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	165198	A. BUILDING _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

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F 000	INITIAL COMMENTS	F 000	The Plan on Correction does not constitute an admission or agreement by Iowa City Rehab & Health Care of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law. This plan of correction shall serve as Iowa City Rehab & Health Care credible allegation of compliance.	
OK/TAG ✓	Correction Date: 06/30/23 The following deficiencies resulted from a Recertification Survey and an investigation of Complaints #112321-C, #112814-C, #112937-C and Facility Self-Reported Incidents #112789-I and #112897-I, conducted by Healthcare Management Solutions, LLC on behalf of the Iowa Department of Inspections and Appeals on May 22, 2023 to May 25, 2023. Complaint #112321-C was substantiated. Facility Self-Reported Incident #112897-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	F 550 1. Res. #14 was assessed by Social Service Director on 06/28/23 with no new concerns noted. 2. On or before 06/30/23 Social Services/Designee will interview random residents regarding staff language and any concerns voiced will be reviewed/investigated and findings taken through our QA process if warranted. 3. On or before 06/30/23Administrator/Designee will educate the facility staff on Resident Rights and customer service. 4. Administrator/Designee will do random resident interviews wkly for 4 weeks then monthly for 2 months to validate staff are following the resident's rights. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	06/30/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
BCarlberg LNHA		06/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and policy review, the facility failed to treat with dignity one out of six residents reviewed for dignity (Resident #14) out of a total sample of 20 residents.

Findings Include:

Review of Resident #14's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 05/11/23, located in the "MDS" tab of the Electric Medical Record (EMR), revealed an admission date of 10/29/18, a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15, indicating Resident #14's cognition was moderately impaired, screaming behavior not

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exhibited, diagnoses of psychotic (out of touch with reality) disorder and schizophrenia (mental illness of hallucinations and delusions), medication received were antipsychotic and antidepressant, and had hospice care.

Review of Resident #14's 11/19/19 "Care Plan," located in the EMR under the "Care Plan" tab, revealed a focus area of "Resident #14 has potential to demonstrate physical behaviors related to (r/t) Anger, Poor impulse control Resident #14 also has potential to demonstrate verbally aggressive behaviors towards staff."

An 11/19/19 intervention included "Communication: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated.

Review of Resident #14's "Orders," located in the EMR under the "Orders" tab, revealed "Monitor for signs and symptoms of psychosis/delusions (firmly held beliefs not based in reality). If behavior occurs, document in behavior progress note description of behavior, nonpharmacological interventions and resident response."

On 05/22/23 at 3:45 PM, Resident #14 was observed screaming at the Nurses' Station wanting to smoke a cigarette. Licensed Practical Nurse (LPN) 2 and Certified Nurse/Medication Aide (CNA) 3 were both observed passing medication on the East Hall about six feet apart having a conversation that included laughing and talking about Resident #14. Both staff members stated, "she's getting crazy it's not smoke break

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F 550	Continued From page 3 yet." Resident #14 wasn't close enough to hear the staff's conversation. On 05/22/23 at 4:00 PM, CNA 3 was asked why Resident #14 was screaming earlier. CNA 3 stated because Resident #14 "wants her cigarette now or to be toileted, especially in the morning when staff are all busy." CNA 3 confirmed Resident #14 is a psychiatric patient and stated, "as is most of the residents here." CNA 3 confirmed that was why Resident #14 was living at the facility. Review of the facility's policy titled, "Resident/Family Care & [and] Services," dated 02/2015, revealed "The facility strives to assure that each resident/patient has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the center."	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of	F 553	F 553 1. Resident #15 no longer resides at the facility. 2. Social Service Director/Designee will audit scheduled Care Plan Conferences on or before 06/30/23 to ensure that residents are invited. 3. Administrator completed education with the Social Service Director on 06/22/23 regarding Care Plan Conference and who is to be invited and documentation of those invited. 4. Administrator/Designee will do audits weekly times 4 weeks then monthly times 2 months to ensure that compliance is met. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	06/30/23

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changes to the plan of care.
(iv) The right to receive the services and/or items included in the plan of care.
(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, and policy review, the facility failed to ensure one resident of a total sample of 20 residents (Resident #2) was afforded the opportunity to be included in all aspects of person-centered care planning.

Findings Include:

Review of Resident #2's "Face Sheet," located in Electronic Medical Record (EMR) under the "Profile" tab, revealed an admission date of 10/08/22 with diagnoses of chronic respiratory failure, bipolar disorder (mental illness of bouts of depression and mania [excitability]), and schizophrenia (mental illness of hallucinations and delusions).

Review of Resident #2's Quarterly "Minimum Data Set (MDS)," located in the EMR under the

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"MDS" tab, with an Assessment Reference Date (ARD) of 04/28/23 revealed Resident #2 was cognitively intact with a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15.

Review of Resident #2's "Care Plan," original date of 10/19/22 and updated on 03/13/23, revealed a focus of "The resident is resistive to care r/t adjustment to nursing home, refuses to use call light, refuses to walk without assist, refuses to wear oxygen at times (feels he doesn't need it, even though he does) current smoker. Ambulates in hall without O2. Verbally abusive to staff at times. Yells and calls staff names. Threatens staff with "beating them". Refuses showers/bathing." The goal for the focus, " Allow the resident to make decisions about treatment regime, to provide sense of control." There was no documentation of Resident #2's participation in the Care Planning Meetings.

During an interview on 05/22/23 at 10:51 AM, Resident #2 revealed, "I do not know what a Care Planning Meeting is. No one has told me or invited me to any kind of meeting about me staying in this facility."

During an interview on 05/23/23 at 1:58 PM with the Social Service Director (SSD), the SSD indicated he and the MDS Coordinator conduct the care planning meetings together. When specifically asking about Resident #2 Care Planning, the SSD was unable to locate any information that Resident #2 was invited to his Care Plan Meetings. The SSD stated Resident #2 does not have a Power of Attorney (POA), nor does he have a resident representative, he is his own representative.

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F 553	Continued From page 6 Review of the facility policy titled, "Care Plan Development," original date 08/2015, read in pertinent part, "The Comprehensive Care Plan is developed by the interdisciplinary team with input from the resident/family/legal guardian and information derived from the Minimum Data Skills and /Care Assessment Area (CAA) assessment. The resident and or family/legal guardian have the right to decline participation in the development of the care plan or decline treatment."	F 553		
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on a Resident Council Meeting, staff	F 572	F 572 1. Resident #15 and #11 no longer resides at the facility. Resident #2, 47, 31, 24, 13, 36, 44, and #21 has received a copy of Resident Rights and invited to a Resident Council Meeting schedule on 06/29/23 by the Administrator/Designee to review Resident Rights. 2. Residents of the facility were invited to Resident Council meeting held on 06/29/23 for review of Resident Rights and offered Resident Rights handouts. 3. On or before 06/30/23 Administrator/Designee will educate the facility staff on Resident Rights. 4. Administrator/designee will do random resident interviews wkly for 4 weeks then monthly for 2 months for any concerns regarding resident's rights, any concerns voiced will be investigated. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	06/30/23

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interviews, document review, and policy review, the facility failed to ensure residents were provided their resident rights both orally and written annually for 10 of 10 residents interviewed in resident council (Resident #2, #47, #31, #24, #13, #15, #36, #44, #11, and #21). This had the potential to affect all 51 residents residing in the facility.

Findings Include:

During a Resident Council Meeting on 05/24/23 at 10:01 AM, the residents were not aware of their resident rights. When asked if they received a copy of the resident's rights written and orally, each resident indicated they had not received a copy or been informed of their rights.

During an interview 05/24/23 at 11:56 AM with the Administrator, Corporate Administrator (CAD), and Vice President of Clinical Services (VPCS), in asking about reviewing the resident rights with the residents, the CAD revealed they will do that the next Resident Council Meeting. The CAD indicated "she understands and is aware they are required to review their rights with them at least once a year during the resident council meeting."

Review of the policy titled, "Resident/Family Care and Services, Residents Rights and Responsibilities," original date 02/2015, revealed "The facility strives to assure that each resident/patient has a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the center. Each resident patient and/or family/responsible party will be presented with a copy of the Federal and State-Specific Resident Rights upon admission and as requested during

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F 572	Continued From page 8 stay and offer an annual presentation and discussion of Resident Rights with the Resident Council."	F 572		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580	F580 1. Resident #29 sliding scale for the last 30 days was reviewed on 06/15/23 by the ARNP with new parameter orders and noted. 2. DON or designee completed a 30 day audit on or before 06/30/23 for residents with sliding scale insulin orders to ensure parameters were being followed and Physician/ARNP if warranted. 3. DON/Designee educated licensed staff on or before 06/30/23 related to the requirements of following MD/ARNP sliding scale parameter orders with notification if warranted. 4. Director of Nursing/ designee will conduct random audits weekly for 4 weeks and then monthly for 2 months to ensure resident sliding scale insulin parameters including when to contact the MD or ARNP are being followed. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow-up	06/30/23

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(e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, and review of the facility's hypoglycemia/hyperglycemia policy and procedures, the facility failed to notify the Physician and/or Nurse Practitioner when the resident's blood glucose (sugar) levels were not within the set parameters and as ordered by the Physician for one of five residents reviewed for unnecessary medications in a total sample of 20 residents (Resident #29). Failure to notify the physician when blood glucose levels were not within set parameters placed the resident at increased risk for hypo/hyperglycemia (low/high blood sugar levels).

Findings Include:

Review of Resident #29's "Admission Record," located in the Electronic Medical Record (EMR) under the "Profile" tab, indicated Resident #29 was admitted to the facility on 04/14/23 from an

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acute care hospital. Resident #29's pertinent diagnosis included diabetes mellitus due to an underlying condition without complications.

Review of Resident #29's admission "Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 04/21/23, located in the EMR under the "MDS" tab, indicated Resident #29 had moderate cognitive impairment, as evidenced by a "Brief Interview Mental Status (BIMS)" score of nine out of 15. Resident #29 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and rejection of care during the review period. The "MDS" did not include a diagnosis of diabetes mellitus, as noted on Resident #29's "Admission Record" and physician orders.

Review of Resident #29's "Comprehensive Care Plan," located in the EMR under the "Care Plan" tab, initiated on 04/27/23, did not reveal a comprehensive care plan for diabetes mellitus. Cross Reference: F656 Develop/Implement Comprehensive Care Plan.

Review of Resident #29's physician's "Order Summary Report," dated 04/01/23 through 05/31/23 and located in the EMR under the "Orders" tab, indicated Resident #29 had a diagnosis of Diabetes Mellitus. The Physician's Orders directed staff to obtain blood glucose results four times daily (before meals and bedtime) and notify the provider if blood glucose results were less than 70 mg/dl or greater than 350 mg/dl.

Review of Resident #29's "Medication Administration Records (MARs)," dated 04/2023, located in the EMR under the "Orders" tab,

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indicated Resident #29's blood glucose results were less than 70 mg/dl on 04/20 (68 mg/dl) and greater than 350 mg/dl on 04/16 (500 mg/dl and 446 mg/dl), 04/21 (554 mg/dl and 387 mg/dl), 04/23 (539 mg/dl), 04/24 (376 mg/dl), 04/25 (508 mg/dl), 04/26 (397 mg/dl), 04/27 (356 mg/dl times two), 04/28 (399 mg/dl), and 04/29 (376 mg/dl).

Review of Resident #29's "Progress Notes," dated 05/2023, located in the EMR under the "Progress Notes" tab, indicated no evidence facility staff notified Resident #29's Physician and/or Nurse Practitioner when Resident #29's blood glucose results were greater than 350 mg/dl on 04/23 (539 mg/dl), 04/24 (376 mg/dl), 04/27 (356 mg/dl times two), 04/28 (399 mg/dl), and 04/29 (376 mg/dl).

