (CMA) was queried about the process if a new area was found on a resident's skin. Staff E explained they would notify the nurse, and if it needed immediate attention she would say come with me you need to see this. Staff E was queried if they cared for Resident #36 and acknowledged they did. Per Staff E, she had been at the facility when they first placed the resident's catheter. Staff E explained the resident could not urinate, had complained of stomach pain, and had not voided in eight hours. Staff E explained the resident had a catheter put in, and the resident had pulled it out multiple times.

Staff E stated, I know it does look pretty bad right now. Staff E explained it had not been like that when the resident first got the catheter, and now there was a slit in his penis. Staff E explained the resident had pulled out the catheter three or four times with the balloon inflated, acknowledged she did not remember who had first found the area, and said they knew it had been a CNA. Staff E was unable to identify the specific staff member, and explained it had been reported.

On 3/01/22 at 3:16 PM, the Director of Nursing (DON) explained the resident's urethra was splitting where the catheter lay. Per the DON, the doctor was aware. The DON was queried how long this area had been present, and responded around a month or a month and a half. The DON was queried if this would be picked up on the skin

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assessment, and acknowledged it would be.

The DON further explained if the resident had a skin sheet, the shower information may document no new skin issues had been identified. The DON explained the nurse would complete a sheet in the skin book. The DON was asked if Resident #36 had a skin sheet for the above mentioned area, and acknowledged the resident did not. The DON was queried about the paper skin sheet and said if there was an active wound, the nurse would complete it when the wound was identified, and would complete it once a week.

The Facility Policy titled Skin Management Standards dated August 2021 documented the following per the Prevention/Body Audits section:
a. All residents will be checked for skin condition changes and/or alterations daily during routine care by the certified nursing assistant. Any changes in skin condition will be reported to the licensed nurse.
b. All residents will receive a head-to-toe body audit by a licensed nurse on admission, transfer, re-admission, weekly and upon change in condition. Any change in resident's skin condition will be documented and immediately reported to the supervising nurse.
c. The supervising nurse is responsible for notifying the Wound Care Nurse and/or the Director of Nursing of changes in a resident's skin condition.
d. The Wound Care Nurse is responsible for reviewing Body Audits at least on a weekly basis and PRN (as needed) on all residents and for implementing appropriate treatment interventions, per physician order.
e. The resident's physician and responsible party shall be notified of a change in the resident's skin

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condition
f. Quarterly skin audits are coordinated by the Director of Nursing to ensure all resident skin data is accurate.

3. The Quarterly MDS dated 1/20/21 revealed Resident #192 scored 1 out of 15 on a BIMS exam, which indicated the resident was severely cognitively impaired. Diagnoses for Resident #192 included acute actinic otitis externa, right ear (dated 11/30/20), and type two diabetes mellitus without complications.

The Nurse Note dated 11/23/2020 at 3:15 PM documented, Resident returned from ENT (Ear, Nose, and Throat) appointment. Resident started on Cipro PO 500 mg (milligram) x 7 days and Cipro HC 3 gtts (drops) AS (left ear) (ear drops) BID (twice a day) x 10 days. Resident to continue cephalexin as ordered. Order faxed to pharmacy and updated in MAR (Medication Administration Record).

The paper Medication Administration Record (MAR) dated 11/01/20 through 11/30/20 revealed the following: Cipro HC 3 gtts AS BID x 10 days (ear drops) L ear (dated 11/23/20) was documented on the MAR, and doses of the medication were not initialed to indicate the drops had been administered.

The Nurse Note dated 11/25/2020 at 8:02 AM documented, in part, Res also c/o (complained of) ear this morning, day nurse addressed this and res to start ear drops when they are available from pharmacy.

The Nurse Note dated 11/28/2020 at 4:24 AM documented, in part, This nurse received report

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from [Name] hospital RN [Staff Name]...[Staff Name] reports that resident had a CT (computerized tomography) of his Right ear, resident has an outer ear infection. ear gtts were initiated 11/27/2020 due to waiting for pharmacy to receive that medication as they had none. MD wants resident to follow up with an ENT and have his Right ear debrided early next week. note in DON communication box to make aware. orders added to MAR.

The Infection Note dated 12/25/2020 at 2:47 AM documented, Resident received last dose of atb. (antibiotic) for dx. (diagnosis) of ear infection. Remains free from adverse effects or reactions to medication. No drainage or pain present to affected ear. Resting in bed with call light in reach at this time.

Nurses Notes for January 2021 and February 2021 revealed, in part, the following:

a. 1/9/2021 at 1:11 PM: This writer in resident's room to perform cares this am and found that resident's right ear was full of yellow/green puss. Resident denies any pain at this time. Findings reported to floor nurse in red zone and DON (Director of Nursing) for follow up since this writer is in yellow zone with resident. This writer cleansed puss on the outside of right ear.

b. 1/15/2021 at 4:19 PM: Res (resident) severely hoh (hard of hearing) which limits assessment somewhat but res able to communicate c/o jaw pain/mouth pain which is not new for res. APAP (Tylenol) administered and is somewhat effective in relieving pain. Res has visible yellow purulent drng (drainage) to left eye and right ear, cleansed with warm water and cont to monitor. Resident

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continues to have green/yellow puss like drainage from right ear.

c. 1/20/21 at 12:53 PM: Resident's right ear continues to have green/yellowish puss drainage.

d. 1/21/21 at 12:58 PM: Resident continues to have green/yellow puss like drainage from right ear.

e. 2/1/2021 at 9:58 AM: resident continues to have foul smelling green drainage from right ear. aurical of right ear cleansed...resident has ENT appointment 2/4/21. will continue to monitor right ear.

f. 2/1/2021 at 12:59 PM; Observed resident having notable pain when swallowing, r/t (related to) ear and mouth pain.

g. The Nurse Note dated 2/4/2021 at 10:03 AM documented, resident returned from ENT with new order for Cipro gtts to be given in right ear twice daily for 10 days and then once daily for 10 days, return appt in 1 month. Pharmacy faxed.

h. The Nurse Note dated 2/6/2021 at 1:38 AM documented, Pharmacy came with order and no gtts were on list or in bag. Re faxed order and left note on fax to call facility if there is a reason these drops can not be delivered.

The February 2021 MAR revealed the first dose for Cipro HC 3 gtts R (right) ear bid (twice a day) x 10 days, then 3 gtts qd (daily) x 10 days had been signed out for 2/6/21 at 7:00 PM.

On 2/28/22 at 1:43 PM, Staff E, Scheduler/CMA was queried about Resident #192. Staff E

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explained the resident would complain about an earache and could not eat. Staff E further explained the resident had complained of ear pain and had been sent to the ENT multiple times. Per Staff E, the resident had been sent back with antibiotics and debrox. Then he had Ciprodex, and Staff E explained the resident had further testing done. Staff E explained insurance did not cover the Ciprodex, and acknowledged the resident had ended up receiving the medication. Staff E was queried about Resident #192's ear draining, and explained it did so when the resident was on the ear drops. Staff E was queried if the ear had been draining when the resident was not receiving the drops, and explained not that she was aware of.

