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	165161	A. BUILDING _____ B. WING _____	07/22/2021

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS Correction Date_____ A re-certification survey and investigation of Complaints #95868-C, #96003-C, #98167-C and #98258-C and Facility Reported Incidents #97250-I, #97666-I, #98258-I, and #98448-I was completed 7/6/21 - 7/22/21 and resulted in the following deficiencies. Complaint #95868-C was substantiated. Complaint #96003-C was substantiated. Complaint #98167-C was substantiated. Complaint #98258-C was substantiated. Facility Reported Incident #97250-I was not substantiated. Facility Reported Incident #97666-I was substantiated. Facility Reported Incident #98448-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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

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receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff and resident interviews, and record review, the facility failed to ensure a clean, homelike environment for three of twenty-five residents reviewed (Resident #106, #25, and #24). The facility reported a census of 56 residents.

Findings include:

1. Resident #106's Minimum Data Set (MDS)

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assessment dated 11/30/20 showed a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive impairment). The resident's Patient Health Questionnaire (PHQ-9) score was 8, indicating mild depression. The resident had diagnoses that included: diabetes mellitus due to underlying condition with foot ulcer, major depressive disorder, recurrent, mild, and chronic obstructive pulmonary disease with (acute) exacerbation.

Resident interview

On 7/12/21 at 3:30 PM the resident described the days she lived at the facility as "the worst days of her life". She revealed her diagnoses included end stage pulmonary hypertension and end stage renal disease (ESRD). The resident said she lived on the Daisy Lane hall. She stated said the wall was peeling, her floor never got cleaned, and "it took everything to get it cleaned".

Record review

The review of the Census confirmed the resident resided on the Daisy Lane hallway.

Observation

On 7/13/21 at 8:56 AM, observation showed a golf ball sized dried brown substance stuck to the popcorn textured ceiling with a similar substance approximately the size of a half dollar noted near the first substance in the resident's room. Observation showed directly above the bed an area of yellow tinged nontextured ceiling measuring around two foot in diameter surrounded by popcorn textured ceiling. The wall paper border near the ceiling peeled in one area

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and the remaining wallpaper had separating seams.

2. The MDS assessment completed 5/10/21 for Resident #25 showed a BIMS score of 13, indicating intact cognition. The resident required extensive assistance of two staff with transfers and personal hygiene. The resident had diagnoses of major depressive disorder, single episode, unspecified, generalized anxiety disorder, hemiplegia, and hemiparesis following unspecified cerebrovascular disease affecting unspecified side.

Observation

On 7/7/21 at 12:34 PM noted food all over the floor of the resident's room.

3. The MDS assessment dated completed 5/10/21 for Resident #24 showed a BIMS score of 10, indicating moderate cognitive impairment. The resident required extensive assistance of one staff with transfers, ambulation, and personal hygiene. The resident had diagnoses of chronic obstructive pulmonary disease with (acute) exacerbation, schizophrenia, unspecified , and major depressive disorder, recurrent, unspecified.

Observations

On 7/7/21 at 9:18 AM observed the resident's floor covered in crumbs.

On 7/12/21 at 10:31 AM noted the resident's floor continued to be covered in crumbs.

On 7/15/21 at 11:32 AM observed the floor noted to be more clean with a few crumbs but not as

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many as previously observed.

Administration interview

On 7/8/21 at 4:45 PM the Administrator stated the facility had contract housekeeping staff. He identified the previous housekeeping supervisor as recently replaced in the last month after asking the contract company for a while to let the previous supervisor go. The Administrator said he would find the previous housekeeper gossiping with other employees and didn't always do the work. Since having the new housekeeper he noted an improvement with the facility and things getting cleaned more often.

Staff interviews

On 7/22/21 at 10:53 AM Staff A, Licensed Practical Nurse (LPN), said she had a concern with a resident keeping cans in their room down bayberry hall which resulted in ants. Staff A stated housekeeping had problems getting the rooms cleaned. Staff A said she felt it is getting better due to new housekeeping. The new housekeeping have new policies and they are only there to sanitize and not allowed to clean up urine on the floor or if there is bowel movement on the toilet seat.

On 7/22/21 at 11:05 AM Staff B, LPN, identified his last day as two weeks ago. Staff B said for the longest time he didn't know there was housekeeping staff. Staff B said he swept and mopped the resident's rooms more times then he saw a housekeeper doing it. Staff B stated he purposely moved hotels to have a bathroom close to the facility so he could go home to the bathroom. Staff B revealed Daisy Lane hallway as

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F 584	Continued From page 5 the dirtiest hallway. He stated this upset him because all the new admissions went to Daisy Lane. He identified ants in some of the resident rooms because of the lack of housekeeping. On 7/22/21 at 11:32 AM Staff G, Certified Nurses' Assistant (CNA), housekeepers could use a more steady amount of staff. With the minimal amount of training they receive they do alright. Staff G said that sometimes the facility had housekeeping staff and sometimes they didn't. Staff G did not have concerns with ants and said ants were a seasonal systemic concern. With some of the residents it is hard to keep their room clean so it is difficult to keep the ants out of their room. Policy review The Environment - Quality of Life (General) policy dated 4/1/08 said that the facility would provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his/her belongs to the extent possible.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		

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the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§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 resident and staff interviews and record reviews, the facility failed to provide immediate notification to the Department of Inspections and Appeals regarding the resident's loss of property with allegations of theft for one of three resident's reviewed (Resident #22). The facility reported a census of 56 residents.

Findings include:

Resident #22's Minimum Data Set (MDS) assessment dated 5/3/21 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had diagnosis of type 2 diabetes mellitus, bipolar disorder, unspecified, and personality disorder, unspecified.

Resident interview

On 7/7/21 at 9:23 AM the resident stated he

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thought some money went missing (under $10) a couple months ago. The resident said he told some nurses who gave him a lockbox and told him to keep it locked up. Since then, he wears the key and denied any issues since.

Record review

First Incident:
The Grievance Form dated 3/3/21 showed the resident missed $37 from his wallet. The resident claimed he had all the money on that Monday and noticed it missing on Wednesday afternoon on 3/3/21. The resident kept his money in a wallet in his coat pocket and only took off his coat at night. The resident did not know when and where the money might have gone- misplaced, dropped, or stolen. The Grievance Resolution identified as: find the money or reimburse the resident. The Summary of the grievance investigation showed staff checked the resident's room for the missing money. Staff announced the resident's missing money to the nursing staff at all three huddle times but no one came forward with any information. Staff called PACE and asked if they found $37, (the resident went to PACE on Monday), but no one knew anything about it. The Summary of Conclusion revealed the grievance as unsubstantiated due to lack of evidence. The facility reimbursed the $37. The corrective action identified as a new system implemented requiring staff to document when they handle the resident's money. The goal is to keep better accountability and avoid these situations in the future. The resident educated to use his lockbox. The form was signed by the Social Worker and the Administrator.

The Resident Trust Account Withdrawal form

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dated 3/3/21 showed the amount of $20 withdrawn for the resident.

Second Incident
The Grievance Form dated 3/20/21 identified the resident reported missing money but unclear how much he in his wallet to know for sure how much gone. The resident acknowledged two staff reimbursed him $37 on 3/16/21. The resident claimed he spent $20 of that money on food and no receipt. Only $1 remained in his wallet which meant he missed $16. The grievance resolution said the resident wanted the "crooked staff" found and fired. The resident would like to have the $16 reimbursed if possible. The summary of the grievance investigation revealed staff checked to see if the resident had ongoing money sheet on the cart, but the resident did not. The resident said he never bought anything from the vending machine. The resident showed the staff that he had $1 left in his wallet. The resident claimed he was missing $16. The summary of conclusion said the Director of Nursing (DON) interviewed the staff, Certified Nurses' Assistants (CNAs) in an attempt to track down the missing money. The DON could not prove where the money went. The facility reimbursed $16 on 3/29/21. Staff informed the resident they were not responsible for money that the resident did not store in the lockbox. The corrective action was that the resident educated to use his lock box so this didn't happen again. The resident agreed to use the lockbox and said he wouldn't keep his wallet in his blue coat pocket. The form was signed by the Social Worker and the Administrator.