Review of Resident #29's "MARs," dated 05/2023, located in the EMR under the "Orders" tab, indicated Resident #29's blood glucose results were greater than 350 mg/dl on 05/01 (378 mg/dl), 05/03 (380 mg/dl), 05/05 (370 mg/dl), 05/06 (370 mg/dl and 397 mg/dl), 05/11 (436 mg/dl), 05/12 (405 mg/dl and 369 mg/dl), 05/14 (403 mg/dl), 05/15 (371 mg/dl and 386 mg/dl), 05/16 (365 mg/dl), 05/18 (400 mg/dl), 05/20 (435 mg/dl), 05/21 (366 mg/dl and 512 mg/dl) and 05/23 (367 mg/dl).

Review of Resident #29's "Progress Notes," dated 04/2023, located in the EMR under the "Progress Notes" tab, indicated no evidence facility staff notified Resident #29's Physician and/or Nurse Practitioner when Resident #29's blood glucose results were greater than 350 mg/dl on 05/03 (380 mg/dl), 05/05 (370 mg/dl), 05/06 (370 mg/dl and 397 mg/dl), 05/11 (436 mg/dl), 05/12 (405 mg/dl and 369 mg/dl), 05/14

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(403 mg/dl), 05/15 (371 mg/dl), 05/18 (400 mg/dl), 05/20 (435 mg/dl), and 05/21 (366 mg/dl).

During an interview on 05/23/23 at 4:00 PM, Registered Nurse (RN) 2 stated the nurses were responsible for obtaining blood glucose results. The nurses were also responsible for notifying the resident's Physician and/or Nurse Practitioner when the blood glucose results were not within the set parameters. The nurses were to document in the resident's Progress Notes any blood glucose results outside the set parameters and that they notified the Physician and/or Nurse Practitioner and any new orders received.

During an interview on 05/24/23 at 7:50 AM, Licensed Practical Nurse (LPN) 1 stated the nurses were responsible for obtaining blood glucose results. If the resident's blood glucose results were outside the set parameters, the nurses were responsible for notifying the physician and/or nurse practitioner to report the abnormal result and obtain new orders.

During a second interview on 05/24/23 at 11:00 PM, LPN 1 reviewed Resident #29's blood glucose results and progress notes for 04/2023 and 05/2023. LPN1 acknowledged the progress notes did not contain evidence that the nurses contacted the physician and/or nurse practitioner when the resident's blood glucose levels were not within the set parameters and as ordered by the physician.

During a telephone interview on 05/24/23 at 11:21 AM, the Nurse Practitioner (NP) indicated that they follow the orders from the hospital and can adjust the blood glucose parameters as needed. The NP stated Resident #29 was a brittle

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diabetic, and they were closely monitoring the resident's blood glucose levels. She stated that the nurses should notify the physician and/or nurse practitioner when the resident's blood glucose levels were less than 70 mg/dl or greater than 350 mg/dl. If the resident's blood glucose results were greater than 450 mg/dl, she may give an order to administer an additional two units of sliding-scale insulin per 50 gm/dl. If the resident's blood glucose results were consistently above 300 mg/dl - 400 mg/dl, she would adjust the resident's long-term insulin dose. Since R29 was a new admission (04/14/2023), they monitored the resident's blood glucose level and would wait approximately one to two months before adjusting the resident's long-term insulin dose.

During an interview on 05/24/23 at noon, the acting Director of Nursing stated the nurses should notify the physician and/or nurse practitioner when the resident's blood glucose levels were not within the set parameters and obtain additional orders. The nurses should also document in the resident's progress notes that they notified the physician and/or nurse practitioner regarding the abnormal blood glucose level and any new orders received.

Review of the facility's policy titled, "Hypoglycemia/ Hyperglycemia: Management of Abnormal Blood Glucose Levels," dated 01/2013, indicated "Purpose: To detect an acute hypoglycemic episode as soon as possible and initiate immediate management of the episode. A diabetic or non-diabetic resident/patient with blood glucose below 60 mg/dl [milligrams per deciliter] or experiencing signs or symptoms of hypoglycemia is evaluated to determine if

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F 580	Continued From page 14 treatment is needed unless physician orders specify different parameters ... Document the following: Date and time of occurrence; Signs and symptoms observed; Initial blood glucose results (if able to obtain); Amount of carbohydrates given and route; Resident/patient response to carbohydrates; Repeat blood glucose results; Time physician notified and orders obtained; Type and amount of protein consumed; Resident/patient response to occurrence and treatment; and Notification of family or responsible party."	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	F 584 1. Resident #38 floor was cleaned and paint-like speckles were removed on or before 06/30/23 by Housekeeping staff/Designee. Room 41 on or before 06/30/23 Housekeeping Department/Designee removed soiled bedding and replaced with clean linen, floor was mopped, clothing picked up off the floor. Resident #26 floor was cleaned on or before 06/30/23 by Housekeeping staff/Designee. Rooms of Resident #24, 13, 36, 2, 21, 11, 44, 15, 47, and 31 floors and bathroom were cleaned on or before 06/30/23 by Housekeeping/Designee. Facility hallways were mopped by housekeeping/Designee on or before 06/30/23. On or before 06/30/23 the Maintenance Director/Designee repaired the Smoking Pavilion back handrail that was warped, railings that were loose have been secured, four nail that were exposed have been corrected, two large window screens have been removed, cigarette butts on the ground have been disposed of, cardboard box with trash has been disposed of.	

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F 584	Continued From page 15 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Council Interview, staff and resident interviews, record review, and policy review, the facility failed to ensure the smoking area and window screens were maintained in good repair, proper disposal of cigarette butts on the facility's exterior, and ensure resident rooms were properly cleaned for 4 of 18 resident rooms reviewed for a safe and clean environment. Findings Include: 1. On 05/22/23 at 10:15 AM, Room 38 observed to need cleaning. The floor noted to have numerous paint-like speckles and dingy tile throughout the room. On 05/22/23 at 2:30 PM, Room 41 observed to need cleaning. The bedding in both beds in Room 41 noted to be soiled with a collection of crumbs. The floor in and around the beds were	F 584	F 584 2. Administrator/Designee on or before 06/30/23 did visual rounds of resident's floors, bathrooms and hallways to ensure cleanliness with any concerns identified were corrected. Administrator/Designee completed on or before 06/30/30 visual rounds of smoking areas to ensure that pavilion does not need repair, ground is free of cigarette butts, and free of trash or window screens. 3. Facility staff will be educated by the Administrator/Designee on or before 06/30/23 on providing a safe clean comfortable-homelike environment. 4. Administrator/Designee will conduct audits weekly for 4 weeks and then monthly for 2 months to ensure compliance is maintained. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. Administrator is responsible for monitoring and follow-up.	06/30/23

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also noted to be heavily soiled with dried spills and food debris. Personal belongings observed piled high in and around the beds. The closet stuffed with clothing and other personal belongings piled on the floor.

On 05/23/23 at 8:05 AM, the Administrator was asked if they had a Housekeeper on duty at this time. The Administrator stated, "not right now as she's transporting a patient, but will be here shortly."

On 05/24/23 at 7:58 AM, Resident #26's room observed to need cleaning. The floor throughout the room noted to be heavily soiled with dried spills and food debris. Resident #26 was asked about the condition of his floor. Resident #26 acknowledged it saying, "it's dirty." Resident #26 went on to say he didn't know why they don't clean it and "of course I want them to."

On 05/24/23 at 8:46 AM, Housekeeper (HK) was observed in the front lobby with a housekeeping cart. HK was asked about housekeeping duties and why resident floors needed cleaning. HK stated, "I wasn't here yesterday, and I usually do the center hall but since I was the only one, rooms didn't get done." HK stated the other Housekeeper cleaned the east hall.

During the Resident Council Interview on 05/24/23 at 10:01 AM, Resident #24, #13, #36, #2, #21, #11, #44, #15, #47 and #31 expressed their complaints about the lack of facility cleanliness. Residents stated hallways weren't getting mopped since the past Housekeeper left. The residents described the facility as "filthy" and "Housekeeping isn't doing a good job." Residents complained the floors in their rooms were "sticky

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and covered with stuff" and bathrooms were dirty. One resident stated "there was no one to do the cleaning because HK 3 quit and there were only two Housekeepers now."

During an interview on 05/25/23 at 5:39 PM, the Corporate Administrator (CAD) stated they had identified an issue with housekeeping due to the frequent changeover in staff.

Review of the facility's policy titled "Housekeeping," dated 03/15, revealed "The facility maintains common areas and resident/patient rooms in a clean and sanitary condition." "Minimum cleaning requirements are as follows: Cleaning of resident/patient rooms will be performed daily. Cleaning will include:
a. Beds
b. Call Bell
c. Chairs
d. Floors
e. High dusting
f. Doors
g. Ledges
h. Light fixtures
i. Tables
j. Vacuuming of carpets

2. Observations of the Smoking Area on 05/22/23 at 1:31 PM, revealed the Smoking Area (pavilion) outside the west dining room was in poor repair. The handrail along the back of the pavilion was warped. Two railings were loose, and four nails were exposed and sticking up. Two large window screens, approximately three feet by two feet, were lying on the cement floor between a bench and the back handrail of the pavilion. Forty to 50 cigarette butts were lying on the ground along the pavilion's perimeter, and an empty cardboard box

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F 584	Continued From page 18 with trash inside was sitting in the corner. Observations of the Smoking Area on 05/23/23 at 12:20 PM, in the presence of the acting Director of Nursing (DON) revealed the pavilion was in poor repair (i.e., warped handrail, two loose railings, and exposed nails). Two window screens remain on the cement floor of the pavilion in between a bench and wrapped handrail. Cigarette butts remain on the ground and around the perimeter of the pavilion. An empty cardboard box with trash inside. Paper towels, an empty medication cup, and a broken plastic cup were observed on the ground. During an interview on 05/23/23 at 12:30 PM, the acting DON/Minimum Data Set (MDS) Coordinator acknowledged the pavilion was in poor repair and contained cigarette buts on the ground and perimeter of the pavilion, a cardboard box with trash inside, paper towels, an empty mediation cup, and broken plastic cup on the ground. She said that staff supervised the residents while they were in the Smoking Area and that they sat in the middle of the pavilion and did not go near the area in disrepair. During an interview with the Administrator on 05/25/23 at 4:03 PM, in the presence of the Corporate Administrator and Vice President of Clinical Services, the Administrator acknowledged that the pavilion was in disrepair, unclean, and an accident hazard. The Administrator stated that none of the staff were responsible for maintaining the area and that she would notify the Maintenance Supervisor regarding the observations made on 05/22/23 and 05/23/23.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation	F 602		

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F 602	Continued From page 19 CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, the facility failed to ensure one of one resident (Resident #21) was free from misappropriation of medication in a total sample of 20 residents. As a result, Resident #21 did not receive five scheduled doses of Gabapentin (an anticonvulsant and nerve pain medication), and the facility could not account for ten (10) missing doses of Gabapentin. Findings Include: Review of Resident #21's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab, indicated Resident #21 admitted to the facility on 07/08/2019 from an acute care hospital. Resident #21's pertinent diagnoses included schizophrenia (mental illness of hallucinations and delusions), cerebrovascular accident (CVA-stroke), arthritis, and pain. Review of Resident #21's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/23/23, located in the EMR under the "MDS" tab, indicated Resident #21 cognitively intact as evidenced by a "Brief Interview for Mental Status (BIMS)" score of 14	F 602	F 602 1. Res. #21 missing gabapentin was reported to the ARNP by the DON on 05/02/23 and missing doses were replaced at the facility cost. On 06/26/23 the DON completed a 30 day look back audit of Res #21 Medication Administration Record and reported to the ARNP missing administration of gabapentin. 2. DON and licensed nurse completed a count on or before 06/30/23 of residents' Gabapentin to verify Gabapentin matched the resident inventory sheet. DON/Designee completed 30 day look back audit using their Medication Administration Record of Residents who receive Gabapentin to ensure that residents received the medication as ordered and reported to the ARNP any missing administration. 3. DON/Designee educated licensed staff on or before 06/30/23 related to the requirements of medication administration, handling and storage of Gabapentin including inventory tracking of medications. 4. DON/designee will audit residents on gabapentin weekly times 4 weeks and then monthly for 2 months to ensure compliance is maintained. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	06/30/23

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out of 15. Resident #21 received scheduled pain medication and non-medication interventions for pain.

