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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165155	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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: 6/26/23 The Salem Lutheran Hom Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from the facility's annual recertification survey with an investigation of intakes #110286-I and #113021-M, conducted May 30, 2023 - June 6, 2023. Facility reported incident #113021-M will be sent under a separate cover letter at a later date. Facility report incident #110286 was substantiated. Total Residents: 48	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim Administrator — (X6) DATE: 06/30/2023

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 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure resident's current code status was available for 1 out of 16 residents reviewed (Resident #201). Findings include: Resident #201's Minimum Data Set (MDS) assessment dated 5/4/23 listed an admission date of 4/28/23 from an acute hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of renal disease, depression, arthritis, and right side back pain with sciatica.	F 578		

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Review of the facility's Code Status Binder revealed a form titled Iowa Physician Orders Scope of Treatment (IPOST). The IPOST indicated that Resident #201 chose to have a Do Not Attempt to Resuscitate (DNR) status with comfort measures only. The IPOST documented comfort measures included the use of medications by any route, positioning, wound care, with other measures to relieve pain and suffering. Use of oxygen, suction, and manual treatment of airway obstruction as needed for comfort. No transfer to hospital for life-sustaining treatment. The form indicated that if the facility could not meet Resident #201's comfort needs Resident #201 wanted transferred. Resident #201 signed the IPOST on 4/28/23 and the physician signed it on 5/1/23.

Review of Physician Orders in the clinical record lacked documentation of the DNR order or comfort measures.

On 5/30/23 at 12:30 p.m. Staff F, Registered Nurse (RN), reported that the facility kept a printed list of resident's code status at the medication cart. Staff F reported that the nurses would reference the list if a resident was to code (heart and respirations stop). Staff F stated the facility printed the list every couple of days and the facility printed the current list on 5/29/23. Staff F verified that the current list did not included Resident #201. Staff F explained that the nurse must add the code status orders to the physician orders in the clinical record. Staff F reported the order would auto populate to the resident's face sheet and the code status list. Staff F acknowledged and verified that Resident #201's clinical record did not include her code status in

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F 578	Continued From page 3 the physician orders. On 5/30/23 at 4:00 p.m., the Director of Nursing (DON) verified that Resident #201's physician's orders did not include her DNR status orders in the electronic clinical record. The DON reported that she would correct it. The DON added that the facility planned to complete an audit on all the residents' charts. On 5/31/23 at 11:40 a.m. Staff Q, Licensed Practical Nurse (LPN), reported if a resident coded, she would look for code status in the clinical record or on the code status list located on the medication or treatment cart. Staff Q, reported that if the clinical record or the list did not include the resident's code status, she would look for the IPOST in the binder kept at nurses' station or in the attachments on the computer which would delay the process of starting a code. On 5/31/23 11:50 a.m. Staff C, LPN, reported the first place she would look for a resident's code status is on the code status list on the medication or treatment cart. Staff C stated if the list did not include the resident she would look for the IPOST in the computer. She added that nurses' station had a binder with IPOST forms. Staff C acknowledged and verified looking for the IPOST would delay the process of starting a code. Staff C explained the person responsible for updating the code in the computer is the nurse who received the signed IPOST. The Advance Directive including Cardiopulmonary (CPR) and Automated External Defibrillator (AED) policy revised 7/21/22 directed the nursing staff each day to print a report of all advance directive orders and keep in a three-ring binder easily	F 578		

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F 578	Continued From page 4 accessible to nursing staff. The policy documented this is necessary to ensure the important information is available if the facility experienced a power outage or other disruption in access to the electronic medical record. On 6/5/23 at 10:52 a.m. the Director of Nursing explained that she expected the nurse to enter the DNR order in the computer on admission.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring 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	F 580		

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resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and policy review the facility failed to notify the family for a significant change in condition for 1 of 16 residents reviewed (Residents #42) for pressure ulcers.

Findings include:

Resident #42's Minimum Data Set (MDS) assessment dated 5/11/23 identified a Brief Interview for Mental Status (BIMs) score of 14, indicating intact cognition. The MDS indicated that Resident #42 required extensive assistance of two persons with bed mobility and toilet use. The MDS listed that Resident #42 required total dependence of two persons with transfers and

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could not ambulate. The MDS identified that Resident #42 had an indwelling catheter. The MDS identified Resident #42 is at risk for developing pressure ulcer and that he had an unhealed stage 2 pressure ulcer during the seven-day lookback period. The MDS included diagnoses of hypertension (high blood pressure), obstructive uropathy, end stage renal disease, and malnutrition.

The Communication - Other note on 5/3/23 at 10:27 p.m. described a new open area to Resident #42's left buttock. The nurse applied duoderm (a type of dressing) and collagen powder (wound treatment). The nurse faxed the Physician to notify them of the change.

The Communication - Other note on 5/5/23 at 11:19 a.m. identified that the Physician gave orders to use collagen powder and duoderm daily. Resident #42 had an appointment with a wound nurse to evaluate area.

The Health Status note on 5/19/2023 at 3:30 p.m. listed that the facility received a fax from the wound nurse with wound care recommendations.

The Clinical Physician Orders included an order dated 5/19/23 for staff to apply collagen to his wound bed and cover with an adhesive foam border to his left gluteal area, cover perineal (peri-) wound area with 3M Cavilon barrier (protection from water) on bath days and as needed.

The clinical record lacked documentation that the facility notified Resident #42's family of his new pressure area on 5/3/23. The clinical record lacked documentation of notification to the family

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F 580	Continued From page 7 of treatment orders received on 5/5/23 and/or the wound nurse's recommendations from 5/19/23. The Notification of Changes policy revised 11/29/22 directed that the facility must immediately notify the Resident's Representative when there is a significant change in the resident's physical, mental, psychosocial status, and when there is a need to alter treatment including changing or adding a new form of treatment. On 6/5/23 at 10:52 a.m., The Director of Nursing (DON) acknowledged and verified the facility did not notify Resident #42's family of his pressure area on 5/3/23.	F 580		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and chart review the facility failed to prevent the mishandling of a resident's narcotic medications for 1 of 4 residents reviewed (Resident #38). Findings include: Resident #38's Minimum Data Set (MDS) assessment dated 5/30/23 listed a re-admission	F 602		

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F 602	Continued From page 8 date of 4/19/23 from another nursing home or swing bed. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognitive ability. The MDS listed that Resident #38 activities of daily living (ADL) only occurred once or twice in the lookback period. The Care Plan Focus revised 4/28/23 indicated that Resident #38 had an ADL self-care performance deficit related To hypertension (high blood pressure), a recent fall with a right hip fracture and repair, evidenced by the need for assistance with ADLs On 5/30/23 at 10:30 AM observed Resident #36 dressed and sitting in her recliner in her room. She said that she did not have any pain or concerns about her care. The Incident Note dated 4/12/23 at 7:59 AM indicated that Resident #38 fell. Resident #38's Representative notified that she will go to the ER for X-Rays. The Health Status Note dated 4/12/23 at 7:14 PM listed that the hospital called to notify the facility of Resident #38's admission to the hospital due to a hip fracture. The Last BM and Admit/Re-Admit Note dated 4/19/23 at 1:58 PM identified that Resident #38 returned to the facility from the hospital with an order of oxycodone (opioid pain medication) for pain. The Clinical Physician Orders included an order dated 4/19/23 at 3:30 PM for oxycodone 5 milligrams (mg) every 6 hours as needed (PRN) for pain related to a displaced fracture of the right	F 602		

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Resident #38's April 2023 Medication Administration Record (MAR) indicated that she received Oxycodone HCL tablet 5 mg on 4/21/23 at 7:38 AM.

Resident #38's May 2023 MAR indicated that she received Oxycodone HCL tablet 5 mg
a. 5/13 at 11:52 AM
b. 5/15 at 6:30 PM
c. 5/16 at midnight
d. 5/16 at 5:41 AM

On 6/1/23 at 10:20 AM Staff I, Registered Nurse (RN), explained as she read the nurses' notes on the morning of 5/16/23, she noticed that Resident #38 had three doses of Oxycodone the day before. Staff I reported this as very unusual for her as she didn't typically have much pain. Staff I reported her concern to the Director of Nursing (DON) that Resident #38 received the PRN doses together. With Staff L, Human Resources, they viewed the facility's video tapes of the activities of the night nurse, Staff K, Licensed Practical Nurse (LPN). They discovered that Staff K did not interact with Resident #38 at the administration times documented for the Oxycodone. Staff I said that Staff K started as an agency staff member and only worked a total of three shifts. Of the 5 times Resident #38 received the Oxycodone, the documentation indicated Staff K gave it to her. Staff I said that on the morning of 5/16/23 she went in, asked Resident #38 how she slept, and if she had any pain. Resident #38 told her that she slept very well and did not have pain at all.

On 6/1/23 at 11:50 AM Staff L provided a viewing of the facility video throughout the night of 5/15/23

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F 602	Continued From page 10 from 6:00 PM until 6:00 AM on 5/16/23. At the beginning of the shift, noted Resident #38 in the dining room at 6:05 PM. Staff K did not interact with her as she sat at the table. She wheeled herself back to her room at 6:18 PM. Resident #38 did not come out of her room the entire night. At 9:00 PM Staff K went down the hallway near Resident #38's room, with the medication cart but she did not go in her room. Staff K did not go into that hallway for the rest of the night. At 5:00 AM she went down that hallway of Resident #38's room and went into a resident's room. It's unclear which room she went into. On 6/1/23 at 2:50 PM Staff G, Certified Nurse Aide (CNA), said that she worked the 10 PM - 6 AM shift on 5/15/23. She remembered that Staff K went out of the building several times throughout the night to have a cigarette. She did not notice how long she went or any unusual behavior. Staff G said that she had a couple of residents ask for Tylenol that night and Staff G gave those doses, but she did not remember anyone asking for anything stronger. On 6/5/23 at 1:11 PM the Director of Nursing (DON) provided a packet of facility policies and expectations for agency staff. She said that she had just initiated an acknowledgement sheet for the agency staff to sign that indicates that they understand and will abide by the facility policies. She did not have an acknowledgement signature from Staff K. On 6/5/23 at 9:35 AM Staff K reported that the facility had several residents with scheduled narcotics. She added that one lady and one man had PRN pain medications that she administered. She did not remember how many doses she gave	F 602		

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or the resident's names.

The Abuse and Neglect policy dated 10/13/22 instructed that the resident had a right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

F 610 SS=D
Investigate/Prevent/Correct Alleged Violation
CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on facility record review, hospital record review, resident, and staff interviews, the facility failed to investigate the sudden increase of pain for a resident who received scheduled pain medication for chronic pain who used a standing lift for transfers for one of one resident reveiwed (Resident #25). Despite reports that Resident #25 had difficulty standing with the standing mechanical lift, the facility did not investigate the

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concern. Without investigation of the concern, the staff continued to transfer Resident #25 with the standing mechanical lift. After a change in condition, the facility sent Resident #25 to the hospital who discovered a compression fracture.

Findings include:

Resident #25's Minimum Data Set (MDS) assessment dated 5/15/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated that Resident #25 required extensive assistance of two persons with bed mobility, dressing, and toilet use. In addition, she required total dependence on two persons for transfers, and extensive assistance of one person for personal hygiene. The assessment indicated that Resident #25 could not ambulate (walk) and needed one person to push her wheelchair. The MDS included diagnoses of cancer, heart failure, diabetes, depression, and a compression fracture of the spine (broken bone caused by weakness in the back).

On 5/30/23 at 10:53 AM Resident #25 stated she fell out of a lift and fractured her back. She stated she went to the hospital and had a raging urinary tract infection (UTI), fluid on her heart, and a fracture in her back. In another interview the same day at 1:05 PM, the resident explained that she fell out of a standing lift, as Staff D, Certified Nursing Assistant (CNA), operated it. She reported that she did not have anyone else in the room when it happened. Resident #25 added that staff now use a full-body mechanical lift to transfer her. Resident #25 explained that oftentimes the staff transfer her alone when there is supposed to be two people. On her wall at the

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SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

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head of the bed, observed a sign that instructed to only use a nonmechanical stand-to-sit for Resident #25.

The Health Status Note dated 4/16/23 at 9:00 PM indicated that Resident #25 reported that her pain management routine worked and she slept better. She added that she could get around better with her medication schedule with the Tylenol and tramadol (pain medication).

The Health Status Note dated 4/18/23 at 12:54 PM written by Staff F, Registered Nurse (RN), indicated that a Certified Nurse Aide (CNA) reported that Resident #25 did not stand well in the mechanical standing lift with an assist of one. The CNA described that Resident #25 pulled her arms up and bent her knees.

The Health Status Note dated 4/19/23 at 1:38 AM documented by Staff E, Licensed Practical Nurse (LPN), that Resident #25 continued to have difficulty standing with transfers.

The Health Status Note dated 4/25/23 at 6:54 AM labeled Late Entry written by Staff F indicated Resident #25 complained of shortness of breath, shallow respirations, poor eye contact, flat voice, and diminished lung sounds. Resident #25 had stable vital signs, oxygen saturation of 98% on room air, denies pain while in bed, and when up has pain of 7 of out 10 (0 no pain, 10 the most pain). The nurse encouraged Resident #25 to increase their activity.

The Communication - Other Note dated 4/25/23 at 2:50 PM listed that the nurse requested a muscle relaxer per therapy recommendation.

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The Communication/Visit with Physician Note dated 4/25/23 at 8:30 PM labeled Late Entry detailed new orders by the provider. Resident #25 will have X-rays on the next day of the T-Spine (upper middle back), and L-Spine (middle to lower back). In addition, the provider provided an order for baclofen (muscle relaxer) one tablet three times a day as needed for back spasms. The nurse notified the family and updated the clinical record.

The Health Status Note dated 4/26/23 at 11:56 AM indicated that Resident #25 had an X-ray. She continued to complain of pain with activity.

The Lab/Diagnostics Note dated 4/27/23 at 5:41 AM listed that the facility received the x-ray results and faxed them to the Primary Care Provider (PCP).

