STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165173	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE REHAB AND HEALTH CARE CENTER	830 SOUTH FIFTH STREET OSAGE, IA 50461

(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 12/15/22, 12/25/22 Investigation of facility complaints #108078-C, #108345-C, #108364-C, #108443-C and #108693-C completed October 20, 2022 to November 18, 2022 resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	The Plan on Correction does not constitute an admission or agreement by Osage Rehab and Health Care Center of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Osage Rehab and Health Care Center credible allegation of compliance.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	F 550 1. Resident #2 was discharged on 11/4/2022. Residents # 5, #6 & # 15 review of progress notes and grievance reports from 11-19 thru 12-20-22 with no further concerns of resident rights completed by DON or Designee by 12/25/22. 2. On or before 12/25/22 the DON or designee will review progress notes for past 14 days, review December resident council minutes and grievance reports to validate staff are following resident rights, no concerns noted. 3. On or before 12/25/22 DON or designee will re-educate staff regarding resident rights. 4. DON or designee will audit three resident weekly for 4 weeks then 3 residents monthly for 2 months to validate staff are following the resident's rights. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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

Jessica Lusher — Administrator — 12/25/22

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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	F 550 1. Resident #2 was discharged on 11/4/2022. Residents # 5, #6 & # 15 review of progress notes and grievance reports from 11-19 thru 12-20-22 with no further concerns of resident rights completed by DON or Designee by 12/25/22. 2. On or before 12/25/22 the DON or designee will review progress notes for past 14 days, review December resident council minutes and grievance reports to validate staff are following resident rights, no concerns noted. 3. On or before 12/25/22 DON or designee will re-educate staff regarding resident rights. 4. DON or designee will audit three resident weekly for 4 weeks then 3 residents monthly for 2 months to validate staff are following the resident's rights. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews and review of the facilities Resident Bill of Rights, the facility failed to treat each resident with dignity and respect and in a manner that enhanced quality of life for 4 of 4 residents reviewed. (Resident #2, #5, #6 and #15) The facility identified a census of 33 residents. Finding include: Review of the facilities Residents' Rights Guarantee Quality of Life dated 7/5/22 at 2:25 p.m. documented all nursing homes are required to provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care. The form documented each resident maintained the right to have been treated with dignity, respect and freedom. 1. A Minimum Data Set (MDS) assessment form	F 550		

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F 550	Continued From page 2 dated 8/31/22 documented Resident #2 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact). An Incident Report form dated 8/26/22 at 12:29 a.m. included the following documentation: The resident arrived at the facility and readmitted to room 35. A verbal altercation between the resident and the Director of Nursing (DON) incurred while the DON yelled, pointed her finger at the resident and slammed his door shut. The DON went through the resident's personal belongings in his room without permission. The DON made comments to the resident like is that all you got and if you don't like it here you can leave as she shook and pointed her finger at the resident's face. Staff member G, Certified Nursing Assistant (CNA) attempted to de-escalate the situation as she held her hand between the resident and the DON. The DON directed Staff G to get the against medical advice (AMA) papers. Staff H had also been present and stated that Resident #2 had asked the DON to stop going through his things but she failed to stop. After Staff G left the room the DON continued to yell as she shook her finger in the resident's face and said, is that all you got. The resident stated the DON yelled at him before he even reached his bed. The resident stated he felt belittled as the DON treated him with sarcasm and nastiness as she pointed her finger in his face and said, you are not going to speak to me that way. The resident indicated he became upset because of his pain level and that the DON screamed at him that she had rummaged through is belongings in his drawers without asking him while she looked for a lighter. The resident stated if she would have asked him he would have told	F 550		

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F 550	Continued From page 3 her where to locate the lighter. During an interview 10/28/22 at 9:37 a.m. Staff G, CNA confirmed her presence during the above altercation with the DON and resident. The ambulance crew had just brought the resident back to the facility on a stretcher post a hospital stay. Staff B, CNA/CMA and herself assisted the resident from the stretcher into his bed. At that time, Staff E, Licensed Practical Nurse (LPN) came into the resident's room to perform an admission summary. Staff B left to assist other residents. Staff G, CNA positioned herself at the foot of the residents bed and as she went around the side of the bed the DON entered the room and started to rummage through the residents drawers as she ripped out his belongings. The resident preferred organization so he started yelling saying "get the f*^# (explicit) out of my drawers". She proceeded to go through the drawers, recliner and etc. The resident continued to yell what the f*^# (explicit) you looking for as the DON totally ignored him. The resident became really nasty and yelled loud. At that time the DON went over and slammed the room door and went right to his bed, almost to his face as she pointed her finger and yelled, at the top of her lungs you do not talk to me and my staff that way, in a threatening manner. The DON stated if you do not want to be here leave AMA as she yelled and pointed her finger at the resident. Then she yelled where is your lighter as the resident responded, if that is all you wanted all you had to do is ask it is in my f*^#ing (explicit) leg walker in the bag that hung on it. The DON went to the walker by the door as she angrily started going through it but never found the lighter as she screamed and pointed her finger as she stated you can leave AMA. Staff E put her arm in front of	F 550		

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F 550	Continued From page 4 the DON to gesture the confrontation as wrong as the DON pushed down the staff member's arm and continued her behaviors. Staff G indicated the DON and resident yelled and screamed for 10 minutes. Finally the resident yelled "get the f*^# (explicit) out" and she left. During an interview 10/28/22 at 10:06 a.m. Staff E, LPN confirmed when the resident returned back from surgery herself and the DON took his bags to his room. As Staff E visited with the resident the DON rummaged through his belongings ie ...bags, dresser drawers and etc. The DON asked where his cigarettes and lighter had been located and he told her they were in his knee scooter and if she would have asked he would have told her the location. The DON walked over to the knee scooter to go through his bag and that is when he yelled and became upset at that point. The DON walked to the door and with one hand slammed the door and walked to the resident's bed. Staff G stood on the side of the bed closest to the wall while Staff G stood closest to the resident's head. The DON positioned herself right next to Staff G, pointed her finger at the resident as she yelled and told him to stop and you cannot talk to me that way. The resident kept saying get the f*^# (explicit) out, you cannot do whatever you want like you do with other residents, I have a voice. Staff E confirmed at one point she held out her arm to stop the altercation and the DON just talked over her and yelled at Staff E to go and get the AMA papers. Staff E confirmed the DON antagonized and badgered the resident through the entire process as she said "is that all you got", "oh no, my feelings are hurt". 2. A MDS assessment form dated 9/10/22	F 550		

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F 550	Continued From page 5 documented Resident #5 with a BIMS score of 15. During an interview 10/27/22 at 11:13 a.m. Resident #5 stated he felt unsafe at the facility related to how the current DON treated residents and staff. The resident indicated approximately 4-5 days ago he turned on his call light and requested the CNA that responded to get the nurse because he had not received his 11:30 a.m. medications. The DON had been the the nurse for the entire building that day but she had been in her office on her telephone. The DON came into the resident's room and showed him her computer that indicated she could have administered his medications from 11:30 a.m. until 2 p.m. As the DON used a snotty tone she said if it was after 2 p.m. she could not have even given his medications. 3. A MDS assessment form dated 8/12/22 documented Resident #6 with a BIMS score of 15. During an interview 10/27/22 at 12:27 p.m. Resident #6 stated she felt unsafe at the facility related to how the current DON threatened her. The resident indicated the DON kept at the bear (meaning herself) and that she acted weird. One night the DON came into the resident's room and stood against the wall and said come on, come on and get me as she used hand gestures which indicated the DON wanted the resident to fight her. Then she said "oh yeah, you cannot get up" which the resident took as a threat. During an interview 10/27/22 at 3 p.m. Resident #4 confirmed she heard the screaming during the above altercation between the resident and the	F 550		

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F 550	Continued From page 6 DON and the resident had not lied when it came to the circumstances of the argument. The resident indicated she failed to hear the content of the entire conversation but rather she heard the raised voices and commotion in the hallway. The resident stated another incident occurred when the DON pulled all the staff that worked the night shift to her door as she pointed at the resident and told all of the workers not to follow through with her requests for medications because the resident had been a drug seeker. During an interview 10/28/22 at 11:12 a.m. Staff H, LPN stated Resident #6 told her the DON said if you were not so fat you could get up and walk. 5. During an interview 11/3/22 at 9:13 a.m. Resident #15 verbalized concern related to the DON and her demeaning mannerisms towards residents. 6. During an interview 10/27/22 at 1:31 p.m. - Staff C, LPN stated she observed the DON threaten staff usually in a public spot with residents present. The staff member indicated residents complained about the DON as she poked at them. During an interview 10/27/22 at 4:35 p.m. the Interim DON stated the situation had gone to far as it affected the residents and they are not happy. Residents #2, #4 and #6 felt for their individual safety and Resident #2 felt retaliated against by the DON. During an interview 10/28/22 at 11:44 a.m. Staff H, LPN cried at this point and described the residents as afraid at the facility related to the	F 550		

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F 550	Continued From page 7 care and treatment of the current DON.	F 550		
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 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	F 580	F 580 1. On or before 12/25/2022 Resident #11 was assessed by nurse and physician informed of current skin condition. 2. On or before 12/25/2022 DON or designee informed physician of current measurements for residents with skin breakdown. 3. On or before 12/25/2022 DON or designee re-educated nurses regarding skin care documentation and physician notification requirements. 4. DON or designee will audit skin breakdown documentation and physician notification weekly for 4 weeks then monthly for two months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 580	Continued From page 8 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 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 facility policy review, the facility staff failed to promptly notify 1 of 4 resident's Physician related to a condition change. (Resident #11) The facility identified a census of 33 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 10/19/22 documented Resident #11 with diagnoses that included diabetes mellitus (DM), unsteady on feet and muscle weakness. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and required limited assistance of one (1) staff member with bed mobility, transfers, ambulation and personal hygiene. A Care Plan addressed a focus area of 1 pressure ulcer or potential for pressure ulcer development related to a history of ulcers. (initiated and revised on 10/26/22). The interventions included the following as dated:	F 580		