On 3/01/22 at 3:23 PM, the Director of Nursing, who was not the DON at the facility at the time of the incident, was queried if a resident had drainage from the ear if nursing should notify the physician. The DON responded absolutely, and explained the facility had a Nurse Practitioner on all all through the night.

The Facility Policy titled Change in Condition/Incident Reporting dated August 2021 documented, Policy: When a resident exhibits a change in condition, action will be taken to coordinate appropriate care to meet resident needs. Procedure
1. When a resident displays a change in condition, Licensed Nurse will complete an assessment of SBAR (situation, background, assessment, recommendation) to determine symptomology and clinical results.
2. Licensed Nurse to check physician orders to address.
3. If there is an actual change in condition, the

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resident's physician is notified promptly and validated as to information. Family/Responsible Party notified promptly.
4. Document the date/time of contacts and with whom you spoke. Document any new physician orders if indicated. Document resident condition and change in condition in nursing notes/SBAR.
4. The MDS assessment dated 1/13/22 documented that Resident#35 had scored a 9 out 15, which indicated a moderately impaired cognitive status for daily decision making. The MDS documented that the resident had diagnoses including, non-traumatic brain dysfunction, Alzheimer's disease, and psychotic disorder.

A Progress Note on 2/9/22 at 7:44 a.m. documented the following; the resident had stated that she had been feeling dizzy, vital signs included blood pressure of 113/74, heart rate 150, respiratory rate of 22, temperature 98.0 Fahrenheit, and 92 percent oxygen saturation, the resident had a productive cough with greenish/yellow phlegm. The resident began to cry,and stated she did not want to go to the hospital. The resident had been reassured by the nurse that she would not be sent to the hospital, then the resident calmed down. A message had been sent to the primary care physician and the medical director.

The COVID-19 Resident Daily Screening Log dated 2/13/22 with time of 10:00 a.m. to 2:00 p.m. the resident had a documented temperature 98.1, blood pressure 119/91, heart rate,55, respirations 24, and oxygen saturation of 82 percent.

The residents clinical record lacked documentation of a follow up assessment on the

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oxygen saturation of 82 percent documented on 2/13/22 for the time period of 10:00 a.m. to 2:00 p.m.

The COVID-19 Resident Daily Screening Log dated 2/13/22 with the time of 2:00 p.m. to 6:00 p.m. documented 98.4 temperature, blood pressure 120/83, heart rate 60, respirations 27, and 84 percent oxygen saturation.

The Progress Note dated 2/13/22 at 7:39 p.m. documented that following; At approximately 4:00 p.m. aides alerted this nurse that the resident's breathing was abnormal, the resident had been diaphoretic, the resident had a racing heart, along with swelling of her lips and eyes. The nurse assessed the resident immediately, called the Director of Nursing (DON), and the Nurse Practitioner, and 911 for the ambulance.

On 02/28/22 at 1:58 p.m. Staff H, Certified Nurses Aid (CNA) reported that the resident had not been feeling well for a couple of days before going to the hospital. Staff H reported that she did check on the resident on 3:00 p.m. rounds at the beginning of the shift. Staff H reported that she then checked on the resident at about 3:45 p.m., and heard that her breathing was not normal, and noticed that the residents lips and eyes were swollen. Staff H reported that the residents breathing sounded nasally with a gurgle. Staff H said she reported to the nurse (Staff G, RN) right away, and she came to check the resident out right away. Staff H reported that the ambulance had been called shortly after that.

On 3/02/22 at 4:01p.m., Staff G, Registered Nurse, reported that the resident had a barking cough a couple of days prior to her transfer to the

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hospital, and had been treated for that. On the day the resident went to the hospital a Certified Nurses Aid (CNA) go the nurse right away when the resident had not been doing well. Staff G reported that the resident had a swollen lip, and one swollen eye. Staff G reported that the day had been very busy and she felt torn in every direction. Staff G reported that the resident had been sent out right away when the resident had been seen with the swelling, as a possible allergic reaction. Staff G reported that the resident had a long list of allergies.

On 03/01/22 9:29 a.m. the Director of Nursing (DON) reported that the 82% oxygen saturation should have been followed up on.

On 03/02/22 at 2:22 p.m. the DON reported that the nurses fill out the COVID-19 Resident Daily Screening Log, and on 2/13/22 the nurse had been Staff G, Registered Nurse.

Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BNP that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure.

On 2/24/22 9:20a.m. Staff J, Doctor Nurse Practitioner (DNP) had been on the health care team that took care of the resident, she took over care on 2/14/22 and 2/15/22. Staff J, reported that with the residents presentation she could have had a cardiac event earlier in the week, especially with the evidence of the poor ventricle movement of the heart, which was newer onset of (Congestive Heart Failure) CHF, and the valves had chronic damage to them. Staff J reported that the liver failure was due to the extent of the

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fluid overload from the heart failure. Staff J reported that even if the resident had been taken to the hospital 4 days prior to her admit, she could not say that the outcome would have been different. Staff J reported that the resident had very poor cognitive status, and would not be a person to make her own decisions. Staff J reported that the BNP level pointed to a cardiac event possibly in the last 7 days prior to her admission to the facility.

Washington County Ambulance Service report dated 2/13/22 at 4:30 p.m. documented that the resident had an oxygen saturation of the upper 80's, lung sounds with wheezing, coarse non productive cough noted.

History and Physical dated 2/13/22 at 10:26 a.m. documented that the resident had a urinalysis with positive nitrates. The resident had been admitted for treatment of acute respiratory failure with hypoxia, and acute unspecified heart failure, acute liver failure, and urinary tract infection. The resident had diminished lung sound throughout bilaterally, with rapid breathing, and resident had been placed on 2 litters of oxygen per nasal canula.

A Pertinent Lab Assessment dated 2/16/22 at 6:38 a.m. documented the following; Echocardiogram results revealed an ejection fraction of 22 percent with severe mitral valve stenosis, mitral valve stenosis, and evidence of elevated right-sided heart pressure. Acute liver failure, this is likely secondary to severe heart failure but could also be secondary to drug interactions, noted that liver enzymes were normal on 2/9/22.

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A History and Physical dated 2/13/22 at 11:59 p.m. documented that the resident had scored 28700 for a Brain Natriuretic Peptide (BNP) test. The reference range 0 being low and high being 450. Brain natriuretic peptide (BNP) test is a blood test that measures levels of a protein called BNP that is made by your heart and blood vessels. BNP levels are higher than normal when you have heart failure.

5. The MDS(Minimum Data Set) assessment tool, dated 12/9/21, listed diagnoses for Resident #10 included Alzheimer's disease, non-Alzheimer's dementia, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for eating, extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition.

The resident's February 2022 Medication Record listed an order for Trazodone(an antidepressant and sedative) 50 mg(milligrams) 1.5 tabs at bedtime for insomnia. The entry for 2/26/21 had Staff K's CMA(Certified Medication Aide) initials to indicate she administered the medication.

A review of Staff K's Timesheet revealed Staff K clocked out of her shift on 2/26/21 at 4:45 p.m.

The facility "Position Summary" for CNAs, dated May 2017, directed the CNA(Certified Nursing Assistant) to carry out non-professional services essential to caring for personal needs. The CNA duties did not include the administration of medications.