Third Incident:
The Grievance Form dated 6/7/21 showed the resident reported someone broke into his lockbox

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and took $18 from him. The resident stated he got $20 on Friday and noticed $18 missing on Sunday. Another resident in the room when the money discovered missing. The resident identified the money locked in the lockbox with the key underneath the lockbox. The grievance resolution said the facility looked at the camera footage and attempted to find the money but could not see the resident's room from the camera. Staff informed the resident they could report the theft to the state and call the police. The summary conclusion revealed the resident didn't want to report it. Staff educated the resident to keep the key on his person moving forward and the resident placed the key on his wrist. Staff counted the money in the lockbox found $4 in the lockbox. Corrective action identified as: no report made per the resident's request. The form was signed by the Social Worker and the Administrator.

The Facility provided reports which showed they reported a Facility Reported Incident (FRI) related to the missing money on 3/3/21. The facility did not report the 3/20/21 or 6/7/21 missing money incidents.

Social Worker (Grievance Officer) interview

On 7/15/21 at 12:41 PM the social worker stated she did not report the 3/20/21 or 6/7/21 incidents to the police or State Agency as the resident did not want to report. She stated the Administrator should have signed off on the reports and identified the Administrator as the one that would report to the State Agency.

The Freedom from Abuse, Neglect, and Exploitation - HDGR policy with a revision date of

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F 609	Continued From page 10 5/20 identified the policy of the community was to take appropriate steps to prevent the occurrence of abuse, neglect, and misappropriation of resident's property. The policy defined misappropriation of resident's property as the deliberate misplacement, exploitation, wrongful, temporary, or permanent use of the resident's belongings or money without the resident's consent. The Administrator, DON, or designee will notify the appropriate regulatory, investigative, or law enforcement agencies immediately, in accordance with the state regulations. The section labeled reporting identified the following: A. Any employee who suspects an alleged violation immediately notifies the Administrator. The Administrator notifies the appropriate state agency in accordance with state law. B. The results of all investigations are reported to the administrator and to the appropriate state agency, as required by state law and / or within five working days of the alleged violation. Administration interview On 7/22/21 at 3:06 PM the Director of Nursing (DON) revealed if a resident missed something and staff could not locate the missing item then the facility needed to report it to the State Agency within twenty-four hours.	F 609		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		

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nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to provide the resident and/or the resident's representative a copy of the facility policy for a bed hold regarding a hospitalization for one of four residents reviewed (Resident #38). The facility reported a census of 56 residents.

Findings include:

Resident #38's Minimum Data Set (MDS) assessment dated 6/7/21 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had

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F 625	Continued From page 12 diagnoses of urinary tract infection (UTI), quadriplegia, and bipolar disorder. Resident interview On 7/7/21 at 1:01 PM the resident reported that she just got out of the hospital for a UTI. Record review The census report reviewed on 7/8/21 at 9:45 AM showed on 5/24/21 the resident was on un-paid hospital leave with Medicaid. The resident returned to the facility on 5/27/2021. The resident's record lacked documentation related to the resident or her representative notified of the bed hold policy. Administration interview On 7/15/21 at 11:05 AM the Director of Nursing (DON) said they didn't do a bed hold for the resident as they missed doing it. Policy review The Bed Hold and Re-Admission policy dated 11/16 said before a resident transfers to a hospital or placed on therapeutic leave, the facility provides written notification to the resident and/or the resident's representative that specifies the bed hold: the duration of the bed hold period. The policy directed bed hold periods to be consistent with the law permitting a resident to return and, in the case of Medicaid, the State plan.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		

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F 644	Continued From page 13 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to resubmit a level 1 PASRR (Preadmission Screening and Resident Review) when the resident received additional mental health diagnoses for 1 of 2 residents reviewed for PASRR (Resident # 48). The facility reported a census of 56 residents. Findings include: A PASRR dated 05/25/21 documented Resident #48 with anxiety disorder. The PASARR documented no known recent or current mental health symptoms and directed if changes occur or new information refutes these findings, the facility must complete a new screen.	F 644		

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F 644	Continued From page 14 On 06/25/21, the admission listed diagnoses that included: anxiety disorder, unspecified, delusional disorders and an unspecified mood (affective) disorder (an illness that affects the way you think or feel). The Minimum Data Set (MDS) dated 06/16/21, identified Resident #48 with a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognitive abilities. The residents self assessment during her mood screening included feeling down, depressed, hopeless for 2-6 days of the prior 14 days and feeling tired or having little energy 12-14 days of the prior 2 weeks. The resident required extensive assistance of 1 to 2 staff with bathing, transfers, toileting and dressing. The care plan, dated 06/24/21 identified a goal of adjusting to the new environment. Interventions included taking psychotropic medications for anxiety, mood disorder and delusional disorder. The care plan directed staff to observe for changes in cognition or condition. On 07/08/21 at 09:25 AM, the Social Worker stated a new diagnoses would trigger a PASRR and this did not yet occur. She stated she did not know of the mental health diagnoses for Resident #48. A review of clinical records on 07/14/21, reflected a PASRR level 1, submitted on 07/09/21, by the Social Worker and revealed a Level 1 negative screen.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review and staff interview, the facility failed to implement the care plan to prevent falls for 1 of 6 residents reviewed (Resident # 44). The facility reported a census of 56 residents.

Findings include:

Resident #44's Minimum Data Set (MDS) dated 06/15/21, revealed a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The MDS revealed the resident required extensive assistance with transfers, repositioning, dressing. The resident did not ambulate. Diagnoses included: diabetes mellitus, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), cerebral vascular accident (damage to the brain from an interruption of it's blood supply), non-pressure ulcer with skin grafting to his right foot and metabolic encephalopathy (brain damage occurs due to toxins or disease) and abnormalities of his mobility and gait.

A Fall-Witnessed Incident Report dated 08/29/20, documents the resident slid out of his wheelchair, "I just kept sliding".

An Unwitnessed- Fall Incident report dated 06/23/21 at 01:49 AM, revealed the resident attempted to stand unassisted while wearing his protective boots which caused him to slide and fall to the floor.

The care plan dated 06/24/21 identified the

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F 656	Continued From page 17 resident as a fall risk with a goal to not suffer serious injury should he fall. Interventions included having non-skid strips on the floor by his bed implemented on 09/02/20. An intervention was added on 06/23/21 instructing staff that the resident's pressure reduction boots worn at night only. On 07/07/21 at 11:25 AM, observation of the resident in his room revealed the absence of non-skid strips on the floor. Resident #44 was observed sitting in his wheelchair dressed, with pressure reduction boots on to his bilateral (left and right) lower extremities. On 07/13/21 at 12:12 PM in an interview and joint observation of resident's room with the DON , she confirmed Resident #44 did not have non-skid strips on the floor as care planned for fall preventions. The DON confirmed the resident wore pressure reduction boots bilaterally while seated in his wheelchair. The DON stated she expected staff to follow and implement care plan interventions. She stated the care plan is available to all staff for review, and she expected the review to occur daily. The DON stated it was likely the strips did not follow the resident to his current room when he changed rooms on 09/30/20.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

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by:
Based on policy and clinical record review, observation, staff and pharmacist interview, the facility failed to provide services that met professional standards by administering medications outside of the time parameters for scheduled medications and as prescribed by the physician, for 8 of 10 residents reviewed (Residents #48, #10, #50, #11, #45, #28, #156, and #106) The facility reported a census of 56 residents.

Findings include:

1. Resident #48's Minimum Data Set (MDS), dated 06/16/21, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognitive abilities. Diagnoses included numerous malignant neoplasms of the brain, lung, bone , liver and breast, and diabetes mellitus, insulin dependent. The resident required extensive assistance of 2 staff with transfers, bathing, toileting and dressing.

The care plan dated 06/24/21 identifies the resident as an insulin dependent diabetic with a goal to keep her blood sugars between 100-250 daily and to receive her insulin daily.

Physician's orders, dated 06/15/21 directed staff to administer Insulin Glargine 50 units (a long acting insulin) one time daily. Physician's orders dated 06/15/21 directed staff to check blood sugars before meals, at bedtime and PRN (as needed). The electronic Medication Administration Record (MAR) for 07/01/21 - 07/13/21 identified the resident's insulin as scheduled for 07:00 AM.