Review of Resident #21's Physician's "Order Summary Report," dated 05/2023, located in the EMR under the "Orders" tab, indicated the Physician ordered Gabapentin 600 milligrams (mg), one tablet by mouth three times a day for pain.

Review of a Facility Reported Incident, dated 05/04/2023, indicated the facility noted Resident #21 was missing Gabapentin.

Review of the Pharmacy's "Delivery Manifest," dated 05/02/2023, located in the facility's Incident/Investigation Folder, indicated the Pharmacy delivered 90 600 mg tablets of Gabapentin on 05/02/23 at 4:44 PM. Further review revealed Licensed Practical Nurse (LPN) 2 signed for the receipt of the medication.

Review of Resident #21's "Medication Administration Record (MAR)," dated 05/2023, located in the EMR under the "Orders" tab, indicated staff entered a chart code of nine (other/see nurses notes) for the administration of Gabapentin 600 mg on 05/02/23 for the morning, lunch, and evening dose, and 05/03/23 for the morning and lunch dose indicating staff did not administer the medication to the resident. Further review revealed staff administered a total of seven doses of Gabapentin 600 mg to the resident (three times on 05/01/23: morning, lunch, and evening dose, once on 05/03/23: evening dose, and three times on 05/04/23: morning, lunch, and evening dose).

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Review of the "Progress Notes," dated 04/30/23, indicated "Gabapentin 600 mg tablet was unavailable; the Pharmacy sent out a 30-day supply on 04/09/23. Unable to refill until 05/06/23. On 05/02/23, the nurse spoke to the Pharmacy, who stated Gabapentin would arrive in the first-afternoon delivery. Nurse Practitioner aware."

Review of Resident #21's "Pain Evaluation Form" dated 05/01/23, located in the EMR under the Assessments tab, indicated Resident #21 experienced moderate generalized and joint pain related to arthritis and neuropathy, which was an acceptable pain level for Resident #21.

Review of three medication cards (photocopies) dated 05/02/23, located in the facility's Incident/Investigation Folder, revealed the Pharmacy delivered three medication cards of Gabapentin 600 mg tabs for a total of 90 tablets. As of 05/04/23 (time not noted), 72 tablets remained (one medication card labeled AM contained 28 tablets, one medication card labeled Noon contained 28 tablets, and one medication card labeled PM contained 16 tabs).

Review of the facility's "5-day Investigation Summary," dated 05/04/23, located in the facility's Incident/Investigation Folder, revealed the facility interviewed staff who had access to the medication from 05/02/23 through 05/04/23. Staff denied any knowledge of the location of the ten (10) missing Gabapentin and denied that they borrowed the medicine for another resident or gave the wrong amount of medication to Resident #21.

During an interview on 05/22/23 at 11:58 AM, Resident #21 denied any knowledge of the

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missing Gabapentin and did not have any concerns regarding pain management.

During an interview on 05/25/23 at 10:16 AM, LPN 2 stated that the Pharmacy delivered 90 600 mg tablets of Gabapentin for Resident #21 on 05/02/23. LPN 2 stated that typically the Certified Medication Aids (CMA's) pass medications on the center hall where Resident #21 resides and was unable to say what happened to the missing doses of Gabapentin

During an interview on 05/25/23 at 10:26 AM, CMA 4 stated that when she came to work on 05/02/23, Resident #21 had three cards of Gabapentin and noted several pills missing from the supply that was just delivered. So, she notified the Director of Nursing and showed her the mediation cards. At that time, the Director of Nursing (DON) started an investigation.

During a telephone interview on 05/25/2023 at 2:18 PM, Registered Nurse (RN)1 stated the DON asked her about the missing medications when it was first identified. RN 1 stated that she did not know anything about the missing medication until then. RN 1 stated that most of the time CMA's pass medications in the center hall and that she was unsure if someone borrowed it for another resident but did not want to speculate what happened to them.

An attempt to interview RN 3 on 05/25/2023 at 2:23 PM was unsuccessful-a message was left for a return call. RN 3 did not return the call.

During an interview with the Administrator on 05/25/23 at 4:16 PM, in the presence of the Corporate Administrator and Vice President of

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F 602	Continued From page 23 Clinical Services, the Administrator stated the DON, who was currently out of the country, conducted the investigation. The Administrator indicated that Resident #21 is the only person in the facility that received Gabapentin 600 mg tablets and questioned if it was a medication error or misappropriation of property. The Administrator indicated the State of Iowa did not consider Gabapentin a controlled substance and that staff did not reconcile the medication as they do with controlled medications. Review of the facility's policy titled, "Abuse Prevention Program and Reporting," dated 09/2014, indicated "The facility prohibits the mistreatment, neglect, and abuse of resident/patients and misappropriation of resident/patient property by anyone, including but not limited to staff, family, or friends. Residents have the right to be free from verbal, sexual, and mental abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms."	F 602		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656	F 656 1. Res. #29 Care Plan was updated by the MDS Nurse/Designee on 05/24/23 to include her Plan of care for her Diabetes. 2. On or before 06/30/23 the MDS/Designee completed an audit of resident with Diabetes to ensure Diabetes Care Plan are in place. 3. On or before 06/30/23 DON/Designee will educate MDS Nurse regarding Care Planning Diabetic Residents and their needs. 4. DON/Designee will audit new residents or newly diagnosed residents with Diabetes to ensure their Care Plan is updated. Audits will be completed weekly times 4 weeks and then monthly for 2 months to validate compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	06/30/23

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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 requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and review of the facility's "Care Plan Development" policy, the facility failed to develop a Comprehensive Care

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Plan for diabetes management for one of one resident (Resident #29) reviewed for diabetic management. As a result, facility staff failed to notify the attending Physician and/or Nurse Practitioner when Resident #29's blood glucose levels were lower than 70 milligrams (mg) per deciliter (dl) and/or greater than 350 mg/dl. Cross Reference: F580 Notify of changes.

Findings Include:

Review of Resident #29's "Admission Record," located in the Electronic Medical Record (EMR) under the "Profile" tab, indicated Resident #29 was admitted to the facility on 04/14/23 from an acute care hospital. Resident #29's pertinent diagnosis included diabetes mellitus due to an underlying condition without complications.

Review of Resident #29's admission "Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 04/21/23, located in the EMR under the "MDS" tab, indicated Resident #29 had moderate cognitive impairment, as evidenced by a "Brief Interview Mental Status (BIMS)" score of nine out of 15. Resident #29 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and rejection of care during the review period. The "MDS" did not include a diagnosis of diabetes mellitus, as noted on Resident #29's "Admission Record" and Physician Orders.

Review of Resident #29's "Comprehensive Care Plan," located in the EMR under the Care Plan tab, initiated on 04/27/23, did not reveal a Comprehensive Care Plan for diabetes mellitus.

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F 656	Continued From page 26 Review of Resident #29's physician's "Order Summary Report," dated 04/01/23 through 05/31/23, located in the EMR under the "Orders" tab, indicated Resident #29 had a diagnosis of diabetes mellitus. The physician's orders directed staff to obtain blood glucose results four times daily (before meals and bedtime) and notify the provider if blood glucose results were less than 70 mg/dL. Administer Insulin Lispro per sliding scale: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, and 401-450 = 12 units subcutaneously with meals for type 1 diabetes. Administer Insulin Lispro 15 units subcutaneously with meals for type 1 diabetes. During an interview on 05/24/23 at 1:00 PM, the acting Director of Nursing/MDS Coordinator stated that she was responsible for developing Comprehensive Care Plans for residents. She stated that diabetes should be Care Planned. Review of the facility's policy titled, "Care Plan Development," dated 08/2015, indicated, "An individualized, Comprehensive Care Plan using the results of the Resident Assessment Instrument (RAI)/MDS Assessment, resident/family/legal representative and interdisciplinary input will be developed for each resident in the facility within 21 days of admission or 7 [seven] days after the completion date of a Comprehensive MDS Assessment, and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The Care Plan will include measurable objectives, interventions, goals, and timetables."	F 656		
F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		

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F 679	Continued From page 27 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations, Resident Council Interview, staff, resident, family and LTC Ombudsman interviews, and review of facility policy, the facility failed to provide an ongoing Activities Program for four of five residents (Resident #21, #32, #36, and #2) reviewed for activities in a total sample of 20 residents. This failure increased the potential of residents developing mood and behavioral symptoms related to not having meaningful activities provided for them. Findings include: 1. Review of Resident #21's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab, indicated Resident #21 was admitted to the facility on 07/08/19 from an acute care hospital. Resident #21's pertinent diagnoses included schizophrenia (mental illness of hallucinations and delusions), cerebrovascular accident (CVA-stroke), major depression, and anxiety	F 679	F 679 1. Activity Director hired and started on 06/19/23 Resident #21, 32, 36, and 2 were interviewed by Administrator/Designee on 06/07/23 and updated their Activity Interest to ensure their needs are being met. 2. On or before 06/30/23 the residents were re-interviewed and their Activity Interest were updated. 3. On or before 06/22/23 the Administrator will educate the Activity Director on meeting the needs of the residents. 4. Activity Director/Designee will complete random audits weekly times 4 weeks and then monthly for 2 months to validate compliance. Activity Director and Administrator will review Resident Council minutes monthly for three months to identify any activities request. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Activity Director is responsible for ongoing monitoring.	06/30/23

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Review of Resident #21's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 06/07/22, located in the EMR under the "MDS" tab, indicated Resident #21 was cognitively intact as evidenced by a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. Resident #21 independent with bed mobility, transfers, walking in his room and corridors, and locomotion on the unit and required supervision from one staff member for dressing and personal hygiene. Further review revealed the facility did not complete the section outlining Resident #21's preferences for customary routine and activities.

Review of Resident #21's "Care Plan," last revised 05/02/23, located in the EMR under the "Care Plan" tab, indicated Resident #21 had little, or no activity involvement related to physical limitations and wished not to participate. The stated goal indicated Resident #21 would express satisfaction with the type of activities and level of activity involvement through the review date. Resident #21's preferred activities included movies, cards, music, television, family, and friends. Resident #21 needed a variety of activity types and locations to maintain interest.

Review of Resident #21's "Activity Data Collection Tool," dated 04/07/23, located in the EMR under the "Assessments" tab, indicated that Resident #21 preferred afternoon activities and self/alone time activity participation. Resident #21's activity interests included reading and other. The "Activity Data Collection Tool" did not identify what "other" activities Resident #21 was interested in doing.

During an interview on 05/22/23 at 1:50 PM,

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Resident #21 stated that the facility did not have a lot of activities that he liked to do. The resident stated that he was more into music and outside activities, but they did not provide a lot of outdoor activities. During a follow-up interview on 05/24/23 at 12:30 PM, Resident #21 stated that the facility had not provided any activities since 04/2023 when the Activities Director left.

During an interview on 05/25/2023 at 12:42 PM, Certified Nurse Aide (CNA) 1 stated Resident #21 stayed in his room, was very antisocial, did not participate in much, and only came out of his room to smoke.

During an interview on 05/25/23 at 12:50 PM, Licensed Practical Nurse (LPN) 2 stated Resident #21 only cared about smoking, and occasionally came out of his room to socialize in the lounge area, but ninety percent (90%) of the time he stayed in his room.

2. Review of Resident #32's "Admission Record," located in the EMR under the "Profile" tab, indicated Resident #32 was admitted to the facility on 04/24/23 from an acute care hospital. Resident #32's pertinent diagnoses included depression, cerebral infarction (stroke), and adult failure to thrive.

Review of Resident #32's Admission "MDS" with an ARD of 04/28/23, located in the EMR under the "MDS" tab, indicated Resident #32 had moderate cognitive impairments as evidenced by a "BIMS" score of eight (8) out of 15. Resident #32 required limited assistance from one staff member for bed mobility, transfers, walking in his room and corridors, locomotion on and off the

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unit, and dressing. Resident #32's activity preferences indicated that it was very important for him to listen to music, keep up with the news, do things with groups of people, participate in his favorite activities, and go outside to get fresh air when the weather is good.