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During an interview on 3/1/22 at 12:42 p.m., Staff O, Dietary Aide, stated a staff member came into the kitchen on 2/26/22 and he thought it was Staff K. He stated she could not get Resident #10 to take his medication and he observed her take the lid of the resident's pureed goulash and add medication to it. He stated Staff K then took a piece of paper and wrote the resident's name on it and taped it to the resident's food. He thought this was around 3:40 p.m. Staff K then placed the food back in the warmer for around an hour and stated Staff H CNA retrieved the food later and the resident ate around 5:00 p.m. or 5:30 p.m.

During an interview on 3/1/22 at 10:25 a.m., Staff H stated on 2/26/22 Staff K informed her and other CNAs that there was medication in Resident #10s food. She stated Resident #10's food had a label on it and she(Staff H) fed him the food and he ate about 70% of the total food on his plate including spaghetti, squash, and apple juice. Staff H stated she was not comfortable with this and she reported it to the Dietary Manager.

During an interview on 3/1/22 at 3:51 p.m., Staff P CNA stated she worked on 2/26/22 and Staff K stated she planned to place the resident's medication into his food but she stated she did not know if she actually carried this out. She stated Staff K was not present in the facility during the evening meal.

During an interview on 3/1/22 at 1:10 p.m., the Dietary Manager stated staff informed him that Staff K placed medications in food and left it in the kitchen. He stated he informed the Administrator of this.

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F 684	Continued From page 72 During an interview on 3/1/22 at 3:40 p.m., the Administrator stated the facility suspended Staff K pending their investigation. He stated his understanding of the situation was that Staff K was having trouble getting the resident to take his medications so she went in the kitchen and added his crushed Trazodone to his pureed spaghetti. He stated he started retraining regarding the incident. During an interview on 3/2/22 at 3:18 p.m., the Administrator stated he verified Staff H fed the resident his food and did not believe that Staff K was in the building at that time. During an interview on 3/8/22 at 11:31 a.m., the Director of Nursing stated Certified Nurse Aides should not administer medications.	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:	F 686		

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F 686	Continued From page 73 Based on observation, clinical record review, policy review, and staff interview, the facility failed to conduct assessments and failed to provide treatments as ordered for 2 of 5 residents reviewed with pressure ulcers (Residents #3 and #11). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 2/19/22, listed diagnoses for Resident #3 included cerebrovascular accident, hemiplegia, and chronic pain. Resident #3 required limited assistance of 1 staff for bed mobility, transfers, and dressings, limited assistance of 2 staff for personal hygiene, and extensive assistance of 2 staff for toilet use. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderately impaired cognition and stated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. During an observation on 3/1/22 at 2:35 p.m., Staff F, Licensed Practical Nurse, measured a red, open area on the resident's left buttock as 0.8 centimeters (cm) in length by 0.5 cm width and a red, open area on the resident's right buttock measures 0.7 cm by 0.5 cm. Staff F stated the area on the right new. Staff F then cleansed the area and applied Vaseline gauze over the area. Staff F stated during the dressing change that there was no order to cover the Vaseline gauze with a dressing to secure it. An 8/20/21 Care Plan entry stated the resident had the potential risk of impaired skin integrity related to hemiplegia.	F 686	The facility does and will continue to ensure to conduct assessments and provide treatments as ordered for residents with pressure ulcers including for resident #3 and #11. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Medication Administration Standard and Skin Standard to conduct assessments and provide treatments as ordered for residents with pressure ulcers. The DON/Designee will review and audit skin sheets to make sure assessments are being completed and will review the order, TAR and TX being provided is being done as ordered for residents with pressure ulcers weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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The Wound Assessment Progress Reports documented the resident refused to have his wound measured during the month of February 2022. The reports documented a measurement of a Stage 2 pressure ulcer to the right buttock of 3.5 cm by 4 cm on 1/25/21. The MDS defined a Stage 2 pressure ulcer as a wound with partial thickness loss of dermis/a shallow open wound.

The Order Summary Report listed 10/28/21 orders to apply Lidocaine cream (for pain) and cover with Vaseline gauze and a dry dressing two times per day for the wound to the bottom.

Review of the resident's Treatment Records for the period of 12/1/21-2/28/22 revealed the following orders:

a. Vaseline Gauze Dressing, apply to affected areas twice daily. The order lacked direction for staff to apply a dry dressing over the Vaseline gauze.

b. Lidocaine 5% Ointment, apply topically to buttocks twice daily and as needed. The Treatment Records for 1/1/22 to 2/28/22 did not include direction for staff to apply the ointment twice per day and only included an entry line for prn use. The records revealed the resident received the ointment a total of 16 times from 1/1/22 to 1/31/22 and a total of 11 times from 2/1/22 to 2/28/22.

During an interview on 3/2/22 at 2:08 p.m., the Director of Nursing (DON) stated she did not think the resident's dressing would stay on without a dressing to secure it.

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During an interview on 3/2/22 at 2:22 p.m., Staff F stated she wondered why the resident did not have a dressing to secure the Vaseline gauze. She stated the Lidocaine ointment was a prn order.

During an interview on 3/2/22 at 3:10 p.m., the DON stated she made corrections on the resident's Treatment Record to reflect the accurate orders.

2. The MDS assessment tool, dated 12/19/21, listed diagnoses for Resident #11 included adult failure to thrive, muscle wasting, and weakness. The MDS stated the resident required 1 person physical assistance with personal hygiene and extensive assistance of 2 staff for bed mobility, transfers, walking, dressing, toilet use, and bathing. The MDS listed the resident's BIMS score as 9 out of 15, indicating moderately impaired cognition and stated the resident had 2 Stage 2 pressure ulcers.

During an observation on 2/28/22 at 9:21 a.m., Staff A, Licensed Practical Nurse, measured a pink area on the resident's coccyx. The area measured 0.5 cm by 0.4 cm and had a red area resembling a scratch that measured 0.3 cm by 0.2 cm. Staff A then applied Triad Paste to the resident's wounds.

A 2/9/22 Nursing Note stated areas on the residents bottom healed.

A 2/17/22 Nursing Note stated the resident had open areas to the bottom again.