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On 07/14/21 at 09:30, an interview with the Director of Nursing (DON) and MDS coordinator, and a joint review of the insulin administration records, confirmed the resident's insulin given in excess of 1 hour past the scheduled time for 11 of the past 14 doses. The DON stated the expectation for a late administration of insulin is to document in the progress notes reasons and assessments and to notify the physician.

On 07/14/21 at 02:45 PM, the DON could not provide a facility policy on scheduled medication administrations and procedures for a late administration. The DON stated she consulted with the corporate HDG Nurse Consultant and was instructed that 1 hour before or 1 hour after the scheduled administration times, is the standard for nursing practice and the expectation of the facility.

2. A MDS for Resident #10 had an assessment reference date of 4/19/21, documented Resident #10's diagnoses included non-Alzheimer's dementia, acute and chronic respiratory failure and pulmonary embolism. A BIMS score of 9 out of 15 indicated moderate cognitive impairment. The resident required extensive assist of 1 for bed mobility, toilet use and personal hygiene.

On 7/08/21 at 8:16 AM, Staff B Licensed Practical Nurse (LPN), administered Advair 500/50 inhaler to Resident #10. He then gave the resident a drink of Ensure Clear. When asked, Staff B stated he did rinse Resident #10's mouth as he gave her a drink. Staff B then looked at the doctor's order and stated the order directed to rinse the mouth after the inhaler is administered.

A Medication Administration Record dated 7/1/21 to 7/31/21, directed staff to give 1 puff of Advair

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Diskus Aerosol Powder 500-50 mcg(microgram). The direction said to rinse mouth with water after use.

Information from the Advair website www.advair.com/how-to-use-advair html printed on 7/15/21 documented to rinse mouth with water without swallowing after using Advair to help reduce your chance of getting thrush.

The facility was unable to provide the package insert for the Advair inhaler.

3. A MDS with an assessment reference date of 6/28/21 documented Resident #50's diagnoses included myopia and diabetes. A BIMS score of 10 out of 15 indicated moderate cognitive impairment. The resident required extensive assist of 2 for bed mobility, toilet use and personal hygiene.

On 07/08/21 at 7:19 AM, Staff A LPN administered 1 drop (gtt) of Polymixin eye drops (gtts) to Resident #50's right eye. Staff A did not apply pressure after administration of the gtt.

On 7/08/21 at 11:05 AM, Staff A stated there were no instructions in the eye drop box. Staff A stated the doctor did not specify to hold pressure and she had no idea she should hold pressure on to the eye.

A Mayo Clinic Drugs and Supplements Order Polymyxin B and Trimethoprim from the website www.mayoclinic.org printed on 7/15/21 with a copyright date of 1998-2021, documented that proper use included to keep the eye closed and apply pressure to the inner corner of the eye with your finger for 1 or 2 minutes to allow the eye to

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absorb the medicine.

A Medication Administration Record dated 7/1/21 to 7/31/21, directed staff to give 1 drop of polymyxin b-trimethoprim in the right eye for drainage for 7 days.

On 7/14/21 at 8:18 AM, the Director of Nursing (DON) stated she expected staff/nurses to follow manufacturers' recommendation for the advair inhaler and polymyxin eye gtts. She agreed that the Advair inhaler should have been rinsed and spit out. She stated the polymix eye gtts should have had pressure applied to the inner eye.

07/14/21 at 1:22 PM, the Pharmacist for Omnicare stated it was medication manufacturer recommendation that the facility should go by when administrating medications. She stated that her recommendation for the Advair inhaler would be to rinse the mouth out and spit after inhalation.

The facility was unable to provide the package insert for polymyxin B-trimethoprim.

4. A Minimum Data Set (MDS) assessment dated 4/26/21, documented Resident #11's diagnoses included renal insufficiency, cerebrovascular accident and depression. Resident #11 Brief Interview for Mental Status (BIMS) score was 12 out of 15 indicating moderate cognitive impairment. This resident required assist of 1 for transfers, personal hygiene and toileting.

A Medication Audit Report dated 7/8/21 -7/10/21, revealed staff administered medications outside of the required timeframe. On the following dates and times staff administered medications greater

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than 1 hour after they were due:
7/9/21 a scheduled medication for 8:00 PM was given at 10:23 PM.
7/10/21 8 scheduled medications for 4:00 AM were given between 5:33 AM and 5:41 AM.
7/10/21 a scheduled medication for 7:00 AM was given at 8:26 AM.

Review of progress notes from 7/8/21 to 7/10/21, revealed no documentation regarding the above medications administered outside of the parameters nor was there documentation of physician notification.

5. The MDS assessment dated 6/21/21, documented Resident #45's diagnoses included cerebrovascular accident, diabetes and asthma. Resident #45 BIMS score was 12 out of 15 indicating moderate cognitive impairment. Resident #45 required assist of 2 for transfer and assist of 1 for toilet use and personal hygiene.

A Medication Audit Report dated 6/30/21 -7/13/21, revealed Resident #45 received her evening scheduled insulin as well as another medications more than 1 hour after the scheduled time. Staff administered the medications outside of the required time frame on the following dates and times:

7/1/21 scheduled medication for 8:00 PM administered between 10:21 PM and 10:33 PM.
7/2/21 scheduled medication for 8:00 PM administered between 9:57 PM and 10:01 PM.
7/3/21 scheduled medication for 8:00 PM administered between 9:31 PM and 9:37 PM.
7/4/21 scheduled medication for 8:00 PM administered at 10:09 PM.
7/6/21 scheduled medication for 8:00 PM

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administered at 9:31 PM.
7/8/21 scheduled medication for 8:00 PM administered between 10:58 PM and 11:50 PM.
7/9/21 scheduled medication for 8:00 PM administered 12:08 AM scheduled medication for 8:00 PM administered at 12:14 AM.
7/11/21 scheduled medication for 8:00 PM administered at 9:55 PM.
7/13/21 scheduled medication for 8:00 PM administered at 11:57 PM

Review of progress notes from 6/30/21 to 7/13/21, revealed no documentation regarding the above medications administered outside of the parameters nor was there documentation that the physician was notified

6. The MDS assessment dated 5/17/21 , documented Resident #28's diagnoses included heart failure, renal insufficiency, and chronic obstructive pulmonary disease. Resident #28's BIMS score was 12 out of 15 indicating moderate cognitive impairment. Resident #82 was independent required assist of 28 for bed mobility and required supervision for dressing and toilet use.

A Medication Audit Report dated 7/1/21 -7/12/21, recorded that Resident #28 received her evening scheduled inhaler as well as another medication more than 1 hour after the scheduled time. The medications were administered outside of the required timeframe on the following dates and times:

7/1/21 scheduled medication for 8:00 PM administered at 10:04 PM.
7/2/21 scheduled medication for 8:00 PM administered at 10:15 PM.

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7/3/21 scheduled medication for 8:00 PM administered at 9:48 PM.
7/4/21 scheduled medication for 8:00 PM administered 9:57 PM.
7/6/21 scheduled medication for 8:00 PM administered at 9:44 PM.
7/8/21 scheduled medication for 8:00 PM and 9:00 PM administered at 11:35 PM.
7/9/21 scheduled medication for 8:00 PM and 9:00 PM administered at 12:20 AM.
7/12/21 scheduled mediation for 4:00 PM administered at 5:12 PM.

Review of progress notes from 7/1/21 to 7/12/21, revealed no documentation regarding the above medications administered outside of the parameters nor was there documentation of physician notification.

7. The MDS assessment dated 7/2/21, documented Resident #156's diagnoses included anemia, diabetes, and depression. Resident #156 BIMS score was 10 out of 15 indicating moderate cognitive impairment. Resident #156 required assist of 1 for transfer, toilet use and personal hygiene.