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F 580	Continued From page 9 a. Assess/record/monitor wound healing. Measure length, width and depth when possible. Assess and document status of the wound perimeter, wound bed and healing progress. Report improvements and declines to the Physician. Review of Weekly Skin Assessment forms revealed the following information as dated for the resident's left buttock a. 9/12/22 at 11 a.m. - The resident's left buttock as excoriated. The facility failed to further assess the area or notify the Physician. According to an email dated 11/17/22 at 1:44 p.m. the Interim Director of Nursing (DON) confirmed the facility staff failed to notify the Physician pertaining to her new open area. A Clinical Change in Condition Management policy dated 6/2015 directed the facility staff to have contacted the resident's Physician.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584	F 584 1. By 12/25/22 the DON or designee audited oxygen concentrators for residents #5, #10 & #15 to validate the machine/filter and tubing is clean. On or before 12/25/2022 Maintenance Director or designee completed an audit to validate the pipes were clean in the resident rooms on the East side of the facility. 2. By 12/25/22 the Administrator or designee will audit vents and piping in the resident rooms/care areas and schedule cleaning/repair as needed. Repairs to be completed by Maintenance Director or designee by 12/25/2022. 3. By 12/25/22 the Administrator or designee will re-educate maintenance/housekeeping department regarding cleaning ventilation system. By 12/25/22 the DON or designee will re-educate the nurses regarding routine cleaning or oxygen concentrators machines & filters. 4. Administrator or designee will audit resident room environment weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	12/25/22

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F 584	Continued From page 10 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, including photos and staff interview the facility failed to assure all residents who resided on the East end of the building resided in a clean, sanitary and homelike atmosphere and failed to properly clean and maintain the filters on 3 of 3 resident's oxygen concentrators. (Resident #5, #10 and #15) The facility identified a census of 33 residents.	F 584		

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F 584	Continued From page 11 Findings include:	F 584		

1. During an interview 10/28/22 at 12 p.m. Staff I, Maintenance Supervisor indicated the heating and cooling elements in all of the rooms on the East side of the building contained hot water that flowed through pipes in the winter and each box in the resident's rooms the hot water flowed through pipes and in the summer the water changed from hot to cold. Related to the set up of the system the water condensed which caused a moisture build up so the pipes contained mold. The current system had been installed in the 1960's.

An observation revealed the following on 10/20/22 as timed below:

a. An occupied room 29 at 1:21 p.m. observed a build up of a black substance with the appearance of mold on the pipes.
b. An occupied room 31 at 1:23 p.m. observed a build up of a black substance with the appearance of mold on the pipes.
c. An un-occupied room 33 at 1:23 p.m. observed a build up of a black substance with the appearance of mold on the pipes.

2. An observation 11/15/22 at 2:30 p.m. revealed the same build up of a black appearance with the appearance of mold in the same rooms as above. Actually, the observation revealed all of the 16 rooms on the East side of the building with a build up of the black substance with the appearance of mold on the pipes.

3. A Minimum Data Set (MDS) assessment form dated 9/5/22 documented Resident #5 with diagnoses that included coronary artery disease

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F 584	Continued From page 12	F 584		

(CAD), congestive heart failure (CHF), hypertension (HTN), diabetes mellitus (DM), shortness of breath (SOB), pacemaker, morbid obesity and anxiety. The assessment documented the resident with a Brief Interview for Mental Status score of 15 out f 15 (cognitively intact) and with SOB while he stood, sat or laid down.

A Medication Administration Record (MAR) form dated 11/1/22 thru 11/31/22 documented the resident with an order for oxygen at 3-4 liters (L) every shift dated 4/11/22 at 4:11 p.m.

During an observation 11/3/22 at 8:30 a.m. revealed all of the oxygen concentrator filters for Resident #5 with a build up of dust, dirt and debris.

4. A MDS assessment form dated 10/9/22 documented Resident #10 with diagnoses that included chronic respiratory failure, acute mylosatic leukemia, thrombocytopenia, anemia and COPD. The assessment documented the resident with a BIMS score of 15 and with SOB while he stood, sat or laid down.

A MAR form dated 11/1/22 thru 11/31/22 documented the resident with an order for oxygen at 2 L a minute via nasal canula every shift dated 10/17/22 at 2:52 p.m.

During an observation 11/3/22 at 2:22 p.m. revealed all of the oxygen concentrator filters for Resident #10 with a build up of dust, dirt and debris.

5. A MDS assessment form dated 8/21/22 documented Resident #15 with diagnoses that

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F 584	Continued From page 13 included CHF, HTN, COPD and anxiety. The assessment documented the resident with a BIMS score of 15 and with SOB while she stood, sat or laid down. During an observation 11/3/22 at 9:13 a.m. revealed all of the the oxygen concentrator filters for Resident #15 revealed a build up of a large amount of dust, dirt and debris.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655	F 655 1. Resident #1 was discharged from the facility on 10/11/2022. 2. On or before 12/25/2022 the DON or designee completed an audit of new admissions in the last 30 days to assure baseline care plan was completed within 48 hours. 3. By 12-25-22 the Regional Director of Clinical Services re-educated the interdisciplinary team regarding baseline care plan process. 4. DON or designee will audit new admission care plans weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 655	Continued From page 14 (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, staff interview and policy review, the facility failed to complete a baseline care plan for 1 of 1 residents (Resident #1) sampled. The facility identified a census of 33 residents. Findings include: The Electronic Health Care Census documented Resident #1 admitted to the facility on 3/11/22. A review of the Baseline Care Plan on 11/03/22 at 12:33 p.m. showed the Baseline Care Plan had been completed on 3/14/22. The staff signatures were dated as follows: a. Staff F Social worker on 3/14/22. b. Interim Assistant Director of Nursing (DON) on 4/05/22 c. Staff B, Certified Nursing Assistant and Activities Director on 5/25/22 d. Director of Nursing, undated.	F 655		

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F 655	Continued From page 15 The Resident or Representative Review date was blank. A Plan of Care, Care Plan Summary dated 3/18/22 at 2:00 p.m. documented by Staff F documented a care conference held with the Resident and family. The Baseline Care Plan lacked documentation of being completed within 48 hours of admission. During an interview on 11/03/22 at 2:35 p.m. the Interim DON reported she would expect the baseline care plan to be completed according the regulation. An email communication dated 11/07/22 at 10:53 a.m. from the Interim Director of Nursing documented the facility did not have a policy specific to baseline care plans as it is not a requirement. They follow the federal regulations.	F 655		
F 657 SS=D	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. (E) To the extent practicable, the participation of	F 657	F 657 1. Resident #2 was discharged to his own home on 11/4/2022. Residents # 4 & # 11 care plan reviewed and updated as needed by the DON or designee on 12/5/2022. 2. By 12/25/2022 the DON or designee will audit residents with catheters and skin breakdown to validate interventions are on the care plan. 3. By 12/25/22 the Regional Director of Clinical Services re-educated the interdisciplinary team regarding care plan updates. 4. DON or designee will residents care plan for peri care and pressure ulcer interventions weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 657	Continued From page 16 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interview the facility failed to update and manage three (3) residents care plans. (Resident #2, #4 and #11) The facility identified a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 8/31/22 documented Resident #2 with diagnoses that included psychoactive substance abuse, bipolar, depression, deep vein thrombosis (DVT), hypertension (HTN) and a hip fracture. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), non-ambulatory and required extensive assistance of two (2) staff with bed mobility, transfers, dressing, toilet use and hygiene. The resident's Care Plan failed to address his illegal drug use. The residents Progress Notes entries included	F 657		

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F 657	Continued From page 17 the following: a. 10/12/2022 at 10:07 p.m. - A nurse documented " I said I don't know but we did find methamphetamine in your room with pipes it does bother me." b. 10/28/2022 at 1:48 p.m. (the actual time of occurrence 10 a.m.) - The staff approached this nurse to state it smelled bad in the resident's room which gave them a headache. This nurse went to the resident's room and could smell methaphetamine before entrance into the room. It smelled very strong. The resident had been advised to keep the door shut and but he refused. When staff shut the door the resident opened the door back up. 2. A MDS assessment form dated 8/20/22 documented Resident #4 with diagnosis that included a neurogenic bladder, obstructive uropathy, multiple sclerosis and urine retention. The assessment documented the resident with an indwelling catheter. A Care Plan documented a focus area of an indwelling catheter due to urine retention. (initiated and revised on 8/11/20). The Care Plan failed to address performance of catheter cares. 3. A MDS assessment form dated 10/19/22 documented Resident #11 with diagnosis that included diabetes mellitus (DM), unsteady on feet and muscle weakness. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and required limited assistance of one (1) staff member with bed mobility, transfers, ambulation and personal hygiene.	F 657		

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F 657	Continued From page 18 A Care Plan addressed a focus area of 1 pressure ulcer or potential for pressure ulcer development related to a history of ulcers. (initiated and revised on 10/26/22). The interventions included the following as dated: a. Assess/record/monitor wound healing. Measure length, width and depth when possible. Assess and document status of the wound perimeter, wound bed and healing progress. Report improvements and declines to the Physician. Review of Weekly Skin Assessment forms revealed the following information as dated for the resident's left buttock a. 9/12/22 at 11 a.m. - The resident's left buttock as excoriated. The facility failed to further assess the area or notify the Physician. According to an email dated 11/17/22 at 1:44 p.m. the Interim Director of Nursing (DON) confirmed the facility staff failed to notify the Physician pertaining to her new open area.	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, resident, staff and physician interview and facility	F 658	F 658 1. Resident #1 was discharged on 10/11/2022. On 11/22/22 the DON completed an observational audit for Resident #9 & #13 & #14 noted no medications were left at bedside. 2. By 12/25/22 the DON or designee performed an observational audit to validate no residents had medications left at bedside. By 12/25/22 the DON or designee audited residents with therapy ordered in past 30 days to validate therapy was initiated as ordered. 3. By 12/25/22 the DON or designee re-educated the licensed nurses and the Director of Rehab Services regarding procedure when therapy is ordered. By 12/25/22 the DON or designee re-educated the licensed nurses regarding medication pass procedure. 4. DON or designee will audit weekly for 4 weeks then monthly for 2 months for timeliness of therapy initiation and medication administration. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 658	Continued From page 19	F 658		

policy review, the facility failed to follow physician's orders for 4 of 7 residents reviewed (Residents #1, #9, #13 and #14) . The facility identified a census of 33 residents.

