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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 3/21/24 The following deficiencies resulted from investigation of Complaints #116994-C, #117523-C, #118474-C, #118427-C, #118467-C, #118508-C, #118544-C, #118526-C, #118659-C and #118725-C conducted January 31, 2024 to February 20, 2024. Complaints #116994-C, #117523-C, #118474-C, #118427-C, #118467-C, #118544-C, #118526-C, #118659-C and #118725-C were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 555 SS=D	Right to Choose/Be Informed Attendg Physician CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or	F 555		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tatesa Jacobs — TITLE: Administrator — (X6) DATE: 3/15/24

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

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F 555 SS=D	Right to Choose/Be Informed Attendg Physician CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or	F 555		

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

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F 555	Continued From page 1	F 555		

her care.

§483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

§483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy, provider interview, resident and staff interview the facility failed to allow a resident to remain under the care of a physician of their choice and coordinate care with the chosen provider for 1 of 1 (Resident #2). The facility reported a census of 24 residents.

Findings include:

The Minimum Data Set (MDS) assessment tool, dated 1/17/24 , listed diagnosis for Resident #2 included type 2 diabetes, recent severe sepsis with septic shock, and peripheral vascular disease (poor circulation). The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

During an interview on 1/31/24 at 2:00 PM, Resident #2 stated upon admission she

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F 555	Continued From page 2 requested her local General Practitioner (GP) assume her care while in the facility. The resident stated the Director of Nursing (DON) informed her the facility had providers who will see her during her stay. The Resident stated the facility providers did see her despite her request. An Electronic Health Record (EHR) revealed the facility Nurse Practitioner (NP) saw the resident and completed Physician Progress notes for visits occurring on: 1/11/24, 1/17/24, 1/26/24, and 1/30/24. During an interview on 2/7/24 at 2:15 PM, the GP stated she considered herself to be the Resident's primary care provider while in skilled care. The GP stated the facility had canceled at least one appointment, and did not send updated lab results or a medication list for the 1/29/24 appointment. During an interview on 2/14/24 at 9:30 AM the DON stated she did not know Resident #2 had a local provider. The DON stated she believed the Resident scheduled the 1/29/24 appointment to establish care. The Resident Admission Agreement, Section III. Rights and Obligations of the Resident regarding Physician's Care indicated: a. Residents shall remain under the care of an attending physician of his or her choice throughout the stay in the facility. b. Resident's Attending Physician shall be one who has agreed to abide by the Facilities policies and who agrees to see Resident either by visiting the Facility or through office visits.	F 555		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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F 656	Continued From page 3 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 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.	F 656		

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F 656	Continued From page 4	F 656		

(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 observation, interview, clinical record review, and facility policy review, the facility failed to ensure comprehensive care plans in place to address a resident's use of antianxiety medication and/or identified high fall risk for two of five residents reviewed for comprehensive care plans (Resident #17, Resident #21). The facility reported a census of 24 residents.

Findings include:

1. Review of the Admission MDS assessment for Resident #17 dated 12/27/23, completed 12/28/23, revealed the resident scored 11 out of 15 on a Brief Interview for Mental Stats (BIMs) exam, which indicated moderately impaired cognition. Per this assessment, the resident took antianxiety medication and wandered daily.

Per Census information in the resident's clinical record, Resident #17 admitted to the facility 12/18/23.

On 2/19/24, review of Resident #17's Care Plan did not address use of antianxiety medication.

Review of the Physician Order for Resident #17, start date 12/18/23 at 4:00 PM, revealed the following: Lorazepam Oral Tablet 0.5 mg

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(milligram) with directions to give 1.5 tablet by mouth three times a day for Anxiety.

Review of the Medication Administration Record (MAR) dated December 2023 revealed an order for Lorazepam 0.5 mg (milligram) scheduled three times per day, with first dose given the morning of 12/19/23. The resident continued on the medication three times per day per review of Resident #17's MAR dated February 2024.

On 2/20/24 at 2:03 PM, the Director of Nursing (DON) explained she completed Care Plans with help from the Regional Nurse Consultant. When queried if a resident on Ativan (Lorazepam) on admit and later on, if would expect to be on the Care Plan, the DON acknowledged it should be.