A Medication Audit Report dated 7/1/21 -7/12/21, recorded that Resident #156 received her evening scheduled insulin as well as other medications more than 1 hour after the scheduled time. The medications were administered outside of the required timeframe on the following dates and times:

7/1/21 scheduled medication for 8:00 PM and 9:00 PM administered between 10:42 PM and 10:55 PM.
7/4/21 scheduled medication for 8:00 PM and

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9:00 PM administered between 9:24 PM and 9:34 PM.
7/6/21 scheduled medication for 8:00 PM administered at 9:31 PM.
7/8/21 scheduled medication for 8:00 PM administered between 9:51 PM and 10:08 PM.
7/9/21 scheduled medication for 8:00 PM administered at 11:34 PM.
7/12/21 scheduled medication for 8:00PM administered at 10:00 PM.

Review of progress notes from 7/1/21 to 7/12/21, revealed no documentation regarding the above medications administered given outside of the parameters nor was there documentation of physician notification

On 7/06/21 at 4:25 PM, Resident #156 stated there are nights when the residents don't get their night meds until 11:30 PM to 12:00 AM when they should receive them around 9 or 9:30 PM.

On 7/14/21 at 8:18 AM, the DON stated knew staff administered medications late. She expected physician notification when a medication isn't administered within the parameters of 1 hour before and 1 hour after the routine set up time. She also expected staff to document the reason why they did not administer the medications timely within the parameters. She expected staff to ask for help by either calling administration or asking another nurse in house if not able to administer medications timely.

On 7/14/21 at 1:22 PM, the Omnicare Pharmacist identified the time frame to administer routine medications as within 2 hours of the scheduled time. The pharmacist said for example if a medication is scheduled at 9 pm, staff should

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administer between 8pm and 10 pm. She stated if a medication is not administered between the 1 hour before and the 1 hour after the medication's scheduled time, then it was not given within the professional standards of practice.
8. The MDS assessment dated 11/30/20 for Resident #106 showed a BIMS score of 11, indicating moderate cognitive impairment. The resident's Patient Health Questionnaire (PHQ-9) score was 8, indicating mild depression. The resident had diagnoses of diabetes mellitus due to underlying condition with foot ulcer, major depressive disorder, recurrent, mild, and chronic obstructive pulmonary disease with (acute) exacerbation.

On 7/12/21 at 3:30 PM the resident described the days she lived at the facility as the worst days of her life. The resident reported the nurses don't give medications timely when due but administer by halls. The resident said she had medication that she should receive with meals or before and they weren't administered correctly. The resident did not receive wound care per orders. The wound care treatments were done differently every time and she was a nurse so she knew how it should be done. She stated she ended up having her leg amputated in February.

The 11/20 Medication Administration Record (MAR) showed an order with a start date of 11/25/20 for Meropenem-Sodium Chloride Solution Reconstituted 500 milligrams (MG) by (/) 50 milliliters, to give 500 MG intravenously (IV) once a day related to cellulitis of left lower limb until 12/15/20. The medication was scheduled to be given at 1:00 PM daily. The medication was documented as given on 11/28/20 at 3:38 PM (late) by Staff B, LPN .

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide baths for one of twenty-five residents reviewed (Resident #106). The facility reported a census of 56 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/30/20 for Resident #106 showed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident's Patient Health Questionnaire (PHQ-9) score was 8, indicating mild depression. The resident had diagnoses of diabetes mellitus due to underlying condition with foot ulcer, major depressive disorder, recurrent, mild, and chronic obstructive pulmonary disease with (acute) exacerbation. On 7/12/21 at 3:30 PM the resident described the days she lived at Touchstone as the worst days of her life. The resident stated it was virtually impossible to get a bath. As she was no weight bearing, it took over an hour to get to the bathroom. When she tried to have staff get a bed pan, commode, or something to go to the bathroom, the staff said that they didn't have anything. The staff told her that she should just go in her bed and they'd clean her up.	F 677		

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F 677	Continued From page 28 Staff interviews On 7/22/21 at 11:05 AM Staff B, Licensed Practical Nurse (LPN), his last day was two weeks ago. Staff B identified concerns with residents not getting changed. On 7/15/21 at 1:00 PM the Director of Nursing (DON) reported that she could not find any paper documentation related to baths for the resident. On 7/15/21 at 1:00 PM during the Quality Assessment and Performance Improvement (QAPI) meeting the interim Administrator and DON said they identified issues regarding bathing and incontinency checks. Policy review The Bath in Shower policy dated 4/1/08 showed that the facility is to provide the resident the opportunity to bathe at least weekly and/or per resident's request or as needed.	F 677		
F 684 SS=D	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 staff and resident interviews, and	F 684		

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record review, the facility failed to ensure a resident with a catheter remained free of infection without the need for hospitalization for one of four residents reviewed (Resident #38). The facility reported a census of 56 residents.

Findings include:

Resident #38's Minimum Data Set (MDS) dated 6/7/21 showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident utilized an indwelling catheter. The resident required total dependence of two staff with toileting. The resident had diagnoses of urinary tract infection (UTI), quadriplegia, and bipolar disorder.

Resident interview

On 7/7/21 at 1:01 PM the resident reported that she just got out the hospital for a UTI.

On 7/12/21 at 1:57 PM the resident stated she refused to allow surveyor to watch any cares.

Census review

The census reviewed on 7/8/21 at 9:45 AM showed on 1/10/21 the resident was on un-paid hospital leave with Medicaid. The resident returned to the facility on 1/26/21.

The census reviewed on 7/8/21 at 9:45 AM showed on 2/6/21 the resident was on un-paid hospital leave with Medicaid. The resident returned to the facility on 2/9/21.

The census reviewed on 7/8/21 at 9:45 AM showed on 5/24/21 the resident was on un-paid

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hospital leave with Medicaid. The resident returned to the facility on 5/27/2021.

Nurse Progress Notes:

On 12/21/20 at 10:36 PM the resident expressed concern over her last urinalysis (UA) collection and wanted to know the results. Upon investigating, the nurse found documentation on 11/27/20 revealing a UA was to be collected but could not find lab results for it. The nurse sent a facsimile (fax) to the physician to request a new UA. Will continue to monitor.

On 12/22/20 at 7:07 AM staff collected a UA and the physician returned the fax with no treatment unless having fever or chills.

On 12/22/20 at 9:31 PM the facility received a fax from the Urologist's office to re-collect a urine specimen for UA and culture and sensitivity (C&S) report for the purpose to rule out infection.

On 12/23/20 at 10:17 PM a urine specimen collected for UA and C&S per the Urologists' order. Staff placed the urine in an ice cooler for morning pick up.

On 12/25/20 at 3:43 AM UA results received and faxed to physician, awaiting orders.

On 12/28/20 at 10:33 AM the facility received a phone call from the Urologist's office with a new order for Omnicef (antibiotic) 100 milligrams (MG) by mouth twice daily for ten days.

On 12/28/20 at 10:58 PM showed the resident started an oral antibiotic (ABT) for a UTI. The resident's temperature was 97.1 degrees

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Fahrenheit (F). Staff encouraged the resident to drink fluids. The resident had no complaints of pain and no adverse reaction noted.

On 1/7/21 at 10:07 PM the resident completed her ABT related to her UTI. The resident's temperature was 97.0 F. The resident had no adverse reactions noted at the time and could make her needs known.

On 1/9/21 at 2:11 PM the resident slept in until 12:00 PM. The resident was alert and spoke with staff appropriately. The resident was heavily blanketed with heat on high and door shut. The resident's body felt warm at 12:20 PM. Once up in the wheelchair, the resident shook from being uncovered. The resident's vital signs were temperature of 104.2 F (greater than 100.4 is usually a fever), pulse of 114 (greater than 100 is considered abnormal), respiration rate of 20, and a blood pressure of 140/88. The resident denied pain or any other symptoms. The resident refused to go to the hospital, as she said she gets like this. Rechecked temperature at 12:22 PM of 100.4 F. By 12:30 PM, the resident's temperature was 99.8 F. The resident refused to eat lunch, but drank 120 milliliters (ML) of water for the nurse. The resident noted as very sleepy. The resident requested Tylenol at 1:40 PM for pain and stiff muscles from laying in bed all day. The resident's temperature at the time was 99.2 F. The information was passed on to the next nurse to monitor.