Review of Resident #32's "Care Plan," dated 04/24/24, located in the EMR under the "Care Plan" tab, indicated Resident #32 was at risk for an alteration in psychosocial well-being related to restrictions on visitation, group activities, and communal dining due to COVID-19. The stated goal indicated Resident #32 would not experience any adverse effects throughout the review period. The pertinent Care Plan interventions indicated activities to maintain engagement while providing a calming and supportive atmosphere. Examples may include but are not limited to music, aromatherapy, favorite movies, audiobooks, or another activity preferred/desired by the resident. Encourage resident phone calls, emails, social media, or cyber contact with loved ones, ministers, priests, rabbis, or other spiritual leaders-one-on-one visits with staff, including reading, playing puzzles, conversation, or other resident-desired activity.

Review of Resident #32's "Activity Data Collection Tool," dated 04/27/23, located in the EMR under the "Assessments" tab, revealed the tool was incomplete.

Review of Resident #32's "Activity Data Collection Tool," dated 05/25/23, located under the "Assessments" tab, indicated Resident #32 preferred evening/night activities, family/friend activity participation, and his activity interests included "other." The Activity Data Collection Tool

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did not identify what "other" activities Resident #32 was interested in.

During an observation on 05/24/23 at 3:00 PM, Resident #32 went out on a pass with his girlfriend.

Review of the "Activities Calendar," dated 05/2023, provided by the facility, indicated the following pertinent scheduled activities:
a. On 05/22/23 at 10:00 AM: Sing-along in the activity room.
b. On 05/23/23 at 10:00 AM: Uno in the activity room, 1:00 PM: Word Game in the activity room, and 5:00 PM: Music in the dining room.
c. On 05/24/23 at 10:00 AM: Volleyball in the activity room.
d. On 05/25/23 at 10:00 AM: Arts and Crafts in the activity room, 1:00 PM: Movie in the activity room, and 5:00 PM - Music in the dining room.

During observations conducted throughout the facility on 05/22/23 at 10:00 AM, 05/23/23 at 10:00 AM, 1:00 PM, and 5:00 PM, 05/24/23 at 10:00 AM, and 05/25/23 at 10:00 AM revealed the facility did not provide any resident activities.

During an observation on 05/25/23 at 1:00 PM, after concerns regarding the lack of activities were discussed with facility Administration, the facility conducted a movie in the activity room, which Resident #21 and Resident #32 attended.

During an interview on 05/25/23 at 12:22 PM, Family Member 1 stated Resident #32 admitted to the facility for strengthening. She stated that she visited Resident #32 daily but has never seen him attend any activity and has not seen the facility provide activities for the residents. She

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stated that she felt activities would help Resident #32 mentally and thought he would like activities that would assist him in getting acquainted with other residents, talking, socializing, and having fun.

During an interview on 05/25/23 at 12:40 PM, CNA 1 stated the facility did not have an Activities Director for two or three weeks. CNA 1 stated that she was unsure of Resident #32's activity preferences and that he was going home tomorrow (05/26/23). CNA 1 stated Resident #32 did not participate much and kept to himself. When he first arrived, he just wanted to stay in bed.

During an interview on 05/25/23 at 12:45 PM, LPN 2 stated Resident #32 kept to himself and did not interact or socialize that much with others. LPN 2 stated Resident #32 visited his girlfriend when she came into the facility. LPN 1 stated the facility had not provided activities since the Activities Director left (04/27/23); however, they did have a BBQ for Nursing Home Week. LPN 2 stated that she was unaware of Department Heads conducting activities for residents in the absence of the Activities Director.

During an interview on 05/24/23 at 5:00 PM, the Administrator stated that the Facility's Activity Director was terminated on 04/27/23 due to poor performance. She said Department Heads provided activities until they hired a new Activities Director and provided activities for the residents during Nursing Home Week. Upon inquiry, the Administrator acknowledged facility staff did not provide activities from 05/22/23 through 05/24/23.

During an interview with the Administrator on

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05/25/23 at 4:08 PM, in the presence of the Corporate Administrator and Vice Present of Clinical Services, the Administrator stated the staff usually completed the Activities Data Collection Tool within five days of admission. The Activities Data Collection Tool helped staff get to know the resident and their activity preferences. She indicated that she completed Resident #32's Activities Data Collection tool today (05/25/23) when she noted that staff did not complete the one dated 04/27/23.

Review of the facility's policy titled, "Recreational and Therapeutic Activities Manual, Program Guide," dated 01/2013, provided by the facility, indicated the "Recreational and Therapeutic Activity staff utilizes programming opportunities to offer variety to residents/patients. Therapeutic program components are integrated throughout the selected program programming options. Program guides offer information and direction on establishing recreational and therapeutic programming within the facility. Facility staff selects and implements programs based on the identified needs of the resident/patient and available resources." Cross Reference: F680 Qualification of Activity Professional.

3. Review of Resident #36's "Face Sheet," located in the EMR under the "Profile" tab, revealed an original admission date of 05/19/22 with a most recent readmission date of 05/16/23.

Review of Resident #36's "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 05/18/23 revealed Resident #36 was cognitively intact with a "Brief Interview for Mental Status

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(BIMS)" score of 13 out of 15.

During an interview 05/22/23 at 12:31 PM, Resident #36 revealed he was upset because there were no activities or anything to do at the facility. Resident #36 stated all he had to look forward to was going outside to smoke and listen to his music. He indicated the remote for his television had been missing so he was not able to watch his television, but staff just found it in the laundry, so he would start back watching television (as an activity).

4. Review of Resident #2's "Face Sheet," located in the EMR under the "Profile" tab, revealed an admission date of 10/08/22.

Review of Resident #2's Quarterly " MDS," located in the EMR under the "MDS" tab, with an ARD of 04/28/23 revealed Resident #2 was cognitively intact with a "BIMS" score of 14 out of 15.

During an interview on 05/22/23 at 10:51 AM, Resident #2 revealed, "there is no Activities Director, and we have nothing to do around this place. All you can do is go outside to smoke and most of the time there is not a staff person to take us outside, so we miss our smoking times. We need to have something to do every day except sit in our room and watch television.

During an interview on 05/24/23 at 8:14 AM, the Long Term Care Ombudsman revealed that the facility had been without an Activity's Director for two to three weeks. "The residents are not happy about not doing any activities. Resident #2 has had a few blow-ups about how things are being

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F 679	Continued From page 35 done at the facility, and not having anyone available to take them out on smoke breaks." During a Resident Council Meeting on 05/24/23 at 10:01 AM, Resident #2, #11, #13, #15, #21, #24, #31, #36, #44, and #47 indicated some concerns about not having an Activities Director. The residents expressed they (the residents) were trying to get together and play cards and sit and talk, but they miss bingo, and "name that tune" specifically.	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on a review of the facility's policy, Employee Termination Notice, and staff interview, the facility failed to ensure the facility's Activity	F 680	F 680 1. Activity Director hired and started on 06/19/23 2. On 06/27/23 the Administrator validated that activities were being done per Activity Calendar. 3. On 06/27/23 the Administrator educated the Activity Director on meeting the needs of the residents. 4. Activity Director/Designee will complete random audits weekly times 4 weeks and then monthly for 2 months to validate compliance. Activity Director and Administrator will review Resident Council minutes monthly for three months to identify any activities request. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Activity Director is responsible for ongoing monitoring.	06/30/23

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Program was under the direction of a qualified therapeutic recreation specialist or activities professional. The facility's failure had the potential for activities not to be individualized for the skills, abilities, interests, and preferences of all 51 facility residents.

Findings Include:

Review of the facility's policy titled, "Recreational and Therapeutic Activities Manual, Program Guide," dated 01/2013, provided by the facility, indicated the "Recreational and Therapeutic Activity staff utilizes programming opportunities to offer variety to residents/patients. Therapeutic program components are integrated throughout the selected program programming options. Program guides offer information and direction on establishing recreational and therapeutic programming within the facility. Facility staff selects and implements programs based on the identified needs of the resident/patient and available resources."

Review of a facility document titled "Employee Termination Notice," dated 04/27/23, provided by the facility, revealed the facility terminated the Activities Director on 04/27/23 due to unsatisfactory performance and violation of company policies/processes.

During an interview on 05/25/23 at 4:06 PM, the Administrator, Corporate Administrator, and Vice President of Clinical Services indicated that on 12/2022, the facility promoted a previous staff member as the Activity Director, who they terminated on 04/27/23 for poor performance. Since then, the facility did not have a qualified

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F 680	Continued From page 37 Activities Director or a Corporate Activities Director to oversee the Activities Program.	F 680		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff and resident interviews, the facility failed to assist in gaining access to vision services to fix broken glasses for one of one resident (Resident #21) out of a total sample of 20 residents. As a result, Resident #21 used tape to fix the broken right arm of his eyeglass frames. Findings Include: Review of Resident #21's Quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/23/23, located in the Electronic Medical Record (EMR) under the "MDS" tab, indicated Resident #21 cognitively intact as evidenced by a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15. Resident #21's	F 685	F 685 1. Res. #21 received new glasses on 06/10/23 and was verified Administrator. 2. On 06/07/23 an audit was completed by Social Services/Designee to identify any resident with glasses in need of repair with none identified. 3. On or before 06/03/23 Administrator/Designee will educate staff that if a resident voices concerns or observe that the classes are in need of repair they will inform Social Services 4. Social Service Director/designee will audit random resident that wear glasses for glasses that need repair weekly times 4 weeks and then monthly for 2 months to ensue compliance is maintained. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Social Services is responsible for ongoing monitoring.	06/30/23

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pertinent diagnoses included glaucoma (eye disease resulting in vision loss). Resident #21 had adequate vision with the use of corrective lenses.

Review of Resident #21's "Care Plan," dated 03/28/23, located in the EMR under the "Care Plan" tab, indicated Resident #21 had the potential for impaired visual function related to glaucoma and a history of cardiovascular accident. The pertinent interventions instructed staff to arrange a consultation with an eye care practitioner as required and identify/record factors affecting visual function.

During an observation and interview with Resident #21 on 05/22/23 at 2:55 PM, Resident #21 sat in his room. He had tape around the right arm of his eyeglass frames. Resident #21 stated that he broke his glasses (date and time unknown) and notified the Administrator (date and time unknown) that he needed them repaired; however, they never addressed the need to fix his glasses.

During an interview on 05/24/23 at 12:50 PM, the Administrator stated that about a week ago, Resident #21 reported that he broke his glasses and needed them repaired. The Administrator stated that she contacted the optical provider to request services. The Administrator stated that she usually emails the provider to request services but called the provider this time instead. The Administrator could not provide supporting evidence that she contacted the optical provider to get Resident #21's glasses fixed.

During a second interview on 05/24/23 at 1:49 PM, Resident #21 stated that he broke his

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F 685	Continued From page 39 glasses a couple of months ago and reported the issue to the Administrator; however, they never scheduled an appointment to fix them. During a phone interview on 05/24/23 at 1:00 PM, the Optical Administrative Assistant (OAA) stated that if a resident required repairs to their glasses, the facility usually contacted the optical provider and asked for request for repair. The OAA reviewed Resident #21's clinical record and stated that the clinical record did not contain any notes that the facility initiated a request for repair order for Resident #21.	F 685		
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, resident and staff interviews, and facility policy review, the facility failed to ensure one of 12 residents who smoke was smoking in a designated area and was using the appropriate receptacles for discarding cigarette butts (Residents #36). The facility reported a census of 51 residents. Findings Include:	F 689	F 689 1. Resident #36 has been reeducated by Administrator/Designee on or before 06/30/23 regarding smoking in designated area and using the appropriate receptacles for discarding cigarette butts with compliance met. 2. Social Service Director/Designee has reeducated on or before 06/30/23 residents who are independent with smoking on smoking only in designated smoking areas and using the appropriate receptacles for discarding cigarette butts. 3. Facility staff were reeducated on or before 06/30/23 by the Administrator/Designee regarding the smoking policy and requirements of residents smoking in designated smoking areas and using the appropriate receptacles for discarding cigarette butts.. 4. Social Service Director/designee will audit random independent smoking resident to ensure they are smoking in smoking area and using the appropriate receptacles for discarding cigarette butts weekly times 4 weeks and then monthly for 2 months to ensure compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Social Services is responsible for ongoing monitoring.	06/30/23

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Review of Resident #36's "Face Sheet," located in Electronic Medical Record (EMR) under the "Profile" tab, revealed an original admission date of 05/19/22 with the most recent readmission date of 05/16/23.