The Health Status Note dated 4/27/23 at 9:30 AM written by Staff F indicated that Resident #25 continued to complain of sharp pain on her left of her back radiating to the flank area (lower left side of back) without radiation to her left arm. Vital signs remain stable with an oxygen saturation of 88% (normal is 90% and above), blood pressure of 126/58, temperature of 95 (average 98.6), pulse of 88 (typical range 60-100), and respirations (typical range 12-20). As the staff assisted Resident #25 to the bath chair in the standing mechanical lift, she complained of a sharp pain in her left side of her back. Resident #25 received her scheduled Tramadol (pain medication) and Tylenol earlier in the morning.

The Communication/Visit with Physician Note on 4/27/23 at 10:12 AM identified the nurse called

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the PCP's office to provide an update on Resident #25's condition.

The Communication/Visit with Physician Note on 4/27/23 at 1:41 PM indicated that the facility received a fax from the physician that dictated that Resident #25 had chronic (long-term) degenerative changes. The physician directed to schedule an appointment with her PCP in the office unless she would not wait. The nurse updated the resident and her niece then got a bed hold agreement. The nurse provided a report to the emergency room (ER).

The Health Status Note dated 4/27/23 at 1:50 PM recorded that Resident #25 went to the ER with staff in the facility van.

The ED Provider Notes dated 4/27/23 at 2:37 PM listed Resident #25's chief complaint as a report of slipping from the sit-stand machine and jarred her back making her pain worse in her back around to her abdomen. Resident #25 came to the ER for an evaluation of mid back pain. She reported when in a lift the machine came down somewhat quickly and stopped. As that happened she developed immediate onset of mid back pain. Resident #25 denied extension of the pain into her legs but did feel like it came across her upper abdomen to her chest. She reports a history of chronic low back pain but explained her current pain is different. Resident #25 denied any exacerbation of her regular back pain. She tried tramadol that day with little or no relief. Resident #25 did have an X-ray the day before that had negative results of any acute fracture. The assessment revealed that Resident #25 had some tenderness at approximately T-11 on palpation (a type of touch used to assess). The

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Discharge instructions directed to increase her tramadol to 50 milligrams (mg) three times a day for one week and continue Tylenol. Apply ice to the affected area for 20 minutes per hour while awake for that day and the next day. If worsening or changing symptoms contact the clinic and follow-up as needed. The Final Impression list thoracic back sprain, initial encounter.

The Progress Notes dated 4/29/23 at 9:29 AM indicated that Resident #25 had back pain of the thoracolumbar region for greater than six weeks. She started on a muscle relaxant and received tramadol for her pain without improvement. The etiology of the pain could be from a kidney infection, however, due to the musculoskeletal nature, regarding the full-boy mechanical lift incident in the nursing home, proceed with CT scans to rule out a compression fracture or any other potential etiology of her back pain while hospitalized.

The CT Thoracic Spine without contrast dated 4/29/23 impression listed the following
a. Inferior endplate fracture at the T8
b. Degenerative change of the spine. There is central canal stenosis and neurol foraminal narrowing at T10-11.
c. Small effusions with bibasilar atelectasis
d. Findings suggesting pulmonary edema.

The Progress Notes dated 4/30/23 at 8:23 AM indicated that Resident #25 told her PCP that she had an incident at the nursing home where she fell. She described the incident as the staff tried to transfer her and pivot her standing, her legs gave out and she went down rather hard on her buttocks into the chair. She reported that she felt the worsening back pain at that time but could not

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F 610	Continued From page 17 remember when the incident occurred. The Communication/Visit with Physician on 5/2/23 at 3:57 AM the facility received Resident #25's X-ray results the PCP wrote that the X-rays on 4/26/23 with negative results. The X-ray results on 4/29/23 revealed a compression fracture at her T-8. The PCP questioned if Resident #25 had a fall. The nurse responded that they did not know of any falls but she did use a sit to stand with a sling. Resident #25 chicken wings (bends her arms at an upward angle) and needs to sit quickly. The Communication/Visit with Physician dated 5/2/23 at 2:21 PM indicated the PCP reviewed the X-Ray and Resident #25 remained in the hospital. The PCP wrote that Resident #25 reported that she fell at the nursing home. The PCP explained that Resident #25 had a compression fracture of her T-8. The PCP indicated that her record did not have any documented falls. On 5/31/23 at 1:35 PM the Director of Nursing (DON) reported that they did not do an investigation or report regarding resident's compression fracture findings due to the hospital discovering it. She explained that they reviewed their records and found no staff reports or documentation of a fall. On 5/31/23 at 2:45 PM Staff F reported that she did not think that she documented on 4/18 that anyone told her that Resident #25 had problems with the mechanical standing lift, and if she did, she couldn't remember. She denied remembering any incidents or concerns with Resident #25 using the stand.	F 610		

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On 5/31/23 at 3:06 PM Staff E, Licensed Practical Nurse (LPN), remarked that she could not remember documenting on 4/19 that Resident #25 had difficulty with the mechanical standing lift. She reported that she did not know about any incidents with Resident #25 using the stand and complaining of back pain. When asked what she would do if that someone reported that to her, she replied that she would let therapy know, but therapy said resident did fine with the mechanical standing lift so to keep using it.

On 5/31/23 at 3:20 PM Staff H, Occupational Therapist (OT), explained that that all staff received training that they could always do more for the resident, but not less. She stated if the staff or the resident felt uncomfortable using the standing mechanical lift or standing lift, they could always use a full-body mechanical lift to transfer the resident without having to call them before using it, and have the nurse notify them of the concern to address it the following day. She stated that Resident #25 did do well with the lift in therapy and that in her opinion, Resident #25 tried harder for them (therapy). She also felt that Resident #25 felt more comfortable with some staff than others. She stated that staff use "chicken winging," but it can present differently from one staff member to another, such as elbows pointed out away from the body or pointing upwards like a flapping motion.

On 6/1/23 at 10:30 AM Resident #25's physician from the ER explained her compression fracture was consistent with a sudden stop coming down in the lift.

F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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§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 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 facility record review, facility policy review, resident, and staff interviews the facility failed to revise and update the Care Plan to address the increased needs of Activities of Daily Living (ADLs) for 1 of 1 residents reviewed (Resident #25).

Findings include:

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Resident #25's Minimum Data Set (MDS) assessment dated 5/15/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated that Resident #25 required extensive assistance of two persons with bed mobility, dressing, and toilet use. In addition, she required total dependence on two persons for transfers, and extensive assistance of one person for personal hygiene. The assessment indicated that Resident #25 could not ambulate (walk) and needed one person to push her wheelchair. The MDS included diagnoses of cancer, heart failure, diabetes, depression, and a compression fracture of the spine (broken bone caused by weakness in the back).

On 5/30/23 at 10:53 AM Resident #25 stated she fell out of a lift and fractured her back. She stated she went to the hospital and had a raging urinary tract infection (UTI), fluid on her heart, and a fracture in her back. In another interview the same day at 1:05 PM, the resident explained that she fell out of a standing lift, as Staff D, Certified Nursing Assistant (CNA), operated it. She reported that she did not have anyone else in the room when it happened. Resident #25 added that staff now use a full-body mechanical lift to transfer her. Resident #25 explained that oftentimes the staff transfer her alone when there is supposed to be two people. On her wall at the head of the bed, observed a sign that instructed to only use a nonmechanical stand-to-sit for Resident #25.

The Care Plan Focus revised 6/23/22 listed that Resident #25 had a self-care deficit with ADLs due to a history of a fracture of her lower left femur. The Care Plan included the following

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interventions:
a. Bed mobility -
i. 6/23/22 - Turn from side to side with assistance of bilateral assist bars.
ii. 12/7/22 - Lying to sitting: assist of one staff
iii. 12/7/22 - Sitting to lying assist of one staff
b.11/23/21 - Resident requires assist of one person with dressing and grooming, allow her to do what she can
c. 5/26/23 - Toilet Use: Resident requires assist of one person with toileting transfers using sit to stand lift and large harness, toileting hygiene and clothing management, she is occasionally incontinent of bowel and bladder.
d. 5/26/23 - Transfer Between Surfaces: Transfer with sit to stand lift with large harness and assist of one staff.

The Care Plan lacked revisions on bed mobility, dressing, and grooming since Resident #25's return from the hospital on 5/9/23. In addition, the Care Plan lacked documentation to show that Resident #25 transferred with the full-body mechanical lift instead of the sit to stand lift.

The Care Plan - R/S, LTC, Therapy and Rehab policy revised 9/22/22 instructed to modify the plan of care to reflect the care currently required/provided for the resident. In addition, the Care Plan directed the Interdisciplinary Team (IDT) to review Care Plans at least quarterly. The IDT should review, evaluate, and update the Care Plan when a resident has a significant change in their condition.

On 6/1/23 at 11:55 AM the Director of Nursing agreed that they should have updated the Care Plan upon return from the hospital.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 2 of 16 residents reviewed (Residents #45 and #33). The facility failed to obtain weights as ordered by the physician for Resident #45. In addition, the facility failed to document the administration of medications, blood sugars, and bed time (HS) snacks for a diabetic resident. Findings include: 1. Resident #45's Minimum Data Set (MDS) assessment dated 3/7/23 identified a Brief Interview for Mental Status (BIMs) score of 13, indicating intact cognition. The MDS included diagnoses of prostate cancer, coronary artery disease, hypertension (high blood pressure), and malnutrition. The Order Details dated 4/4/23 directed to weigh Resident #45 three times a week and report a weight loss or gain of three to five pounds. Resident #45's April 2023 Treatment Administration Record (TAR) included an order dated 4/5/23 to weight him three times per week, then report weight loss or gain of three to five	F 658		

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points. In the morning of every Monday, Wednesday, and Saturday. The TAR lacked documentation to indicate the staff completed the order on 4/17, 4/26, and 4/29/23. In addition, the order included documentation without a weight to see the nurses' notes for 4/8 and 4/22. The TAR included the following weights
a. 164.2lbs (pounds) on 4/5/23
b. 157.6lbs on 4/10/23
c. 153.4lbs on 4/24/23

The clinical record lacked documentation that the facility notified Resident #45's Physician or family of the 6.6lb weight loss.

Resident #45's May 2023 Treatment Administration Record (TAR) included an order dated 4/5/23 to weight him three times per week. Then report weight loss or gain of three to five points. In the morning of every Monday, Wednesday, and Saturday. The TAR lacked documentation to indicate the staff completed the order on 5/6/23. In addition, the order included documentation without a weight to see the nurses' notes for 5/13, 5/15, 5/17, 5/20, and 5/27. The TAR included the following weights
a. 148.8lbs on 5/1/23
b. 143.6lbs on 5/3/23

The clinical record lacked documentation that the facility notified the family of the 4.6lb weight loss between 4/24/23 and 5/1/23. In addition, the record lacked documentation that the facility notified the Physician or the family for a weight loss of 5.2lbs.

The Clinical Record lacked documentation of the reason Resident #45 did not weighed for the dates listed on the MARS indicating to look at the

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nurses' notes.

The eAdmin Record (Default Note) on 4/22/23 at 11:55 a.m. indicated that the facility did not weigh Resident #45 due to staffing.

The eAdmin Record (Default Note) on 5/15/23 at 11:55 a.m. indicated that the facility did not weigh Resident #45 due to his COVID isolation.

A facility policy titled Physician Orders revised 3/29/23 documented the purpose of the policy was the following:
1. Provide individualized care to each resident by obtaining appropriate, accurate and timely physicians orders.
2. Provide a procedure that facilitates the timely and accurate process of physician orders.

A facility policy titled Weight and Height revised 9/22/22 documented the purpose of the policy was the following:
1. To ensure that the resident maintains acceptable parameters of nutritional status regarding weight.
2. To report changes in the resident's clinical condition (significant weight change) immediately to physician and family and/or resident.
3. To accurately measure weight or height.
4. To monitor weight loss or gain in a resident
5. To monitor gradual loss of height.

On 6/5/23 at 10:52 a.m. the Director of Nursing (DON) reported she expected staff to follow the physician orders.

2. Resident #33's MDS dated 3/14/23 assessment identified a BIMs score of score of 99, which indicating that Resident #33 could not

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complete the interview. The MDS identified a completed staff assessment for mental status that indicated Resident #33 had moderately impaired decision making. The MDS included diagnoses of diabetes mellitus, Alzheimer's disease, malnutrition, anxiety, and depression.

The Clinical Physician's Orders reviewed on 5/31/23 at 8:51 AM included the following orders:
a. 4/4/23 - Give Resident #33 a HS snack to defer hypoglycemia (low blood sugar) in the morning (am).
b. 5/17/23 - Inject 6 units of Humalog Injection Solution 100 units/ml (milliliter) subcutaneously at bedtime for diabetes.
c. 4/30/23 - Inject 8 units of Novolog Injection Solution subcutaneously at supper for diabetes.
d. 3/2/23 - Complete an accucheck (blood sugar) two times a day in the AM and HS related to type 2 diabetes.

Resident #33's May 2023 Medication Administration Record (MAR) lacked documentation for the following medications and treatment to indicate that she received the orders based on the physician's order on the following days:
1. HS Snack - 5/25, 5/26
2. Humalog 6 units at bedtime - 5/25, 5/26
3. Novolog 8 units at supper - 5/1, 5/7, and 5/12
4. HS Accucheck - 5/25, 5/26

The Medications: Insulin Administration policy revised 4/26/23 instructed that the purpose of the policy is to administer insulin injection correctly. The policy further directed staff to document dosage, time, and site of the injection on the MAR or TAR.