On 1/9/21 at 4:00 PM per the day shift nurse report, the nurse assessed the resident at 3:00 PM. The resident sat in her wheelchair and appeared lethargic (extremely sleepy). The resident's vital signs were a blood pressure of

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130/72, temperature of 102.1 F, pulse of 103, respirations of 20, and oxygen saturation of 92 percent (%) on room air (RA). The nurse called and spoke with the on-call provider for the Primary Care Physician (PCP). The nurse received a new order to send the resident to the emergency room (ER) for further evaluation, if the family agrees. The nurse called and spoke with the resident's daughter. The resident's daughter agreed to send the resident to the ER. The daughter requested that the resident's phone and purse to be sent with the resident. The resident left to go to the ER at 3:30 PM by an ambulance. The Medication Administration Record (MAR), Treatment Administration Record (TAR), face sheet, and bed hold policy sent with resident.

On 1/9/21 at 6:18 PM the nurse called and spoke with the ER nurse to get an update on the resident's status. The ER nurse stated that resident was diagnosed for UTI and admitted for possible sepsis.

On 1/26/21 at 2:42 PM the nurse called the hospital at 2:12 PM. The report was for the resident to be on skilled nursing related to urosepsis. The suprapubic (in abdominal area below belly button) catheter changed on 1/5/21.

The Admission Summary / Move In Note dated 1/26/21 at 3:47 PM said the resident arrived by facility van at 11:58 AM with the admitting diagnosis of urosepsis on skilled level of care for nursing.

On 1/29/21 at 11:28 PM the resident complained of the catheter leaking urine and requested the catheter replaced. The nurse replaced the catheter with 24 French, 30 ML balloon at the

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time. The resident had no complaints of pain or discomfort. There was immediate return of urine noted upon insertion into suprapubic stoma. The nurse continued to monitor for urine return.

On 1/30/21 at 12:41 PM the suprapubic catheter was removed due to leakage and replaced with a 24 French 30 ML balloon. Urine return noted upon insertion.

The eMAR - Administration Note dated 2/2/21 at 10:49 PM said to change suprapubic catheter every three weeks and as needed (PRN) for obstructed, leaking, or pulled out with a 24 French, 30 ML balloon one time a day every 21 day(s) for reduce UTI's. Catheter was not changed as already changed on 1/30/21.

On 2/4/21 at 1:57 PM identified the resident appeared lethargic during the shift. The resident aroused easily but difficult to wake up. The resident's vital signs were temperature 98.7, pulse 83, respirations 16, and blood pressure of 122/62 at 1:45 PM. The nurse uncovered the resident and turned down the heat. The resident could not take medications this shift due to the increased lethargy. The resident could not eat breakfast and lunch. The suprapubic catheter drained dark yellow urine. The Physician's office gave an okay for a UA and C&S then to continue to monitor.

On 2/4/2021 13:57 the Doctor's office said it was okay to collect a UA and C&S due to increased lethargy during the shift.

The MDS Progress Note dated 2/4/21 at 6:11 PM documented the follow-up with the resident's increased lethargy. The resident was alert and

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orientated to person, place, and time (A&O x 3). The resident could voice her needs. The resident stated she felt tired but she enjoyed her birthday dinner. The resident ate and said she felt fine and not sluggish.

On 2/5/21 at 9:20 PM the resident was followed up on due to a condition change. The resident was up and in her wheelchair during the shift. The resident was alert and orientated to person, place, time, and situation (A&O x 4). The resident was able to make needs her known. The UA and a complete blood count (CBC) results returned and were faxed to the PCP office. This nurse called out and spoke with the on-call provider for the PCP. The On-Call provider said to monitor the resident and they would review the lab results.

On 2/6/21 at 2:47 PM the nurse completed a head to toe assessment on the resident. The resident was in her bed, lethargic, and slow to respond. At 3:00 PM, the on-call provider for the PCP was notified and he gave a new order to send the ER for further evaluation. The resident left to the ER at 3:24 PM by ambulance. The resident's MAR, TAR, and face sheet was sent with the resident. The resident's daughter was notified at 3:30 PM and the Director of Nursing (DON) was notified.

On 2/6/21 at 9:50 PM showed the nurse called the hospital and received an update on the resident's status. The resident admitted to the hospital for the diagnosis of acute metabolic encephalopathy and UTI.

On 2/9/21 at 2:19 PM explained the resident readmitted to the facility following a weekend hospital stay. The resident to see their PCP on

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2/11/21 at 9:45 AM.

On 2/10/21 at 1:42 PM stated the facility received signed orders for UA with C&S in 10 days.

On 2/20/21 at 6:03 PM staff collected the UA in the morning. The lab advised the nurse they could not process the UA due to no date of birth being on the UA sample. The nurse spoke to the on-call Doctor to see if they were able to obtain the UA on Monday as the lab didn't come on Sundays. The on-call Doctor gave the ok to collect the UA on Monday.

On 2/22/21 at 5:47 AM staff collected the UA by catheter per order. The UA specimen cup was labeled, and put into cooler for pick-up. The lab was called and notified of need for pick-up. The resident's catheter was changed per PRN order before specimen was collected. The patient tolerated well and the urine flow was unobstructed.

The Lab Progress Note dated 2/23/21 at 4:47 AM documented that the facility received a fax from the lab regarding the UA with C&S obtained on 2/22/21. The nurse faxed the PCP the results with the pending culture and asked if doctor had any further orders at this time or await culture results.

On 2/23/21 at 1:03 PM the fax returned regarding the urine results from 2/21/21 with no new orders and to await culture results.

On 3/16/21 at 7:21 AM the catheter was changed due to leaking. The catheter had immediate output of 500 ML.

The eMAR - Administration Note dated 3/17/21 at

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8:03 AM revealed an order to flush the suprapubic catheter as needed for obstruction. The catheter was flushed with 60 ML of saline twice due to large amount of blood in the catheter bag. After the flushes, the resident's output changed from very dark red to light pink.

On 4/7/21 at 10:08 AM the facility received a fax back from the PCP with the UA results from collection 2/28/21 with no new orders or recommendations.

On 5/13/21 at 11:20 AM staff noticed amber colored and foul-smelling urine that morning while the Certified Nurses' Assistant (CNA) cleaned and changed the resident. The resident denied any pain or feeling any symptoms. Staff sent a fax to the resident's primary doctor regarding the resident's urine.

On 5/14/21 at 9:12 AM the nurse followed up with a phone call to the clinic regarding resident's urine appearing amber in color and foul smelling. The nurse asked if they want the facility to do a urinalysis and urine culture? The nurse at the clinic said they would call back about it.

The Social Service Progress Note dated 5/21/21 at 2:20 PM the resident stated that her gray visa gift card was missing. Staff assisted the resident in looking through her lockbox to find the missing card. As the resident had several gray visa gift cards in her lockbox, the staff called the number on the back of each card to access the available balance on the cards. The resident stated she missed one that had about $200.00 on it. Staff searched through her room but did not find another gray visa gift card. The next day, staff went to residents room again to look for her

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missing card and it was in the lockbox. The available balance on the card was a little over $200.00. The resident was relieved to have located the correct card. The resident seemed to be misplacing items more frequently. The staff informed nursing management and they would continue to monitor residents behavior to assess for cognitive decline and/or attention seeking behavioral patterns.

On 5/24/21 at 12:21 PM the night Licensed Practical Nurse (LPN) reported that morning, that the CNA told her that her resident didn't have any urine output in her suprapubic catheter. The resident looked weaker and pale in color as observed on rounds. The resident didn't have an appetite to eat. The nurse checked the resident's vital signs (VS). The resident's blood pressure (BP) was on the low side with a reading of 82/50. The nurse tried to flush the resident's catheter but still no output. The nurse called the resident's primary provider at the office and she order for the resident to be sent to the hospital. Transportation arranged, the Unit Manager, and family notified.

On 5/24/21 at 1:13 PM the resident was picked up by the Medical Transportation company for transfer to the hospital for admission for possible septic UTI? The facility assisted the responder on transferring the resident to the stretcher. The resident's daughter was informed about her being admitted to the hospital thru a phone call.

On 5/27/21 at 6:00 PM the resident discharged from the hospital and got back to the facility around 3:00 PM. The resident was alert and oriented, at times forgetful, but reoriented easily.