The Facility Policy titled Resident Assessment Instrument (RAI)/Care Planning Management, dated October 2023, revealed the following: The Comprehensive Care Plan is completed within seven (7) days after the Care Area Assessments (CAAs) are completed (and at no time will this time frame exceed 21 days), and reviewed quarterly thereafter. If modifications, deletions, additions are necessary, changes should be made at the time of occurrence.
2. The Minimum Data Set (MDS) assessment tool, dated 11/15/23 , listed diagnosis for Resident #21 included traumatic brain injury, aphasia (impaired communication skills), dementia, repeated falls, lack of coordination, and wandering indiseases classified elsewhere. The MDS assessed the resident required substantial assistance to transfer from bed to a chair, and due to medical and safety concerns does not walk. The MDS documented The MDS listed the resident's Brief Interview for Mental Status (BIMS)

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F 656	Continued From page 6 score as 01 out of 15, indicating severely impaired cognition. The Electronic Health Record (EHR) Census revealed an admission date of 10/17/23. A review of Assessment records indicated an initial Fall Risk Evaluation completed on 10/17/23, with a score of 13. A score of 10 or greater indicated a high fall risk. The Care Plan, dated 11/08/23, lacked a focus area and interventions related to a risk of falls. The Care Plan, dated 1/5/24, included a focus area to address risk of falls. The focus area addressed falls that occurred on: 12/10/23, 12/17/23, 12/30/23, 1/12/24, and 1/14/24. The Care Plan, dated 1/5/23, intervention for falls included: a. The intervention for the fall on 12/10/23 initiated on 1/5/24 b. The intervention for the fall on 12/17/23 initiated on 1/5/24 c. The intervention for the fall on 12/23/23 initiated on 1/5/24 d. The intervention for the fall on 1/12/24 initiated on 1/12/24 e. The intervention for the fall on 1/14/23 initiated on 1/14/24	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure Care Plans updated to address a void trial, falls, and resident behaviors for three of five residents reviewed for Care Plans (Resident #1, Resident #4, Resident #17). The facility reported a census of 24 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #4 dated 1/25/24, completed on 2/5/24, revealed the resident scored 15 out of 15 on a Brief Interview for

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Mental Status (BIMs) assessment, which indicated intact cognition. Per this assessment, the resident did not have any falls since admission, entry, re-entry, or the prior assessment, whichever more recent.

The Resident had a Care Plan to address falls dated October 2023 with all interventions dated in October 2023.

The Care Plan dated 11/15/23, revised 1/17/23, documented, Risk for Falls. Review of Interventions per the Care Plan documented the following:

a. Date initiated 1/8/24 created on 1/17/24: Assistance. with ambulation as needed when returning to facility due to medical appointments/hospitalizations.
b. Date initiated and created 11/15/23: Determine Residents ability to transfer
c. Date initiated and created 11/15/23: Evaluate fall risk on admission and as needed (PRN)
d. Date initiated and created 11/17/23: I will ask for help when feeling weak

The Care Plan dated 2/9/24 documented, Risk for Falls. All interventions per the Care Plan were initiated and created on 2/9/23 as follows:

a. Assist Resident with ambulation and transfers, utilizing therapy recommendations
b. If fall occurs, alert provider
c. If Resident is a fall risk, initiate fall risk precautions

Review of the resident's Care Plans to address falls lacked interventions between the intervention created on 1/17/24, initiated on 1/8/24, and the

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Care Plan interventions dated 2/9/24.

Review of Resident #4's clinical record and Incident Report documentation revealed the resident fell on the following dates:

a. 1/6/24 (times two)
b. 1/8/24
c. 1/29/24
d. 2/4/24
e. 2/8/24
f. 2/9/24
g. 2/10/24

2. Review of the Admission MDS assessment for Resident #17 dated 12/27/23, completed 12/28/23, revealed the resident scored 11 out of 15 on a BIMs exam, which indicated moderately impaired cognition. Per this assessment, the resident took antianxiety medication and wandered daily.

The Care Plan dated 12/28/23, revised 1/31/23, revealed the following focus area for Resident #17: I am a wanderer related to (r/t) Resident wanders aimlessly, significantly intrudes on the privacy of others. Interventions included the following:

a. Date Created 12/28/23: Monitor for fatigue and weight loss.
b. Date Created 1/29/24: Encourage activity involvement.
c. Date Created 1/29/24: Notify Medical Doctor (MD) as needed.
d. Date Created 1/29/24: Redirect me as needed.

Observation on 2/1/24 at approximately 11:23 AM revealed Resident #17 walked into [first resident's

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room where resident did not reside] room in front of [first resident's room] sink. When queried, Resident #17 talked about going to restroom.

On 2/1/24 at 11:32 AM, Resident #17 again went into [first resident's room where resident did not reside]. Staff A and Staff C observed in the dining room at the time. On 2/1/24 at 11:24 AM, the cart with lunch trays brought onto the dementia unit, and Resident #17 observed to leave [first resident's room where resident did not reside] and enter [second resident's room where Resident #17 did not reside] room.

On 2/20/24 at 2:07 PM, the facility's Director of Nursing (DON) queried how and when interventions would be added for the Care Plan. The DON explained interventions would be added as wandering occurred.