The resident's clinical record lacked further detail

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	165453	A. BUILDING _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF WASHINGTON	601 E POLK ST WASHINGTON, IA 52353

(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 686	Continued From page 76 regarding the resident's open areas noted on 2/17/22 and did not contain further assessments of the area until 2/28/22. The resident's Wound Assessment Progress Report documented a Stage 2 pressure ulcer measured 0.5 cm by 0.4 cm and a Stage 2 pressure ulcer measured 0.3 cm by 0.2 cm. The report listed the identification date of the wounds as 2/28/22 and did not include the location of the wounds. The Skin Management Standard policy dated August 2021, stated the facility would prevent and manage wounds including identification, documentation, consistent wound care, and tracking. The Care Plan entry dated 2/22/22 stated the resident had potential/actual impairment to skin integrity of the buttocks related to deconditioning and previous living situation. During an interview on 3/2/22 at 2:04 p.m., the DON stated staff should assess wounds weekly.	F 686		
F 689 SS=E	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:	F 689		

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F 689	Continued From page 77 Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure the front door alarm activated to prevent an elopement for 1 of 1 residents reviewed for elopement (Resident #15). The facility identified 7 residents as cognitively impaired and independently mobile. The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool dated 9/22/21, listed diagnoses for Resident #15 included non-Alzheimer's dementia, paranoid schizophrenia, and anxiety. The MDS stated the resident required supervision and setup assistance for eating, limited assistance of 1 staff for bed mobility, transfers, walking, and toilet use, and extensive assistance of 1 staff for dressing, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. The Care Plan dated 5/5/21 documented that resident had an elopement risk and wandered aimlessly. Distract the resident from wandering by offering diversions such as activities, food, conversation, television, and books. The resident had a wanderguard device which alerted the staff if a resident attempted to exit the facility. A 12/3/21 Nursing Note stated the resident was awake all night and came up to the desk with her coat on and asked to use the phone to "get out of this place". A 12/5/21 Nursing Note stated the resident stated she needed to go home and see her children and	F 689	The facility does and will continue to ensure that the front door alarm is activated to prevent elopement for cognitively impaired and independently mobile residents including for resident #15. All residents have the potential to be affected by the alleged deficient practice. The staff was educated by DON on 3/31/22 on our Elopement Management Standard and the need for all door alarms to remain activated and not turned off. The Maintenance Director/Designee will review and audit all doors to make sure they are not unlocked weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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F 689	Continued From page 78	F 689		

told staff they couldn't keep her there.

A 12/12/21 1:00 p.m. Nursing Note stated kitchen staff related that the resident stood outside the front door rang the doorbell at approximately 10:00 a.m. Staff redirected the resident and she returned inside the building.

According to the National Weather Service the high temperature for Washington, Iowa on 12/12/21 was 43 degrees Fahrenheit (https://www.weather.gov/wrh/Climate?wfo=dvn).

The December 2021 Treatment Record stated the resident had a wanderguard and directed staff to check it for proper function and placement every shift. The Treatment Record included staff initials until 12/29/21 to indicate completion of the task.

A 12/29/21 Physician's Order directed staff to discontinue the resident's wanderguard as the system was not working.

The Care Plan lacked any further interventions to prevent the resident from eloping after 5/5/21. The Care Plan continued to include a wanderguard as an intervention even though the system had not functioned since at least May of 2021.

The Care Plan lacked any updates following the resident's elopement on 12/12/21.

A list provided to the survey team by the Director of Nursing (DON) on 2/24/22, listed 8 cognitively impaired, independently mobile residents including Resident #15.

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F 689	Continued From page 79	F 689		

The facility policy "Elopement Management", dated 2021, stated after an elopement, the facility would conduct a full investigation of how the elopement happened and where the process failed. The policy directed staff to develop an individualized elopement risk/mood/behavior plan.

During an interview on 2/23/22 at 10:49 a.m., Staff A, Licensed Practical Nurse, stated she worked the day the resident left the building. She stated the resident went out the front door and did a "U-turn" and came right back in. She stated she saw the resident approximately 30 minutes before.

During an interview on 2/23/22 at 4:44 p.m., Staff N, Dietary Aide, stated he was in the kitchen and heard the doorbell ring and was "flabbergasted" the resident was outside ringing the doorbell. He stated he had not heard the alarm. He stated when he let the resident in, the rug was not stuck in the door and there was no key in the door.

During an interview on 2/23/22 at 12:00 p.m., Staff M, Housekeeping Supervisor, stated she was in the kitchen and Staff N, Dietary Aide, told her he let the resident into the building. She stated after he told her this she went to the front door because she wondered how the resident got out. The surveyor accompanied Staff M to the front door so she could explain what she observed. Staff M stated after the resident came back in the lights on the door were green and not red to indicate the door was locked. She stated she had to go and get the key to lock it because it was totally unlocked. She stated someone turned it off and she had to turn it back on.

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F 689	Continued From page 80	F 689		

During a follow-up interview on 2/23/22 at 4:08 p.m., Staff M stated when she checked the door on the day of the elopement when it was unlocked, there was no key in the door and the rug was not stuck in the door.

During an interview on 2/23/22 at 2:57 p.m., the Maintenance Director stated after the elopement, he checked the door and it worked fine. He stated there were no problems with the sensor.

During an interview on 2/23/22 at 3:09 p.m., the Administrator stated after the elopement, the door worked fine. He stated he didn't believe staff could have turned the alarm off because the key would need to be in the door. He stated he thought possibly the rug was stuck in the door and that was why it did not alarm. He stated the facility's wanderguard system had not worked since May of 2021 when the facility owners switched. After the interview, the surveyor and the Administrator attempted to remove the key from the door while it was in an unlocked state and it was impossible to remove.

During an observation on 2/23/22 at 4:03 p.m. the Administrator put the code into the front door pad, opened the door, placed the rug between the door and the threshold to prevent the door from closing and the alarm did not go off.

During a observation on 2/24/22 at 3:40 p.m. the front door had an additional alarm system on it. In order to leave the facility, staff had to enter codes into 2 keypads or an alarm sounded.

During an interview on 2/28/22 at 7:45 a.m., the Administrator stated the rug at the front door had been there since the new company took over in

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F 689	Continued From page 81 May of 2021. During an interview on 3/8/21 at 11:31 a.m., the Director of Nursing stated elopement interventions was something they should care plan.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690	The facility does and will continue to ensure to provide treatment to the extent possible to restore bladder continence including for resident #4. All residents have the potential to be affected by the alleged deficient practice. The nursing staff was educated by DON on 3/31/22 on our Incontinent Management Standard, Bowel and Bladder Screener Assessment and to provide treatment to the extent possible to restore bladder continence. The MDS Coordinator/Designee will review and audit Bowel and Bladder Screener Assessments for candidates for retraining, make sure retraining is initiated and being completed weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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F 690	Continued From page 82	F 690		

comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, resident interview, and staff interview, the facility failed to provide treatment to the extent possible to restore bladder continence for 1 of 1 residents reviewed for bladder continence(Resident #4). The facility reported a census of 39 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment tool, dated 11/29/21, listed diagnoses for Resident #4 included thyroid disorder, hypertension, and depression. Resident #4 had independence with Activities of Daily Living and had a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. The MDS documented the resident always continent of bowel and bladder.

During an interview on 2/21/22 at 12:16 p.m., the resident stated she had an "uncontrolled bladder" and always incontinent of urine. The resident stated the facility did not discuss a bladder retraining program with her.

The 11/16/21 Bowel and Bladder Screener stated the resident voided appropriately with incontinence "not always, but at least daily" and stated the resident was a "good candidate for retraining".