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On 5/29/21 at 2:48 AM revealed the resident received an antibiotic for a UTI and recent hospitalization for urosepsis. The resident's temperature was 97.3 F. The resident denied reports of dysuria (difficulty with urination). The new catheter continued to drain well with amber urine and sediment in the tubing. Catheter remains patent to down drain bag with unobstructed flow. Resident remains afebrile.

The Care Plan problem date identified the resident at risk for infection related to her suprapubic catheter. The resident's urologist frequently orders UAs with C&S. On 7/8/21 the resident received orders for oral antibiotic. The resident's goal said she would like to remain free from infection as much as possible. The Care Plan included the following interventions
A. Administer medications as ordered
B. Change catheter as ordered.
C. The resident frequently request her urine be screened for infection despite not having symptoms, the resident would also request to smell her own urine.
D. The resident sometimes has breakthrough leakage through her urethra and her urologist is aware.
E. Notify the resident's physician if the resident's signs and symptoms of a UTI do not improve or worsen
F. Observe the resident's urine for changes in color, odor, and decreased amount then notify nurse as needed.
G. Provide resident with catheter care per facility protocol.

The Care Assessment Area (CAA) dated 3/15/21 said the resident had a suprapubic catheter and it was managed by the staff. The resident was

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incontinent of bowel and needs staff assistance for incontinent cares.

The 5/21 Treatment Administration Record (TAR) lacked documentation that the resident's catheter was changed. The TAR showed the catheter was to be changed on 5/18/21.

The 4/21 TAR showed the last time the catheter was changed was on 4/27/21 but was not documented as ordered for 4/6/21.

The resident's record lacked documentation on the resident's urine appearance, odor, or further follow-up from 5/15/21 until 5/24/21.

The Hospital Discharge Summary dated 5/27/21 explained the resident admitted to the hospital for a UTI, encephalopathy of infectious etiology likely secondary to UTI, elevated troponin level possibly secondary to an acute infection, and leukocytosis. Her culture grew Escherichia coli (E. Coli), pseudomonas, and proteus species. The resident had a chronic suprapubic catheter and remains at a high risk of recurrent UTIs. The resident has been admitted to the hospital with recurrent UTIs and found to have another UTI.

The review of the Point of Care records on 7/19/21 at 10:45 AM showed no atypical (out of the normal) behaviors charted in May for the resident in the Certified Nursing Assistant (CNA) charting.

Medical Doctor interview

On 7/21/21 at 12:34 PM the resident's Primary Care Physician said that with the resident it is very difficult to prevent UTIs as she is a

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quadriplegic and has the chronic suprapubic catheter. The Physician thinks the facility is doing a good job with the resident considering her condition. The Physician said that it is hard to say that if the assessment was completed if it would've prevented the resident's hospitalization. With this resident it is very difficult as it is a tail they keep chasing. It seems almost every ten days they are running a UA for her. The Physician said that at some point it is a matter of letting it go and having the symptoms get further along as she frequently has these UTIs.

Administration interview

On 7/22/21 at 3:06 PM the Director of Nursing (DON), said that she would expect staff to follow-up with the Physician if the resident is experienced symptoms of a UTI. If unable to get in touch with the Physician, she would expect them to contact the On-Call Physician. If that didn't work out, as a last resort, the staff should contact the Medical Director for an order for a UA. She will need to educate the staff on this to ensure something like this doesn't happen again. The DON said that she would expect the staff to get the UA as ordered especially for this resident as her history of going septic is so high.

Policy review

The Notification to Physician/Family/Resident Representative of Change in Resident Health Status - HDGR policy with a revision date of 11/16 said the community would consult the resident's physician, nurse practitioner, or physician assistant and notify the resident's representative or an interested family member when there was

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F 684	Continued From page 41 A. An acute illness or significant change in the resident's physical, mental, or psychosocial status (i.e. "example" deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). B. A need to alter treatment significantly (i.e. a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment.) The Procedure said that the community would contact the resident's physician or their PCP responsible for the resident's care with changes as described above.	F 684		
F 689 SS=D	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 clinical record review, observation and staff interview the facility failed to update and implement a fall prevention intervention to the care plan or provide increased supervision for Resident #44 following falls for 1 of 6 reviewed (Resident #44). Facility census was fifty-six (56) residents. Findings include: Resident #44's Minimum Data Set (MDS) dated 06/21/21, identified Resident # 44 with a Brief	F 689		

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Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The MDS revealed the resident required extensive staff assistance with bathing, repositioning, dressing and transferring. The resident did not ambulate and transferred from bed to chair via a mechanical lift.

The resident had diagnoses that included: diabetes mellitus, peripheral vascular disease, non-pressure chronic ulcer of right foot, metabolic encephalopathy(brain function is disturbed due to toxins or disease) , and weakness with impaired mobility.

The care plan dated 06/24/21 identified the resident as a fall risk with a goal to not suffer serious injury should he fall. Interventions included having non-skid strips on the floor by his bed implemented on 09/02/20. An intervention was added on 06/23/21 instructing staff that the resident's pressure reduction boots worn at night only.

Incident Reports:

An incident report (IR) dated 8/29/20 at 4:15 p.m. revealed a witnessed fall in the resident's room. The resident slid out of the wheelchair onto the floor. The intervention following the incident listed as: dycem in the wheelchair. The resident did not receive injury.

An IR dated 5/8/21 at 8:25 p.m. revealed an unwitnessed fall in the resident's room. The resident's spouse found him on the floor at the foot of the bed. The resident removed heel protectors and could not explain what occurred. The incident report identified the resident with

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impaired gait and impaired memory. The resident did not receive injury. The report did not identify an intervention following the incident. The IR did not identify when staff last saw or toileted the resident or if care plan interventions in place and followed. The resident did not receive injury.

An IR dated 5/12/21 at 7:30 p.m., revealed an unwitnessed fall in the resident's room. Staff found the resident laying on the left side behind his wheelchair. The resident stated got out of the wheelchair because he wanted to get up. The intervention listed following the incident was to encourage the resident to use the call light and ask for help and remind the resident he needs assistance with mobility. The intervention was not appropriate due to the resident's moderate cognitive impairment. The IR identified the resident as drowsy and did not identify when the staff last saw or toileted the resident. The resident did not receive injury.

An IR dated 6/22/21 at 8:37 p.m. revealed a witnessed fall in the resident room. Another resident witnessed the fall. The resident tried to stand without assistance and fell. The resident's feet slid while he wore protective boots and he landed on his bottom. The intervention was to educate the resident to wait for staff and never stand without appropriate footwear. The intervention was not appropriate due to the resident's moderate cognitive impairment. The IR did not identify when the staff last saw or toileted the resident or if care plan interventions in place and followed. The resident did not receive injury.

An IR dated 7/2/21 at 2:25 a.m. revealed an unwitnessed fall in the resident's room. The resident's roommate informed staff he was on the

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F 689	Continued From page 44 floor. Staff found the resident on the floor by the bed with his arm in the wheelchair and head on the mattress with legs extended. The resident was incontinent of bowel and bladder. The intervention listed was encourage the resident to alert staff of he wants to get up. Staff also moved the resident's wheelchair away from his bed. The intervention to remind the resident to alert staff was not appropriate due to the resident's moderate cognitive impairment. The IR did not identify when the staff last saw or toileted the resident or if care plan interventions in place and followed. The resident did not receive injury. On 07/07/21 at 11:25 AM, observation of the resident in his room revealed the absence of non-skid strips on the floor. Observation showed Resident #44 sitting in his wheelchair dressed, with pressure reduction boots on to his bilateral (left and right) lower extremities. An interview on 07/13/21 at 12:12 PM with the DON, stated she is unable to locate an intervention implemented or added to the resident's care plan as a result of the 05/12/21 fall. She stated the expectation is for the nurse management team to review incidents every morning in a clinical meeting and determine appropriate interventions and ensure fall protocols are followed.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, resident and staff interview, the facility failed to provide appropriate cleaning and storage of a BPAP (bilevel positive airway pressure machine used to facilitate breathing), follow professional standards and the comprehensive person-centered care plan for 1 of 2 residents reviewed for respiratory care (Resident # 43). The facility reported a census of 56 residents.