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F 658	Continued From page 26 On 6/5/23 at 10:52 a.m. the DON reported she expected the staff to document administrations and refusals of medication and treatments.	F 658		
F 684 SS=G	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 facility record review, hospital record review, resident, and staff interviews, the facility failed to investigate a change in condition for three of three residents reviewed (Residents #22, #25, and #42). Two of the residents had a sudden increase of pain (Residents #22 and #25). Resident #22 walked independently in the facility and experienced a bout of dizziness causing her to fall on 5/13/23. At the time of the fall, Resident #22 denied pain but started to report pain later that evening and requested pain medication. Resident #22 did not use any as needed medication until after her fall on 5/13/23. Resident #22 received no evaluation by a provider until 5/17/23. During the hospital stay, the staff determined Resident #22 had multiple compression fractures in her back. Resident #22 received treatment to one of the compression fractures involving an invasive procedure. Resident #25 received a scheduled pain medication for chronic pain and used a standing	F 684		

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lift for transfers. Resident #25 reported that she had an increase in pain after a staff member transferred her with the standing mechanical lift. The facility failed to determine when the injury occurred and failed to have Resident #22 evaluated following her increased pain until Resident #22 requested to go to the emergency room. After a change in condition, the facility sent Resident #25 to the hospital who discovered a compression fracture. In addition, the facility failed to assess Resident #42 who had a history of urinary tract infections (UTI) and sepsis (an infection that is so severe it spreads to the blood) when he experienced signs and symptoms of a UTI. The facility did not provide interventions to Resident #42 until he transferred to the emergency room (ER) seven days after the first documented symptom.

Findings include:

1. Resident #22's Minimum Data Set (MDS) assessment dated 5/9/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the Resident #22 required limited assistance of one person with dressing. She could independently move in bed, walk in her room, walk in the corridor, use the toilet, and complete her personal hygiene. Resident #22 used a walker and a wheelchair. She could stabilize herself without staff assistance but was not steady with moving from a seated to a standing position, turning around, moving on and off the toilet, and surface-to-surface transfer. Resident #22 received a scheduled pain medication in the previous five days of the lookback period. She had one fall without injury since the previous assessment.

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The Care Plan Focus revised 6/9/22 indicated that Resident #22 had a risk for falls related to her history of falls. The interventions directed the staff to monitor her for significant change in gait, mobility, positioning device, standing balance, sitting balance, and lower extremity joint function.

On 6/1/23 at 2:10 PM observed Resident #22 in her recliner in her room. Resident #22 said that she did not have pain but she did have a lot of pain before and after her back surgery. She said that she got getting dizzy and that's what caused her falls.

The Incident Report dated 5/13/23 at 10:30 AM indicated that Staff K, Licensed Practical Nurse (LPN), witnessed Resident #22 fall backwards to the floor landing on her buttocks, then she laid herself down.

The Incident Note dated 5/13/23 at 10:30 AM labeled as a Late Entry listed that Staff K witnessed Resident #22 fall. She walked form her bathroom to her chair and fell backward landing on her buttock, then she laid herself down. Resident #22's had range of motion (ROM) within her normal limits. She denied pain and did not hit her head. The staff assisted her with two and a mechanical lift to bed. The nurse notified the Director of Nursing (DON), the physician, and the daughter.

The eAdmin Record (Default Note) on 5/13/2023 at 7:07 PM indicated that Resident #22 received a tramadol HCl Oral Tablet 50 milligrams (MG) for back and shoulder pain. Resident #22's family remained at her bedside and requested as needed (PRN) administration as soon as possible

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(ASPA) as she rarely had such a high pain level.

The eAdmin Record (Default Note) on 5/14/23 at 7:45 AM listed that Resident #22 complained of pain from her fall the day before.

The eAdmin Record (Default Note) on 5/15/23 at 12:13 AM recorded that Resident #22 could not sleep and requested a PRN pain medication due to pain all over.

The Care Plan Review note dated 5/15/23 listed that Resident #22 had one fall during the lookback without injury. She met her pain goal with routine Tylenol.

The eAdmin Record (Default Note) on 5/16/23 at 7:30 AM documented that Resident #22 reported back pain.

The Communication/Visit with Physician on 5/16/23 at 7:33 PM indicated that Resident #22 had a lot of pain at the start of the shift. She reported the pain came from a fall over the weekend. The physician gave an order for an X-ray of her spine. At 5:45 PM she received the X-ray. In addition, the physician gave an order for a urinalysis (UA). The physician reported that too much tramadol could cause hallucinations.

The Health Status Note dated 5/17/23 at 4:15 AM Resident #22 experienced hallucinations and complained of pain but did not know why.

Resident #22's May 2023 Medication Administration Record (MAR) listed the following orders and usage:
a. 3/24/23 - Tramadol 50 milligrams (mg) one tab three times as day as needed (PRN) for pain.

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i. Resident #22 did not use the medication until the 13th.
ii. Resident #22 received on 5/13 for pain of 6/10, 5/14/23 for pain 8/10, and 5/15/23 for pain of 5/15.
b. 3/24/23 - Tramadol 50 MG a half tablet three times a day PRN pain.
i. Resident #22 did not use the medication until the 13th.
ii. Resident #22 received a half tablet of Tramadol on 5/15 for pain of 8/10. 5/16 for pain of 4/10.

The Transfer to Hospital V5 on 5/17/23 at 3:34 PM revealed the nurse sent Resident #22 to the hospital due to complaints of pain rated 8 out of the 10-pain scale (0 no pain, 10 worst pain ever) in her left and right scapula.

The Provider Progress Notes dated 5/20/23 at 6:47 PM lists Resident #22's assessment finding as a closed fracture of multiple thoracic vertebrae and an acute cystitis without hematuria (bladder infection without blood in the urine). The Plan directed that the MRI showed a burst fracture (A type of traumatic spinal injury in which a vertebra breaks from a high-energy axial load such as traffic collisions or falls from a great height or high speed, and some kinds of seizures), with shards of vertebra penetrating surrounding tissues and sometimes the spinal canal) at C7 and an endplate compression fracture of L1.

The MRI Thoracic Spine without Contrast Results dated 5/20/23 indicated that the evaluation of Resident #22's thoracic spine demonstrates mild exaggeration of the normal thoracic kyphosis. Resident #22 had vertebral body hemangiomas (common vascular lesion found within the

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vertebral body of the thoracic and lumbar spine) on the T12, T11, and T4. Resident #22 had a T6 burst fracture with fracture line extending to involve the back and front cortex (an outer or surrounding layer of an organ or body part) of the vertebrae.

The Provider Progress Notes dated 5/26/23 at 9:54 AM indicated that Resident #22 had a fall two weeks before. She had increased pain since that time. The pain increases with movement and appears constant within the mid back. The pain severity ranges from 6-9 out of 10 on the pain scale. The MRI (specialized assessment images of the body) demonstrated an acute (short-term) supra endplate compression (a type of vertebral fracture that occurs when the vertebrae compress and collapse) of the T6 vertebral body with approximately 50% loss of height. The note indicated to proceed with vertebroplasty (a procedure involving special cement injected into a fractured vertebra - with the goal of relieving spinal pain and restoring mobility).

The Discharge Summary dated 5/26/23 included four diagnoses Resident #22 received treatment for in the hospital.
a. Osteoporosis
b. Closed fracture of multiple thoracic vertebrae
c. Closed stable burst fracture of the sixth thoracic vertebra with delayed healing.
d. Closed fracture of lumbar vertebra, unspecified fracture morphology, unspecified lumbar vertebral level.
The Discharge Summary directed the nursing facility to schedule the Prolia injection (injection used to treat bone loss).

On 6/1/23 at 3:40 PM Resident #22's

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F 684	Continued From page 32 Representative (RR #22) said that they got a call from the facility after her fall on 5/13 that Resident #22 had a great deal of pain. She thought they facility called her over a weekend, and they brought in a portable X-ray machine on a Monday or Tuesday. Resident #22 had surgery and then she fell again the day she went back to the facility. On 6/5/23 at 1:37 PM a Clinic Nurse verified that the clinic received a call from the facility on 5/13/23 regarding Resident #22's fall. She did not see in the notes that the doctor responded with any specific questions or new orders. On 6/5/23 at 9:35 AM Staff K said that as she walked down the hallway, she saw Resident #22 fall back as she transferred to her chair. She said that Resident #22 denied pain at the time, she called an on-call nurse, and left a message. She denied knowing if the doctor called back for a follow up or if anyone followed up later with the doctor. On 6/6/23 at 8:11 AM the DON said that she expected the nurse to call the on-call doctor who worked as the emergency room (ER) doctor over a weekend, if an incident occurred at the facility. The DON agreed that someone followed-up with the doctor when Resident #22 continued to have pain after her fall. 2. Resident #25's Minimum Data Set (MDS) assessment dated 5/15/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated that Resident #25 required extensive assistance of two persons with bed mobility, dressing, and toilet use. In addition, she required total dependence on two persons for transfers, and	F 684		

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extensive assistance of one person for personal hygiene. The assessment indicated that Resident #25 could not ambulate (walk) and needed one person to push her wheelchair. The MDS included diagnoses of cancer, heart failure, diabetes, depression, and a compression fracture of the spine (broken bone caused by weakness in the back).

On 5/30/23 at 10:53 AM Resident #25 stated she fell out of a lift and fractured her back. She stated she went to the hospital and had a raging urinary tract infection (UTI), fluid on her heart, and a fracture in her back. In another interview the same day at 1:05 PM, the resident explained that she fell out of a standing lift, as Staff D, Certified Nursing Assistant (CNA), operated it. She reported that she did not have anyone else in the room when it happened. Resident #25 added that staff now use a full-body mechanical lift to transfer her. Resident #25 explained that oftentimes the staff transfer her alone when there is supposed to be two people. On her wall at the head of the bed, observed a sign that instructed to only use a nonmechanical stand-to-sit for Resident #25.

The Health Status Note dated 4/16/23 at 9:00 PM indicated that Resident #25 reported that her pain management routine worked and she slept better. She added that she could get around better with her medication schedule with the Tylenol and tramadol (pain medication).

The Health Status Note dated 4/18/23 at 12:54 PM written by Staff F, Registered Nurse (RN), indicated that a Certified Nurse Aide (CNA) reported that Resident #25 did not stand well in the mechanical standing lift with an assist of one.

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F 684	Continued From page 34 The CNA described that Resident #25 pulled her arms up and bent her knees. The Health Status Note dated 4/19/23 at 1:38 AM documented by Staff E, Licensed Practical Nurse (LPN), that Resident #25 continued to have difficulty standing with transfers. The Health Status Note dated 4/25/23 at 6:54 AM labeled Late Entry written by Staff F indicated Resident #25 complained of shortness of breath, shallow respirations, poor eye contact, flat voice, and diminished lung sounds. Resident #25 had stable vital signs, oxygen saturation of 98% on room air, denies pain while in bed, and when up has pain of 7 of out 10 (0 no pain, 10 the most pain). The nurse encouraged Resident #25 to increase their activity. The Communication - Other Note dated 4/25/23 at 2:50 PM listed that the nurse requested a muscle relaxer per therapy recommendation. The Communication/Visit with Physician Note dated 4/25/23 at 8:30 PM labeled Late Entry detailed new orders by the provider. Resident #25 will have X-rays on the next day of the T-Spine (upper middle back), and L-Spine (middle to lower back). In addition, the provider provided an order for baclofen (muscle relaxer) one tablet three times a day as needed for back spasms. The nurse notified the family and updated the clinical record. The Health Status Note dated 4/26/23 at 11:56 AM indicated that Resident #25 had an X-ray. She continued to complain of pain with activity. The Lab/Diagnostics Note dated 4/27/23 at 5:41	F 684		

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AM listed that the facility received the x-ray results and faxed them to the Primary Care Provider (PCP).

The Health Status Note dated 4/27/23 at 9:30 AM written by Staff F indicated that Resident #25 continued to complain of sharp pain on her left of her back radiating to the flank area (lower left side of back) without radiation to her left arm. Vital signs remain stable with an oxygen saturation of 88% (normal is 90% and above), blood pressure of 126/58, temperature of 95 (average 98.6), pulse of 88 (typical range 60-100), and respirations (typical range 12-20). As the staff assisted Resident #25 to the bath chair in the standing mechanical lift, she complained of a sharp pain in her left side of her back. Resident #25 received her scheduled Tramadol (pain medication) and Tylenol earlier in the morning.

The Communication/Visit with Physician Note on 4/27/23 at 10:12 AM identified the nurse called the PCP's office to provide an update on Resident #25's condition.

The Communication/Visit with Physician Note on 4/27/23 at 1:41 PM indicated that the facility received a fax from the physician that dictated that Resident #25 had chronic (long-term) degenerative changes. The physician directed to schedule an appointment with her PCP in the office unless she would not wait. The nurse updated the resident and her niece then got a bed hold agreement. The nurse provided a report to the emergency room (ER).

The Health Status Note dated 4/27/23 at 1:50 PM recorded that Resident #25 went to the ER with

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F 684	Continued From page 36 staff in the facility van. The ED Provider Notes dated 4/27/23 at 2:37 PM listed Resident #25's chief complaint as a report of slipping from the sit-stand machine and jarred her back making her pain worse in her back around to her abdomen. Resident #25 came to the ER for an evaluation of mid back pain. She reported when in a lift the machine came down somewhat quickly and stopped. As that happened she developed immediate onset of mid back pain. Resident #25 denied extension of the pain into her legs but did feel like it came across her upper abdomen to her chest. She reports a history of chronic low back pain but explained her current pain is different. Resident #25 denied any exacerbation of her regular back pain. She tried tramadol that day with little or no relief. Resident #25 did have an X-ray the day before that had negative results of any acute fracture. The assessment revealed that Resident #25 had some tenderness at approximately T-11 on palpation (a type of touch used to assess). The Discharge instructions directed to increase her tramadol to 50 milligrams (mg) three times a day for one week and continue Tylenol. Apply ice to the affected area for 20 minutes per hour while awake for that day and the next day. If worsening or changing symptoms contact the clinic and follow-up as needed. The Final Impression list thoracic back sprain, initial encounter. The Progress Notes dated 4/29/23 at 9:29 AM indicated that Resident #25 had back pain of the thoracolumbar region for greater than six weeks. She started on a muscle relaxant and received tramadol for her pain without improvement. The etiology of the pain could be from a kidney infection, however, due to the musculoskeletal	F 684		

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nature, regarding the full-boy mechanical lift incident in the nursing home, proceed with CT scans to rule out a compression fracture or any other potential etiology of her back pain while hospitalized.