The February 2022 Documentation Survey

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F 690	Continued From page 83 Report documented the resident was incontinent of urine every day of the month. The Clinical Record lacked a toileting program including a customized toileting schedule or other interventions to assist the resident in restoring continence. The Care Plan lacked documentation of the resident's incontinence and customized interventions to assist the resident in restoring continence. The Incontinence Management Standard policy dated August 2021, stated the goal of the facility was to ensure that staff identified and assessed each incontinent resident and assisted the resident to restore as much normal bladder function as possible. During an interview on 3/3/22 at 12:08 p.m., the Director of Nursing (DON) stated staff should take resident's to the bathroom every 2 hours. She stated Resident #4 was not on a bowel and bladder training program. During an interview on 3/3/22 at 2:47 p.m., the MDS Coordinator stated when Resident #4 admitted she did not require the use of incontinent briefs.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		

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F 697	Continued From page 84 and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assess pain and carry out interventions to relieve pain for 1 of 1 residents reviewed for pain (Resident #18). The facility reported a census of 39 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/25/21, listed diagnoses for Resident #18 included heart failure, diabetes mellitus, and morbid (severe) obesity due to excess calories. The MDS stated the resident required limited assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 14 out of 15, which indicated cognitively intact. During an interview on 02/23/22 at 11:32 AM, Resident #18 stated she did not receive her pain medication hydrocodone (a narcotic pain medication) for several weeks in December 2021. The resident stated various nurses informed her the pharmacy kept saying they were going to deliver the medication. The resident stated one facility nurse told her "if it does not get here soon I will go pay for it myself". The resident stated that staff used Tylenol for the pain during this time. The resident stated she had pain in her knees and Tylenol was not really effective and she was hurting. A record review on 2/23/22 at 2:24 PM revealed Resident #18 had an order for	F 697	The facility does and will continue to ensure to assess pain and carry out interventions to relieve pain including for resident #18. All residents have the potential to be affected by the alleged deficient practice. The nursing staff was educated by DON on 3/21/22 on our Pain Management Standard and assessing pain and carrying out interventions to relieve pain. The DON/Designee will review and audit MARS for assessment of pain, PRN medication use and documentation of follow up on relief of pain weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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hydrocodone-acetaminophen tablet 5-325 MG(milligrams) give 1 tablet PRN (as needed) every 12 hrs for pain.

The December 2021 Medication Admission Review (MAR) revealed staff administered hydrocodone on: 12/3/21, 12/4/21, 12/6/21, 12/8/21, 12/20/21, 12/21/21, 12/22/21, and 12/29/21. Staff administered Tylenol on 12/9/21, 12/10/21, 12/12/21, 12/13/21, 12/14/21, 12/15/21, 12/16/17, 12/17/21, 12/18/21, 12/20/21, and 12/24/21.

A review of the Controlled Substances Proof of Use form revealed a receipt of 60 tablets of hydrocodone-acetaminophen 5-325 mg on 9/15/21 for Resident #18. Per the documentation the last tablet was used on 12/8/2021.

A review of pharmacy invoices for December 2021 revealed Resident #18 had 30 tablets of hydrocodone-acetaminophen 5-325 mg delivered on 12/20/21.

A review of the form Controlled Substances Proof of Use revealed a receipt of 30 tablets of hydrocodone-acetaminophen 5-325 mg on 9/15/21 for Resident #18. Per the documentation staff administered the first medication on 12/20/21.

The electronic and paper chart record reviews completed 2/23/22 at 3:27 PM revealed a lack of documentation regarding any changes in the hydrocodone-acetaminophen order in December 2021, pain assessments completed in December 2021, and attempts to contact the pharmacy, and prescribing provider regarding the need for a refill.

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F 697	Continued From page 86 A Pain Management Standard policy dated August 2021 directed staff to document evaluation, treatment, and effectiveness of the treatment on the PRN Pain Medication Flow Sheet. During an interview on 3/3/22 at 11:39 a.m., the Director of Nurses (DON) stated the reason Resident #18 did not have hydrocodone for 11 days may be explained by the difficulty with contacting the former facility medical director. The DON explained that if a resident was out of a prescribed pain medication the expectation was the nurse staff would call the pharmacy, and provider if needed to request a review and then document this communication. The DON stated that the expectation was for nursing staff to complete pain assessments when a resident received medication and then an hour after to assess effectiveness. During an interview on 3/8/22 at 11:10 a.m., the DON stated the PRN Pain Medication Flow Sheet referenced in the facility policy Pain Management Standard was the pain assessment information documented in the Electronic Health Record.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		

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F 700	Continued From page 87 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed conduct assessments for the use of side rails, and address use of side rails in the Care Plan for one of one resident reviewed for bed rails (Resident #10). The facility reported a census of 39 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated 12/9/21 for Resident #10 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was severely cognitively impaired. Diagnoses for Resident #10 included dementia without behavioral disturbance and muscle weakness. The Care Plan for Resident #10 did not address the use of side rails. The Side Rail Assessment preset in Resident #10's electronic assessments had been dated	F 700	The facility does and will continue to ensure to conduct side rail assessments for the use of side rails and address the use of side rails in the Care Plan including for resident #10. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator was educated by DON on 3/31/22 on our Restraint Management Standard and to conduct side rail assessments for the use of side rails and address the use of side rails in the Care Plan. The MDS Coordinator/Designee will review and audit the need for side rails and conduct assessments for side rails and include side rails in the Care Plan weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/31/22	

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F 700	Continued From page 88 6/5/18. On 3/01/22 at 3:26 PM, the Director of Nursing (DON) was queried about bed rails, and explained there was a bed rail assessment that would be in the electronic health records under assessments. On 2/22/22 at 8:33 AM, Resident #10 was observed to have partial side rails present to both sides of the resident's bed. On 3/2/22 at approximately 1:20 PM, the DON acknowledged Resident #10 did not have any side rail assessments for 2021 or 2022. The Restraint Management Standard policy revised August 2021 documented the following: 1. The need for side rails and/or assist bars will be evaluated on admission and with change in condition, mobility or with significant change as noted on the MDS using the Side Rail Assist Bar Screen. 2. If side rail(s) and/or assist bars are used to aid the resident in mobility and do not restrict freedom of movement, address the reason and use of side rails in the progress notes and plan of care. 3. If the resident's comatose or unable to move in bed, and the side rails are used only to comfort the resident and/or family, address the reason and use of the side rails in the progress notes and plan of care. A Siderail Consent form will be completed by the resident/representative.	F 700		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		

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F 727	Continued From page 89 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility schedule review and policy review, and staff interview, the facility failed to utilize the services of an Registered Nurse at least 8 consecutive hours a day, 7 days a week for 2 of 31 days reviewed. The facility reported a census of 39 residents. Findings: Review of the facility nursing schedule from 1/22/22 to 2/22/22 revealed a lack of Registered Nurse coverage on 2/5/22, and 2/6/22. An undated Clinical Staff Standard policy stated Registered Nurse staff will follow state and federal regulations. During an interview on 3/2/22 at 11:39 AM, the Director of Nursing stated the schedule was correct and no other nurses worked. She looked at the schedule and confirmed the facility did not	F 727	The facility does and will continue to ensure utilizing the services of a Registered Nurse at least 8 consecutive hours a day, 7 days a week. All residents have the potential to be affected by the alleged deficient practice. The Scheduler was educated by Administrator on 3/30/22 on our Clinical Staffing Standard and utilizing the services of a Registered Nurse at least 8 consecutive hours a day, 7 days a week. The Scheduler/Designee will review and audit the schedule and staffing sheets daily for utilizing the services of a Registered Nurse at least 8 consecutive hours a day, 7 days a week, weekly X 4 weeks, monthly X 2 months and then quarterly X 3. The facility continues to advertise and recruit for licensed nurses, including RNs, through a variety of mediums, including Indeed, Facebook, and local media. The facility offers generous sign-on and referral bonuses for new employees. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/30/22	