Review of Resident #36's "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab, with an Assessment Reference Date (ARD) of 05/18/23 revealed Resident #36 was cognitively intact with a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15.

Review of Resident #36's "Smoking Evaluation," located in the EMR under the "Forms" tab and dated 05/22/23, revealed the resident was identified "as a smoker, smokes morning, afternoon, evenings, resident can light own cigarette, no supervision, no smoking related incidents and resident does not always smoke in the designated smoking area." Resident #36 was noted to be able to safely smoke independently.

Observation on 05/23/23 at 8:53 AM revealed Resident #36 in front of the facility smoking a cigarette. The Corporate Administrator (CAD) opened the door and helped Resident #36 inside the facility.

Another observation was on 05/23/23 at 3:43 PM, Resident #36 was outside in the front of the facility at the door smoking. Resident #36 revealed "He likes to come outside and smoke and listen to his music".

Other observations were on 05/23/23 at 5:00 PM, Resident #36 was out front smoking and listening to his music. There were cigarettes butts all over the ground as there was no place to properly

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dispose of the cigarettes.

During an interview on 05/23/23 at 1:58 PM, the Social Service Director (SSD) revealed Resident #36 had been smoking out front because he and another resident had a verbal altercation, so the Administrator decided to have Resident #36 smoke out front, to separate the two residents. "Resident #36 prefers to be out front smoking. He can take himself out and bring himself back into the building. Resident #36 is okay to smoke independently."

During an interview 05/24/23 at 11:56 AM with the Administrator, Corporate Administrator (CAD) and the Vice President of Clinical Services (VPCS), the Administrator revealed Resident #36 was told he could smoke in the front but needed to be fifteen feet away from the building due to fire codes. "Resident #36 originally started smoking out front to separate him and another resident that got into a verbal altercation." The CAD stated, "we are looking into getting a receptacle for disposal of cigarette butts, but with an open parking lot, we are having difficulty in finding a place to put one."

Review of the facility policy titled, "Smoking Policy," last revised in 09/2019, read in pertinent part, "The facility provides safe, designated smoking areas for residents/patients who smoke. Smoking is prohibited in any resident rooms, or outside the designated smoking area. Approved, non-combustible ashtrays are provided in the designated smoking areas. Safety equipment available for use in the designated smoking areas include smoking blanket,
smoking aprons and fire extinguisher. Smoking may not occur within 20 feet of an exit or

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F 689	Continued From page 42 entrance to the facility (or as specified by state requirements)."	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, interview, and policy review, the facility failed to reorder narcotic pain medication in a timely manner, notify timely the Nurse Practitioner or Physician that narcotic pain medication was unavailable, and/or notify the Nurse Practitioner (NP) or Physician when the narcotic pain medication was ineffective or when the resident experienced breakthrough pain causing undue pain for one of four residents reviewed for pain management in a total sample of 20 residents (Resident #48) . Findings Include: Review of Resident #48's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 04/07/23, located in the "MDS" tab of the Electric Medical Record (EMR), revealed an admission date of 03/31/23, a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating Resident #48 was cognitively intact, a diagnosis of Type 1 diabetes mellitus with foot ulcer, had frequent pain at a pain	F 697	F 697 1. Resident #48 pain medication has been administered per order and physician was notified by the DON/Designee of the omission on 06/28/23 . A Pain assessment was completed by a License Nurse on 06/26/23 with the Physician notified if warranted. 2. On or before 06/30/23 the DON/Designee completed an audit to ensure that resident who receive narcotic pain medication have available medication. 3. On or before 06/30/23 The DON/Designee educated the Lic. Nurses and CMA's on administration of narcotic medication and requiring of notification to the physician if medication is not available, to order the medication timely and if ARNP not able to order timely the Physician will be notified. 4. DON/Designee will audit random resident who receive narcotic pain medication to ensure that medication is available weekly times 4 weeks and then monthly for 2 months to ensure compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	06/30/23

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intensity of 8 out of 10, had a diabetic foot ulcer, and prescribed an opioid (narcotic pain medication).

Review of Resident #48's 04/11/23 "Care Plan," located in the "Care Plan" tab of the EMR, revealed a focus area of "The resident has (chronic) pain related to (r/t) diagnosis of Peripheral Vascular Disease (PVD) has Deep Tissue Injury (DTI) on left heel and surgical wounds on right foot from 2nd toe amputation." Interventions included "Administer analgesia (specify medication) as per orders, Give 1/2 hour before treatments or care, Evaluate the effectiveness of pain interventions every shift or with cares. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition."

Review of Resident #48's "Orders," located in the "Orders" tab of the EMR, revealed a Physician's Order for "Oxycodone HCl [hydrochloric acid] Oral Tablet 10 milligram (mg) (Oxycodone HCl-narcotic pain medication), Give 10 mg by mouth every 4 hours as needed for Pain" and "Acetaminophen [generic Tylenol] Tablet Give 650 mg by mouth four times a day for pain give every 6 hours for pain."

Review of Resident #48's "Medication Administration Record (MAR)," dated 05/01/23 through 05/20/23 and located in the "Orders" tab of the EMR, revealed under the oxycodone medication, 55% of the time Resident #48's pain level was documented as 7 to 10 (43 out of 67 times). The "MAR" also revealed from 05/19/23 to 05/22/23 at 1:33 PM, 12 blanks were noted under the oxycodone medication meaning the

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oxycodone was not given to Resident #48. Further review of the "MAR" revealed Resident #48 did receive the Acetaminophen as ordered every six hours.

On 05/22/23 at 11:10 AM, Resident #48 stated the facility was out of her pain medication, oxycodone. Resident #48 stated the staff told her they called the Physician's Order into the Pharmacy. Resident #48 went on to say, "this has happened before." Resident #48 described her current pain level as 10 out of 10.

On 05/22/23 at 11:25 AM, Certified Nurse/Medication Aide (CNA) 3 was observed at the doorway of Resident #48's room with a medication cart. CNA 3 was heard telling Resident #48 "a script (prescription) was sent to the Nurse Practitioner (NP) and we are waiting for her to respond," "not much else can be done except I can give you Tylenol." Review of the May 2023 MAR located in the "Orders" tab of the EMR, revealed acetaminophen was given on 05/22/23 at 0600 and 1200 with a pain level of "7." Review of the "MAR" revealed Resident #48 received a dose of oxycodone on 05/22/23 at 7:33 PM, 7.5 hours after receiving the Acetaminophen which was not controlling her pain.

On 05/22/23 at 1:15 PM, Resident #48 was observed in bed eating her lunch. Resident #48 confirmed what CNA 3 said about the NP hadn't sent over the prescription for oxycodone yet to the Pharmacy and Tylenol was given. Resident #48 stated the Tylenol didn't help her pain.

On 05/23/23 at 3:10 PM, the Director of Nursing (DON) was asked about ordering controlled

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medications, such as oxycodone, as Resident #48 had indicated her pain level was at a 10 and her medication ran out. The DON stated they must have a hard copy or e-copy prescription for the NP or doctor to sign and then it is sent to the pharmacist at least 4 days ahead of time.

On 05/24/23 at 12:06 PM, the NP, was asked if Resident #48 was her patient and she said "yes." NP was asked about Resident #48 running out of oxycodone for one to two days. NP stated the facility called her on Monday, 05/22/23, and she refilled it right away. NP went on to say she wasn't sure about who was on-call over the weekend, but it would be her expectation for staff to call in a refill when two to three pills were remaining as controlled drugs take longer to fill.

On 05/25/23 at 8:35 AM, Licensed Practical Nurse (LPN) 2 was asked about reordering Resident #48's oxycodone. LPN 2 stated she starts reaching out to the NP up to five days ahead of time. LPN 2 confirmed Resident #48 ran out of her oxycodone stating, "she needs it." LPN 2 stated she was the third person to text the NP's personal cell phone. LPN 2 stated this wasn't the first time Resident #48's oxycodone had run out and the NP did not respond. LPN 2 was asked for documentation of her and other staff reaching out to the NP. LPN 2 looked in the EMR for documentation of contacting NP but none was found, LPN 3 stating, "I texted the NP." When LPN 2 was asked if she had attempted to notify the physician when the NP was unavailable, LPN 2 had no answer either verbal or documented in the medical record.

On 05/25/23 at 11:02 AM, the week-end on-call NP 2 was called, and a message was left. As of

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exit there was no response or return call.

On 05/25/23 at 2:06 PM, Resident #48 was observed in bed. Resident #48 stated the facility had run out of her pain medication before and still the oxycodone wasn't taking care of her pain completely. In a later interview at 5:33 PM, Resident #48 stated when her pain was at a 9 or 10 level, she couldn't sleep or get comfortable.

On 05/25/23 at 2:08 PM, LPN 3 was informed of Resident #48's complaint of the oxycodone not completely eliminating her foot pain. LPN 3 stated Resident #48 "just had her foot debrided yesterday so she's a little more sore than usual." LPN 3 stated Resident #48 could only get oxycodone every four hours and there was nothing for break-through pain except Tylenol. LPN 3 stated Resident #48 has refused the Tylenol as Resident #48 reported to her the Tylenol wasn't effective for her. Review of the "Orders" revealed no new orders for pain management after the wound was debrided.

On 05/25/23 at 4:15 PM, the Administrator, Vice President Clinical Services (VPCS), and the Corporate Administrator (CAD) were asked why the physician wasn't notified when Resident #48's oxycodone ran out and NP wasn't responding. None were aware of this situation. VPCS responded saying "we don't have an answer, the nurse would have to answer that." The Administrator, VPCS, and CAD were asked to please find out the answer before the survey team exited. No answer was provided by the end of the survey.

Review of the facility's policy titled, "Pain Management," dated 04/2013, revealed "Pain

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F 697	Continued From page 47 management includes addressing underlying causes of pain, evaluation of effectiveness of interventions, and progress towards goals. The resident/patient will determine goals for pain relief. If a resident/patient is unable to self-report progress towards goals, individual clinical indicators and behavior characteristics are utilized by the interdisciplinary team to evaluate progress."	F 697		
F 727 SS=F	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, document review and staff interview, the facility failed to ensure a Registered Nurse (RN) was on duty eight consecutive hours per day seven days a week. This had the potential to affect all 51 residents residing in the facility. Findings include: Review the Casper Payroll Based Journal (PBJ),	F 727	F 727 1. On or before 06/30/23 an audit was completed by the Administrator/Designee that 8 consecutive hours of RN coverage has been entered into payroll for the last 30 days. 2. On or before 06/30/23 the DON/Administrator/Designee will review weekly schedule to ensure that there is 8 consecutive hours of RN coverage for the next 30 days 3. On or before 06/30/23 the Administrator will reeducate DON and BOM on ensuring that 8 consecutive hours of RN coverage is scheduled, worked and entered. 4. DON/Designee will audit weekly for 4 weeks and then monthly for 2 weeks to ensure compliance is met. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. DON is responsible for monitoring and follow up as needed.	06/30/23

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F 727	Continued From page 48 First Quarter 2022 for dates October 1 -December 31, 2022, revealed during the first quarter the facility was identified as not having a RN working on the dates of 10/01, 10/02, 10/07, 10/08, 10/09, 10/13, 10/14, 10/15, 10/16, 10/22 10/23, 10/29, 10/30, 11/05, 11/06, 11/12, 11/13, 11/25, 11/26, 11/30, 12/10, 12/13, 12/14, 12/15, 12/16, and 12/23, for 8 consecutive hours each day. Review of Payroll documentation on 05/23/23 at 11:48 AM, and invoices from the staffing agency that worked for the facility during this period, revealed the facility had four days that RN coverage was not provided at the facility. Those dates were 10/22/22, 11/06/22, 11/25/22, and 11/27/22. During an interview on 05/23/23 at 12:15 PM with the Administrator and the Corporate Administrator (CAD), revealed they reviewed the payroll and invoices that were provided and for the dates of 10/22/22, 11/06/22, 11/25/22, and 11/27/22, verified no required RN coverage.	F 727		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732	F 732 1. Daily census and Clinical hours were entered onto the Staff Data Posting on 05/25/23 by Administrator per surveyor recommendation. 2. Medical Records/Designee will verify information on Staff Data Posting is accurate prior to posting. 3. On or before 06/30/23 the Administrator/Designee reeducated the DON, MDS Nurse and Medical Records on completing the Nurse Staff Data Posting to include census and that the License Professional Nursing hours are entered. 4. DON/Designee will audit weekly Nursing Staff Data Posting weekly times 4 weeks and then monthly for 2 months to validate compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	06/30/23

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(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observations, document review and staff interviews, the facility failed to ensure staffing information was complete and accurate, posted in a prominent place, and in a readable format for residents and visitors. There were 51 residents residing in the facility.