Findings include:

1. The Medication Administration Policy, dated 1/13, provided by the facility, documented a purpose to administer the following according to the principles of medication administration, including the right medication, to the right resident at the right time and in the right dose and route. The Procedure under #16 directed the nurses and Certified Medication Aide (C.M.A.'s) to remain with the resident until all medication is taken.

2. The Electronic Health Record Census documented Resident #1 discharged from the facility to the hospital on 7/06/22 and returned to the facility on Medicare Part A Services on 7/12/22.

A Progress Note, Health Status Note, signed by the Provider on 7/13/22 documented the Provider agreed to order skilled services for Resident #1 for another 100 days under the COVID waiver since she had a qualifying hospital stay with orders for physical, occupational, and speech therapies.

A Nursing Home Admission note with a date of service of 7/15/22 signed by the Provider on 7/17/22 documented a recent hospitalization for a herpes zoster infection that resulted in a superimposed Methicillin-Resistant Staphylococcus Aureus (MRSA) bacterial infection as well as a complex urinary tract

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F 658	Continued From page 20 infection with Pseudomonas and Enterococcus. The Admission Note Plan ordered to re-admit the Resident for further strengthening and conditioning. Physical and Occupational Therapy is appreciated. A review of the electronic health record under physician orders on 11/01/22 at 1:21 p.m. lacked documentation of orders for physical and occupational therapy for 7/15/22 in the electronic orders. The Physical Therapy (PT) Evaluation and Plan of Treatment documented Resident #1 received a PT evaluation with a Start of Care date of 7/22/22. The Physical Therapy Treatment Encounter Notes for Resident #1, provided by the facility, documented therapy services from 8/01/22 thru 9/08/22 documented by the Physical Therapy Assistant (PTA). There were no Physical Therapy Treatment Encounter Notes documented by the PTA for July 2022. During an interview on 11/01/22 at 3:48 p.m. the Interim DON reported the PTA had been off for surgery for a while in there. She thought some of the staff had filled in to provide range of motion to the residents during that time, but needed to check on that. During an interview on 11/01/22 at 3:58 p.m. the Interim DON reported their therapy provider utilized two Physical Therapists on an as needed basis. She reported the PTA had been off work due to a surgery starting 6/02/22 and returned to work on 8/01/22.	F 658		

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F 658	Continued From page 21 During an interview on 11/02/22 at 12:45 p.m. the Nurse Consultant reported the Physical Therapist does the evaluation then the PTA provides the daily treatment as specified by the physical therapist. During an interview on 11/02/22 at 2:27 p.m. the PTA reported she is the only PTA that comes to the facility on a regular basis. She reported she had been out due to a surgery from 6/2/22 until she came back on 8/01/22. She had tried to set up other PTA's to come cover for a few weeks and the Speech Language Pathologist (SLP) had also assisted to schedule the PTA's. She reported when a resident is skilled, therapy usually completes the evaluations within 48 hours of when there is an order for therapy. The facility utilizes two physical therapist on an as needed basis. Physical therapy evaluations would get done on Wednesdays, Saturdays or Sundays. The PTA reported she became aware when she returned on 8/01/22 that the physical therapy evaluations were occurring late. Both physical therapists decided to go on vacation at the same time. They couldn't find anyone to fill in during that time. She reported when a resident is skilled they are seen 5 times a week. The PT completes the evaluation and then she is the primary person providing their therapy treatments, so she makes sure the residents are seen. She stated she is a team of one. She reported Resident #1 had made some progress during therapy but due to the loss of a loved one she then stopped progressing. During an interview on 11/03/22 at 2:34 p.m. the Interim DON reported she would expect that physician orders would be followed and implemented right away.	F 658		

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F 658	Continued From page 22 A review of the Therapy Patient's Schedule for Staff from 6/01/22 to 7/29/22 revealed Resident #1's name did not appear on the schedule for physical therapy evaluation. An email on 11/07/22 at 10:53 a.m. from the Interim Director of Nursing documetned the facility did not have a policy for physician ' s orders. There is no requirement for a physician order policy. The facility follows the federal regulations related to physician orders. 3. The Minimum Data Set (MDS) dated 10/08/22 for Resident #9 showed a Brief Interview for Mental Status (BIMS) Score of 13 indicating intact cognition. The MDS identified the Resident utilized antipsychotic, antidepressant, anticoagulant and diuretic medications with a diagnosis of heart failure, depression, schizophrenia and hypertension. During an observation on 11/02/22 at 7:28 a.m. Staff A, Licensed Practical Nurse (LPN), prepared the following medications: 1. Acetaminophen 500 milligrams (mg) two tablets by mouth. 2. Atenolol-Chlorthalidone Tablet 50-25 mg. Give 0.5 tablet by mouth. 3. Benztropine Mesylate Tablet 2 mg. Give 1 tablet by mouth. 4. Apixaban Tablet 5 mg. Give 1 tablet by mouth. 5. Fluphenazine hydrochloride Tablet 2.5 mg. Give 1 tablet by mouth. 6. Furosemide Tablet 20 mg. Give 1 tablet by mouth one. 7. Levothyroxine Sodium Tablet 25 microgram (mcg). Give 1 tablet by mouth. 8. Miralax Packet 17 grams. Give 17 gram by mouth in 4-8 ounces of fluid.	F 658		

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F 658	Continued From page 23 9. Multivitamin Tablet Give 1 tablet by mouth. Staff A then took the medication into Resident #9's room. Observation at this time revealed Resident #9 sitting on the toilet in the bathroom. Staff A placed the cup of medications with the cup of Miralax in water on the Resident's bedside table and told her medications were on her table, closed the door and walked out of the Resident's room and did not observe the resident take the medications. A review of the electronic health record Assessments on 11/02/22 at 7:55 a.m. from 12/29/21 - 11/01/22 revealed no evidence of a medication self-administration assessment being completed for Resident #9. A review of the Care Plan lacked documentation that medications could be left at the bedside or the Resident could self-administer her own medications. A review of the Physician Orders on 11/02/22 at 7:59 a.m. signed by the physician revealed no orders for self-medication administration or that medications could be left at the bedside. The November 2022 Medication Administration Record (MAR) documented Staff A administered the medications to Resident #9. 4. The MDS for Resident #13 dated 9/02/22 showed a BIMS of 13 indicating intact cognition. The MDS identified the Resident received antidepressant and diuretic medications for a diagnosis of depression and hypertension. During an observation on 11/02/22 at 7:31 a.m. Staff A set up the following medications for Resident #13:	F 658		

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F 658	Continued From page 24 a. Cetirizine HCl Tablet 10 mg. Give 1 tablet by mouth. b. Duloxetine hydrochloride Capsule Delayed Release Sprinkle 20 mg. Give two capsules by mouth. c. Lasix Tablet 20 mg. Give 1 tablet by mouth. d. Levothyroxine Sodium Tablet 75 mcg. Give 1 tablet by mouth. e. Levetiracetam Tablet 500 mg. Give 1 tablet by mouth. f. Carbamazepine Extended Release Tablet 200 mg. Give 2 tablets by mouth. g. Multivitamin-Minerals Tablet give 1 tablet by mouth. h. Omeprazole Tablet Delayed Release 20 mg. Give 1 tablet by mouth. j. Acetaminophen 325 mg Give 2 tablets by mouth. During an observation on 11/02/22 at 7:38 a.m. Resident #13 lay in bed as Staff A entered the Resident's room. Staff A asked Resident #13 to sit up on the edge of the bed and take her pills. Staff A placed the cup of pills on Resident #13's bedside table and walked out of the room closing the Resident's door on the way out of the room. Staff A failed to observe Resident #13 swallow her medications. A review of the electronic health record Assessments on 11/02/22 at 8:00 a.m. from 5/27/21 - 11/01/22 revealed no evidence of a medication self-administration assessment being completed for Resident #13. A review of the Care Plan lacked documentation that medications could be left at the bedside or the Resident could self-administer her own medications. A review of the Physician Orders on 11/02/22 at	F 658		