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F 727	Continued From page 90 have Registered Nurse coverage for the above dates.	F 727		
F 732 SS=C	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. §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	F 732	The facility does and will continue to ensure posting nurse staffing information in a prominent place for the residents and the public to review. All residents have the potential to be affected by the alleged deficient practice. The nurses and scheduler were educated by Administrator on 3/30/22 our Staffing Standard regarding the posting of nurse staffing information in a prominent place. The Scheduler/Designee will monitor staffing sheets for completion and accuracy as well as positing in a prominent place weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of Compliance 3/30/22	

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F 732	Continued From page 91 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 observation, policy review, and staff interview, facility failed to post Nurse Staffing Information for 1 of 1 days observed. The facility reported a census of 39 residents. Findings include: During an observation on 3/2/22, the surveyor could not locate posted nurse staffing. The Clinic Staffing Standard policy, dated August 2021, stated the facility would post staffing hours daily in a public space. During an observation/interview on 3/22/22 at 10:00 a.m., the surveyor asked the Director of Nursing the location of the Nurse Staffing Information. The DON stated the posting was in Staff E, Scheduler's, office and walked with the surveyor to her office. Staff E stated that she was confused about who was supposed to complete the posting. She stated the last time she completed the posting was 12/31/21 and provided the surveyor with a copy. During an interview immediately following, the DON stated it was Staff E's responsibility to complete the postings daily.	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	F 755		

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F 755	Continued From page 92 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. §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 observation, clinical record review, policy review, resident interview, and staff interview, the facility failed to ensure the availability of medications for 1 of 20 residents sampled (Resident #4) and 1 of 2 residents observed during medication administration (Resident #15). The facility reported a census of 39 residents.	F 755	The facility does and will continue to ensure the availability of medications including for resident #4 and #15. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on the Pharmacy P&P of Delivery and Receipt of Medication and Pharmacy Documents Policy and the availability of medications. The DON/Designee will review and audit the MARS for availability of medications weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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Findings:

1. The Minimum Data Set (MDS) assessment tool, dated 11/29/21, listed Resident #4 had diagnoses of thyroid disorder, hypertension, and depression. The MDS stated the resident was independent with her Activities of Daily Living and listed her Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS listed the resident's admission date as 11/16/21.

During an interview on 2/22/22 at 2:21 p.m., Resident #4 stated she did not have her medications for 3 days after she admitted including patches.

The pharmacy Delivery Receipt documented the pharmacy delivered the resident's Lidocaine (used for pain relief) and Fluticasone (used for allergies) on 11/18/21.

The November 2021 Medication Record listed a 11/16/21 order for Lidocaine patch apply in morning, remove at bedtime and an 11/16/21 order for Fluticasone 50 micrograms (mcg) 2 sprays in both nostrils daily.

The Medication Record showed circles around the 11/17/21 and 11/18/21 entries for the Lidocaine and the Fluticasone.

The facility lacked documentation the resident received the medications as ordered.

2. The MDS assessment dated 9/22/21, listed diagnoses for Resident #15 included non-Alzheimer's dementia, paranoid

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schizophrenia, and anxiety. The MDS stated the resident required supervision and setup assistance for eating, limited assistance of 1 staff for bed mobility, transfers, walking, and toilet use, and extensive assistance of 1 staff for dressing, personal hygiene, and bathing. The MDS listed the resident's BIMS score as 10 out of 15, indicating moderately impaired cognition.

During an observation on 3/1/22 at 7:15 a.m., Staff N (Certified Medication Aide) administered Resident #15's morning medications. Staff N failed to administer the resident's Memantine (to treat dementia) and stated the medication was not available from the pharmacy.

The resident's Medication Record listed an order for Memantine 28 milligrams once a day. The entries dated 3/1/22 and 3/2/22 documented "NA" meaning not available.

The Deliver and Receipt of Medication and Pharmacy Documents policy, revised 1/1/13, stated the pharmacy and the facility should coordinate to determine delivery days and times.

During an interview on 3/2/22 at 10:35 a.m. Staff Q, Certified Medication Aide, stated Resident #15's Memantine was not available from the pharmacy.

During an interview on 3/8/22 at 11:31 p.m., the Director of Nurse stated if a MAR entry had a circle and an "NA" that would mean the medication was not available. She stated she called the pharmacy about missing medications and sometimes even if she called, they did not deliver the medications.

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F 756	Continued From page 95	F 756	The facility does and will continue to ensure there is prompt follow up on pharmacy Medication Regimen Reviews for unnecessary medications including for resident #9. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Behavior Management Standard and Pharmacy P&P of Drug Regimen Review (DRR) and the prompt follow up on pharmacy Medication Regimen Reviews for unnecessary medication. The DON/Designee will review and audit the prompt follow up of Medication Regimen Reviews weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		

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when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy the facility failed to ensure prompt follow up on pharmacy Medication Regimen Reviews for one of seven residents reviewed for unnecessary medications (Resident #9). The facility reported a census of 39 residents.

Findings include:

The Quarterly Minimum Data Set (MDS) assessment dated 12/8/21 revealed Resident #9 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was cognitively intact. Diagnoses for Resident #9 included paranoid schizophrenia and type two diabetes mellitus with diabetic chronic kidney disease.

The Consultation Report dated 11/18/21 through 11/18/21 documented, Resident #9 receives Bupropion XL 150mg (milligram) po (oral) daily (decreased in August) and Risperdal 1mg po bid (twice a day). She is due for a review. Note no s/s (signs/symptoms) of depression, anxiety, delusions or behaviors noted per recent nursing notes. Recommendation: Please re-evaluate for the lowest possible doses. If no change is indicated, please provide specific rationale. The form was dated 11/18/21. The rationale had been declined with the following documentation: Bupropion XL discontinued 11-23-2021. This form had been signed on 12/15/21.

The Consultation Report dated 12/1/21 through 12/24/21 documented, Comment: The pharmacy

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recommendation for Resident #9 from November (GDR evaluation) has not been acted upon by the intended recipient of the recommendation in accordance with regulation or facility policy. Recommendation: Please follow up with the recipient of the outstanding pharmacy recommendation to ensure compliance. The form had been dated 12/24/21.

Another Consultation Report dated 12/1/21 through 12/24/21 documented, Comment: REPEATED RECOMMENDATION from 11/18/21: Please respond promptly to assure facility compliance with Federal regulations. [Resident #9] receives Risperidone and her last AIMS test was done in April. Recommendation: Please monitor for involuntary movements now and at least every 6 months or per facility protocol. Thank you. The form had been dated 12/24/21.

The clinical record revealed an AIMS had been completed for the resident on 4/27/21 and 12/27/21.

On 3/1/22 at 3:22 PM, the Director of Nursing (DON) explained the pharmacy came in do to monthly medication regimen reviews. The pharmacy staff member would send the information to the DON, the DON would distribute the recommendations to the appropriate person, and would wait for their response.