The CT Thoracic Spine without contrast dated 4/29/23 impression listed the following
a. Inferior endplate fracture at the T8
b. Degenerative change of the spine. There is central canal stenosis and neurol foraminal narrowing at T10-11.
c. Small effusions with bibasilar atelectasis
d. Findings suggesting pulmonary edema.

The Progress Notes dated 4/30/23 at 8:23 AM indicated that Resident #25 told her PCP that she had an incident at the nursing home where she fell. She described the incident as the staff tried to transfer her and pivot her standing, her legs gave out and she went down rather hard on her buttocks into the chair. She reported that she felt the worsening back pain at that time but could not remember when the incident occurred.

The Communication/Visit with Physician on 5/2/23 at 3:57 AM the facility received Resident #25's X-ray results the PCP wrote that the X-rays on 4/26/23 with negative results. The X-ray results on 4/29/23 revealed a compression fracture at her T-8. The PCP questioned if Resident #25 had a fall. The nurse responded that they did not know of any falls but she did use a sit to stand with a sling. Resident #25 chicken wings (bends her arms at an upward angle) and needs to sit quickly.

The Communication/Visit with Physician dated 5/2/23 at 2:21 PM indicated the PCP reviewed the

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X-Ray and Resident #25 remained in the hospital. The PCP wrote that Resident #25 reported that she fell at the nursing home. The PCP explained that Resident #25 had a compression fracture of her T-8. The PCP indicated that her record did not have any documented falls.

On 5/31/23 at 1:35 PM the Director of Nursing (DON) reported that they did not do an investigation or report regarding resident's compression fracture findings due to the hospital discovering it. She explained that they reviewed their records and found no staff reports or documentation of a fall.

On 5/31/23 at 2:45 PM Staff F reported that she did not think that she documented on 4/18 that anyone told her that Resident #25 had problems with the mechanical standing lift, and if she did, she couldn't remember. She denied remembering any incidents or concerns with Resident #25 using the stand.

On 5/31/23 at 3:06 PM Staff E, Licensed Practical Nurse (LPN), remarked that she could not remember documenting on 4/19 that Resident #25 had difficulty with the mechanical standing lift. She reported that she did not know about any incidents with Resident #25 using the stand and complaining of back pain. When asked what she would do if that someone reported that to her, she replied that she would let therapy know, but therapy said resident did fine with the mechanical standing lift so to keep using it.

On 5/31/23 at 3:20 PM Staff H, Occupational Therapist (OT), explained that that all staff received training that they could always do more for the resident, but not less. She stated if the

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staff or the resident felt uncomfortable using the standing mechanical lift or standing lift, they could always use a full-body mechanical lift to transfer the resident without having to call them before using it, and have the nurse notify them of the concern to address it the following day. She stated that Resident #25 did do well with the lift in therapy and that in her opinion, Resident #25 tried harder for them (therapy). She also felt that Resident #25 felt more comfortable with some staff than others. She stated that staff use "chicken winging," but it can present differently from one staff member to another, such as elbows pointed out away from the body or pointing upwards like a flapping motion.

On 6/1/23 at 10:30 AM Resident #25's physician from the ER explained her compression fracture was consistent with a sudden stop coming down in the lift.

3. Resident #42's MDS assessment dated 5/11/23 listed a readmission date of 2/17/23 from an acute hospital. The MDS identified a BIMs score of 14, indicating intact cognition. The MDS indicated that Resident #42 required extensive assistance of two persons with bed mobility and toilet use. The MDS listed that Resident #42 required total dependence of two persons with transfers and could not ambulate. The MDS identified that Resident #42 had an indwelling catheter. The MDS identified Resident #42 is at risk for developing pressure ulcer and that he had an unhealed stage 2 pressure ulcer during the seven-day lookback period. The MDS included diagnoses of hypertension (high blood pressure), obstructive uropathy, end stage renal disease, and malnutrition.

On 5/30/23 at 1:28 PM Resident #42 reported

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that he went to the hospital a couple of days ago.

The Care Plan Focus revised on 7/21/22 indicated that Resident #42 had an indwelling catheter related to benign prostatic hyperplasia with obstructive uropathy (prostate gland enlargement with obstructed urinary flow). The Care Plan intervention dated 12/9/21 directed the staff to monitor for signs and symptoms of a urinary tract infection such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increase pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns.

The Transfer to Hospital V5 note dated 2/13/23 at 3:23 p.m. indicated that Resident #42 went to the hospital due to urosepsis (severe UTI).

The eAdmin Record (Default Note) dated 2/16/23 at 1:26 p.m. indicated that Resident #42 remained in the hospital.

The Last BM and Admit/Re-Admit note dated 2/17/23 at 7:13 p.m. indicated that Resident #42 had a septic UTI that required hospitalization. Resident #42 required physical therapy for strengthening.

A Physician order dated 2/17/23 directed staff to administer Apixaban (anticoagulant/blood thinner) 2.5mg (milligrams) two times a day for atrial fibrillation (irregular heart rate).

The Care Plan revised on 5/17/23 identified Resident #42 was on anticoagulant therapy and directed staff to monitor, document and report to the doctor as needed for signs and symptoms of

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F 684	Continued From page 41 anticoagulant complications such as bruising.	F 684		

The Health Status note dated 5/20/23 at 3:58 p.m. indicated that Resident #42 had strong smelling dark urine. The note directed to push fluids.

The Communication/Visit with Physician dated 5/23/23 at 1:38 p.m. identified that Resident #42 saw the physician for nursing home rounds. The physician gave no new orders.

The Health Status note dated 5/24/23 at 12:07 a.m. documented that Resident #42 experienced confusion. He attempted to change the channel on his tv with his recliner remote.

The Care Plan Review note dated 5/26/23 at 7:46 a.m. indicated that Resident #42 used apixaban without adverse reactions.

The Health Status dated on 5/27/23 at 2:09 p.m. listed that the nurse faxed the physician on 5/26/23 due to Resident #42's strong smelling urine that contained mucus and his confusion. At the time of the note, the physician had not responded to the fax. Resident #42 appeared slumped in the chair most of the time, with purple urine in his urinary catheter. He reported being fine just tired. The nurse noted his vital signs with in normal range for him. Resident #42 described his urine flowing across the floor that made a puddle in front of him that he could see. The nurse looked at the floor and noted it as dry. The nurse visited with the ER staff about Resident #42 and received an order to send him for an evaluation. At 2:40 PM Resident #42 left the facility in route to the hospital with his family following.

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Resident #42's After Visit Summary from the ER dated 5/27/23 listed a diagnosis of a urinary tract infection with hematuria (blood in urine). The form instructed the facility to administer Bactrim DS as ordered.

The Health Status note on 5/28/23 at 2:26 a.m. indicated that Resident #42 returned to the facility at 7:35 p.m. with a diagnosis of a UTI and a new order to start Bactrim DS (antibiotic) by mouth twice a day for five days.

The Order Details dated 5/29/23 identified an order for Bactrim DS Oral Tablet 800-160 milligrams (MG) one tablet two times a day for a UTI for 5 days.

Resident #42's clinical record lacked documentation, assessment, treatment, and follow up on Resident #42's urinary symptoms after 5/20/23 until 5/27/23.

On 6/1/23 at 7:25 a.m. observed Resident #42 lying in bed with his catheter drainage bag hanging from the bed and touching the floor. The urinary catheter contained pink tinged urine in the tubing and the bag. Resident #42's arms appeared to have extensive bruising (dark in color), the left arm looked to have an old scabbed skin tear. Staff C, LPN, reported that Resident #42 commonly had bruises to his arms.

On 6/1/23 at 1:07 p.m. Staff S, License Practice Nurse (LPN), acknowledged that he made an entry in the progress notes on 5/20/23 regarding Resident #42's dark and strong-smelling urine. Staff S reported having concern because he knew Resident #42 had a history of UTIs and

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sepsis. Staff S stated he thought he faxed the physician but could not state for sure. Staff S explained that he only worked weekends and did not know what happened on Monday through Thursday. Staff S verified that he sent Resident #42 to the ER the following Saturday (5/27) due to Resident #42 appearing dopey, slouchy, and had purple colored urine.

On 6/1/23 at 1:38 p.m. the Director of Nursing (DON) reported that she could not locate a physician notification on or after 5/20/23 until Resident #42 went to the ER.

On 6/1/23 at 4:51 p.m. the DON reported the facility did not have a policy for UTIs.

The Change in Condition Policy revised 3/29/23 instructed the purpose of the policy related to the following:
1.To improve communication between nurses and a provider with nursing is monitoring a change in condition.
2. To enhance the nursing evaluation of and documentation of a resident who has a condition change.
3. To provide a standard format to collect pertinent clinical data prior to contacting the provider when there is a condition change.
4. To standardize shift to shift communication about a resident change in condition

On 6/5/23 at 10:52 a.m. the DON stated she expected the nurse to notify the Physician with a condition change and to complete a follow-up urinary assessment.

On 6/5/23 at 4:25 p.m. observed Resident #42's bilateral arms and hands with extensive dark

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F 684	Continued From page 44 colored bruising. Observed two black colored scabbed areas to the left wrist area and one black colored scab to the left elbow area. Observed Resident #42's bilateral arms were very dry. Resident #42 reported the bruising occurred from bumping his arms. On 6/5/23 at 4:30 p.m. Staff T, Certified Nursing Assistant (CNA) reported Resident #42's arms usually appear like that. Staff T, CNA stated Resident #42 picks at his arms at times and usually wears short sleeve shirts. Review of Resident #42's clinical record lacked documentation, assessment, and treatment on the bruises and scabbed areas to the bilateral arms and hands. In addition, the record lacked a skin assessment, an incident report, notification to the physician or his family. The clinical record lacked an intervention or treatment to reduce the risk of further bruising. The clinical record contained no request for labs related to his use anticoagulant therapy and bruising. The facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/23 documented if staff observed a bruise, contusion, abrasion, or skin tear on a resident, staff should report it to the nurse immediately. The policy further directed to monitor the bruise/contusion/skin tear/abrasion every week, document any changes and/or progress towards healing, and update the resident's Care Plan. On 6/5/23 at 5:10 p.m. the DON explained that she expected an assessment of bruises and scabbed areas with documentation according to the facility policy.	F 684		

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility record review, and policy review the facility failed to ensure residents received the necessary interventions and care consistent with professional standards of practice to prevent deterioration of a wound, heal a stage 2 pressure ulcer, and prevent the development of new ulcers for 2 of 2 residents reviewed (Residents #251 and #24). 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 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	F 686		

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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 has no bone, tendon or muscle 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.

Findings include:

1. Resident #24's Minimum Data Set (MDS) assessment dated 3/21/23 identified a Brief Interview for Mental Status (BIMS) of 5, indicating severe cognitive deficits. Resident #24 required extensive assistance from two persons for bed mobility, toilet use, and hygiene. The MDS described Resident #24 as always incontinent of bowel and bladder. The MDS included diagnoses of Alzheimer's disease, malnutrition (inadequate amount nutrition), cellulitis (red, swollen, skin infection), and gout (red, swollen, extremely pain area on the body, usually the big toe). The MDS listed that Resident #24 had a risk for pressure ulcers. The MDS identified that Resident #24 did not have pressure ulcers.

On 5/31/23 at 7:47 AM observed Staff O, Certified Nurse Aides (CNA), and Staff P, CNA,

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provided perineal care to Resident #24. As they completed the care, his wound treatment patch came loose from the coccyx area. His right buttock wound lacked a dressing. Staff C, Licensed Practical Nurse (LPN), gathered supplies and provided a new treatment covering. The two areas looked open, red, and bleeding. Staff C commented that he received the same treatment for a while and it did not seem to be doing the trick.

The following are a series of observations of Resident #24:
a. 5/31/23 at 8:18 AM sitting in a wheel chair (WC) at the breakfast table
b. 5/31/23 at 9:00 AM sitting in the commons area by the nurse's station in his WC.
c. 5/31/23 at 10:03 AM sitting in his WC in the chapel.
d. 5/31/23 at 10:11 AM sitting in his WC pushed up to the table in common area and sleeping in the chair.
e. 5/31/23 at 10:51 AM sitting in his WC in commons area sleeping.
f. 5/31/23 at 11:22 AM sitting in his WC in the commons area talking to staff.
g. 5/31/23 at 11:37 AM sitting in his WC in the commons area sleeping
h. 5/31/23 at 12:01 PM at the dinner table in his WC
i. 5/31/23 at 12:37 PM in his WC at the lunch table with staff helping him to eat.
j. 5/31/23 at 1:01 PM sitting in his WC in the commons area sleeping
k. 5/31/23 at 1:48 PM lying in his bed

The Care Plan Focus revised 4/5/23 identified that Resident #24 had actual skin impaired due to immobility (lack of movement) and weakness.

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The Care Plan included an Intervention to reposition Resident #24 at least every two hours as he allowed.

The Wound Data Collection - V 2 assessment dated 4/5/23 at 2:42 PM identified that Resident #24 had a new open area to his coccyx that measured 2.0 centimeters (cm) by (x) 1.0 cm. The wound bed contained 100 % epithelization (the regrowth of new skin over a partial-thickness wound surface or in scar tissue forming on a full-thickness wound).

The Wound Data Collection - V 2 assessment dated 4/6/23 at 10:18 PM indicated that Resident #24 still had an open wound on their coccyx. The assessment lacked measurements but indicated the wound margins appeared pink and it had a dressing of duoderm (a type of dressing for pressure ulcers) on it.

The Wound Data Collection - V 2 assessment dated 4/11/23 at 10:21 AM indicated that Resident #24's open wounds continued to measure 2.0 cm x 1.0 cm.

The Wound RN Assessment dated 4/11/23 at 10:23 AM listed the open area to Resident #24's coccyx as a stage two pressure ulcer. The Healing process section recorded the wound decreased in size. The facility's modifications of interventions included repositioning, support surfaces, moisture/incontinence protection, friction/shear management, wound treatment, and pain treatment. The author documented the notification of the physician and to continue with the current plan of treatment.