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F 658	Continued From page 25 8:05 a.m. for orders signed by the Provider on 10/28/22 revealed no orders for self-medication administration or that medications could be left at the bedside. The November 2022 Medication Administration Record (MAR) documented Staff A administered the medications to Resident #13. 5. The MDS dated 10/05/22 for Resident #14 showed a BIMS of 15 indicating intact cognition. The MDS identified Resident #14 received antidepressant, anticoagulant and opioid medications and had a diagnosis of history of fracture, chronic pain, paroxysmal atrial fibrillation, and heart failure. During an observation on 11/02/22 at 7:40 a.m. Staff A prepared the following medication for Resident #14: a. Allopurinol Tablet 300 mg. Give 1 tablet by mouth one time. b. Centrum Tablet give 1 tablet by mouth. c. Apixaban Tablet 5 mg give 1 tablet by mouth. d. Sacubitril-Valsartan (Entresto) Tablet 49-51 mg, give 1 tablet by mouth. e. Famotidine Tablet 20 mg, give 1 tablet by mouth. f. Farxiga Tablet 10 mg, give 1 tablet by mouth g. Furosemide Tablet 40 mg, give 1 tablet by mouth h. Gabapentin Capsule 300 mg, give 2 capsules by mouth. i. Metoprolol Succinate Extended Release Tablet 24 Hour 25 mg, give 1.5 tablets by mouth. j. Iron Polysaccharide Complex-B12-Fast Acting Capsule 150-0.025-1 mg, give 1 capsule by mouth. k. Pramipexole Dihydrochloride Tablet 0.25 mg, give 1 tablet by mouth.	F 658		

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F 658	Continued From page 26 During an observation on 11/02/22 at 7:48 a.m. Staff A entered Resident #14's room. Resident #14 sat in his recliner watching television. Staff A left the cup of medications on the Resident's bedside table, turned shutting the door as she walked out of the room. Staff A failed to observe Resident #14 to ensure he took his medications appropriately. A review of the electronic health record Assessments on 11/02/22 at 8:15 a.m. from 8/06/22 - 11/01/22 revealed no evidence of a medication self-administration assessment being completed for Resident #14. A review of the Care Plan lacked documentation that medications could be left at the bedside or the Resident could self-administer his own medications. A review of the Physician Orders on 11/02/22 at 8:15 a.m. for orders signed by the Provider on 8/11/22 revealed no orders for self-medication administration or that medications could be left at the bedside. The November 2022 Medication Administration Record (MAR) documented Staff A administered the medications to Resident #14. During an interview on 11/02/22 at 10:41 a.m. Staff B, Certified Medication Aide (CMA), reported medications are not to be left at the bedside unless the Director of Nursing (DON) has done a self-medication administration assessment on the resident. When you look at the MAR if it is green, then it means they can keep medications in their room. She checked the electronic Medication Administration Records and reported Residents #9, #13 and #14 did not have any indications they	F 658		

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F 658	Continued From page 27	F 658		

could keep medications at the bedside. She reported she did not believe they had any resident currently in the facility that could self-administer their own medications.

During an interview on 11/02/22 at 11:21 a.m. Staff C, LPN, reported nurses are not to leave medications at the bedside unless there is an order to do so.

During an interview on 11/02/22 at 2:21 p.m. Staff D, CMA, reported they are not to leave medications at the resident's bedside unless the care plan specifies they can do that.

During an interview on 11/02/22 at 3:24 p.m. Staff E, LPN, reported medications are not to be left at the bedside unless the MAR specifies the medication can be left at the bedside and the care plan should specify the medications can be left at the bedside.

During an interview on 11/02/22 at 3:35 p.m. the Interim Director of Nursing reported medications should not be left at the bedside. She is responsible for completing a self-medication administration assessment. She reported there are no residents at this time that self-administer their medications and her expectation is that medications will not be left at the bedside for residents to take on their own.

The Medication Administration Policy, dated 1/13, provided by the facility, documented a purpose to administer the following according to the principles of medication administration, including the right medication, to the right resident at the right time and in the right dose and route. The Procedure under #16 directed the nurses and

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F 658	Continued From page 28 C.M.A.'s to remain with the resident until all medication is taken.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked	F 660	F 660 1. Resident # 2 was discharged from the facility to his home on 11/4/2022. 2. By 12/25/22 the Social Services Director or designee will audit residents care plan to determine if a resident needs detailed discharge care plan. 3. By 12/25/22 the Regional Director of Clinical Services re-educated the interdisciplinary team regarding discharge planning. 4. The Social Services Director or designee will audit discharge care plans weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Social Services Designee is responsible for ongoing monitoring.	12/25/22

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F 660	Continued From page 29 about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 660		

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F 660	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility policy review, the facility failed to properly develop and implement and effective discharge plan the focused on the resident's discharge goals, preparation of the resident's in home ancillary services and pharmacy and home care equipment services to enable an effective transition to home and post-discharge care for 1 of 3 resident's reviewed. (Resident #2) The facility identified a census of 33 residents. Findings include: A letter to Resident #2 dated 9/23/22 included the following information: "This letter is written pursuant to officially notify you that you will be involuntarily discharged from Osage Nursing and Rehab Center 30 days from receipt of this letter on 10/23/22." "You are being discharged due to the welfare of the other residents of our facility. You were observed smoking illegal drugs in your bathroom on 9/21/22 and charges were brought against you by the Osage Police Department for possession of drug paraphernalia." During a telephone interview 11/2/22 at 12:15 p.m. the Ombudsman stated the facility planned to discharge Resident #2 at that moment. An observation at the same time, revealed the resident as he sat on the edge of the bed with the Office Manager, Social Worker and an unknown staff member present. All of the resident's belonging had been	F 660		

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F 660	Continued From page 31	F 660		

packed up and ready to go. When asked the staff for the discharge summary form staff indicated they had called home health who planned to arrange meals on wheels, and the facility staff called the pharmacy about his medications so the facility planned to send the medication cards and all his meds in house with the resident. When questioned the resident's ability to self administer the medications from the med cards staff indicated the resident had been educated on the proper procedure which the resident denied. When questioned the staff about a home study the staff stated they only conduct home studies when a resident is on therapy services and discharged home and the resident had not been on therapy services. At that point, the Social Worker brought the resident's Care Plan to the resident's room and indicated that form had been the discharge summary. The Social Worker had not been trained and had no knowledge on how to proceed with the discharge summary form and the process included with a resident's discharge back into the community.

During an interview 11/2/22 at 12:29 p.m. with the Interim DON and Corporate Nurse who indicated the facility had already made arrangements for transportation to pick up Resident #2 at 2 p.m. and take him home to stay. The staff were reminded of their responsibility to make sure the resident's transition is safe. The Interim DON then stated the facility needed to assure the resident's discharge occurred on that day as another resident threatened to call the local TV station and report the facility housed a drug user.

During an observation and interview 11/2/22 at approximately 1 p.m. the Social Worker, Interim

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F 660	Continued From page 32 DON and Corporate nurse made arrangements for a home study. Per the Corporate Nurse the facility planned for the resident's transport home accompanied by the Maintenance Supervisor and the Corporate Nurse who planned to conduct a home study and the facility planned for the resident's return to the facility until all details had been properly arranged. During an interview 11/2/22 at 4:20 p.m. the Interim DON indicated the home study went well and the resident had been able to go up the stairs to get into his trailer home and able to sit and get up from his recliner. The staff member confirmed the house required cleaning and a narrow pathway through the trailer (due to belongings stacked up) needed cleared but the facility planned to come up with a plan to clean. Plan for now is to arrange for pharmacy to package Resident #2's medications for proper administration at home and the cleansing of his trailer. The Interim DON expected discharge on 11/4/22 at the earliest. During an interview 11/3/22 at 11:24 a.m. the Maintenance Supervisor confirmed the resident's trailer house as locked and the resident had no key so the Maintenance Supervisor had to jimmy (break in) into the house. The resident had been able to get up and down the stairs into the house and maneuvered around without difficulty per his cane and/or knee walker.	F 660		
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	F 677		

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F 677	Continued From page 33 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 and staff and resident interview, the facility failed to provide baths/showers for 2 residents reviewed. (Resident #4 and #15) . The facility identified a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 8/20/22 documented Resident #4 with diagnosis that included multiple sclerosis (MS), with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and as dependent on staff with the bathing process. During an interview 10/27/22 at 3 p.m. Resident #4 confirmed the staff failed to shower residents for approximately a week because something append with the water heater. 2. A MDS assessment form dated 8/31/22 documented Resident #15 with diagnosis that included heart failure (HF) chronic obstructive pulmonary disease (COPD) and hypertension (HTN), a BIMS score of 15 and required physical help in part of the bathing process from the facility staff. During an interview 11/3/22 at 9:13 a.m. Resident #15 confirmed the facility failed to provide her showers as scheduled on Tuesday ' s and Friday ' s and she wanted them. The resident stated when the water heater broke down they gave the resident's wet wipes but no one offered a bed bath.	F 677	F 677 1. By 12/25/2022 the DON completed an audit of bathing for residents #4 & #15 to validate they are receiving bi-weekly bathing. 2. By 12/25/22 the DON or designee audited resident bathing documentation to validate resident are receiving their baths as scheduled. 3. By 12/25/22 the DON or designee re-educated the nursing staff regarding bathing schedule and required documentation. 4. DON or designee will audit completion of bathing weekly for 4 weeks then monthly for two months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring. Compliance Date: 12/25/2022	12/25/22

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F 677	Continued From page 34 During an interview 10/27/22 at 1:31 p.m. Staff C, LPN indicated the facility recently, within the last 3 weeks, went without hot water for one (1) week so no showers had been performed.	F 677		
F 684 SS=J	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, clinical record review, staff and resident interview and facility policy review the facility failed to provide the necessary assessments for 1 of 7 residents reviewed with a condition change, (Resident #2). A determination was made the facility's non-compliance placed residents in the facility in immediate jeopardy, beginning on 9/17/22. The facility identified a census of 33 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 8/31/22 documented Resident#2 with diagnosis that included psychoactive substance abuse, bipolar, depression, deep vein thrombosis (DVT), hypertension (HTN) and a hip fracture. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of	F 684	F684 1. Resident #2 was discharged from the facility on 11/04/22. 2. Residents were assessed by a licensed Nurse on or before 12/15/22 related to signs and symptoms of change in condition with no changes in condition noted. 3. Nursing staff were reeducated by DON or designee on or before 12/15/22 related the signs and symptoms of changes in condition related to substance use disorders including decreased responsiveness or altered mental status. 4. Director of Nursing or designee will complete observational assessments of residents weekly for 4 weeks, then monthly for 2 months to ensure resident's change in condition continue to be identified and address including changes related to substance use disorders as required. The results of these audits will be presented to the QAPI committee meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up.	12/15/22