Findings Include:

During an observation/review on 05/24/23 at 8:00 AM of a document titled "Nursing Staff Information," located on the right side of the wall

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F 732	Continued From page 50 behind a plastic cover just past the entrance, revealed the following information was missing: a. Resident Census b. License Professional Nursing number of staff and hours. Review of documentation of "Nursing Staff Information" revealed from 05/03/23 through 05/24/23, none of the documentation included the census and/or License Professional Nursing Hours. During an interview on 05/24/23 at 8:06 AM, looking at the documentation with the Administrator, the Administrator verified the documentation was missing the Resident Census and the number and hours of Licensed Professional Nursing on duty .	F 732	F 758 1. Resident #3 Quetiapine Fumarate side effects were entered into the MAR/TAR on or before 06/30/23 by the DON/Designee for monitoring and a new Psychoactive Mediation Assessment was completed on by the DON/Designee to include neurological evaluation. Resident #26 MAR/TAR was updated by the DON/Designee to include monitoring of his sleeping pattern for his use of Trazodone and melatonin for sleep. 2. On or before 06/30/23 the DON/Designee completed audit to ensure that residents on Quetiapine Fumarate medication are being monitored for side effects and neurological evaluation is completed along with Trazodone and Melatonin ordered for sleep are being monitored for sleep patterns. 3. On or before 06/03/23 the DON/Designee reeducated Lic. Nurses and CMAs on monitoring of Quetiapine Fumarate side effects monitoring and Trazadone and Melatonin for sleep patterns of residents 4. DON/Designee will audit random residents weekly for 4 weeks then monthly for 2 months to validate compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. DON is responsible for ongoing monitoring.	06/30/23
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 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	F 758		

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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 clinical record review, observation, interview and review of facility policy, the facility failed to monitor the side effects/adverse consequences for two of five residents reviewed for the use of psychotropic medications in a total sample of 20 residents (Resident #3 and #26) .

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Findings Include:

1. Review of Resident #3's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 02/21/23, located in the "MDS" tab of the Electric Medical Record (EMR), revealed an admission date of 12/31/20, a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, indicating cognitively intact, and diagnoses of anxiety disorder and depression.

Review of Resident #3's 04/10/23 "Order," located in the EMR under the "Orders" tab, revealed Resident #3 was prescribed "Quetiapine Fumarate Oral Tablet 50 milligram (mg) (Quetiapine Fumarate) Give 50 mg by mouth one time a day for psychosis (hallucinations), depression, and anxiety."

Review of Resident #3's "Care Plan," located in the EMR under the "Care Plan" tab, revealed a 01/14/22 intervention to "Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Antidepressant side effects: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations."

Review of Resident #3's 04/02/23 "Psychoactive Medication Assessment," located in the EMR under the "Assessment" tab, revealed "Diagnosis for medication #3 [diagnosis code] anxiety disorder, unspecified [diagnosis code] major depressive disorder, single episode, unspecified." No adverse consequences or neurological evaluation were included in the assessment.

Review of Resident #3's May 2023" Medication Administration Record (MAR)," located in the EMR under the "Orders" tab, revealed no

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documentation for side effects/adverse consequents monitoring for Quetiapine.

Review of Resident #3's "Progress Notes," dated 04/23/23 through 05/23/23, located in the EMR under the "Progress Notes" tab, revealed no documentation for side effect monitoring for Quetiapine.

On 05/22/23 at 10:40 PM, Resident #3 observed ambulating about her room, waiting for her shower. Resident #3 stated she doesn't like to leave her room much and prefers not to participate in activities.

During an interview on 05/24/23 at 4:19 PM, Vice President Clinical Services (VPCS) and the Director of Nursing (DON) were asked about monitoring side effects for quetiapine VPCS reviewed the EMR and confirmed side effects were not being monitored and no neurological evaluation was completed.

2. Review of Resident #26's Annual "MDS" with an ARD date of 03/02/23, located in the "MDS" tab of the EMR, revealed an admission date of 05/03/18, a "BIMS" score of 15 out of 15, indicating cognitively intact, medications received included antipsychotic and antidepressant, and diagnoses of anxiety disorder, depression, and psychotic disorder.

Review of Resident #26's "Orders," located in the EMR under the "Orders" tab, revealed Resident #26 was prescribed "Trazodone HCl (hydrochloride) Tablet 100 MG Give 100 mg by mouth one time a day for Insomnia- order date 12/28/22" and "Melatonin Tablet 5 MG Give 10

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mg by mouth one time a day for sleep- Order Date 07/05/22."

Review of Resident #26's May 2023 MAR, located in the EMR under the "Orders" tab, revealed no documentation for sleep tracking monitoring for trazodone or melatonin.

Review of Resident #26's "Progress Notes," dated 05/01/23 through 05/25/23, located in the EMR under the "Progress Notes" tab, revealed only one entry of Resident #26 sleeping on 05/10/23 at 8:52 PM.

On 05/25/23 at 10:26 AM, Resident #26 was observed asleep in his bed dressed in street clothes.

During an interview on 05/24/23 at 4:19 PM, VPCS and the DON were asked about Resident #26's medication for sleep and insomnia. VPCS and the DON stated they weren't aware sleep should be monitored as they find him asleep so it must be effective. VPSC was asked when was Resident #26 observed sleeping, day or night and was it documented. VPSC and DON stated it wasn't documented.

Review of the facility's policy titled, "Medication Management," dated 08/2020, revealed "In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use . . .ii. The resident is monitored for the effectiveness of the medication or possible adverse consequence. Results are documented in the

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F 758	Continued From page 55 resident's active record."	F 758		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on facility Menu Spreadsheets, clinical record review, observation, resident and staff interviews, and policy review, the facility failed to: 1. plan menus for a therapeutic diet for one of four residents reviewed for therapeutic diets (Resident #3) and 2. follow menus for 18 of 18	F 803	F 803 1. On the DON/Designee reviewed Resident #3 diet with Physician/NP with new orders received and noted. 2. On or before 06/30/23 the DON/Designee reviewed 2 GM NA diets with Physician/NP with new orders obtained. On 06/26/23 the Administrator verified the approved menu was being followed as directed by Registered Dietitian. 3. On 06/22/23 the Administrator educated the DON and Dietary Manager on following ordered diets. On or before 06/30/23 the Dietary Manager/Designee educated kitchen staff that the approved menu needs to be followed and if substitutions are needed the exchange item needs to be approved by the Certified Dietitian. 4. Administrator/designee will complete an audit meal weekly for four weeks, then once monthly for two months DON/Designee will audit new Admissions or change in diet orders to ensure correct diets are being served weekly times 4 weeks and then monthly for two months. Results of these audits will be presented to the Quality Assurance Performance Improvement Committee meeting once monthly for three months for recommendations as needed. The Administrator/DON is responsible for monitoring and follow up	06/30/23

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residents reviewed for menus out of a total sample of 20 residents

Findings Include:

1. Review of the Week Five Menus Cycle Spreadsheet revealed the following diets: "Regular/NAS (no added salt), Small Portions, Large Portions, Regular with (w) ground (GRD) Meat, House Mechanical Soft, Puree, Finger Foods, and Heart Healthy." There was no 2-gram sodium diet listed.

Review of the 05/22/23 Lunch Menu Spreadsheets revealed the same food items for all the diets, except Heart Healthy; Seasoned chicken, baked sweet potato, seasoned pinto beans, bread, vanilla ice cream with caramel sauce. Heart Healthy included Fat Free (FF) - green beans instead of pinto beans and sherbet instead of ice cream.

Review of the 05/23/23 Lunch Menu Spreadsheet revealed the same food items for all the diets; glazed pork, baked potato/margarine, broccoli florets, bread/margarine, and strawberry angel dessert.

Review of 05/25/23 lunch menu spreadsheet revealed the same food items for all the diets, except Heart Healthy; beef pot roast, gravy, roasted potatoes, carrots & onions, bread/margarine, fruited gelatin. Heart Healthy included margarine instead of gravy.

Review of Resident #3's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 02/21/23, located in the

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"MDS" tab of the electric medical record (EMR), revealed an admission date of 12/31/20, a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, indicating Resident #3 was cognitively intact, and diagnoses of cancer, congestive heart failure (CHF), and malnutrition.

Review of Resident #3's "Diet Order," located in the EMR under the "Orders" tab, revealed Resident #3 was prescribed a "2 GM [gram] Sodium diet, Regular texture related to chronic diastolic (congestive) heart failure."

Review of Resident #3's "Care Plan," located in the EMR under the "Care Plan" tab, revealed a 01/17/23 revised intervention of "Diet to be followed as prescribed 2 gm Sodium, 2000 milliliter (ml) fluid restriction."

Review of Resident #3's "Nutrition Progress Note," dated 05/19/23, located in the EMR under the "Assessment" tab, revealed a "Current Diet Order and Texture 2000 ml fluid restriction/2 gm sodium restriction."

On 05/22/23 at 12:30 PM, Resident #3 was served her lunch tray in her room that included chicken, mashed potatoes with gravy, and mixed vegetables. Resident #3's meal ticket revealed a diet order of "7 (regular texture) Regular (IDDSI [International Dysphagia Diet Standardization Initiative])." No 2-gram sodium food items were provided.

On 05/23/23 at 12:42 PM, Resident #3 served her lunch tray in her room that included pork with gravy, baked potatoes with sour cream and butter, broccoli, half a slice of bread, fruit, milk, and juice. Resident #3 was observed using her

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personal bottle of Mrs. Dash for seasoning. Resident #3's Meal Ticket revealed a diet order of "7 Regular (IDDSI)." There were no 2-gram sodium food items provided.

On 05/25/23 at 10:19 AM, Resident #3 was asked about her diet. Resident #3 stated she was supposed to be on a low salt diet, so she provided her own Mrs. Dash. Resident #3 went on to say, "my meals are also supposed to be low salt."

On 05/25/23 at 12:30 PM, Resident #3 was served her lunch tray in her room that included beef, baby potatoes, carrots, bread, gelatin, orange juice, and milk. Resident #3's Meal Ticket revealed a Diet Order of "7 Regular (IDDSI)." There were no 2 gm sodium food items provided.

During an interview on 05/24/23 at 11:30 AM, Dietary Manager (DM) was asked about the 2 GM NA diet prescribed to Resident #3. DM stated he had never heard of that diet, but everyone got the same. The Menu Spreadsheets were reviewed together, and DM confirmed there were no 2 GM NA diets listed on the Menu Spreadsheets. DM went on to say, "everyone gets the same foods," and confirmed the food vendor provided the menus and the Registered Dietitian (RD) signed off on them."

During an interview on 05/24/23 at 2:13 PM, the Administrator was asked why the menus spreadsheets didn't include other therapeutic diets, such as a 2 GM NA. The Administrator did not respond.

On 05/25/23 at 8:01 AM, the Administrator was asked again why the Therapeutic Diet was

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prescribed for a 2 GM NA diets and no menus were available to follow on the spreadsheets. The Administrator gave no response and stated she would look into it.