Findings include:

The Minimum Data Set (MDS) dated 06/21/21 for Resident #43 identified a Brief Interview for Mental Status (BIMS) score of 8. A score of 8 indicates moderate cognitive impairment. The MDS revealed the resident required extensive assistance of 1-2 persons in activities of daily living (ADLs) including transfers, hygiene, position changes and toileting. The MDS documented diagnoses of Chronic Obstructive Pulmonary Disease (COPD) (a chronic inflammatory lung disease causing obstructed airflow).

The care plan, dated 06/24/21, documented a problem area of shortness of breath at times when sleeping due to obstructive sleep apnea, COPD and morbid obesity. The care plan instructed staff to provide oxygen (O2) as directed. The care plan revealed the resident often refused to wear the BPAP at night.

Physician orders dated 03/27/21 instructed the

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night nurse to ensure the resident's portable O2 tank is refilled every night. An order dated 02/05/18 directed staff to change tubing, wipe down machine and rinse filter every Monday.

The Treatment Administration Record (TAR) reflected the physicians orders were being completed as ordered and the BPAP administered for 7 out of 13 days in July 2021. The TAR reflected the resident refused for 6 of 13 days. The TAR documented the O2 tank as checked and filled for 10 out of 13 days and refused for 3 of 13 days.

Observation on 07/07/21 at 02:59 PM revealed a BPAP machine with tubing and mask sitting on the floor in a narrow confined space between the resident's bed and window wall. Observations revealed dust and lint on the mask and Velcro closures. Observations of the portable oxygen tank revealed the gauge as indicating empty. An observation of the O2 tubing attached to the O2 concentrator reflected a date of 06/19/21. At that time, Resident #43 stated she did not use the BPAP or oxygen and estimated last use as "months ago".

On 07/12/21 at 01:08 PM, an interview and joint observation with the DON of residents room , the DON verified the O2 tank as empty. The DON verified the BPAP as inaccessible and stored directly on the floor behind the resident's bed. The DON verified the O2 tubing as dated 06/19/21 and verified the changing as 3 weeks overdue.

On 07/12/21 at 01:59 PM, the DON provided the Oxygen Administration policy dated April 1, 2008 and revised on March 1, 2014. the policy

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F 695	Continued From page 47 instructed staff to replace the oxygen tubing weekly and PRN (as needed). The DON provided an undated, untitled document that instructed users to replace a CPAP mask every 3 months, replace cushions on the mask every 2 weeks, replace headgear and straps every 6 months and replace filters every 2 weeks. The DON identified no documentation of any maintenance or replacing recommended components available for the BPAP machine .	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		

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designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews and call light record reviews, the facility failed to ensure staff responded to call lights within the required 15 minute timeframe for 5 out of 24 sampled residents. (Resident #11, #45, #2, #28, #156) The facility reported a census of 56 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment dated 4/26/21, documented Resident #11's diagnoses included renal insufficiency, cerebrovascular accident and depression. Resident #11 Brief Interview for Mental Status (BIMS) score was 12 out of 15 indicating moderate cognitive impairment. This resident required assist of 1 for transfers, personal hygiene and toileting.

On 7/06/21 at 1:58 PM, Resident #11 stated sometimes it takes 30 minutes to get her call light answered and then other times, staff answers it right away.

2. The MDS assessment dated 6/21/21, documented Resident #45's diagnoses included cerebrovascular accident, diabetes and asthma. Resident #45 BIMS score was 12 out of 15 indicating moderate cognitive impairment. Resident #45 required assist of 2 for transfer and assist of 1 for toilet use and personal hygiene.

On 7/06/21 at 4:38 PM, Resident #45 stated it could take 25 minutes before staff answered her call light. She stated the facility knows when State comes. She identified on that day, 3 staff

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working on her hall and they normally have 2 staff working on her hall.

3. The MDS assessment documented Resident #2's diagnoses included congenital myopathy, osteoarthritis, and anemia. Resident #2 BIMS score was 13 out of 15 indicating intact cognition. Resident #2 required assist of 2 for bed mobility and assist of 1 for toilet use and personal hygiene.

On 7/07/21 at 10:02 AM, Resident #2 identified not enough staff on weekends and holidays. She stated one time she almost fell off the edge of her bed but they got to her in time.

4. The MDS assessment dated 5/17/21 documented Resident #28's diagnoses included heart failure, renal insufficiency, and chronic obstructive pulmonary disease. Resident #28's BIMS score was 12 out of 15 indicating moderate cognitive impairment. Resident #28 was independent required assist of 28 for bed mobility and required supervision for dressing and toilet use.

On 07/07/21 at 10:31 AM, Resident #28 stated sometimes the facility only has 2 nurses for 3 hallways and the residents are late getting their medicines. Resident #28 stated it happens at night before they go to bed and it happens about every day.

5. The MDS assessment dated 7/2/21, documented Resident #156's diagnoses included anemia, diabetes, and depression. Resident #45 BIMS score was 10 out of 15 indicating moderate cognitive impairment. Resident #156 required assist of 1 for transfer, toilet use and personal

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hygiene.

On 7/06/21 at 4:25 PM, Resident #156 stated she did not think they have enough staff. They run a lot in the hall to do what they need to do. Resident #156 identified nights when the residents don't get their night meds until 11:30 PM to 12:00 AM when they should be given around 9 or 9:30 PM.
.
The Device Activity Report (call light report) dated 2/15/21 to 2/16/21 revealed call lights not answered in a timely manner. The following are the times the call lights not answered within 15 minutes:

2/15/21
4:39 AM 23 minutes(m) 38 seconds(s)
6:43 AM 15m 36's
7:05 AM 26m 17's
10:31 AM 16m 7s
11:07 AM 20m 49s
11:31 AM 18m 27s
1:47 PM 22m 25s
4:35 PM 31m 47s
6:27 PM 15m 39s
6:43 PM 20m 19s
10:15 PM 15m 10s

2/16/21
10:25 AM 15m 47s
11:11 AM 19m 22s
12:04 PM 26m 34s
12:21 PM 24m 31s
1:46 PM 55m 20s
2:12 PM 20m 40s
2:49 PM 18m 36s
4:13 PM 18m 42s
4:30 PM 16m 6s
8:09 PM 16m 13s

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F 725	Continued From page 51 On 7/14/21 at 1:08 PM, the Director of Nursing (DON) and the Interim Nursing Home Administrator (NHA), both stated staff needed to answer call lights within 15 minutes. They reviewed the call light report for 2/15/21 to 2/16/21 and concurred staff did not answer call lights within 15 minutes.	F 725		
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 record review and interviews, the facility didn't have a Registered Nurse (RN) at least eight hours a day for seven days a week. The facility reported a census of 56 residents. Findings include:	F 727		

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F 727	Continued From page 52 Record review The review of the daily staffing sheets on 7/7/21 at 10:47 AM showed the facility didn't have a Registered Nurse (RN) at least eight hours a day for seven days a week for the following days A. Saturday 6/26/21 B. Sunday 7/4/21 Administration interview On 7/7/21 at 11:48 AM the Director of Nursing (DON) said they didn't have those dates covered with a RN. Policy review The Nursing Administration Staffing policy dated 4/1/08 said that the facility ensure that services are provided by sufficient numbers of staff 24 hours a day, seven days a week. A registered nurse is on site for at least eight consecutive hours a day, seven days a week, except when under a waiver from the state.	F 727		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 53 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain an order with a 14 day stop	F 758		

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date or rationale with the duration of the order for extending the as needed (PRN) order beyond 14 days for a PRN psychotropic order for 1 (Resident #156) of 5 residents reviewed for unnecessary medications. Resident #156's medication orders upon her admission to the facility on 6/25/21, included an order for PRN Clonazepam (antianxiety medication/psychotropic) without a 14 day stop date or rationale for extension of the 14 days.

Findings include:

A Minimum Data Set (MDS) with an assessment reference date of 7/2/21, documented diagnoses for Resident #156 included encounter for surgical aftercare for surgery on the nervous system and depression. Resident #156 had a Brief Interview for Mental Status (BIMS) score of 10 out of 14, indicating moderate cognitive impairment. The resident required limited assistance of 1 for bed mobility, toilet use and personal hygiene.