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OSAGE REHAB AND HEALTH CARE CENTER	830 SOUTH FIFTH STREET OSAGE, IA 50461

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F 684	Continued From page 35 15 out of 15 (cognitively intact), with verbal behavioral syptoms directed towards others and rejection of cares 1-3 days a week in the look back period, non-ambulatory and required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use and hygiene. The resident's Care Plan failed to address his illegal drug use. The residents Progress Notes entries included the following: a. On 9/13/22 at 3:22 p.m. - Received a fax from the resident's Physician for an order for a urinalysis (UA) with culture and a drug panel. The staff obtained the UA and sent it to the lab. 1. A Lab Report form dated 9/13/22 at 3:38 p.m. documented the resident as positive for methamphetamine. b. On 9/17/22 at 1:27 p.m. - The resident screamed at staff over a TV that he claimed was his that had been a facility TV but the resident changed rooms. The resident stated "Get me my f'ing (explicit) tv right now or I am going to start breaking shit!" The resident had a tv in his room already. The resident then went in to another resident's room and ripped off his oxygen. The staff told this resident to stay out of other resident's rooms, Resident #2 stated "I don't give a f*$# (explicit), I am going to start tearing shit apart!' c. On 9/22/22 at 2:48 a.m. - A nurse documented the resident had been very difficult and the police came to the facility several times	F 684		

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F 684	Continued From page 36 the past week but they could not do anything as the resident refused for the police or staff to go through his belongings. Earlier that evening the evening nurse walked into the resident's room while he smoked methamphetamine from a methamphetamine pipe. The police returned that evening and searched the room and found 3 methamphetamine pipes and white residue in a bag and in a bag on his knee scooter that tested positive for methamphetamine. d. On 10/12/2022 at 10:07 p.m. - A nurse documented " I said I don't know but we did find Methamphetamine in your room with pipes it does bother me." e. On 10/28/2022 at 1:48 p.m. (the actual time of occurance 10 a.m.) - The staff approached this nurse to state it smelled bad in the resident's room which gave them a headache. This nurse went to the resident's room and could smell methaphetamine before entrance into the room. It smelled very strong. The resident had been advised to keep the door shut but he refused. When staff shut the door the resident opened the door back up. The residents record lacked documentation of staff assessment and/or intervention according to the given circumstance. f. On 10/28/2022 at 1:30 p.m. (the actual time of occurance 10:30 a.m. - 11 a.m.) - The resident in the morning had been found as he cleaned his room with a broom and then cleaned the toilet and sink with the dirty broom, he was also taking his clothes washing them in the sink and then putting them in the toilet and then back into the sink, when the staff went in to ask him if he needed help he told them to leave his room and that he would be fine without their help. The	F 684		

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F 684	Continued From page 37 residents record lacked documentation of staff assessment and/or intervention according to the given circumstance. g. On 10/28/2022 at 12:55 p.m. - The Business Office Manager (BOM) and Social Services Designee (SSD) went into the resident's room to talk about discharge plans. The staff found the resident resting in his chair and hard to arouse with a lot of drool coming from his mouth. The resident would not open his eyes while they visited with him. The staff asked if he would like them to set up a treatment facility for discharge, he said "I don't know". The staff attempted many times to ask what his plans had been for discharge and asked if he would accept help from Home Health and he had been unsure. The BOM and SSD left the room and let him know they would return. The residents record lacked documentation of staff assessment and/or intervention according to the given circumstance. h. On 10/28/2022 at 1:27 p.m. - Resident was in his room, positioned in his wheel chair, with his arms crossed and his head down, drooling and very hard to arouse. The resident answered the nurse but he had been alert that morning as he conversed with staff and cleaned his room and toilet with a broom. i. On 10/28/2022 at 1:28 p.m. - The staff placed a call the resident's physician related to his lethargy. j. On 10/28/2022 at 1:32 p.m. - Resident #2's vital signs were, Temperature - 97.8 degrees Fahrenheit (F), pulse 77, respirations16, oxygen saturation rate at 99% and his blood pressure registered 130/90.	F 684		

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F 684	Continued From page 38 k. On 10/28/2022 at 1:35 p.m. - Staff assisted the resident to bed with 2 assistance. The resident assisted but continued with slurred speech. During an interview on 10/21/22 at 2:30 p.m. the resident confirmed staff caught him in his rom as he smoked methamphetamine not to long ago. According to an email dated 11/9/22 at 10:42 a.m. the Interium Director of Nursing documented the expectation when nurses performed skin assessments to have completed a head to toe assessments, with the proper form and measurements documented for each area identified. A Clinical Change in Condition Management form dated 6/2015 included the following procedural directives: a. Assessment of the resident's clinical status with a condition change to have included but not limited to: 1. Vital signs, lung sounds, pulse oximeter, mental/neurological satus, bowel sounds, skin color/turgor and temperature and pain. 2. Contact the Physician and family. On 10/28/22 at 2:15 PM the facility was notified of the immediate jeopardy at F684 and was given the IJ Template. The facility provided staff education on substance abuse disorder and education given to staff members to report to nurse if they observe any signs and symptoms. The nurse is to complete an assessment and notify doctor, family, and DON/Administrator if signs and symptoms exist. After the surveyor verified implementation of the removal plan the	F 684		

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F 684	Continued From page 39 immediate jeopardy was removed on 10/29/22 and the scope and severity was lowered to a D.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff, resident and Physician interviews, the facility failed to ensure that based on a comprehensive assessment, staff provided care consistent with professional standards to prevent pressure ulcers from developing unless the individual's clinical condition demonstrated that they were unavoidable. The facility also failed to ensure residents with existing pressure sores received necessary treatment care and services consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 3 of 4 residents reviewed. (Resident #4, #9, #11 and #1) The facility identified a census of 33 residents. Findings include:	F 686	F 686 1. By 12/25/2022 the DON or designee validated the treatments for residents #4 , #9 & #11 were completed. as ordered and skin assessment was completed timely. Resident #1 no longer resides at the facility as of 10/11/2022. 2. By 12/25/22 the DON or designee will audit residents with skin breakdown to validate skin assessments are being completed weekly and treatments being completed as ordered. 3. By 12/25/2022 the DON or designee will re-educate the licensed nurses regarding weekly skin assessment process and required documentation. 4. The DON or designee will audit pressure ulcer assessments weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 686	Continued From page 40 The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or	F 686		

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F 686	Continued From page 41 cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. A MDS assessment form dated 8/20/22 documented Resident #4 with diagnosis that included multiple sclerosis (MS) and lymphedema. The assessment documented the resident with a BIMS score of 15. A Care Plan identified a focus are of MS, initiated and revised on 9/20/21. The interventions included the following as dated: a. Change PICC line dressing per sterile technique weekly. Review of the facilities Treatment Administration Record (TAR) forms for 9/1/22 thru 9/30/22, 10/1/22 thru 10/31/22 and 11/1/22 thru 11/30/22 directed the facility staff to have changed the resident's PICC line dressing once a week on Wednesdays. The facility failed to complete the treatment 9/7/22, 9/14,/9/21, 9/28, 10/12, 10/19, 10/26 and 11/8. According to an eMAR Progress Notes entry dated 11/9/22 at 1:22 p.m. the staff failed to change the resident's PICC line dressing due to no supplies. During an interview and observation 11/16/22 at 12:30 p.m. the resident confirmed the PICC dressing as not changed since Staff C, Licensed Practical Nurse (LPN) changed it on 11/2/22. (no date present on bandage)	F 686		

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F 686	Continued From page 42 According to a fax form signed by the resident's Physician 11/17/22, the Physician expected the facility staff to have followed his order to change the dressing on the resident's PICC line every week. Failure to follow order may have resulted in infection. 2. A MDS assessment form dated 10/8/22 documented Resident #9 with diagnosis that included schizophrenia, lymphedema, obesity and a stage II sacral pressure ulcer. The assessment documented the resident with a BIMS score of 13 (cognitively intact), required limited assistance of 1 staff with personal hygiene, independent with bed mobility, transfers and ambulation in her room. The assessment documented the resident as at risk for pressure ulcers, with MASD and on no turning and repositioning program. A Care Plan addressed a focus area of at risk for pressure ulcers, initiated 1/8/22 and revised 11/18/22. The interventions included the following as dated. a. Assess/record/monitor wound healing. Measure length, width and depth when possible. Assess and document status of the wound perimeter, wound bed and healing progress. Report improvements and declines to the Physician. (initiated and revised 1/8/22) An observation and interview on 11/2/22 at 10:51 a.m. revealed Staff A, LPN cleansed the resident's open area (approximately pea sized open area on her left buttock) with wound cleanser as the staff member wiped back and forth over the wound, applied nutrishield and again wiped back and forth over the area. According to a Weekly Skin Assessment form	F 686		

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F 686	Continued From page 43 dated 11/6/22 at 1:52 p m. the resident's right and left buttocks had been excoriated. The facility staff failed to further assess the area up to and including any measurements or description of the excoriation. According to a Fax Form dated 11/17/22 (no time) the resident's Physician indicated he expected the facility staff to fully assess her skin areas at least weekly and her pressure area had been preventable. 3. A MDS assessment form dated 10/19/22 documented Resident #11 with diagnosis that included diabetes mellitus (DM), unsteady on feet and muscle weakness. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact) and required limited assistance of one staff member with bed mobility, transfers, ambulation and personal hygiene. A Care Plan addressed a focus area of 1 pressure ulcer or potential for pressure ulcer development related to a history of ulcers, initiated and revised on 10/26/22. The interventions included the following as dated: a. Assess/record/monitor wound healing. Measure length, width and depth when possible. Assess and document status of the wound perimeter, wound bed and healing progress. Report improvements and declines to the Physician. Review of Weekly Skin Assessment forms revealed the following information as dated for the resident's right buttock. a. 9/5/22 at 11 a.m. - The resident's right	F 686		