On 3/3/22 at 12:33 PM, the DON was queried about the time frame for medication regimen review responses, and explained they did not know if there was a specific policy.

The facility provided a document titled with the pharmacy name, dated 2/21/22 on the Medical

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Director line, stated, PHARMACY SERVICES: DRUG REGIMEN REVIEW (DRR)
Documentation of Irregularities: A pharmacist must document in a separate, written report any irregularities found during DRR. The report must include, at the minimum, a resident's name, the relevant drug, and the irregularity. Documentation Recipients: The pharmacist's report must be sent to: attending Physician; and Medical Director; and Director of Nursing.

The Facility Policy titled 9/1 Medication Regimen Review dated 12/01/07, last revised 3/3/20, documented the following:

7. Facility shall encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR.
7.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected.
7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it.
7.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record.
8. Facility should alert the Medical Director where MRRs are not addressed by the physician in a timely manner.

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F 757	Continued From page 99	F 757	The facility does and will continue to ensure a resident's drug regimen is free from an unnecessary medication including for resident #18. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/21/22 on our Medication Administration Standard and ensuring a resident's drug regimen is free from an unnecessary medication. The DON/Designee will review and audit new orders for allergies weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to ensure a resident's drug regime was free from an unnecessary medication for 1 of 5 residents reviewed for unnecessary drugs (Resident #18). The facility reported a census of 39. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/25/21, listed diagnoses for Resident #18 of heart failure, diabetes mellitus,	F 757		

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and morbid (severe) obesity due to excess calories. MDS stated the resident required limited assistance of 1 staff for bed mobility, walking, dressing, transfers, toilet use, personal hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, which indicated cognitively intact.

On 2/23/21 at 11:27 AM, during an interview the resident stated she was in the hospital in October 2021 due to an allergic reaction to an antibiotic. The resident shared pictures of the rash on the palms of her hands, upper body, and both legs. The rash appeared very red, and had raised areas.

On 10/11/21 the facility received a physician's order for Keflex (Cephalexin generic name, an antibiotic) capsule 500 MG one capsule by mouth four times a day for 10 days for a wound infection.

On 10/11/21 at 4:23 PM, the Electronic Health Record system note stated the system had identified a possible drug allergy for Keflex (Cephalexin) capsule 500 milligrams.

A review of the Electronic Health Record revealed a Progress Note from the hospital dated 7/19/21 indicated the resident had a known allergy to Cephalexin with an onset date of 8/20/20.

The facility October 2021 Medication Administration Record (MAR) for the resident noted the allergy to Cephalexin. The record review lacked documentation of the provider being notified of this listed allergy, or a response to the system note that warned of a possible drug

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF WASHINGTON	601 E POLK ST WASHINGTON, IA 52353

(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 757	Continued From page 101	F 757		

allergy.

On 10/17/21 at 7:29 PM the facility received an order to discontinue Cephalexin and start Clindamycin due to culture and sensitivity results from wound culture.

On 10/18/21 at 9:44 PM, a nursing note stated the resident was on an antibiotic with possible mild reaction related to a rash on the resident ' s abdomen/upper legs.

On 10/19/2021 at 4:50 PM a shower note revealed the resident had reddened areas on perineal area, abdominal folds, groin, coccyx, under breasts, toes, heels and behind knees.

On 10/19/21 at 6:00 PM a provider order directed staff to discontinue Clindamycin due to the resident developing a rash and itching, and restart Cephalexin. The clinical record lacked documentation of the provider being informed of the listed Cephalexin allergy.

On 10/21/21 at 9:18 PM, a nursing note stated the resident complained of nausea and diarrhea, and had not urinated since early morning. The note stated the resident continued Kelfex for infection to right lower leg, and rash presented and visible over most of the resident's skin. The provider notified and order received for the resident to be evaluated at emergency room.

A 10/21/21, Hospital Emergency Department record stated a chief complaint of skin rash that started four days ago. The report stated the patient with reported hypoxia (low oxygen levels), confusion, nausea, diarrhea, decreased urinary output, fever and worsening generalized rash.

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F 757	Continued From page 102 The resident took Cephalexin for Methicillin-resistant Staphylococcus Aureus (MRSA) for lower extremity infection, switched to Clindamycin but developed rash on 10/17/21 and so switched back to Cephalexin per nurse at long term care facility. Rash is generalized and worse and is still present. The document listed Cephalexin as known allergy. The Medication Administration Guidelines policy dated August 2021 did not address procedure to follow when a known allergy is prescribed. On 3/3/22 at 11:39 AM the Director of Nursing (DON) stated if a resident is prescribed a medication that is a known allergy the expectation is the nurse would contact the provider and to inform them of the allergy so the medication can be discontinued and an alternative medication found.	F 757		
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; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure the medication error rate remained below 5% for 2 of 2 residents observed during the medication pass (Residents #15 and #30). The facility error rate calculated at 6.67%. The facility reported a census of 39 residents.	F 759		

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F 759	Continued From page 103 Findings include: 1. During an observation on 2/23/22 at 8:58 a.m., Staff I, Certified Medication Assistant, administered Magnesium Oxide 400 milligrams (mg) to Resident #30. A 12/3/21 Order Entry form listed an order for Magnesium Oxide 420 milligrams daily. During an interview on 3/2/22 at 10:35 a.m. Staff Q, Certified Medication Aide, stated they used the 400 milligrams Magnesium Oxide tablets for Resident #30's 420 milligrams order. 2. During an observation on 3/1/22 at 7:15 a.m., Staff R, Certified Medication Aide, administered Resident #15's morning medications. Staff R did not administer the resident's Memantine (used to treat dementia) and stated the medication was not available from the pharmacy. The Medication Administration Record listed an order for Memantine 28 milligrams once daily. The entries for 3/1/22 and 3/2/22 stated "NA". The facility's medication error rate calculated as 6.67%. The facility policy "Medication Administration Guidelines", dated August 2021, stated the facility would ensure accurate and timely delivery of medications. During an interview on 3/3/22 at 12:08 p.m., the Director of Nursing stated she fixed the concern regarding the resident's Magnesium Oxide and conducted re-education with the nurses and Certified Medication Aides.	F 759	The facility does and will continue to ensure the medication error rate remain below 5% including for resident #15 and #30. All residents have the potential to be affected by the alleged deficient practice. The Nursing staff was educated by DON on 3/31/22 on our Medication Administration Standard and medication error rates remaining below 5%.. The DON/Designee will review and audit the MARs for medication availability and cross matching orders and stock medication bottles for accuracy on strength weekly X 4 weeks, monthly X 2 months and then quarterly X 3. All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 4/5/22	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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:	F 880	The facility does and will continue to ensure appropriate hand hygiene has been completed during cleaning of resident rooms and during resident care including for resident #36 and #40. All residents have the potential to be affected by the alleged deficient practice. The Housekeeping and Nursing staff was educated by DON on 3/21/22 on our Hand Hygiene standard and completing hand hygiene during cleaning of resident rooms and during resident care. The DON/Designee will review and audit hand hygiene weekly X 4 weeks, monthly X 2 months and then quarterly X 3. t All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/21/22	

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F 880	Continued From page 105 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure appropriate hand hygiene had been completed during cleaning of resident rooms, and failed to ensure appropriate hand hygiene had been completed during resident cares for two of eight residents observed (Resident #36, #40). The facility reported a census of 39 residents. Findings include:	F 880		

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F 880	Continued From page 106	F 880		

1. Observation on 2/24/22 at 8:20 AM, Staff C, Housekeeper, observed in Room 303 wearing blue gloves, swept trash, returned to the resident's room, and came out to the cart outside of the room. At 8:24 AM, Staff C took the mop into the room while wearing blue gloves. At 8:27 AM, Staff C doffed the gloves and sprayed an aerosol. Hand hygiene was not observed to have been performed.