The Wound Data Collection - V 2 assessment

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dated 4/18/23 at 10:02 AM indicated that Resident #24's open wounds measured 1.5 cm x 0.5 cm. The wound contained 25% granulation tissue (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process). The wound edges appeared pink and intact. The dressing and/or Treatment section listed a dressing of collagen and duoderm every three days and as needed.

The Wound Data Collection - V 2 assessment dated 4/25/23 at 10:26 AM indicated that Resident #24's open wound measured 1.5 cm x 0.7 cm. The wound contained 100% epithelized tissue with pink and intact surrounding skin.

The Wound RN Assessment dated 4/25/23 at 10:26 AM indicated that Resident #24 had a healing stage 2 pressure ulcer. The Healing process section recorded the wound decreased in size. The facility's modifications of interventions included repositioning, support surfaces, nutritional, moisture/incontinence protection, friction/shear management, wound treatment, and pain treatment. The assessment directed to continue with the current plan of treatment.

The Wound Data Collection - V 2 dated 5/2/23 at 1:49 PM indicated that Resident #24's coccyx open wound measured 1.5 cm x 0.7 cm. The wound contained 25% epithelial tissue and 75% granulation tissue. The wound margins appeared macerated (soft, wrinkled tissue due to moisture).

The Wound Data Collection - V 2 dated 5/9/23 at 4:45 PM indicated that Resident #24's coccyx wound measure 2 cm x 0.7 cm. The wound contained 100% granulation tissue with

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macerated surrounding skin. The assessment indicated the wound had collagen powder and a duoderm patch.

The Wound Data Collection - V 2 assessment dated 5/16/23 at 11:55 AM indicated that Resident #24's coccyx wound measured 3 cm x 0.3 cm. The wound contained 100% granulation tissue. The surrounding skin appeared pink and intact. The assessment indicated the wound had collagen powder and a duoderm patch.

The Wound RN Assessment dated 5/16/23 at 12:20 PM indicated that Resident #24 had a stage 2 pressure ulcer. The Healing process section recorded the wound got smaller in width. The facility's modifications of interventions included repositioning, support surfaces, nutritional, moisture/incontinence protection, friction/shear management, wound treatment, and pain treatment. The assessment directed to continue with the current plan of treatment.

The Wound Data Collection - V 2 assessment dated 5/19/23 at 9:35 AM identified that Resident #24 had an open area to his coccyx. The wound had 75% granulation tissue. The assessment indicated the wound had collagen powder and a duoderm patch. The comments indicated that the healing appeared smaller than last seen.

The Wound Data Collection - V 2 assessment dated 5/23/23 at 11:20 AM identified that Resident #24 had an open area to his coccyx that measured 2.7 cm x 0.2 cm. The wound had 100% granulation tissue. The assessment indicated the wound had collagen powder and a duoderm patch.

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The Wound Data Collection - V 2 assessment dated 5/30/23 at 7:46 AM identified that Resident #24 had a wound to his right buttocks that measured 0.3 cm x 0.2 cm. The assessment indicated the wound had collagen powder and a duoderm patch change every three days and as needed. The Comments section indicated his wound appeared basically closed at the time and directed that he needed repositioned more often to get off his buttocks.

The Wound RN Assessment dated 5/30/23 at 9:52 PM indicated that Resident #24 had an unstaged pressure ulcer to his buttocks. The Healing process section recorded the wound decreased in size without signs of infection. The facility's modifications of interventions included repositioning, support surfaces, nutritional, moisture/incontinence protection, friction/shear management, wound treatment, and pain treatment. The assessment directed to continue with the current plan of treatment.

On 6/1/23 at 9:59 AM the Hospice Nurse explained that she had not seen Resident #24's coccyx and buttocks wounds because whenever she came to visit, he is usually in the wheelchair or in the recliner. She said that when she visited him on 5/31, she saw him in bed for the first time. She reported that many of the times she visited Resident #24, he had different staff working with him who are not familiar with him or the history of the wounds. The Hospice Nurse said they got a new treatment order for Resident #24 after Staff C told her the day before that the current treatment did not seem to work.

On 6/6/23 at 8:11 AM the Director of Nursing (DON) said they encouraged the staff to put

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F 686	Continued From page 52 Resident #24 in bed at least once per shift. The Pressure Ulcers policy dated 2/10/23 instructed that residents with pressure ulcers will receive the necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure ulcers.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, emergency room, hospital and facility record review, the facility failed to provide adequate nursing supervision to prevent injuries for 3 of 4 residents reviewed (Residents #22, #25, and #33) for falls. In addition, the facility failed to complete neurological assessments for 1 of 4 residents (Resident #22) reviewed for falls. Despite the facility documenting that Resident #25 had difficulties with standing with her transfers using the mechanical standing lift, no one adjusted the transfer technique to ensure her safety with transfers. Due to the staff continuing to transfer Resident #25 with an unsafe technique, she fell out of the standing lift resulting in a compression fracture in her back. Resident #33 had a history of falls and the facility added interventions to the Incident Report or the Progress notes but never updated the Care Plan	F 689		

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to reflect the interventions. In addition, the facility knew that some of the interventions did not work but did not modify the intervention. The facility could not provide documentation to verify the implementation or modification of the interventions. On the fourth fall, Resident #33 fell fracturing her hip and required surgery to repair it. Resident #22 experience an unwitnessed fall that resulted in an emergency room visit following her discharge earlier in the day from the hospital. See F684 regarding additional information related to Resident #22.

Findings include:

Resident #25's Minimum Data Set (MDS) assessment dated 5/15/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated that Resident #25 required extensive assistance of two persons with bed mobility, dressing, and toilet use. In addition, she required total dependence on two persons for transfers, and extensive assistance of one person for personal hygiene. The assessment indicated that Resident #25 could not ambulate (walk) and needed one person to push her wheelchair. The MDS included diagnoses of cancer, heart failure, diabetes, depression, and a compression fracture of the spine (broken bone caused by weakness in the back).

On 5/30/23 at 10:53 AM Resident #25 stated she fell out of a lift and fractured her back. She stated she went to the hospital and had a raging urinary tract infection (UTI), fluid on her heart, and a fracture in her back. In another interview the same day at 1:05 PM, the resident explained that she fell out of a standing lift, as Staff D, Certified

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Nursing Assistant (CNA), operated it. She reported that she did not have anyone else in the room when it happened. Resident #25 added that staff now use a full-body mechanical lift to transfer her. Resident #25 explained that oftentimes the staff transfer her alone when there is supposed to be two people. On her wall at the head of the bed, observed a sign that instructed to only use a nonmechanical stand-to-sit for Resident #25.

The Health Status Note dated 4/16/23 at 9:00 PM indicated that Resident #25 reported that her pain management routine worked and she slept better. She added that she could get around better with her medication schedule with the Tylenol and tramadol (pain medication).

The Health Status Note dated 4/18/23 at 12:54 PM written by Staff F, Registered Nurse (RN), indicated that a Certified Nurse Aide (CNA) reported that Resident #25 did not stand well in the mechanical standing lift with an assist of one. The CNA described that Resident #25 pulled her arms up and bent her knees.

The Health Status Note dated 4/19/23 at 1:38 AM documented by Staff E, Licensed Practical Nurse (LPN), that Resident #25 continued to have difficulty standing with transfers.

The Health Status Note dated 4/25/23 at 6:54 AM labeled Late Entry written by Staff F indicated Resident #25 complained of shortness of breath, shallow respirations, poor eye contact, flat voice, and diminished lung sounds. Resident #25 had stable vital signs, oxygen saturation of 98% on room air, denies pain while in bed, and when up has pain of 7 of out 10 (0 no pain, 10 the most

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pain). The nurse encouraged Resident #25 to increase their activity.

The Communication - Other Note dated 4/25/23 at 2:50 PM listed that the nurse requested a muscle relaxer per therapy recommendation.

The Communication/Visit with Physician Note dated 4/25/23 at 8:30 PM labeled Late Entry detailed new orders by the provider. Resident #25 will have X-rays on the next day of the T-Spine (upper middle back), and L-Spine (middle to lower back). In addition, the provider provided an order for baclofen (muscle relaxer) one tablet three times a day as needed for back spasms. The nurse notified the family and updated the clinical record.

The Health Status Note dated 4/26/23 at 11:56 AM indicated that Resident #25 had an X-ray. She continued to complain of pain with activity.

The Lab/Diagnostics Note dated 4/27/23 at 5:41 AM listed that the facility received the x-ray results and faxed them to the Primary Care Provider (PCP).

The Health Status Note dated 4/27/23 at 9:30 AM written by Staff F indicated that Resident #25 continued to complain of sharp pain on her left of her back radiating to the flank area (lower left side of back) without radiation to her left arm. Vital signs remain stable with an oxygen saturation of 88% (normal is 90% and above), blood pressure of 126/58, temperature of 95 (average 98.6), pulse of 88 (typical range 60-100), and respirations (typical range 12-20). As the staff assisted Resident #25 to the bath chair in the standing mechanical lift, she

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complained of a sharp pain in her left side of her back. Resident #25 received her scheduled Tramadol (pain medication) and Tylenol earlier in the morning.

The Communication/Visit with Physician Note on 4/27/23 at 10:12 AM identified the nurse called the PCP's office to provide an update on Resident #25's condition.

The Communication/Visit with Physician Note on 4/27/23 at 1:41 PM indicated that the facility received a fax from the physician that dictated that Resident #25 had chronic (long-term) degenerative changes. The physician directed to schedule an appointment with her PCP in the office unless she would not wait. The nurse updated the resident and her niece then got a bed hold agreement. The nurse provided a report to the emergency room (ER).

The Health Status Note dated 4/27/23 at 1:50 PM recorded that Resident #25 went to the ER with staff in the facility van.

The ED Provider Notes dated 4/27/23 at 2:37 PM listed Resident #25's chief complaint as a report of slipping from the sit-stand machine and jarred her back making her pain worse in her back around to her abdomen. Resident #25 came to the ER for an evaluation of mid back pain. She reported when in a lift the machine came down somewhat quickly and stopped. As that happened she developed immediate onset of mid back pain. Resident #25 denied extension of the pain into her legs but did feel like it came across her upper abdomen to her chest. She reports a history of chronic low back pain but explained her current pain is different. Resident #25 denied any

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exacerbation of her regular back pain. She tried tramadol that day with little or no relief. Resident #25 did have an X-ray the day before that had negative results of any acute fracture. The assessment revealed that Resident #25 had some tenderness at approximately T-11 on palpation (a type of touch used to assess). The Discharge instructions directed to increase her tramadol to 50 milligrams (mg) three times a day for one week and continue Tylenol. Apply ice to the affected area for 20 minutes per hour while awake for that day and the next day. If worsening or changing symptoms contact the clinic and follow-up as needed. The Final Impression list thoracic back sprain, initial encounter.

The Health Status Note dated 4/27/23 at 6:15 PM written by Staff F indicated that Resident #25 returned to facility, refused supper, and requested to go to her room. She appeared alert and oriented. When the nurse went to give Resident #25 her evening medications, she noted involuntary jerking of resident's head and arms. She further documented that Resident #25 appeared pale and had a clear but vague speech. Resident #25 could not hold her medication cup but could to take her medications without difficulty.

The Health Status Note dated 4/27/23 at 8:15 PM written by Staff F described Resident #25 as continuing to act different from usual, she could not feed herself, she did not speak, and had weak extremities.

The Communication - Other Note dated 4/27/23 at 8:20 PM identified that the nurse called the ER and notified them of Resident #25's condition. The ER recommended sending her to the ER for

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an evaluation. The nurse contacted 911.

The ED Provider Notes dated 4/27/23 at 9:47 PM listed a chief complaint of an altered mental status. The nursing home staff reported that she could not speak, feed herself, or stand. The nursing home staff indicated this started after returning from the ER that afternoon. The note listed that Resident #25 came to the ER earlier in the day and had a negative work-up at that time. After returning to the nursing home, she became more lethargic, could not speak, or feed herself. Resident #25 returned to the hospital in an ambulance and could not give any history but could follow commands. Her physical exam revealed that she opened her eyes to a sternal rub (type of touch used when unable to arouse) and could make eye contact. She had generalized weakness but not focal deficits noted. The Plan/Medical Decision-Making section listed the hospital would admit her for neurological (neuro) checks and telemetry (heart monitoring). The provider indicated that they did not know the cause of her delirium but would check a urinalysis (UA) to rule out a cystitis (bladder infection).

The Communication - Other Note dated 4/27/23 at 10:56 PM listed that the facility received a call from the ER nurse. The ER nurse reported they planned to keep Resident #25 for observation that night. The ER completed a CT Scan (special imaging) the revealed no changes. The ER planned to check neurological (neuro) checks (assessment to determine changes in the brain). They reported that she continued to be twitchy at times. Resident #35 had on and off issues with being able to talk, knowing her name, and knowing what was happening.

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The History and Physical dated 4/28/23 at 9:14 AM repeated the information from the ED Provider note from 4/27/23. The note added that the hospital found her to have nasty looking urine. They admitted her and started her on ceftriaxone (an antibiotic) with a diagnosis of acute delirium. The morning of 4/28/23 Resident #25 observed awake and responding appropriately. She appeared very somnolent, very cool, and clammy. The Assessment section listed delirium, permanent atrial fibrillation (irregular heart rate), type 2 diabetes mellitus with other specified complication. The Plan listed to admit her to acute care, already started on ceftriaxone for pretty nasty looking urine. Her last culture did grow Proteus (bacteria), which should be susceptible to ceftriaxone.

The Communication - Other Note dated 4/29/23 at 1:06 AM identified that the nurse called the hospital for an update on Resident #25. The hospital reported that Resident #25 had congestive heart failure, elevated renal function, a urinary tract infection (UTI), an okay chest X-ray, and a negative CT of her head. Resident #25 received oxygen and albuterol treatments (inhaled steroids to open the lungs). She continued to have confusion and inability to track.