During a telephone interview on 05/25/23 at 9:43 AM, the RD was asked if she was aware Resident #3 had a diet order for 2 GM NA due to CHF and that there were no Menu Spreadsheets for her diet. The RD stated the kitchen should be serving the 2 GM NA diet and food vendor who provides the menus can add the diet to the Spreadsheet. The RD went on to say a 2 GM NA "should not get canned or processed foods and no gravy, fresh fruit and vegetables should be served preferably."

2. Review of the Resident Council Minutes revealed on 01/19/23 residents expressed their dislike for the lack of "food choices- not liking the menu."

On 05/22/23 during the lunch hour of 11:30 AM to 12:30 PM, all the residents were served chicken, mashed potatoes with gravy, mixed vegetables, and a cookie. Review of the planned week-at-a-glance lunch menu for 05/22/23 revealed chicken, sweet potatoes, pinto beans, bread, and ice cream.

During an interview on 05/24/23 at 3:35 PM, the Dietary Manager (DM) was asked why the planned lunch menu for 05/22/23 wasn't followed. The DM stated the residents don't like sweet potatoes and it was an oversight for not serving the pinto beans as he didn't realize the pinto beans were on the menu. The DM went on to say they ran out of ice cream.

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On 05/23/23 during the breakfast hour of 7:30 AM to 8:30 AM, all the residents were served an egg omelet, a donut, and oatmeal. Review of the planned week-at-a-glance breakfast menu for 05/23/23 revealed eggs, bacon, and toast.

During an interview on 05/24/23 at 3:41 PM, the DM was asked why the planned breakfast menu for 05/23/23 wasn't followed. The DM stated he had the cooks serve donuts instead of toast because the bread was frozen, and the bacon didn't come in on the truck.

On 05/23/23 during the lunch hour of 11:30 AM to 12:30 PM, all the residents were served pork, baked potatoes, broccoli, bread, and chopped strawberries. Review of the planned week-at-a-glance lunch menu for 05/23/23 revealed pork, a baked potato, broccoli, bread, and strawberry angel dessert.

On 05/24/23 at 10:01 AM during the Resident Council interview, residents expressed complaints about the menus not being posted. The residents stated on the occasion the menus were posted, the menus weren't followed. Consequently, they never knew what they were going to be served. Additionally, residents felt as if they were forced to eat what was served as the only alternative meal was sandwiches.

During an interview on 05/24/23 at 3:40 PM, the DM asked why the planned lunch menu for 05/23/23 wasn't followed, the DM stated the strawberry dessert didn't come in on the truck.

On 05/24/23 during the lunch hour of 11:30 AM to 12:30 PM, all the residents were served chicken

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noodle casserole, green beans, banana pudding, and bread. Review of the planned week-at-a-glance lunch menu for 05/24/23 revealed turkey noodle casserole, corn, and banana pudding.

During an interview on 05/24/23 at 3:36 PM, the DM was asked why the planned lunch menu wasn't followed. The DM stated he didn't have enough corn.

On 05/24/23 at 11:43 AM, the tray line was observed in the dining room with chicken noodle casserole, green beans, half sliced bread, and pudding. At 11:49 AM, Cook (C)1 was asked about alternates, and he stated residents could get a hamburger or a grilled cheese sandwich. The DM provided the alternate menu that included only entrees of Cheeseburgers, Breaded Chicken, Chef Salad, Deli Sandwiches, and peanut butter and jelly sandwiches. The DM was asked what if a resident didn't want the vegetable served. The DM stated, "we don't provide an alternate vegetable, only entrees."

During a telephone interview on 05/25/23 at 9:43 AM, the RD was asked if she was aware the menus weren't followed. The RD stated the DM does a good job, but she worries if finances were the reason. The RD was asked why only entrée alternatives were provided but not for vegetables and side dishes. The RD confirmed alternatives for vegetables and side dishes should be provided but she wasn't sure why it wasn't. The RD stated she wondered if it was because of staffing or finances.

On 05/25/23 at 12:20 PM, the board titled "Today's Menu" with three slots, located just

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F 803	Continued From page 62 inside the dining room, was observed to be empty as no menus were posted. During an interview on 05/25/23 at 10:25 AM, the Corporate Administrator (CAD) was asked if there had been a problem with food deliveries as the DM stated he wasn't always able to follow the menus because food items hadn't come in on the truck. CAD stated she wasn't sure but would check for any notices of something being out of stock. None were provided by the end of survey. Review of the facility's policy titled, "Menu Planning," dated 06/2015, revealed "Menus are planned and reviewed to provide nourishing well-balanced meals that meet the nutritional needs of residents/patients."	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on review of past Resident Council Minutes, current Resident Council Interview, observation of meal service, record review, and policy review, the facility failed to serve food that was palatable, attractive, and at an appetizing temperature to three of six residents sampled for food palatability out of a total sample of 20	F 804	F 804 1. Resident #3, #24 and #26 was interviewed on or before 06/30/23 by the Administrator/Designee and voiced no concerns regarding the meal that was served. 2. Administrator/Designee interviewed random resident regarding Palatable of meal with no concerns voiced on or before 06/30/23 3. Dietary Manager/Designee reeducate dietary staff on or before 06/30/23 regarding serving palatable meals. 4. Dietary Manager/Designee will interview random resident weekly for 4 weeks and then monthly for 2 months to ensure compliance. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Dietary Manager is responsible for monitoring and follow up as needed.	06/30/23

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residents (Residents #3, #24, and #26).

Findings Include:

Review of the Resident Council Minutes revealed:
a. On 03/23/23 "residents want more fresh fruit and veggies [vegetables]."
b. On 12/07/22 "meals cold, don't like meals."

On 05/24/23 at 10:01 AM, during the Resident Council Interview, complaints were expressed about the food. Residents #3, #24, and #26 stated there wasn't enough variety in the meals, the food was poorly seasoned and served cold, salt was only available if you ate in the dining room, and sometimes the food could be dry.

1. Observation of Resident #3's meal on 05/22/23 at 12:30 PM, revealed Resident #3 served her lunch in her room. Resident #3's meal consisted of baked chicken, mashed potatoes with gravy, and mixed vegetables. Resident #3 stated the food wasn't very hot and mashed potatoes were served a lot, but she would eat it anyway.

2. Observation of Resident #24's meal on 05/23/23 at 10:01 AM, revealed Resident #24 was served her breakfast in her room. Resident #24's meal consisted of scrambled eggs, oatmeal, and a donut. No salt was provided on the tray. Resident #24 stated "it's cold" and no seasoning so she would not eat it. The oatmeal appeared dry and hard.

3. Observation of Resident #26's meal on 05/24/23 at 8:56 AM, revealed Resident #26 was served his breakfast in his room. Resident #26's meal consisted of scrambled eggs with cheese, cream of wheat, and a slice of toast with a cup of

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juice and coffee. No salt was provided on the tray. Resident #26 stated the toast was burnt and his eggs, cream of wheat and coffee were all cold, stating "I won't be eating it." Resident #26 went on to say, "they don't care." The toast was noted to have black edges and stripes in the center and the cream of wheat appeared to be dry and hard.

On 05/25/23 at 12:36 PM, a Test Tray was sampled, and no issues were found except no salt and pepper packets were provided.

During a confidential interview on 05/22/23 at 10:40 AM, a resident stated the food was of poor quality and served cold many times.

During an interview on 05/24/23 at 8:14 AM, Cook (C)1 was asked about the appearance of burnt toast at breakfast. C 1 confirmed the appearance of the toast stating, "I had the toaster on the second setting and that's just the way it turned out."

During an interview on 05/25/23 at 2:20 PM, the Dietary Manager (DM) was asked if he had received any food complaints and he said "yes, a few in Resident Council but not lately". DM was asked about the breakfast toast served on 05/24/23 that appeared burnt. DM stated he wasn't aware of it. DM confirmed hall trays do not receive salt packets as salt was only available for residents who ate their meals in the dining rooms as the tables have salt shakers.

During an interview on 05/25/23 at 4:13 PM, the Administrator was asked if she was aware of food palatability complaints and burnt toast that was served to residents at breakfast on 05/24/23. The Administrator stated she wasn't aware of any food

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F 804	Continued From page 65 complaints of burnt toast or cold food. Review of the facility policy titled, "Menu Production," dated 06/2015, revealed "Residents/patients are provided food that is prepared by methods that conserve nutritive value, flavor, and appearance and are served in an attractive manner at the proper temperature."	F 804	F 812 1. The Dietary Manager/Designee disposed of the apple strudel sticks and bags of biscuits, the convection oven cleaned, wall behind the steamtable has been cleaned and areas painted if needed, lower walls at the Unit #2 refrigerator has been repaired and cleaned, lower wall under the coffee maker has been cleaned, floor to the entry way were clean of food debris and broken tile was fixed with loose base board reattached, mop water is being disposed of properly, nourishment refrigerator that contained resident food has been cleaned and items with no date or outdated date has been disposed of, and a temperature gauge has been installed into the freezer of the nourishment refrigerator on or before 06/30/23. . 2. An observation audit was completed by the Administrator on or before 06/30/23 to ensure that the kitchen has been clean and the repair to the floor and wall were repaired. 3. Dietary Manager/Designee reeducated dietary staff on or before 06/3023 on kitchen sanitation. Completion of logs, proper storing and dating of food and cleaning. 4. Dietary Manager/Designee will audit weekly for 4 weeks and then monthly for 2 months to ensure compliance. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. The Dietary Manager is responsible for monitoring and follow up as needed.	06/30/23
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, policy review, and review of the United States Federal Food & Drug Food Code, the facility failed to ensure the kitchen floors and walls were clean and easily cleanable, foods stored in refrigerators and freezers were sealed, labeled, and/or	F 812		

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discarded after the expired date, and mop water was discarded properly. This deficient practice had the potential to affect 51 of 51 residents who received meals prepared in the facility's only kitchen.

Findings Include:

During the kitchen tour on 05/22/23 at 9:43 AM and on 05/23/23 at 2:03 PM with the Dietary Manager (DM) the following observations were made:

The freezer located in the DM's office contained a box of apple strudel sticks and a bag of biscuits that were undated and open, exposing the products. During a follow-up review on 05/24/23 at 3:31 PM, the box of apple strudel sticks was still open and undated, and the bag of biscuits was still undated but sealed. The DM was asked about these items, and he stated they should be sealed and dated.

The convection oven was observed heavily soiled with baked on splatters and debris. During a follow-up review on 05/24/23 at 11:27 AM, the DM was asked about the convection oven's cleaning schedule. The oven was observed in the same condition. The DM stated the oven would be cleaned Friday.

The walls behind the steamtable had an accumulation of dried food splatters as well as worn and scraped paint. The lower walls at the Unit #2 refrigerator were broken and soiled with debris build-up. The lower wall under the coffee maker contained a collection of brown dried splatters.

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During a follow-up review on 05/24/23 at 11:27 AM, the above wall conditions were pointed out to the DM and the DM stated these wall areas would be cleaned on 05/24/23.

The floors to the entry way to the food storeroom contained a build-up of food debris and broken tile that created crevices. The corners were broken causing the base boards to be loose and detached. The floor at the back door contained a collection of debris along the tile and crevices. The baseboards in and around steamtable had a buildup of food residue.

During a follow-up review on 05/24/23 at 11:27 AM, the above floor conditions were pointed out to the DM and the DM stated these floor areas would be cleaned on 05/24/23.

On 05/23/23 at 2:15 PM, the DM was asked where the mop water was discarded. The DM stated the mop water was poured out the back door on the parking lot or poured in the garbage disposal on the dirty side of the dish room as they have no drain to pour it into. A small closet was observed with mops and a bucket with no drain. The DM then opened the back door and pointed to the ground where the mop water was poured.

During the inspection of the nourishment refrigerator that contained resident food on 05/24/23 at 1:54 PM with Certified Nurse Aide (CNA)3, the following observations were made:

The refrigerator contained seven food items that were observed without dates; a box of pizza, two take-out dinners, a pack of sliced ham, a box a fried chicken, a bag with two whole cucumbers that were soft and slightly moldy, and a bag of

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sliced cucumbers. An additional four food items were observed past the expiration date; a cake slice dated 05/20/23, a half cake dated 04/07/23, a cupcake dated 05/16/23, and a soup container dated 05/17/23.