On 7/14/21 at 8:15 AM, the Director of Nursing (DON) stated she did not know anything about psychotropic PRN medications upon admission or the stop date for them and would refer me to the admissions nurse.

On 7/14/21 at 8:52 AM, Staff C, Admissions Director/Licensed Practical Nurse (LPN) stated residents come from the hospital she needs to clarify their PRN psychotropic medications. She stated she usually looked for a 14 day stop date for any PRN psychotropic. She did not think she had gotten clarification on Resident #156's Clonazepam. Staff C stated it was her fault that it was missed. She stated she normally called the doctors to let them know the facility would need to

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F 758	Continued From page 55 issue a stop date. She stated the doctors don't always remember to put a stop date on a psychotropic medication, so she calls to get a clarification order. On 7/14/21 at 1:22 PM, the Omnicare Pharmacist stated PRN psychotropics should have a discontinue date of 14 days or have a documented rationale why the order is needed longer than 14 days. Staff C provided a fax titled Current Medications as of 6/21/21 at 1:16 PM, to show the resident's medication list from prior to admission to the facility. The sheet documented Clonazepam 0.5mg by mouth at bedtime as needed for anxiety if Trazadone ineffective. The directions documented that no doses administered for 6 months and a new prescription necessary to continue the medication. A Medication Administration Record (MAR) dated 7/1/21-7/31/21 and printed on 7/14/21 at 8:32 AM, directed staff to administer Clonazepam 0.5mg by mouth as needed for anxiety at bedtime only if Trazadone is ineffective with documented start date of 6/25/21. The order did not contain a stop date. The facility was unable to produce rationale for the Clonazepam to remain on Resident #156's medication list for more than 14 days.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		

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professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, policy and clinical record review and staff interview, the facility failed to initiate safeguards for similar or same named residents, and a discontinued controlled medication remained in the locked controlled medication drawer in the medication cart following discontinuation and discharge of Resident #107, which resulted in Resident #206 receiving a scheduled medication that belonged to Resident #107. The facility identified a census of 56 residents.

Findings include:

1. Resident #107's Minimum Data Set (MDS)

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dated 1/25/20 documented an admission date of 1/18/21 from an acute hospitalization and revealed cognitively intact. Resident was discharged to hospital on 1/28/21.

An admission fax dated 1/18/21 documented an order for Hydrocodone-acetaminophen (narcotic) 5-325 milligrams (mg.) 1 tablet by mouth every 6 hours as needed for pain.

A document titled Controlled Medication Utilization Record for Resident #107 revealed on 1/18/21, three (3) tabs Hydrocodone 5-325 mg received in a bottle upon admission. The document further revealed two tablets removed for administration: One (1) tablet on 2/12/21 at 10:37 a.m. and one (1) tablet on 2/15/21 at 9:58 a.m. Both of these dates are noted to be after the date the resident had discharged home. The amount remaining was documented as one. The medication was signed as destroyed on 2/18/21 with two staff witnesses.

A document titled Controlled Medication Utilization Record for Resident #107 revealed on 1/19/21, 30 tabs of Hydrocodone 5mg-325mg every 8 hours as needed for pain was received at the facility. The document further revealed no doses removed for administration, and 30 doses destroyed with two staff witnesses on 2/12/21.

2. Resident #206's MDS dated 2/11/21 documented an admission date of 2/4/21 from an acute hospitalization and revealed severe cognitive impairment.

An admission fax dated 2/4/2021 documented an order for Hydrocodone-acetaminophen 5-325mg, 1 tablet by mouth every six hours as needed.

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A faxed document titled Physician Communication dated 2/12/21 at 2:15 p.m. revealed an order for Hydrocodone-acetaminophen 5-325mg take one tablet two times daily at 9:00 a.m. and 5:00 p.m.

The Medication Administration Record (MAR) for February 2021 documented Staff E, Licensed Practical Nurse (LPN) administered one tablet to Hydrocodone 5-325mg on 2/12/21 at 10:37 a.m. and one tablet on 2/15/21 at 9:00 a.m.

A document titled Controlled Medication Utilization Record for Hydrocodone 5-325mg, for Resident #206 failed to document tablets removed for administration on 2/12/21 or 2/15/21 at 9:00 a.m.

On 7/13/21 at 4:40 p.m. the Director of Nursing (DON) stated she investigated the concern of the scheduled medications signed out for Resident #107 after discharge from the facility and determined Staff E administered Resident #107's Hydrocodone 5-325mg to Resident #206. The medication was the correct medication at the correct dosage and interval. The investigation brought to light the following concerns: The facility had no place to store scheduled discontinued medications or scheduled medications after discharge from the facility, no system in place to alert staff of residents with same (Resident #107 and #206 with same last name) or similar names, and staff did not follow the 5 rights of medication administration, and incorrectly documented. The DON presented a typed action plan for wrong resident medication error and incorrect documentation that included the following:

Education with staff on the 5 rights of

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medication administration
Audit on all carts for correct narcotic counts
Audit on all halls for other same named residents
Flag incoming patients with the same name for staff
Plan for proper removal of medication from cart when resident discharges or passes
Use of signage of same mane cautions for future residents with same names

In a written statement on 2/22/21 Staff E, confirmed she had given Resident #206 hydrocodone and taken it from the supply of Resident #107, who had the same last name. Resident #107 discharged from the facility and staff did not remove the narcotics from the medication cart. When interviewed on 7/14/21 at 6:13 p.m. Staff E, confirmed she had been made aware that she used hydrocodone from the wrong resident. Staff E stated scheduled medications were often just left in the cart, and required two management staff to destroy. Staff E further stated there was no scheduled or routine method of removing and often would remain until staff would alert management. Staff E, responded that she was unaware of any signage or alerts for same or similar named residents at the facility.

On 7/14/21 at 10:42 a.m., Staff F, Registered Nurse, (RN) stated that she was unaware of special signage or alerts for same or similar named residents. Staff F administered medications on Bayberry Hall on this date and stated that there were 4 residents with the same first name in this hall. Staff F RN opened the cart and no signage was observed.

On 7/14/21 at 11:00 a.m., Staff D, Certified

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F 761	Continued From page 60 Medication Aide (CMA) identified self as responsible for administering medications on the Aspenwood hall. Staff D CMA stated there were two residents with the same first name on Aspenwood hall, and responded she was not aware of any signage or alerts regarding same or similar named residents. Staff D CMA opened the cart and no signage observed. On 7/14/21 at 11:10 a.m., Staff A, RN opened the cart for surveyor and acknowledged there are residents in the Cherry Blossom hall with the same or similar names, which included a married couple with the same last name, and residents with the same first name. Stated she was not aware of any alerts or signage, and none were observed. Review of facility policy titled Medications-controlled, dated as last reviewed on 3/1/2014 included: Scheduled II or higher controlled substances are kept under double lock either in the medication room or the medication cart. If the medication is not discharged with the resident or in the event of death, the medication nurse takes the unused portion of the medication and the control record to the nursing director's office. Review of facility policy titled Medications-discontinued or for deceased or discharged residents, dated as last reviewed on 3/1/2014 included: All medication which are no longer being administered to the residents will be removed and appropriately discarded. All discontinued medications are kept locked until destroyed.	F 761		
F 880 SS=D	Infection Prevention & Control	F 880		

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F 880	Continued From page 61 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility policy review, the facility failed to conduct annual review of their infection prevention and control policies. The facility reported a census of 56 residents.

Findings include:

On 7/14/21 at 10:25 AM, the Infection Preventionist (IP) stated infection control policies are reviewed annually. When she looked over

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F 880	Continued From page 63 the policies she concurred the last date of review was 5/2020 and was overdue for review. The IP stated she would get a hold of corporate to see if they had updated the policies. On 7/14/21 at 2:07 PM, the IP stated she was unable to find an updated policy for Infection Prevention and Control: Antibiotic Stewardship. She stated it was not reviewed annually and concurred it was last reviewed May of 2020. Review of a policy titled Infection Prevention and Control Antibiotic Stewardship Program revealed a revision date of May 2020. The Infection Prevention and Control (General) policy provided by the facility revealed a revision date of May 2020.	F 880		