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F 686	Continued From page 44 buttock with a superficial area and no signs and symptoms of infection. The resident denied pain. The form failed to address any further assessment. According to a MD/Nursing Communications form signed by a Physician 9/6/22 directed the facility staff for an application of hydraguard two times a day (BID) and PRN. The facility described the area as superficial. b. 10/10/22 at 9:01 a.m. - No new areas of impairment noted at that time Current treatment of hydraguard to superficial area on right buttock with no signs and symptoms of infection. Resident denied pain. The facility failed to further assess the area. Review of Weekly Skin Assessment forms revealed the following information as dated for the resident's left buttock a. 9/12/22 at 11 a.m. - The resident's left buttock as excoriated. The facility failed to further assess the area or notify the Physician. b. Based on clinical record review no further skin assessments occurred to this area. According to a fax form signed by a Physician on 11/17/22 the Physician felt the resident's pressure ulcers required a minimum of a weekly assessment, proper Physician notification when the ulcers increased in size and/or changed. The Physician documented the pressure ulcers as hard to determine if preventable or not due to her sedentary lifestyle. 4. The Minimum Data Set (MDS) Assessment dated 3/18/22 for Resident #1 showed a Brief Interview for Mental Status (BIMS) score of 14	F 686		

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F 686	Continued From page 45	F 686		

indicating no cognitive loss. The Resident required extensive assistance with bed mobility, dressing, personal hygiene and full assistance with bed mobility and toileting use. The MDS listed a diagnosis of peripheral vascular disease, diabetes mellitus, chronic obstructive pulmonary disease and pressure ulcers of the left and right heel. The MDS identified the Resident at risk of a pressure injury and admitted with two unstageable pressure wound injuries which they received pressure injury care for as well as a pressure reducing chair and device for the bed. The MDS further identified the resident received application of dressings to the feet.

The Braden Scale Skin Risk Assessment dated 3/11/22, 3/18/22 and 3/25/22 all documented a score of 16 indicating a low risk of skin breakdown.

The Nursing Admission Data Assessment dated 3/11/22 documented the presence of a unstageable left heel pressure ulcer measuring 3 cm in length, 2 cm in width and 0 cm in depth and a unstageable right heel pressure ulcer measuring 0.5 cm in length, 0.5 cm in width and 0 cm in depth.

A weekly Skin Assessment -V1 dated 3/12/22 day of admission documented an intact pressure ulcer to the left heel with no measurements. The Assessment documented an area to the right heel measuring 0.5 centimeters (cm) by 0.5 cm. The Assessment documented the skin integrity as "open areas."

The Baseline Care Plan dated 3/14/22 completed by Staff F, Social Worker, noted the presence of pressure injuries with specialized wound care

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F 686	Continued From page 46 provided including a pressure reducing cushion in the wheelchair, pressure reducing mattress to the bed and to follow the physician orders for wound treatment. The Pressure Injury Weekly Assessment dated 3/26/22 documented the following pressure injuries as community acquired: a. Right heel length 0.6 centimeters (cm) x width 0.5 cm, unstageable. b. Right heel length 0.4 cm x width 0.3 cm, unstageable. c. Left heel length 3.4 cm x width 3.8 cm, unstageable. The Assessment further documented the wound bed as dark purple, MD notified 3/11/22, boots in place with skin preparation treatment and co-morbidities of complete intestinal obstruction, unspecified cause, atherosclerotic heart disease of native coronary artery with angina pectoris and significant other notified of the areas on 3/11/22. A Review of the Electronic Medical Record (E.H.R.) under Assessments on 10/31/22 at 11:20 a.m. lacked documentation of pressure injury weekly assessments, non-pressure weekly skin records, or weekly skin assessments for 4/2/22 and 4/9/22. Pressure Ulcer Injury Weekly Assessment dated 4/16/22 showed the pressure wound unchanged in assessment from 3/26/22. The Resident still continued to wear pressure reducing boots. A Review of the E.H.R. under Assessments on 10/31/22 at 11:23 a.m. lacked documentation of pressure injury weekly assessments from 4/17/22 to 6/7/22. A Weekly Skin Assessment dated	F 686		

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F 686	Continued From page 47 4/30/22, 5/07/22, 5/14/22, and 5/21/22 documented the presence of a left heel pressure area and the right heel with two small pressure areas. The Weekly Skin Assessment dated 5/28/22 and 6/04/22 documented the presence of blisters and areas to the right and left heel. The Weekly Skin Assessment lacked assessment of the pressure injury measurements, wound bed, peri-wound area, odor, or pain. A Pressure Injury Weekly Assessment dated 6/18/22 documented a stage 1 facility acquired pressure wound present to the left buttock measuring 1 cm in length by 1.4 cm in width. The area was cleansed and Mepilex dressing applied. Repositioning every 2 hours to off load the area, side to side when in bed. The physician and Resident notified of the new area 6/18/22. A Pressure Injury Weekly Assessment dated 6/18/22 documented a pressure injury to the left heel measuring 2 cm length by 106 cm in width, stage 1, dark purple with the physician notified 4/23/22 and a treatment of betadine to the area daily. The Assessment identified co-morbidities of muscle weakness and diabetes without complications. The Assessment lacked documentation of the right heel pressure injury. A Weekly Skin Assessment dated 6/18/22 documented the right heel with a purple pressure area. A Pressure Injury Weekly Assessment dated 6/27/22 (9 days after the assessment on 6/18/22) documented a pressure injury to the left heel measuring length 2.1 cm x width 1.3 cm with black eschar present with the physician notified of condition 6/18/22. A review of the electronic	F 686		

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F 686	Continued From page 48 health record from 6/19/22 - 6/27/22 lacked documentation of any Weekly Skin Assessments or Non-Pressure Weekly Skin Records being completed. The Assessments lacked documentation of the pressure injury to the right heel. A Pressure Injury Weekly Assessment dated 6/27/22 (9 days after the assessment on 6/18/22) documented a stage 2 pressure injury to the coccyx measuring length 1.0 cm by width 1.0 cm by depth 0.1 cm., wound granulating. Mepilex treatment in place with interventions of repositioning every 2 hours to off load the area, side to side when in bed. A review of the E.H.R. assessment on 10/31/22 at 11:45 a.m. revealed a lack of pressure injury assessment from 6/28/22 - 7/17/22. A Weekly Skin Assessment dated 7/02/22 documented the presence of a left heel open area. The Assessment lacked documentation of the wound bed, peri-wound area, wound characteristics and if pain had been present. The Skin Assessment lacked documentation of the right heel and coccyx/left buttock condition. A Health Status Note dated 7/13/22 documented the buttocks as healed with notification to the physician to discontinue the treatment. A Pressure Injury Weekly Assessment dated 7/18/22 documented a pressure injury, unstageable to the left heel measuring length 2.3 cm x width 3.8 cm. The Assessment lacked documentation of the two pressure injuries to the right heel from admission. Further review of the electronic health record revealed no	F 686		

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F 686	Continued From page 49 comprehensive assessment of the pressure injury wounds from 7/19/22 - 7/29/22. The Assessment lacked documentation of the pressure injury to the right heel. A Pressure Injury Weekly Assessment dated 7/30/22 (12 days after the Assessment on 7/18/22) documented an unstageable pressure injury to the left heel measuring length 1.5 cm x width 2.5 cm with eschar to the wound bed. The physician had been updated 7/18/22. The betadine treatment continued along with the use of protective boots. The Assessment lacked documentation of the assessment of the right heel. A Pressure Injury Weekly Assessment dated 8/7/22 documented an unstageable pressure injury to the left heel measuring length 1.8 cm x width 1.5 cm with eschar present in the wound bed. The betadine treatment continued. The Assessment lacked documentation of the condition of the right heel. A Pressure Injury Weekly Assessment dated 8/13/22 documented an unstageable pressure injury to the left heel measuring length 1.5 cm x width 1.8 cm with eschar present to the wound bed with the betadine treatment continuing. The Assessment lacked documentation of the pressure injury to the right heel. A Review of the E.H.R. on 10/31/22 at 12:01 p.m. lacked documentation of Pressure Injury Weekly Assessments for 8/20/22 or 8/27/22. A Weekly Skin Assessment dated 8/20/22 documented the left heel with a dry scab with betadine being utilized. A Weekly Skin	F 686		

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F 686	Continued From page 50 Assessment dated 8/27/22 documented the left heel scabbed measuring length 2 cm x width 1 cm. The Assessments lacked documentation of the wound bed, peri-wound area, odor, or pain. A Pressure Injury Weekly Assessment dated 9/1/22 documented an unstageable pressure injury to the left heel measuring length 2.5 cm x width 4 cm with black eschar in the wound bed. The Assessment under comments documented the left heel had a scabbed area with a soft discolored area next to the scab. The entire area measured 2.5 cm x 4 cm and is tender to touch. A Physician Notification dated 9/01/22 documented the physician notified of the left heel pressure injury worsening with orders given for a consultation. A Pressure Injury Weekly Assessment dated 9/10/22 documented an unstageable pressure injury to the left heel measuring length 3 cm x width 1.6 cm with black eschar in the wound bed. The Assessment lacked documentation of pressure wound assessment to the right heel. A Review of the E.H.R. Assessments on 10/31/22 at 12:08 p.m. lacked documentation of a Pressure Injury Weekly Assessment for 9/17/22, 9/24/22 and 10/1/22. A Pressure Injury Weekly Assessment dated 10/8/22 documented an unstageable pressure injury to the left heel measuring length 2 cm x width 3 cm. The Assessment did not assess pressure injuries to the right heel. A Pressure Injury Weekly Assessment dated 10/11/22 documented the unstageable pressure	F 686		