The Progress Notes dated 4/29/23 at 9:29 AM indicated that Resident #25 had back pain of the thoracolumbar region for greater than six weeks. She started on a muscle relaxant and received tramadol for her pain without improvement. The etiology of the pain could be from a kidney infection, however, due to the musculoskeletal nature, regarding the full-boy mechanical lift incident in the nursing home, proceed with CT scans to rule out a compression fracture or any

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other potential etiology of her back pain while hospitalized.

The CT Thoracic Spine without contrast dated 4/29/23 impression listed the following
a. Inferior endplate fracture at the T8
b. Degenerative change of the spine. There is central canal stenosis and neurol foraminal narrowing at T10-11.
c. Small effusions with bibasilar atelectasis
d. Findings suggesting pulmonary edema.

The Progress Notes dated 4/30/23 at 8:23 AM indicated that Resident #25 told her PCP that she had an incident at the nursing home where she fell. She described the incident as the staff tried to transfer her and pivot her standing, her legs gave out and she went down rather hard on her buttocks into the chair. She reported that she felt the worsening back pain at that time but could not remember when the incident occurred.

The Communication/Visit with Physician on 5/2/23 at 3:57 AM the facility received Resident #25's X-ray results the PCP wrote that the X-rays on 4/26/23 with negative results. The X-ray results on 4/29/23 revealed a compression fracture at her T-8. The PCP questioned if Resident #25 had a fall. The nurse responded that they did not know of any falls but she did use a sit to stand with a sling. Resident #25 chicken wings (bends her arms at an upward angle) and needs to sit quickly.

The Communication/Visit with Physician dated 5/2/23 at 2:21 PM indicated the PCP reviewed the X-Ray and Resident #25 remained in the hospital. The PCP wrote that Resident #25 reported that she fell at the nursing home. The PCP explained

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F 689	Continued From page 61 that Resident #25 had a compression fracture of her T-8. The PCP indicated that her record did not have any documented falls. On 5/31/23 at 1:35 PM the Director of Nursing (DON) reported that they did not do an investigation or report regarding resident's compression fracture findings due to the hospital discovering it. She explained that they reviewed their records and found no staff reports or documentation of a fall. On 5/31/23 at 2:45 PM Staff F reported that she did not think that she documented on 4/18 that anyone told her that Resident #25 had problems with the mechanical standing lift, and if she did, she couldn't remember. She denied remembering any incidents or concerns with Resident #25 using the stand. On 5/31/23 at 3:06 PM Staff E, Licensed Practical Nurse (LPN), remarked that she could not remember documenting on 4/19 that Resident #25 had difficulty with the mechanical standing lift. She reported that she did not know about any incidents with Resident #25 using the stand and complaining of back pain. When asked what she would do if that someone reported that to her, she replied that she would let therapy know, but therapy said resident did fine with the mechanical standing lift so to keep using it. On 5/31/23 at 3:20 PM Staff H, Occupational Therapist (OT), explained that that all staff received training that they could always do more for the resident, but not less. She stated if the staff or the resident felt uncomfortable using the standing mechanical lift or standing lift, they could always use a full-body mechanical lift to transfer	F 689		

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the resident without having to call them before using it, and have the nurse notify them of the concern to address it the following day. She stated that Resident #25 did do well with the lift in therapy and that in her opinion, Resident #25 tried harder for them (therapy). She also felt that Resident #25 felt more comfortable with some staff than others. She stated that staff use "chicken winging," but it can present differently from one staff member to another, such as elbows pointed out away from the body or pointing upwards like a flapping motion.

On 6/1/23 at 10:30 AM Resident #25's physician from the ER explained her compression fracture was consistent with a sudden stop coming down in the lift.
2. Resident #33's MDS dated 3/14/23 assessment identified a BIMs score of score of 99, which indicating that Resident #33 could not complete the interview. The MDS identified a completed staff assessment for mental status that indicated Resident #33 had moderately impaired decision making. The MDS identified Resident #33 required supervision and assistance of one person with bed mobility. The MDS described Resident #33 as independent with transfers and ambulation. The MDS indicated that Resident #33 required limited assistance of one person for toilet use. The MDS documented Resident #33 had occasional incontinence of bladder. The MDS included diagnoses of diabetes mellitus, Alzheimer's disease, malnutrition, anxiety, and depression.

The Incident Report (IR) labeled Found on Floor dated 1/4/23 at 9:30 a.m. indicated that the staff found Resident #33 on the floor with her pants and briefs around her knees. Resident #33 could

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not describe what happened. The Immediate Action Taken identified the nurse requested a urinalysis (UA) and wound culture from the Primary Care Provider (PCP) due to her high blood sugars.

Resident #33's Falls Tool Assessment dated 1/4/23 listed a score of 20, indicating a high risk for falls.

The Incident note dated 1/5/23 at 5:22 a.m. identified that a Certified Nurse Aide (CNA) found Resident #33 lying on the floor with her supper tray.

Resident #33's clinical record lacked an IR or a Fall Tools Assessment related to the fall on 1/5/23.

The Health Status note dated 1/5/23 at 5:41 p.m. indicated the staff attempted the whole shift to obtain a urine specimen. Resident #33 did not understand the need and moved the collection hat from the toilet several times. The staff did get the wound culture.

The clinical record lacked documentation that of completion of the 30 minutes checks for the 1/12/23 fall intervention.

The IR labeled Slipped or Fell dated 1/12/23 at 7:25 p.m. identified that the nurse heard a loud thud and found Resident #33 lying on her right side next to the toilet with her head under the sink holding on to a dry brief and a dry pair of pants. Resident #33 reported she slipped while going to the bathroom. The IR documented an immediate intervention of 30-minute checks.

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SALEM LUTHERAN HOME	**2027 COLLEGE AVENUE** **ELK HORN, IA 51531**

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Resident #33's Falls Tool Assessment dated 1/12/23 listed a score of 19, indicating a high risk for falls.

The IR labeled Found on Floor dated 1/21/23 at 7:00 p.m. indicated that a Certified Nurse Aide (CNA) found Resident #33 on the floor by her bathroom with her head facing towards the bathroom lying on her right side. The IR listed an immediate intervention of a motion alarm in her room to alert staff when she went to the bathroom.

Resident #33's Care Plan lacked documentation of the intervention of a motion alarm following the fall on 1/21/23.

Resident #33's Falls Tool Assessment dated 1/21/23 listed a score of 19, indicating a high risk for falls.

The IR labeled Found on Floor dated 2/21/23 at 7:45 p.m. indicated that the staff found Resident #33 on the floor in her room. The staff assisted Resident #33 to bed with a mechanical lift. After getting off the floor, Resident #33 started complaining of pain. The nurse sent her to the emergency room for possible fracture to her left hip. The IR lacked documentation if the motion sensor was in place and functioning at the time of the fall. The Immediate Action's description indicated the nurse put a pressure mat alarm to her recliner.

The Transfer to the Hospital V5 note dated 2/21/23 at 8:15 p.m. indicated that Resident #33 went to the hospital due to a fall with a pain level of 10 on the pain scale of 0 meaning no pain and 10 meaning excruciating pain.

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The Health Status note dated 2/21/23 at 11:51 p.m. documented that the staff heard a loud noise in Resident #33's room at 7:45 p.m. Upon entering the room, they found Resident #33 on the floor rolling around calling for her mother. The nurse called for assistance of another nurse then assessed Resident #33. The assessment revealed that Resident #33 complained of significant pain in her left thigh/hip area. When the nurse palpated (assessment touch) the area during her assessment, Resident #33 did not respond with pain and the nurse did not notice shortness of her left leg at that time. After the staff assisted her with two people off the floor with a full-body mechanical lift and put her in her chair, she continued to complain of pain to her left thigh/hip. At 8:05 p.m. the nurse contacted the Emergency Room (ER) and received an order to transfer Resident #33 to the ER. The nurse contacted emergency medical services (EMS) who arrived and transported Resident #33 to the ER. The ER called the facility to notify them that Resident #33 fractured her left hip and they transferred her to another hospital.

Resident #33's Falls Tool Assessment dated 2/21/23 listed a score of 19, indicating a high risk for falls.

The hospital's Discharge Documents dated 2/28/23 listed Resident #33's principal discharge diagnosis as a left intertrochanteric fracture (hip fracture) following an intramedullary nail (a type of repair in hip surgery) with a left hip hematoma (large bruise), anemia (low blood volume), and hypotension (low blood pressure). The Reason for Admission indicated that Resident #33 fell at the nursing home and fractured her hip. Resident

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#33 did not appear lucid at the time of admission but her daughter consented to her having hip surgery. The documents included an order to for treatment of an incisional wound.

The Last BM and Admit/Readmit note dated 2/28/23 at 3:10 p.m. recorded that Resident #33 went to the hospital for a left hip fracture. Resident #33 required the skilled services of a daily assessment, blood transfusion two times, and diabetes management.

On 6/1/23 at 10:00 a.m. Staff M, Restorative Aide, described herself as the person responsible for checking the resident alarms in the facility. Staff M stated she put the alarms in place and check them on the 5th of each month. Staff M reported Resident #33 had an assigned motion sensor prior to her fall when she fractured her hip. Staff M reported that Resident #33 would turn around the motion sensor or put it in a drawer to prevent it from alerting the staff. Staff M stated after her fall with fracture, they decided to switch to a pressure alarm. Staff M reported that she tracked and documented the alarms on a flow sheet.

On 6/1/23 at 10:17 a.m. Staff N, Certified Medication Aide (CMA), reported that Resident #33 used to have a motion sensor in her room. Staff N stated the motion sensor chimed at the nurses' desk. Staff explained that the alarm stop chiming after Resident #33 moved out of the way of the alarm. Staff N added that if staff are not at the nurses' station or in the hallway, they could not hear the chimes from the motion sensor. Staff N reported that sometimes she found the motion alarm turned towards the wall and she would correct it. Staff N explained that Resident #33 knew the purpose of the alarm. Staff N reported

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that Resident #33 received the pressure alarm after her fall with fracture.

On 6/1/23 at 11:00 a.m. Staff I, Registered Nurse (RN)/MDS Coordinator, acknowledged and verified that Resident #33's Care Plan did not have the motion sensor added it. Staff I reported they placed the motion sensor in Resident #33's room and put the base for the motion sensor at the nurses' station. Staff I stated the motion sensor chimed at the desk while the resident is near the sensor and then it stopped chiming when she moved out of range. Staff I verified that staff could not hear the chimes if they are not close to the nurses' desk if it chimed. Staff I expressed that she hated alarms.

The Weekly Monitoring of Alarms form indicated the staff checked Resident #33 pull tab alarm on 2/31/23 (2/28/23 last day in February 2023). The form lacked any documentation regarding a motion sensor for Resident #33.

The Weekly Monitoring of Alarms form included a scribbled section that Resident #33 had a pull tab alarm. Above the scribble listed a chair pressure alarm. The form indicated that someone checked the alarm on 3/26/23 and changed the sensor mat on 4/5/23. The form included scratched out documentation for the battery change due date and the 5 for 4/5/23 with an 8 written above.

The Fall Prevention and Management policy revised 3/29/23 listed the purpose of the policy as the following:
a. To promote resident well-being by developing and implementing a fall prevention and management program
b. To identify risk factors and implement

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interventions before a fall occurs
c. To give prompt treatment after a fall occurs
d. To prevent further injury
e. To provide guidance for documentation.

The policy directed staff after a fall to complete an Incident Report in risk management, complete a Fall Tool assessment, and update the Care Plan with any changes or new interventions. The Procedure directed the staff to not move the resident. In addition, the policy instructs to not move the resident has a suspected hip fracture.

The Alarms - Bed, Chair, and Door policy revised 8/24/22 listed the Purpose of the policy as to ensure dignified and appropriate use of alarms based on the resident's condition and identify a process used to check the facility alarms. The policy further directed the Rehab or Nursing staff to check the motion sensor daily to check the alarms functionality. Staff should check the resident's condition to determine if the resident benefited from the use of an alarm.

On 6/5/23 at 10:52 a.m. the DON reported that she expected the staff to assess the effectiveness of a fall intervention. If the intervention did not work, she expected them to change the intervention.

On 6/5/23 at 5:15 p.m. the DON verified that she could not locate the 30-minute checks for 1/12/23.

On 6/6/23 at 3:02 p.m. the DON reported that she expected the nurse to complete a Fall Risk evaluation quarterly and after a fall.
3. Resident #22's Minimum Data Set (MDS) assessment dated 5/9/23 identified a Brief

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Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the Resident #22 required limited assistance of one person with dressing. She could independently move in bed, walk in her room, walk in the corridor, use the toilet, and complete her personal hygiene. Resident #22 used a walker and a wheelchair. She could stabilize herself without staff assistance but was not steady with moving from a seated to a standing position, turning around, moving on and off the toilet, and surface-to-surface transfer. Resident #22 received a scheduled pain medication in the previous five days of the lookback period. She had one fall without injury since the previous assessment.

The Care Plan Focus revised 6/9/22 indicated that Resident #22 had a risk for falls related to her history of falls. The interventions directed the staff to monitor her for significant change in gait, mobility, positioning device, standing balance, sitting balance, and lower extremity joint function.

On 6/1/23 at 2:10 PM observed Resident #22 in her recliner in her room. Resident #22 said that she did not have pain but she did have a lot of pain before and after her back surgery. She said that she kept getting dizzy and that's what caused her falls.

The Discharge Summary dated 5/26/23 included four diagnoses Resident #22 received treatment for in the hospital.
a. Osteoporosis
b. Closed fracture of multiple thoracic vertebrae
c. Closed stable burst fracture of the sixth thoracic vertebra with delayed healing.
d. Closed fracture of lumbar vertebra, unspecified

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fracture morphology, unspecified lumbar vertebral level.
The Discharge Summary directed the nursing facility to schedule the Prolia injection (injection used to treat bone loss).

On 6/1/23 at 3:40 PM Resident #22's Representative (RR #22) said that they got a call from the facility after her fall on 5/13 that Resident #22 had a great deal of pain. She thought the facility called her over a weekend, and they brought in a portable X-ray machine on a Monday or Tuesday. Resident #22 had surgery and then she fell again the day she went back to the facility.