On 2/24/22 at 8:29 AM, Staff C filled out paperwork, and at 8:30 AM, Staff C donned gloves at the cart in the hall. Next, Staff C went into the cart and took out products. At 8:31 AM, Staff C entered Room 300. At 8:35 AM, Staff C was working at the cart in the hall. At 8:36 AM, Staff C opened a new box of gloves and transferred gloves from one box into another box of gloves while they were wearing gloves. On 2/24/22 at 8:41 AM, Staff C doffed the blue gloves and went into the cart. No hand hygiene was observed. New gloves were applied, and Staff C went into Room 300.

On 2/24/22 at 8:43 AM, Staff C came out with gloves on and put items on the housekeeping cart. Staff C went back and forth to the resident room. At 8:47 AM, Staff C was observed to go back and forth to Room 300 while wearing gloves. At 8:48 AM, Staff C was observed to doff their gloves, walk down the hall, and used the hand sanitizer dispenser on the wall.

2. On 2/28/22 at 9:46 AM, Staff B, Certified Nursing Assistant (CNA) and Staff D, CNA, were observed to provide cares to Resident #36. Resident #36 was observed in bed, and catheter tubing was observed to the right side of the resident's bed which went to a dignity bag.

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F 880	Continued From page 107	F 880		

Clothes were obtained, and Resident #36's socks were applied by Staff D. Staff B grabbed the trash can with gloves applied, removed the resident's brief while wearing the gloves, and handled a towel while wearing the gloves. Staff B then doffed the gloves. At 9:59 AM and 10:01 AM during the observation, Resident #36's catheter drainage bag was observed resting directly on the floor in the resident's room.

On 3/02/22 at 2:52 PM, the Minimum Data Set (MDS) Coordinator was queried about hand hygiene and glove use, and acknowledged hand washing should occur before putting on gloves, staff do what they needed to do, and then should wash their hands again. The MDS Coordinator explained staff needed to either be washing their hands or using alcohol.

On 3/3/22 at 12:35 PM, the Director of Nursing (DON) explained staff should wash their hands before donning gloves, anytime the gloves got contaminated, and after the cares were done, taking gloves off and washing their hands again.

Review of a Hand Hygiene Power Point, undated, provided by the facility documented, Hand Hygiene and Glove Use GLOVES PLUS HAND HYGIENE=CLEAN HANDS GLOVES WITHOUT HAND HYGIENE=GERM TRANSMISSION.
2. The Minimum Data Set (MDS) assessment tool, dated 1/20/22, listed diagnoses for Resident #40 included cerebral infarct due to unspecified occlusion or stenosis of unspecified cerebral artery, non-Alzheimer's dementia, and morbid (severe) obesity due to excess calories. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal

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F 880	Continued From page 108	F 880		

hygiene, and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 4 out of 15, which indicated a severe cognitive impairment

During an observation on 02/24/22 at 09:02 AM, Staff T, Certified Nursing Assistant, stated normally she would sanitize her hands prior to resident care, but the room lacked alcohol based hand rub. She did not complete hand hygiene prior to the start of the cares. Staff T assisted the resident to the restroom, and then took off the resident's wet pants and brief that was heavily soiled with bowel and bladder. She then took off her gloves and stated she would use hand sanitizer again, but did not. Staff T donned one glove, and explained the box of gloves was empty. Staff T proceeded to put the resident's wet pants in a trash liner, and went to the resident's closet to get clean clothing. Staff T doffed the glove and without completing hand hygiene stepped out of the room to get another box of gloves. Upon return, she completed hand hygiene with soap and water and donned clean gloves. Staff T doffed gloves and stated she would normally sanitize right now. Without washing hands or donning clean gloves, Staff T CNA placed a disposable bed pad on the resident's recliner.

The undated document titled Hand Hygiene directed staff to complete hand hygiene at the point of care. The document directed the staff to use both gloves with hand hygiene to prevent the transmission of bacteria.

During a interview on 03/03/22 at 11:39 AM the Director of Nursing (DON) state the staff should perform hand hygiene and don gloves prior to

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F 880	Continued From page 109 cares, and after removal of gloves.	F 880		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to have a process to inform families of positive COVID-19 status at the facility. The facility reported a census of 39 residents. Findings include:	F 885	The facility does and will continue to ensure to have a process to inform families of positive COVID-19 status at the facility. All residents have the potential to be affected by the alleged deficient practice. The BOM, DON, and SS were educated by Administrator on 3/30/22 on CMS guidelines of the process of informing positive COVID-19 cases to the families, QSO-20-29-NH (cms.gov) Ref: QSO-20-29-NH. The BOM/Designee will review and audit positive COVID-19 cases and informing families weekly X 4 weeks, monthly X 2 months and then quarterly X 3. t All findings will be submitted through the QA and QAPI process for further improvement implementation. Date of compliance: 3/30/22	

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F 885	Continued From page 110 On 3/02/22 at 2:33 PM, the Minimum Data Set (MDS) Coordinator was queried about the facility's Infection Control Program. The MDS Coordinator was queried about notification when there was a positive case of COVID. The MDS Coordinator acknowledged they believed notification would occur when a person was positive. When queried about the time frame notification would occur, the MDS Coordinator responded the same day. The MDS Coordinator was queried about notification for the whole building, responded the facility was not calling the whole building, and further explained that if someone called and asked about the facility's visitation policy then they would be told they could come in and the facility did have positive cases. The MDS Coordinator explained they thought there was supposed to be something with a newsletter. Review of a document provided by the facility revealed twelve residents had been positive for COVID-19 in the past four weeks. On 3/02/22 at 3:14 PM, the Administrator was queried about a letter provided on entrance to the facility, which stated, in part, [Date] Dear Residents, Families, and Friends: We want to inform you that at [Facility Name], we have identified [#] of confirmed cases of COVID-19 among residents and staff. The Administrator was queried about how the letter was used, and explained that he did not believe it had been sent out yet to primary contacts. The Administrator explained the letter had been developed two weeks ago, and acknowledged he did not believe the facility had a process for notifying all families when there was a COVID positive resident. There	F 885		

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F 885	Continued From page 111 was not a process for mass mailing, email, or telephone system. The Administrator was queried as to the process if there was resident who was COVID positive today, and explained the Business Office Manager would send out letters to the primary contact for all residents. The Facility Policy, undated, titled, Title: Receiving a Positive COVID-19 Result documented, in part, Procedure Residents 1. Record testing information on COVID-19 log 2. Notify the following..... f. Families and responsible parties notified via facility standardized letter or phone.	F 885		