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F 686	Continued From page 51 injury to the left heel had not been assessed prior to transfer to the hospital. During an interview on 11/02/22 at 11:21 a.m. Staff C, LPN, reported she remembered Resident #1 admitted to the facility with pressure areas to her heels. She reported nurses are to assess pressure wounds weekly and do the measurements in the electronic health care assessments. The nurses are to look at the wounds when they do wound treatments. But the full assessments are to be completed weekly. During an interview on 11/03/22 at 2:30 p.m. the Interim DON reported she expected the nurses to complete a full assessment of each pressure injury wound weekly and document on the weekly pressure injury assessment in the electronic health care record. The Skin Care and Wound Management Policy, dated 6/2015, provided by the facility documented the facility staff strives to prevent resident skin impairment and to promote healing of existing wounds. The Interdisciplinary team works with the resident and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition contributing to it, and description of impairment to determine appropriate treatment. Components of the skin care and wound management program include, but are not limited to the following: 1. Identification of the resident at risk for developing pressure ulcers. 2. Implementation of prevention strategies to	F 686		

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F 686	Continued From page 52 minimize the potential for developing pressure ulcers and skin integrity issues. 3. Weekly monitoring of resident skin status. 4. Daily monitoring of existing wounds. 5. Application of treatment protocols based on the clinical "best-practice" standards for promotion of wound healing. 6. Interdisciplinary review of identified skin impairments. 7. Monitoring of consistent implementation of interventions and effectiveness of interventions. 8. Review and modification of treatment plans, as applicable. 9. Analysis of facility pressure ulcer data for quality improvement opportunities. A pressure ulcer is defined as a localized injury to the skin and/or underlying tissue usually over a boney prominence, as a result of pressure or pressure in combination with shear and/or friction. The Policy Procedure under Prevention directed the staff in the following: 1. Complete the Braden Scale on admission, weekly x 4, then quarterly, to identify resident pressure ulcer risk indications. 2. Complete the Admission Skin Sweep and the Admission Clinical Information/Readmission Data Collection and Initial Care Plan on admission. Initiate the Weekly Skin Sweep thereafter. Identify areas of skin impairment and any pre-existing signs. The Policy under Treatment specified to monitor and document progress toward goals.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 53 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to lock and secure medication carts and/or treatment carts on 2 separate occasions. The facility identified a census of 33 residents. Findings include: An observation on 10/20/22 at 12:29 p.m. revealed a unlocked and unattended treatment cart, which contained a variety of treatment supplies, creams and ointments, positioned along the wall outside the North wall of the West nurse's station and an unlocked and unattended medication cart, which contained a variety of medications, positioned along the South wall just outside the West nurse's station. The same observation revealed an unlocked, unattended medication cart, which contained a variety of medications positioned along the sounth wall of the East nurse's station. An observation on 11/15/22 at 8:30 a.m. revealed an unlocked and unattended medications cart, postioned along the South wall just outside the West nurse's station. According to an email dated 11/15/22 at 5:49 p.m. the Interim Director of Nursing documented one resident wandered around the facility.	F 689	F 689 1. On or before 11/25/22 the DON or designee completed an observational audit to validate the medication and treatment carts were locked when unattended by staff with no concerns noted. 2. On or before 12/25/22 the DON or designee performed an observational audit of the medication & treatment carts at various times of the day for 4 days to validate the carts are locked when unattended by staff. 3. On or before 12/25/2022 the DON or designee re-educated licensed nurses and Certified Medication Aides regarding locking medication and treatment carts. 4. The DON or designee will audit weekly for 12 weeks to validate carts are locked when unattended. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON responsible for ongoing monitoring.	12/25/22

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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 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 observation, clinical record review,	F 690	F 690 1. On or before 12/25/2022 the DON or designee performed an observational audit of catheter/peri cares for Residents #4 & #6. 2. On or before 12/25/2022 The DON or designee performed an observational audit of residents requiring catheter cares. 3. On or before 12/25/2022 the DON or designee re-educated nursing staff regarding peri/catheter cares. 4. DON or designee will audit peri/catheter cares weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON responsible for ongoing monitoring.	12/25/22

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F 690	Continued From page 55 resident interview and facility policy review, the facility failed to properly care two residents with a foley catheter,(Resident #4 and #6). The facility identified a census of 33 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 8/20/22 documented Resident #4 with diagnosis that included a neurogenic bladder, obstructive uropathy, multiple sclerosis and urine retention. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated cognitively intact and with an indwelling catheter. A Care Plan documented a focus area of an indwelling catheter due to urine retention, initiated and revised on 8/11/20. The Care Plan failed to address performance of catheter cares. During an interview on 10/28/22 at 11:12 a.m. Staff H, LPN stated Resident #4 indicated her catheter hurt on the inside. The staff member deflated the balloon and flushed the catheter with a return of a brown substance. The staff member and an unknown CNA provided external catheter cares as they smelled a yeasty substance. As Staff H separated the resident's vaginal area she noted a large amount of a white yeasty substance throughout the resident's entire vaginal area which made the staff member angry. The staff member changed the resident's catheter, called the Physician and received an order for an anti-fungal cream. A MD/Nursing Communications form dated 10/19/22 at 5:20 a.m. documented the resident noted with redness to her groin area, with yeast in	F 690		

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F 690	Continued From page 56 her folds and an odor. The Physician ordered the house anti-fungal cream PRN (as needed) until healed, signed by the Physician on the same date, no time documented. An observation on 11/3/22 at 9:50 a.m. Staff D, CMA/CNA and Staff L, CNA provided catheter cares and perineal cares for the resident but failed to entirely cleanse the resident's labia majora and minora areas particularily around the catheter insertion site. 2. A MDS assessment form dated 8/12/22 documented Resident #6 with diagnosis that included morbid obesity, renal insufficiency and obstructive uropathy. The assessment documented the resident with a BIMS score of 15 and with an indwelling catheter. A Care Plan documented a focus area of an indwelling catheter due to obstructive and reflux uropathy, intiated 3/1/22 and revised 10/25/22. The Care Plan failed to address performance of catheter cares. An observation and interview dated 11/3/22 at 3:55 p.m. revealed staff Staff J,CNA and Staff K,CNA as they provided perineal and catheter cares. Staff J separated the resident's labia majora there was a large amount of a white thick substance between her labia majora and labia minora confirmed by Staff J. The resident confirmed staff failed to perform perineal cares and catheter cares on a regular basis.	F 690		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy	F 691		

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F 691	Continued From page 57 care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation including photos, clinical record review, staff interview and facility policy review, the facility failed to complete appropriate care for a jejunostomy tube (J-tube) for one resident reviewed, (Resident #2). Findings include: A Minimum Data Set (MDS) assessment form dated 8/31/22 documented Resident #2 with malnutrition. The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and required extensive assistance of two staff with personal hygiene. A Care Plan documented a focus are of a J tube feeding, intiated and revised 9/1/22. The interventions included the following initiated 9/1/22. a. 30 cubic centimenter (cc) flushed three (3) times a day (TID) for maintenance of patency. b. Provided local care to J-tube as ordered and monitored for signs and symptoms of infection. During an interview on 10/21/22 at 2:30 p.m. the resident confirmed the nurse's failed to flush his feeding tube and that he recently went three days without a flush. The resident also confirmed staff failed to cleanse around his J-tube and that he	F 691	F 691 1. Resident #2 was discharged to his own home on 11/4/2022. 2. On or before 12/25/2022 the DON or designee audited residents with J tubes to validate tube insertion site cares are being provided with no other residents identified as having a J tube. 3. On or before 12/25/22 the DON or designee re-educated the licensed nurses regarding completing J tube cares as ordered. 4. The DON or designee will audit J tube cares weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 691	Continued From page 58 just cleansed the area himself because the bandages were full of "buggers" (yellow/green drainage). An observation on 11/2/22 at 4:39 p.m. revealed a large amount of dried green/yellow drainage around the resident's J-tube and on the bandage the nurse removed.	F 691		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident and staff interviews and facility policy review, the facility failed to properly care for one resident with a peripherally inserted central catheter (PICC) line, (Resident #4). The facility identified a census of 33 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 8/20/22 documented Resident #4 with diagnosis that included a multiple sclerosis. A Care Plan addressed a focus area of multiple sclerosis, initiated and revised 9/20/21. The interventions included the following: a. Power PICC solo: change the PICC line dressing using sterile technique weekly. Flush the PICC line after every use or at least weekly	F 694	F 694 1. Resident #4 PICC Line was flushed, and dressing changed on December 14th with no concerns noted. 2. By 12/25/2022 the DON audited residents and identified there are no other residents have PICC lines. 3. On or before 12-25-22 the DON or designee re-educated licensed nurses regarding PICC line dressing changes and flushes. 4. The DON or designee will audit PICC line dressing changes/flushes weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	12/25/22