The Incident Note dated 5/26/23 at 11:58 PM indicated that the nurse went to Resident #22's room at 8:00 PM and found her lying on the floor by her bed on her left side. She appeared wrapped up in her bed pad and complained of pain when moved. Resident #22 had increased confusion talking about nonexistent children that she needed to find and that she had mouse traps around her bed. Resident #22 could not say what happened due to her confusion and hallucinations. Resident #22's Representative (RR #22) arrived while Resident #22 remained on the floor. She requested to have her evaluated at the hospital due to her having vertebroplasty (a procedure involving special cement injected into a fractured vertebra - with the goal of relieving spinal pain and restoring mobility) that morning. At 10:20 PM the hospital called to notify that Resident #22 would return to the facility by ambulance. They reported that she appeared alert, oriented, doing well, and walking ok. RR #22 questioned if she could have a motion alarm that night.

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The Neuro Check - V 4 dated 5/26/23 at 8:15 PM indicated that Resident #22 had weakness to all her extremities, confusion, and hallucination.

The Neuro Check - V 4 dated 5/26/23 at 8:45 PM lacked an assessment of her eyes, hand strength, or orientation with the vital signs from the 8:15 PM assessment. The Comments section described Resident #22 as stable and the facility waited for the ambulance.

On 6/5/23 at 8:06 AM the Director of Nursing (DON) said that when a fall occurred the team met to discuss the incident, but, they did not necessarily do a root cause analysis or document the meetings.

On 6/6/23 at 8:11 AM the DON provided a hard copy the neurological assessments and referred to the electronic assessments that included eye assessment, hand strength and orientation. She said that she expected the staff to take a set of vitals and complete all the areas of the assessment when a resident had an unwitnessed fall.

F 698 SS=D

Dialysis
CFR(s): 483.25(l)

§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview

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and policy review the facility failed to complete dialysis assessments before and after outpatient hemodialysis treatments for 1 of 1 resident reviewed (Resident #42).

Finding include:

Resident #42's Minimum Data Set (MDS) assessment dated 5/11/23 identified a Brief Interview for Mental Status (BIMs) score of 14, indicating intact cognition. The MDS indicated that Resident #42 required extensive assistance of two persons with bed mobility and toilet use. The MDS listed that Resident #42 required total dependence of two persons with transfers and could not ambulate. The MDS identified that Resident #42 had an indwelling catheter. The MDS included diagnoses of hypertension (high blood pressure), obstructive uropathy, end stage renal disease, and malnutrition. Resident #42 received dialysis while a resident of the facility in the last 14 days in the lookback period.

The Care Plan Focus revised 5/17/23 identified Resident #42 needed hemodialysis (the process of running the blood through an external machine to rid the blood of toxins). The Interventions directed the following:
a. 9/13/22 - Staff obtain vital signs before and after dialysis and obtain weight per protocol.
b. 12/17/21 - Staff to monitor access to the left arm for redness, swelling, warmth or drainage and report to the health care provider as needed.
c. Do not to take blood pressure in the left arm.
d. 12/9/21 - Monitor/document for peripheral edema.
e. 12/9/21 - Monitor/document/report to health care provider as needed (PRN) for signs and symptoms (s/s) of the following: Bleeding,

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hemorrhage, bacteremia, septic shock.
f. 12/9/21 - Monitor/document/report to health care provider PRN for s/s of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.

Resident #42's May 2023 Medication Administration Record (MAR)/Treatment Administration Record (TAR) lacked direction to complete a daily assessment, a pre (before) hemodialysis assessment, or a post (after) hemodialysis assessment on Monday, Wednesday, and Friday.

Review of May 2023 calendar listed that Resident #42 had hemodialysis appointments on 5/1/23, 5/3/23, 5/5/23, 5/8/23, 5/10/23, 5/12/23, 5/15/23, 5/17/23, 5/19/23, 5/22/23, 5/24/23, 5/26/23, 5/29/23, and 5/31/23.

The clinical record lacked completed pre and post dialysis assessments for Resident #42 on 5/3/23 and 5/5/23.

The following days in May 2023 included partially completed pre and post dialysis assessments for Resident #42
a. 1 - Pre-dialysis access site - no thrills/bruits documented as assessed
    Post-dialysis access site - no thrills/bruits documented as assessed
b. 10 - Pre-dialysis access site not assessed (dressing, redness, drainage, pain/burning, thrills/bruits)
    Post-dialysis access site - no thrills/bruits documented as assessed
c. 12 - Pre-dialysis access site - no thrills/bruits documented as assessed and resident status

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blank
Post-dialysis access site - no thrills/bruits documented as assessed
d. 15 - Incomplete post-dialysis assessment only included the vital signs with the nurse signature and date blank
e. 17 - Pre-dialysis access site not assessed.
Post-dialysis assessment blank
f. 19 - Post-dialysis assessment blank
d. 22 - Pre-dialysis resident status not assessed
Post-dialysis resident status not assessed
5/24 - Pre-dialysis nurse signature and date blank
Post-dialysis access site lacked documentation of the thrills/bruits, a nurse signature, and the date.
5/26 - Post-dialysis access site not assessed
5/29 - Pre-dialysis resident status and dialysis access site not assessed
Post-dialysis access site - no thrills/bruits documented as assessed
5/31 - Pre-dialysis access site - no thrills/bruits documented as assessed
Post-dialysis access site - no thrills/bruits documented as assessed

The Clinical Record lacked an evaluation on non-dialysis days in the month of May 2023.

A facility policy titled Dialysis Services revised 9/22/22 stated the purpose of the policy is to provide dialysis services to residents when necessary.

On 6/5/23 at 10:52 a.m. the Director of Nursing (DON) reported that she expected the nurse to complete dialysis assessments before and after dialysis, including vital signs, the dialysis access site for bleeding, check for the thrills/bruits, and the resident's status to ensure no changes. The

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F 698	Continued From page 75 DON remarked that she expected the nurse to fill out the dialysis assessment form entirely. On 6/5/23 at 1:07 p.m. the DON acknowledged and verified that Resident #42 did not have completed dialysis assessments from 5/3 and 5/5.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility schedule and staff interviews, the facility failed to have a Registered Nurse (RN) on duty for 8 hours a day, 7 days per week. The facility reported a census of 49 residents. Findings included: The review of the facility's April 2023 nursing staff schedule lacked a RN on duty for 8 hours on the following days: a. 4/29/23	F 727		

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b. 4/30/23

The review of the facility's May 2023 nursing staff schedule lacked a RN on duty for 8 hours on the following days:
a. 5/6/23
b. 5/20/23
c. 5/27/23
d. 5/28/23

On 6/1/23 at 6:45 AM, Staff C, Licensed Practical Nurse (LPN), reported the facility did not have eight hours of RN coverage on the weekends.

On 6/1/23 at 12:14 PM, the Director of Nursing (DON), confirmed that the facility lacked RN coverage on the dates listed. The DON acknowledged that she expected the facility to have 8 hours of RN coverage every day.

The facility failed to provide a policy related to RN staffing requirements.

F 755 SS=E | F 755

Pharmacy Srvcs/Procedures/Pharmacist/Records
CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and

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biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observations interviews and record review the facility failed to destroy and have an accurate account for discontinued narcotic medications for 2 of 2 residents reviewed (Residents #25 and #101). Resident #25 and Resident #101 had their narcotic medications discontinued but the pills remained in the medication storage room and the medication cart.

Findings include:

1. Resident #25's Minimum Data Set (MDS) assessment dated 5/15/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #25 required total dependence for transfers with help of 2 persons. The MDS indicated that Resident #25 received no opioids in the previous seven days of the lookback period.

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The Care Plan Focus revised 6/23/22 indicated that Resident #25 had chronic pain and discomfort related to a history of a fractured ankle and arthritis as evidenced by (AEB) her experiencing pain at times. The Interventions directed a Black Box Warning related to Tramadol due to a risk of medication errors. The information continued to direct the Health care providers to counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products.

The Clinical Physician Orders reviewed on 6/5/23 at 10:28 AM included a discontinued order dated 5/9/23 for tramadol 50 milligrams (mg) one tablet every morning and at bedtime related to left knee pain.

Resident #25's Individual Narcotics Record related to tramadol 50 MG listed the last count on 5/12/23 of 30 pills.

An observation on 5/30/23 of the medication storage room revealed 30 tabs of Resident #25's discontinued tramadol 50 MG.

2. Resident #101's MDS assessment dated 5/7/23 listed an admission date of 5/1/23 from an acute hospital. The MDS identified a BIMS score of 15, indicating intact cognition. The MDS indicated that Resident #101 required limited assistance from one person for transfers and walking. The MDS described Resident #101 as in constant pain. The MDS indicated that Resident #101 did not receive an opioid in the previous seven days of the lookback period.

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F 755	Continued From page 79 Resident #101's Census listed that he admitted to hospice services on 5/27/23 and discharge from the facility on . The Care Plan Focus dated 5/1/23 indicated that Resident #101 had acute and chronic pain related to prostate cancer AEB the use of pain medications and verbal complaints of pain. The Interventions included a Black Box Warning for Oxycodone due to addiction, abuse, and misuse. The information continued to direct the Health care providers to counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products. The Clinical Physician Orders reviewed on 6/5/23 at 10:42 AM included an order discontinued on 5/27/23 for oxycodone 5 MG three times a day related to malignant neoplasm (cancer). Resident #101's Individual Narcotic Record listed a count of 56 tabs of oxycodone in the medication storage room prescribed to Resident #101. The form indicated that on 5/25/23, the facility moved 10 pills from the medication room to the medication cart. The last entry on 5/27/23, identified 8 tablets left in the medication cart drawer. On 6/1/23 at 8:39 AM observed Staff C, Licensed Practical Nurse (LPN), looked through the cassettes of narcotics. She reported that she did not see Resident #101's oxycodone. She explained that he had red cassettes due to him receiving hospice services. Upon a second inspection, Staff C found his left-over oxycodone in blue cassettes due to the discontinuation of the order before his admission to Hospice. The	F 755		

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observation confirmed that Resident #101 had 56 tablets in the medication storage room and 8 tablets in a cassette still in the medication cart.

On 6/6/23 at 8:11 AM the Director of Nursing (DON) said that the pharmacy recommended that they keep discontinued medications for 10 days before destroying them just in case the provider reordered the medications.

On 6/06/23 at 2:14 PM the Pharmacist explained that he was working on a policy regarding the storage and holding of scheduled medication. He said that the intended situation of holding onto scheduled medications for 10 days related to the following instances:
a. If the resident did not use an as-needed (PRN) medication for 10 days they could consider destroying the pills.
b. If a certain medication did not work and the resident started a new trial on a different medication, the facility could hold the initial medication for 10 days. In case the other option did not work and they could restart the initial one. The intent of storing medications for 10 days did not include discontinued scheduled medications.

The Medications: Controlled policy revised 12/5/22 direct to follow the state regulations for the disposition and destruction of medications. All discontinued schedule II-controlled medications must be in a locked box in the medication room as soon as they get discontinued. The facility should continue to count the controlled medications with two nurses until the medication is disposed.

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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F 804	Continued From page 81 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to serve hot food to residents in their rooms. The facility reported a census of 48 residents. Findings include: On 5/31/23 at 11:34 AM observed the Cook check the temperature of the food on steam table within appropriate temperatures. After serving the dining room residents, the Cook prepared the room trays. On 5/31/23 at 12:43 PM observed 10 resident room trays and an extra tray placed in an enclosed food carrier. Someone immediately paged to notify the staff that South room trays were ready. On 5/31/23 at 12:46 PM witnessed three room trays ready for the West Hall. The staff paged that the West Hall trays were ready. Staff A, Certified Nursing Assistant (CNA), retrieved the West food cart and deliver the three trays. On 5/31/23 at 1:00 PM watched Staff A take the South cart from the kitchen. Staff A served the	F 804		

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F 804	Continued From page 82 final room tray at 1:15 PM. Observed Staff A take the temperature of the extra tray. The temperature measured 111 degrees Fahrenheit. On 6/1/23 at 11:55 AM the Director of Nursing (DON) agreed that they may need to look at getting another type of carrier. The DON reported that she expected the residents to receive hot food.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		

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(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:

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Based on clinical record review and staff interviews, the facility failed to have a complete and accurate medical record for 2 of 16 residents reviewed (Residents #45 and #251). After Resident #45 fell, their clinical record lacked a progress note related to the incident. During incontinence cares, the facility staff observed open areas to Resident #251. After reporting the concerns to the nurse, the clinical record lacked documentation of his open areas.

Findings include:

Resident #45's Minimum Data Set (MDS) assessment dated 3/7/23 identified a Brief Interview for Mental Status (BIMs) score of 13, indicating intact cognition. Resident #45 required limited assistance of one person with bed mobility, transfers, and ambulation in his room. The MDS indicated that he required extensive assistance of one person with toilet use. The MDS included diagnoses of prostate cancer, coronary artery disease, hypertension (high blood pressure), and malnutrition.

The Incident Report dated 4/21/23 at 2:00 p.m. listed that Resident #45 fell due to one of his brakes not working.

Resident #45's clinical record lacked documentation related to his fall on 4/21/23, including an assessment following the fall.

On 6/5/23 at 10:52 a.m. the Director of Nursing (DON) reported that she expected the staff to document a fall in the resident's progress notes.

The Fall Prevention and Management - Rehab/Skilled, Therapy and Rehab policy revised

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3/29/23 indicated the Purpose of the policy to provide guidance for documentation. The Procedure instructed that if a fall occurred unwitnessed, the facility requires the nurse to do neurological checks and document them in the medical record.
2. Resident #251's Minimum Data Set (MDS) assessment dated 5/9/23 identified a BIMS score of 15, indicating intact cognition. The MDS indicated that Resident #251 required extensive assistance of two persons with bed mobility, dressing, and personal hygiene. Resident #251 required total dependence of two persons for transfers and toilet use. Resident #251 did not ambulate and used a wheelchair with the assistance of one person. The MDS included diagnoses of anemia, heart failure, pneumonia, arthritis, malnutrition, depression, respiratory failure, and morbid obesity.