The top freezer of the nourishment refrigerator did not contain a temperature gauge. The freezer was filled with ice cream, popsicles, and other foods.

Review of the cleaning schedule, provided by the DM, revealed "Floors must be swept and washed daily (including corners/baseboards). Use detergent and hot water; dry thoroughly." The last completed date was documented as 05/21/23. "Painted walls and ceiling should be washed with a mild detergent solution. Rinse using a clean cloth and dry to eliminate streaking." This section was left blank with no completion date documented. The refrigerators/coolers and freezer section included to "Discard any out-of-date inventory" and no completion date was documented. The oven section included "Use a blunt scraper or wire brush. Racks and shelves should. be removed and cleaned in a warm detergent solution. Clean oven door and oven after use. Clean exterior of oven and polish" and the last completion date was documented as 05/17/23.

During a telephone interview on 05/25/23 at 9:30 AM, the Registered Dietitian (RD) was asked about the kitchen's sanitation and repair issues observed on 05/22/23 and 05/23/23. The RD stated she was hopeful the new company would spend some money on the necessary repairs.

On 05/25/23 at 10:25 AM, the Administrator was

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asked who was responsible for cleaning the nourishment refrigerator. The Administrator stated she didn't know but she would find out.

On 05/25/23 at 2:20 PM, the DM was asked about pouring mop water outside on the back premises and he said he had been doing it for four years. He stated he didn't know there was a regulation prohibiting this.

On 05/25/23 at 4:15 PM, the Administrator, Vice President Clinical Services (VPCS), Corporate Administrator (CAD), were informed of the kitchen sanitation observations including the mop water being poured on the outside premises. They were unaware of mop water being poured out on the outside premises.

Review of the facility policy titled, "Nutrition Services Manual," dated 06/15, revealed "Nutrition Services staff follows sanitation and food production guidelines to prepare and maintain food safely . . . When food item is opened and not completely used, write the open date on the food container. Write a "use by" date on the food container. . . 2. Dispose of all outdated food."

Review of the facility policy titled, "Food brought into room from outside sources," dated 06/15, revealed "7. Any food, which is not to be eaten right away, should be transported in a clean, disposable, sealed container (i.e., butter dish, whipped cream bowl, etc.). The container should be small enough to fit into the vegetable bin of a refrigerator. Your nurse will label, date, and store this food in the Nursing Unit's Nourishment Refrigerator. If the food is not used within 3 days,

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F 812	Continued From page 70 it will be discarded ..." Review of the United States Federal Food & Drug Food Code 2022 revealed: 5-203.13 Service Sink. (A) At least 1 service sink or 1 curbed cleaning facility equipped with a floor drain shall be provided and conveniently located for the cleaning of mops or similar wet floor cleaning tools and for the disposal of mop water and similar liquid waste. 6-501.15 Cleaning Maintenance Tools, Preventing Contamination. Food preparation sinks, handwashing sinks, and ware washing equipment may not be used for the cleaning of maintenance tools, the preparation or holding of maintenance materials, or the disposal of mop water and similar liquid wastes.	F 812		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that:	F 847	F 847 1. On or before 06/30/23 the Administrator/Designee reviewed the Arbitration Agreement with Resident #2, #21, 24, and #36 and answered questions they had for better understanding. 2. Administrator/Designee will review the Arbitration Agreement on 06/29/23 at an Resident Council meeting. 3. Admission team members will be reeducated by the Administrator/Designee on or before 06/30/23 on presenting the Arbitration Agreement. 4. Administrator/Designee will audit new admissions to ensure understanding of the Arbitration Agreement for 4 weeks then monthly for 2 months to validate compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	06/30/23

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IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

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F 847	Continued From page 71	F 847		

(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on record review, Resident Council Meeting interview, staff interviews and policy review, the facility failed to ensure residents understood the Binding Arbitration Agreement before signing the agreement for four of five sampled residents reviewed for binding arbitration agreements in a total sample of 20 residents

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F 847	Continued From page 72 (Residents #2, #21, #24, and #36).	F 847		

Findings include:

During the entrance Conference on 05/23/23 at 10:10 AM the Administrator, Corporate Administrator (CAD), and Vice President of Clinical Services (VPCS), revealed the facility offered Binding Arbitration Agreements to residents. The Business Office Manager was responsible for explaining and going over the paperwork with the resident.

During an interview on 05/24/23 at 9:39 AM, when asked to explain the Binding Arbitration Agreement as she would to a resident the Business Office Manager (BOM) stated, "The agreement is like a legal thing they are offered to my knowledge. If they have any dissatisfaction with the facility. Then I provide them with a copy of the agreement if they request one."

During a Resident Council Meeting on 05/24/23 at 10:01 AM, there were ten residents that attended the meeting. In talking with the residents about the Arbitration Agreement, none of the residents were familiar with any documentation that was being described to them. All of the residents were in agreement if they signed it, they did not know what they were signing.

1. Resident #2's EMR revealed a "BIMS" of 14 with a signature on the Arbitration Agreement on 10/10/22. Resident #2 was their own responsible party.

2. Resident #21's EMR revealed a "BIMS" of 15 with a signature of the arbitration agreement on

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06/19/20. Resident #21 was their own responsible party.

3. Resident #24's EMR revealed a "BIMS" of 15 with a signature on the Arbitration Agreement on 09/27/16. Resident #24 was their own responsible party.

4. Review of Resident #36's Electronic Medical Records (EMR) revealed a "Brief Interview for Mental Status (BIMS)" of 13 with a signature on the Arbitration Agreement on 05/19/22. Resident #36 was their own responsible party.

During an interview on 05/24/23 at 11:56 AM with the Administrator, CAD and VPCS, revealed that the BOM and Social Service Director (SSD) would be receiving training on understanding arbitration agreements and on how to explain the arbitration agreement to residents and resident representatives.

Review of the facility's "Binding Arbitration Agreement," provided by the facility, revealed, " . . The Arbitration shall be conducted by a Panel of three (3) arbitrators. Each side will select one arbitrator. The two selected arbitrators will select the third arbitrator from a list of potential arbitrators agreed to by the parties. Unless agreed to otherwise by the Parties, the source for the list to determine the third arbitrator will be the Federal Court List of Mediators for the U.S. District Court for the jurisdiction in which the Facility is located. Majority of Panel Required for Verdict. A majority of the three-person Panel must agree with the verdict for it to be binding. This Agreement represents the parties' entire agreement regarding Disputes, supersedes any

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F 847	Continued From page 74 other agreement relating to disputes and may only be changed by a writing signed by all Parties. This Agreement shall remain in full force and effect notwithstanding the termination, cancellation or natural expiration of the admissions Agreement."	F 847		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed	F 851	F 851 1. On or before 06/30/23 an audit was completed by the BOM/Designee verified that direct care staffing information has been entered into payroll for the last 30 days. 2. On or before 06/30/23 Administrator/Designee reviewed and verified Direct Care Staffing information has been submitted. 3. On or before 06/30/23 the Administrator educated the BOM on ensuring that Direct Care Staffing information has been submitted to CMS. 4. BOM/Designee will audit weekly for 4 weeks and then monthly for 2 weeks to ensure compliance is met. Results of these audits will be presented to the QAPI meeting monthly for 3 months for review and recommendations as needed. BOM is responsible for monitoring and follow up as needed.	06/30/23

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practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and audited data.
This failure affected 51 of 51 residents.

Finding include:

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F 851	Continued From page 76 Review with the Payroll Based Journal (PBJ), staffing data report Casper Report Fiscal Year Quarter 1 2022, October 1- December 31, 2022, revealed failure to have License Nursing Coverage 24 hours/day. Those days include: a. For October 2022: 10/01, 10/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31. b. For November 2022: 11/01 11/02, 11/04, 11/05, 11/06, 11/07 11/10, 11/11, 11/12, 11/13, 11/17, 11/18, 11/22, 11/24, 11/25, 11/26, 11/27, 11/29, 11/30. c. For December 2022: 12/01 12/02, 12/03, 12/04, 12/06, 12/07, 12/08, 12/10, 12/13, 12/14, 12/15, 12/16, 12/20 , 12/21, 12/22, 12/23, 12/28. Review of Payroll documentation on 05/23/23 at 11:48 AM, and invoices from a Staffing Agency that worked for the facility during this period it was discovered the facility had four days that Registered Nurse (RN) coverage was not provided at the facility. Those dates were 10/22/22, 11/06/22, 11/25/22, and 11/27/22. Further review indicated there were Licensed Nursing Staff on duty each day. During an interview on 05/23/23 at 12:15 PM with the Administrator and the Corporate Administrator (CAD), revealed they had looked at the payroll and invoices that were provided and for the dates of 10/22/22, 11/06/22, 11/25/22, and 11/27/22, verified no required RN coverage.	F 851		
F 925 SS=E	Maintains Effective Pest Control Program	F 925		

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F 925	Continued From page 77 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on pest control receipt review, resident interviews, observations, staff interviews and policy review, the facility failed to have an effective pest control program for four of four residents interviewed about pest control out of a total sample of 20 residents (Resident #13, #24, #45, and #48). This failure affected 51 of 51 residents who resided in the facility. Findings Include: Review of the pest control receipts dated 11/17/22, 12/07/22, 01/07/23, and 02/07/23, provided by the facility, revealed only payment information and no details on what type of treatment was provided. On 05/22/23 at 10:15 AM, Resident #13 called the surveyor into her room stating, "I have mites." Resident #13 pointed to her floor and numerous tiny insects were observed crawling on the tile floor. Resident #13 stated Housekeeping cleaned her room but that didn't help with the mites. On 05/22/23 at 2:30 PM, Resident #24 was asked about insects in her room. Resident #24 stated roaches were found in the birdseed bag in her closet recently. She was moved to another room until the roaches were treated and now, she's back in her original room.	F 925	F 925 1. Administrator on or before 06/30/23 did a visual audit of resident #3, 24, 45 and #48 rooms for any current concerns regarding pest with none noted. 2. On 06/29/23 the Administrator completed a visual facility audit of pest in the facility and findings reported to Pest Control Company if warranted 3. On or before 06/30/23 l the Administrator/Designee reeducated the facility staff on reporting of pest and prevention. 4. Administrator/Designee will complete visual audits weekly times 4 weeks then monthly for 2 months to validate compliance. Results of audits will be taken to the monthly QA meeting for 3 months for review and discussion. Administrator is responsible for ongoing monitoring.	06/30/23

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On 05/23/23 at 8:58 AM, Resident #45 was asked about insects in her room. Resident #45 stated she sometimes had spiders in her room.

On 05/24/23 at 8:31 AM, Resident #48 was asked if she ever saw insects in her room. Resident #48 stated "yes, spiders and I'm very scared of them." Resident #48 also stated at night several roaches come out in her bathroom.

During an interview on 05/24/23 at 2:06 PM, Certified Nurse Aide (CNA)1 was asked if she ever saw insects in the building. CNA 1 stated "yes, only spiders, ants if food is on the floor and an occasional beetle."

On 05/25/23 at 12:11 PM, a large spider web was observed in the copy room above the cabinet in the right-hand corner on the ceiling.

On 05/25/23 at 12:51 PM, a live spider was observed crawling across the hallway at the back Nurse Station, outside the copy room. The Administrator was standing nearby, and the spider was pointed out to the Administrator.

During an interview on 05/25/23 at 12:25 PM, the Administrator was asked for a pest control contract and when the was the last time the facility was treated for pests. The Administrator stated she thought the time pest control came was February 2023. No contract was provided as of end of survey.

During an interview on 05/25/23 at 5:39 PM, the Corporate Administrator (CAD) stated the pest control had been an issue and a new company was hired but they never showed up. CAD stated, "payment was an issue and is still ongoing."

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F 925	Continued From page 79 Review of the facility's policy titled, "Pest Control," revised 12/2019, revealed "The facility strives to protect the resident/patients, staff, and visitors from insects and other pests by controlling infestation through contracts with outside pest control agencies."	F 925		