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F 694	Continued From page 59 when no in use with a 10 milliliter (ml) or larger syringe. Flush with 10 ml of 0.9% sodium chloride as a pulse or a stop start technic had been used. According to Treatment Administration Records (TAR) form dated 9/1/22 thru 9/30/22, 10/1/22 thru 10/31/22 and 11/1/22 thru 11/30/22, the resident's physician's orders included a directive to change the PICC line dressing one time a week on Wednesdays,dated 2/10/22 at 2:36 p.m.. The facility failed to change the resident's PICC dressing on 9/7/22, /9/14, 9/21, 9/28, 10/12/22, 10/19, 10/26 and 11/9/22. A eMAR Progress Notes form dated 11/9/22 at 1:22 p.m. documented the resident's PICC line as not changed due to no supplies. During an interview and observation on 11/16/22 at 12:30 p.m. the resident confirmed the PICC dressing as not changed since Staff C, Licensed Practical Nurse (LPN) changed it on 11/2/22 but rather staff have been piecing together coverings because they were falling off. There was no date present on current layered transparent dressings.	F 694	F 741 1. Resident #2 was discharged from the facility on 11/04/22. 2. DON or designee completed an audit on or before 12/15/22 related to staff training/competency for substance use disorders. 3. Nursing staff reeducated by Director of Nursing or Designee on or before 12/15/22 on identifying signs and symptoms of changes in condition from SUD (substance use disorder), related to drug use including decreased responsiveness or altered mental status. 4. Director of Nursing or designee will complete audits weekly for 4 weeks then monthly for 2 months to ensure new staff continue to be trained to identify changes in condition related to SUD as required. The results of these audits will be presented to the QAPI committee meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up.	12/15/22
F 741 SS=J	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 741		

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F 741	Continued From page 60 diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy review the facility failed to provide sufficient staff with appropriate competencies and skills to provide nursing and related services to assure resident safety for one resident with psychosocial disorders, (Resident #2). A determination was made the facility's non-compliance placed residents in the facility in immediate jeopardy, beginning on 9/17/22. The facility identified a census of 33 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 8/31/22 documented Resident#2 with diagnosis that included psychoactive substance abuse, bipolar, depression, deep vein thrombosis (DVT), hypertension (HTN) and a hip fracture.	F 741		

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	165173	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 741	Continued From page 61 The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), non-ambulatory and required extensive assistance of two (2) staff with bed mobility, transfers, dressing, toilet use and hygiene. The resident's Care Plan failed to address his illegal drug use. The residents Progress Notes entries included the following: a. On 9/13/22 at 3:22 p.m. - Received a fax from the resident's Physician for an order for a urinalysis (UA) with culture and a drug panel. The staff obtained the UA and sent it to the lab. 1. A Lab Report form dated 9/13/22 at 3:38 p.m. documented the resident as positive for methamphetamine. b. On 9/17/22 at 1:27 p.m. - The resident screamed at staff over a TV that he claimed was his that had been a facility TV but the resident changed rooms. The resident stated "Get me my f'ing (explicit) tv right now or I am going to start breaking shit!" The resident had a tv in his room already. The resident then went in to another resident's room and ripped off his oxygen. The staff told this resident to stay out of other resident's rooms, Resident #2 stated "I don't give a f*$# (explicit), I am going to start tearing shit apart!" c. On 9/22/22 at 2:48 a.m. - A nurse documented the resident had been very difficult and the police came to the facility several times the past week but they could not do anything as the resident refused for the police or staff to go	F 741		

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F 741	Continued From page 62 through his belongings. Earlier that evening the evening nurse walked into the resident's room while he smoked methamphetamine from a methamphetamine pipe. The police returned that evening and searched the room and found 3 methamphetamine pipes and white residue in a bag and in a bag on his knee scooter that tested positive for methamphetamine. d. On 10/12/2022 at 10:07 p.m. - A nurse documented " I said I don't know but we did find Methamphetamine in your room with pipes it does bother me." e. On 10/28/2022 at 1:48 p.m. (the actual time of occurrence 10 a.m.) - The staff approached this nurse to state it smelled bad in the resident's room which gave them a headache. This nurse went to the resident's room and could smell methaphetamine before entrance into the room. It smelled very strong. The resident had been advised to keep the door shut and but he refused. When staff shut the door the resident opened the door back up. f. On 10/28/2022 at 1:30 p.m. (the actual time of occurrence 10:30 a.m. - 11 a.m.) - The resident in the morning had been found to be cleaning his room with a broom and then found to be cleaning the toilet and sink with the dirty broom, he was also taking his clothes washing them in the sink and then putting them in the toilet and then back into the sink, when the staff went in to ask him if he needed help he told them to leave his room and that he would be fine without their help. g. On 10/28/2022 at 12:55 p.m. - The Business Office Manager (BOM) and Social Services Designee (SSD) went into the resident's	F 741		

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F 741	Continued From page 63 room to talk about discharge plans. The staff found the resident resting in his chair and hard to arouse with a lot of drool coming from his mouth The resident would not open his eyes while they visited with him. The staff asked if he would like them to set up a treatment facility for discharge, he said "I don't know". The staff attempted many times to ask what his plans had been for discharge and asked if he would accept help from Home Health and he had been unsure. The BOM and SSD left the room and let him know they would return. h. On 10/28/2022 at 1:27 p.m. - Resident is in his room, positioned in his wheel chair, with his arms crossed and his head down, drooling and very hard to arouse. The resident answered the nurse but he had been alert that morning as he conversed with staff and cleaned his room and toilet with a broom. i. On 10/28/2022 at 1:28 p.m. - The staff placed a call the resident's physician related to his lethargy. j. On 10/28/2022 at 1:32 p.m. - Resident #2's vital signs were temperature - 97.8 degrees Fahrenheit (F), pulse 77, respirations 16, oxygen saturation rate at 99% and his blood pressure registered 130/90. k. On 10/28/2022 at 1:35 p.m. - Staff assisted the resident to bed with 2 assistance. The resident assisted but continued with slurred speech. During an interview on 10/21/22 at 2:30 p.m. the resident confirmed he was caught in the room smoking methamphetamine in his room at the	F 741		

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F 741	Continued From page 64 facility not to long ago. During an interview on 11/16/22 at 10:50 a.m., Staff J, nursing assistant (NA) confirmed the facility failed to educate her on how to manage residents with an active drug addiction prior to the most recent education provided. During an interview 11/16/22 at 10:52 a.m., Staff B, CNA/CMA confirmed the facility failed to educate her on how to manage residents with an active drug addiction prior to the most recent education provided. On 10/28/22 at 2:15 PM the facility was notified of the immediate jeopardy at F741 and was given the IJ Template. The facility provided staff education on substance abuse disorder and education given to staff members to report to nurse if they observe any signs and symptoms. The nurse is to complete an assessment and notify doctor, family, and DON/Administrator if signs and symptoms exist. After the surveyor verified implementation of the removal plan the immediate jeopardy was removed on 10/29/22 and the scope and severity was lowered to a D.	F 741		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	F 839		

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F 839	Continued From page 65 This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy review, the facility failed to provide qualified personal to administer insulin and direct resident cares for one resident, (Resident #6). The facility identified a census of 33 residents. Findings included: 1. A Minimum Data Set (MDS) assessment form dated 8/12/22 documented Resident #6 with medical diagnosis that included diabetes mellitus (DM) and with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated cognitively intact skills for dailt decision making. A Medication Administration Record (MAR) form dated 10/1/22 through 10/31/22 documented Resident # 6 with the following insulin order which had been documented as administered on 10/15/22 on the evening shift by Staff K, Certified Nursing Assistant/Certified Medication Assistant (CNA/CMA). a. Insulin Lispro solution 100 unit/milliliter (ml) 6 units subcutaneous three times a day related to type II diabetes mellitus with diabetic neuropathy. (dated 8/2/22 at 10:52 a.m.) In a typed statement (not dated) the Corporate Nurse Consultant included the following documentation: a. Staff K worked as a CMA on October 15, 2022. At 5:26 p.m. she signed the electronic medication administration record (eMAR) that she administrated the insulin for resident #6 on her right arm.	F 839	F 839 1. On 11-18-22 Staff J has passed written and skills testing and is a Certified Nursing Assistant. By 12/22/22 the DON or designee verified Direct Care Workers status for staff J. Staff K no longer works at the facility and Resident #6 had no adverse reaction to insulin injection and her post blood sugars remained within her normal range. 2. On or before 12/25/2022 the DON or designee audited nursing staff to validate nurse aides and medication aides have appropriate certification. An Audit from 12/01/22 was completed by the DON/Designee on 12/25/22 to validate Licensed Nurses are administering Insulin. 3. On or before 12-25-22 the Regional Director of Clinical Services re-educated the DON regarding hiring uncertified nurse aides. On or before 12-25-22 the DON or designee re-educated the Certified Medication Aides regarding scope of practice. 4. The DON/Designee will audit new hires for appropriate certifications/licensure and that Lic Nurses are administering insulin weekly for 4 weeks then monthly for 2 months. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON responsible for ongoing monitoring.	12/25/22

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F 839	Continued From page 66 During an interview by a facility staff on 10/23/22 at 1:50 p.m., Resident #6 indicated Staff K administered her insulin once a while ago and the last time had been 10/15/22. After the staff member administered the insulin she stated, see I did not kill you, don't tell anyone I gave it to you. According to a Medication Administration - Insulin Injection policy dated 1/13 documented the purpose as a means for safe administration of an insulin injection. 2. Review of the facilities Assisted4Living form dated 7/5/22, Staff J, NA (non-certified nursing assistant) had been hired to work at the facility as a certified nursing assistant (CNA). A CNA Written Exam Results form dated 6/16/22 documented the staff member passed her written exam. During an interview 11/16/22 at 9:25 a.m., Staff J, NA confirmed she provided direct resident cares independently (transfers, perineal cares, grooming and etc) as a non-certified nursing assistant however she is scheduled for her skills test today 11/16/22. According to an email dated 11/16/22 at 10:10 a.m. the Corporate Nurse Consultant confirmed they did not want CMA's to act outside their scope of practice and it is expected the CNA be certified within the appropriate timeframe of hired prior to acquiring the certification.	F 839		