The Care Plan Focus revised 3/21/23 identifies that Resident #251 has a potential for impaired skin integrity related to morbid obesity and incontinence AEB the moisture area to his buttocks. The Care Plan included a Goal that Resident #251 would not have complications related to his moisture area on his buttocks and it will heal by the review date. The Intervention revised 5/23/23 directed to monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, maceration, signs or symptoms of infection to his health care provider.

The Order Summary Report dated 5/31/23 included the following orders
a. 2/16/21 - Moisture banter ointment twice daily (BID) as indicated to keep irritants or moisture from skin surface

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b. 5/19/23 - Barrier cream with zinc to buttocks BID and as needed (PRN) every morning and at bedtime for prevention.
c. 5/19/23 - Calmoseptine to Resident #251's right buttock twice daily every morning and at bedtime.

On 5/31/23 at 11:15 AM observed Staff A, Certified Nurse Aide (CNA), and Staff B, CNA provide Resident #251 incontinence care. Staff A removed a urine saturated brief off Resident #251. Staff A folded the brief in on itself and tossed it in the waste can. When the wet brief hit the bottom, it made a significant thud noise and the liner came off the sides of the waste can. Observed open areas to Resident #251's left upper buttock, his left, and his right posterior perineal (peri) areas. Observed two new areas to his right inner thigh. Staff B stated she needed to notify Staff C, Licensed Practical Nurse (LPN), and paged her on the radio.

The clinical record review completed on 6/1/23 at 7:30 AM lacked documentation of new wounds to Resident #251's right inner thigh, notification to the physician, or new treatment orders.

On 6/1/23 at 11:55 AM the Director of Nursing (DON) reported she thought Resident #251's chart included documentation. She reviewed the medical record, but could not find anything. The DON went to find Staff C. On return, the DON stated that Staff C told her that she looked at the area. She noted it appeared red and excoriated but it did not have open areas. After the interview, the DON went and inspected Resident #251's inner thighs. The DON initially looked on the left inner thigh and reported that she did not see anything. After learning that Resident #251's area

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appeared on the right side, she verified the area as red and excoriated. When instructed to look further in and she agreed that Resident #251 did have an open area. She told Resident #251 that she would need to come back to measure it. The DON confirmed the nurse should have documented the area.

The Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled revised 4/26/23 listed the Purpose as to accurately document observations and assessments of residents. The Policy directed that an in-service for nursing and other disciplines would occur as necessary related to the instruction on accurate documentation. The section labeled Documentation listed the following assessments (UDA) to document a new skin concern:
a. Braden Scale for Predicting Pressure Sore Risk UDA
b. Positioning Assessment and Evaluation UDA
c. Skin Observation UDA
d. Wound Data Collection UDA
e. Wound RN Assessment UDA

F 880 SS=D — Infection Prevention & Control — F 880
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.

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F 880	Continued From page 88 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. The facility failed to follow hand hygiene and gloving practices consistent with accepted standards of practice for 1 of 2 residents reviewed (Resident #45) while providing catheter care.

Findings include:

Resident #45's Minimum Data Set (MDS) assessment dated 3/7/23 identified a Brief Interview for Mental Status (BIMs) score of 13, indicating intact cognition. Resident #45 required limited assistance of one person with bed mobility, transfers, and ambulation in his room. The MDS indicated that he required extensive assistance of one person with toilet use. The MDS listed that Resident #45 had an indwelling

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(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 880		F 880		

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catheter. The MDS included diagnoses of prostate cancer, obstructive uropathy (obstructed urinary flow), and a urinary tract infection (UTI) in the last 30 days.

The Care Plan Focus revised 3/17/23 indicated that Resident #45 had a suprapubic catheter (a tube through the stomach that drains urine into a bag outside the body) due to prostate cancer and uropathy. The Care Plan Interventions dated 4/1/22 directed the staff to:
a. Perform catheter care every shift and as needed.
b. Monitor for signs and symptoms of a UTI.

The Transfer to Hospital V5 note dated 3/25/23 at 1:15 p.m. indicated the provider returned the facility's call and directed to send Resident #45 to the emergency room (ER) for an evaluation. At 1:15 p.m. the nurse spoke with the ER nurse who reported that they admitted Resident #45 to the hospital for a UTI.

The eAdmin Record (Default Note) dated 4/4/23 at 11:15 AM recorded that Resident #45 returned to the facility from the hospital.

On 5/31/23 at 10:54 a.m. observed Staff R, Certified Nursing Assistant (CNA), complete catheter care for Resident #45. Staff R completed hand hygiene and applied a pair of gloves. Staff R assisted Resident #45 with pulling down his pants and his brief by rolling him back and forth in bed. While wearing the same gloves, Staff R removed a wipe from the container on the bedside table, then cleansed the catheter tubing and the suprapubic site with the wipe. Observed a small amount of dried brown drainage around the suprapubic catheter site. Staff R changed their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING ______ B. WING ______	C 06/06/2023

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SALEM LUTHERAN HOME	**2027 COLLEGE AVENUE ELK HORN, IA 51531**

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F 880		F 880		

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gloves in the bathroom, then removed a new wipe and cleaned the suprapubic site again to make sure to remove all the dried drainage. Staff R removed their gloves, applied a cleansing cream (non-rinse) and applied new pair of gloves. Staff R opened the bedside drawer and took out a package of four by four (4x4) gauze, opened the package, applied one 4x4 to the suprapubic site, and secured it with a piece of tape. Staff R while wearing the same pair of gloves turned Resident #45 back and forth to pull up his pants. Staff R reported the Cleansing Cream as a quick way to clean his hands.

On 5/31/23 at 11:15 a.m. the Director of Nursing (DON) stated that she expected staff to change their gloves after turning the resident and before doing catheter care. The DON reported that she expected the staff to use hand sanitizer or wash their hands when changing their gloves, not the cleansing cream. The DON added that she expected the nurses to apply the dressing to the suprapubic site.

On 5/31/23 at 6:06 p.m., the DON reported the facility did not have a gloving policy.

The Hand Hygiene policy revised 3/29/22 listed the purpose of the policy as the following:
a. To define terms related to hand hygiene
b. To guide compliance for hand hygiene with the Centers of Disease Control and Prevention (CDC) and the World Health Organization's Moment of Hand Hygiene recommendations.
c. To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in health care settings.
d. To provide guidance regarding lotion use, glove

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F 880	Continued From page 92 use, and fingernail care. The policy directed health care workers to use alcohol-based hand sanitizer or soap and water to clean their hands: a. When entering a resident's room. b. If using gloves to perform a clean/aseptic procedure, staff must complete hand hygiene before applying gloves. c. After removing their gloves regardless of the task completed. d. After contact with the patient's non-intact skin, wound dressings, secretions, excretions, and mucous membranes. e. When moving from a contaminated body site to a clean body site during resident care. f. When entering healthcare zone (supply drawers, linen drawers, or cupboards) g. When exiting a resident's room. The policy instructed to change gloves when moving from a dirty to clean or sterile activity while performing hand hygiene in between changing gloves.	F 880		

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Correction date: 6/26/23

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F578:

1. Resident #201's code status was immediately placed into her eMAR 5/30/23 by charge nurse.
2. All Residents have the potential to be affected.
3. Social Services will review all records and makes sure all residents have their code status on their eMAR this will be completed by 6/26/23.
4. All residents upon admission or with any changes in code status will be placed in their chart during that time. Director of nursing or designee will audit weekly x3 months to ensure all residents code status are complete. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F580:

1. All Licensed nurses were educated 6/13/23 on notification policy by director of nursing.
2. All Residents have the potential to be affected.
3. Licensed Nurses will notify family of residents with any new changes to skin, medication, condition, etc.
4. Will audit progress notes for family notification weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F602:

1. Resident #38's narcotics were destroyed on 5/18/23 by two licensed staff members.
2. All residents with controlled medication have a potential to be affected.
3. All licensed nurses and certified medication aides were educated 6/13/23 on our policies related to controlled medications, medication disposition, and medications: acquisition receiving dispensing and storage by director of nursing. Licensed nurses and certified medication aides will move discontinued medications to the lock box and out of the med cart, destroy discontinued narcotics in a timely manner with either 2 nurses or 1 nurse and

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a CMA, and will monitor the last time controlled medication was given and look to discontinue as appropriate.

4. Will audit for narcotic no longer in use weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F610:

1. Resident #25 has been reviewed for pain and mobility status and skilled therapy was initiated 5/10/23. Routine medication and treatment provided for pain management.
2. All residents have a potential to be affected.
3. All nursing staff were educated 6/13/23 on our policy of change in condition evaluation by the director of nursing. Nurse will evaluate the effectiveness of a pain medication and monitor for change in condition.
4. Will audit progress notes, and MAR for pain management effectiveness weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F657:

1. Resident #25's careplan was updated to her current ADL needs by MDS RN.
2. All residents have a potential to be affected.
3. All care plans have been reviewed to ensure they are up to date and accurate as of June 26, 2023. MDS Nurse and other licensed nurses educated on 6/13/23 by Director of Nursing regarding the practice of updating careplans with any change in resident status.
4. Audits will be completed on careplans weekly x2, bi-weekly x2, and monthly x2. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F658:

1. Resident #45 has been admitted to hospice care with weight loss expected. Resident #33's careplan has been updated to document noncompliance to medications and treatments. Staff will provide as resident will allow
2. All residents have a potential to be affected.
3. All staff was educated 6/13/23 on our weight monitoring policy and importance on documenting medications and treatments and resident refusals by director of nursing.
4. Will audit weights, medications and treatments weekly x2, bi-weekly x2, and monthly x2 for completion or documentation of refusal. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.

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5. Compliance Date: June 26, 2023

F684:

1. Resident #25 & #22 has been reviewed for pain and mobility status and skilled therapy was initiated 5/10/23. Routine medication and treatment provided for pain management. Resident #42 received oral antibiotics and no longer exhibits signs of infection.
2. All residents have the potential to be affected
3. All nursing staff were educated 6/13/23 on our policy of change in condition evaluation by the director of nursing. Nurse will evaluate the effectiveness of a pain medication and monitor for change in condition and signs of infection.
4. Will audit pain management effectiveness and signs of infection weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F686:

1. Resident #24 wound healed as of 6/20/23. Resident #251 is having skin treatment provided, repositioning help, has therapeutic mattress, cushion in wheelchair, recliner placed in room to allow for more frequent repositioning, and careplan updated to show noncompliance with repositioning.
2. All residents and residents who are at risk for break down have the potential to be affected.
3. All nursing staff was educated 6/13/23 on our policies of Skin Tear Treatment and Prevention and Repositioning. Nurses were also educated on our policies of Skin Assessment Pressure Ulcer Prevention and Documentation and Pressure Ulcers. Telligen contacted for information and training opportunities on pressure ulcer care and prevention.
4. Will audit repositioning and skin documentation weekly x12. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F689

1. Resident's #22, #25, and #33 are currently still in the building and are stable. All careplans have been updated appropriately.
2. All residents have a potential to be affected.
3. All nursing staff was educated on 6/13/23 on our policies of Fall Prevention and Management, Incident Report, and Neurological Evaluation and importance of follow up of fall interventions by director of nursing
4. Will audit fall documentation, and interventions put into place for effectiveness with each fall x3 months. Audits will be completed by the Director of Nursing or Designee. All

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results will be brought to monthly quality meeting for review and further recommendations.

5. Compliance Date: June 26, 2023

F698

1. Resident #42 three times a week, pre- and post-dialysis assessment will be completed.
2. Residents who are currently on dialysis have a potential to be affected.
3. All licensed nurses were educated on 6/13/23 on our dialysis policy and the importance of documentation. Switched to Clinical Monitoring – Dialysis UDA pre- and post-dialysis rather than previous dialysis sheets on 6/26/23.
4. Will audit dialysis documentation for completion on Dialysis days x2 months. Audits will be completed by Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F727

1. Facility has had a RN for 8 consecutive hours within 24 hours 7 days a week since 6/9/23
2. All residents have a potential to be affected.
3. Will monitor daily staffing schedule to have a RN scheduled weekly x2 months. All results will be brought to monthly quality meeting for review and further recommendations.
4. Compliance Date: June 26, 2023

F755:

1. Resident #25 and #101 medications were destroyed.
2. All residents with controlled medication have a potential to be affected.
3. All licensed nurses and certified medication aides were educated 6/13/23 on our policies related to controlled medications, medication disposition, and medications: acquisition receiving dispensing and storage by director of nursing. Licensed nurses and certified medication aides will move discontinued medications to the lock box and out of the med cart, destroy discontinued narcotics in a timely manner with either 2 nurses or 1 nurse and a CMA, and will monitor the last time controlled medication was given and look to discontinue as appropriate.
4. Will audit for narcotic no longer in use weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F804

1. All staff was educated 6/13/23 of room tray process. Kitchen staff did competencies 6/26/23.
2. All residents who receive room trays have potential to be affected.

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3. Bath aides will get and deliver room trays in a timely manner and communicate with other staff if unable to grab when they are ready.
4. Room tray temps will be monitored 2 days a week for x1 month, weekly x 1 month, monthly x2. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F842

1. Resident #45 and #251 had careplans updated and are updated as needed by 6/26/23.
2. All residents have potential to be affected.
3. Licensed nurses were educated on 6/13/23 of the importance of documentation.
4. Will audit nursing documentation related to placing progress note for falls and documenting any changes in residents skin weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by the Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
5. Compliance Date: June 26, 2023

F880

1. All nursing staff were educated 6/13/23 on hand hygiene and catheter cares
2. All residents have potential to be affected.
3. Will audit hand hygiene and gloving with catheter cares weekly x2, bi-weekly x2, and monthly x2. Audits will be completed by Director of Nursing or Designee. All results will be brought to monthly quality meeting for review and further recommendations.
4. Compliance Date: June 26, 2023