The Facility Policy titled Resident Assessment Instrument(RAI)/Care Planning Management, dated October 2023, revealed the following: Care plans are to be updated in an acute situation when identified, such as falls, falls with injury, new skin alterations, worsening skin conditions, behaviors, resident events, weight loss, infections, uncontrolled pain, allegations of abuse and other concerns that involve resident care/condition. These updates are to be prompt upon notification and should be reviewed and implemented in the daily clinical meeting and as they occur.

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F 657	Continued From page 11 3. The Minimum Data Set (MDS) assessment tool, dated 1/30/24, listed diagnosis for Resident #1 included: neurogenic bladder (lack of bladder control), muscle spasms, and type 2 diabetes. The MDS assessed the resident required intermittent catheterization for urine elimination. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. The Care Plan, dated 10/31/23, included a focus area related to the resident having a foley catheter at admission. An intervention, dated 10/31/23, directed staff to complete catheter care as indicated and per physician orders. A review of the Electronic Health Record (EHR) revealed a 12/18/23 urology physician progress note ordering a void trial (a test period to determine if a person can eliminate urine without a catheter) at the next catheter change. A review of the January 2024 Medication Administration Record (MAR) revealed a void trial documentation started on 1/20/24. The Care Plan lacked updated interventions to include the void trial.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		

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Based on clinical record review, staff interview, and facility policy review the facility failed to ensure medication and treatments administered per Physician Order, and failed to provide passive range of motion per Physician progress note guidance for four of four residents reviewed for Physician Orders (Resident #1, Resident #2, Resident #3, Resident #19). The facility reported a census of 24 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #3 dated 12/8/23 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

The Care Plan dated 12/27/23 documented, [Resident #3] uses psychotropic medications related to (r/t) schizophrenia. The Intervention dated 1/29/24 documented, Administer psychotropic medications as ordered by physician.

a. The Physician Order dated 12/2/23 documented, Clozapine Oral Tablet 200 milligram (MG) (Clozapine) Give 1 tablet by mouth two times a day for add to 50 MG Dose in AM to equal 250 MG in AM related to schizoaffective disorder, unspecified...add to 100 MG dose to equal 300 MG at evening (HS).

Review of the resident's January Medication Administration Record (MAR) for the above order revealed administration marked with a code of "5" which indicated Hold/See Nursing Notes on 1/11/24 AM dose and 1/30/24 AM dose. The code of "9" which indicated Other/See Nursing Notes

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marked on 1/7/24 HS dose, 1/8/24 AM dose, 1/9/24 AM dose, 1/10/24 AM and HS dose, 1/18/24 HS dose, 1/19/24 AM dose, 1/28/24 AM dose, 1/30/24 HS dose and 1/31/24 AM dose . Administration of medication left blank on the MAR for 1/26/24 HS dose,

b. The Physician Order dated 12/2/23 documented, clozapine Oral Tablet 50 MG (Clozapine) Give 1 tablet by mouth one time a day related to schizoaffective disorder, unspecified.. give with 200 MG dose to equal 250 MG in AM.

Review of the resident's January MAR for the above order revealed administration marked with a code of "5" which indicated Hold/See Nursing Notes on 1/11/24 and 1/30/24. The code of "9" which indicated Other/See Nursing Notes marked on 1/8/24, 1/9/24, 1/10/24, 1/19/24, 1/28/24, and 1/31/24.

c. The Physician Order dated 12/2/23 documented, clozapine oral tablet 100 MG (Clozapine) Give 1 tablet by mouth one time a day related to schizoaffective disorder, unspecified.. take with 200 MG dose to equal 300 MG at HS.

Review of the resident's January MAR for the above order revealed administration marked with a code of "5" which indicated Hold/See Nursing Notes on 1/10/24, code of "9" which indicated Other/See Nursing Notes on 1/18/24 and 1/30/24, and left blank on 1/26/24.

Review of Resident #3's Progress Notes for January 2024 revealed, in part, the following:

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a. 1/7/24 9:47 PM: clozapine Oral Tablet 200 MG...not available per pharmacy.
b. 1/8/24 at 9:14 AM: clozapine Oral Tablet 200 MG...not avail.
c. 1/9/24 at 9:50 AM: clozapine Oral Tablet 200 MG....Medication not available. Not given at this time.
d. 1/9/24 at 9:52 AM: clozapine Oral Tablet 50 MG...Medication not available. Dose not given at this time.
e. 1/18/24 at 856 PM: clozapine Oral Tablet 100 MG...not available.
f. 1/18/24 at 8:56 PM: clozapine Oral Tablet 200 MG...not available.
g. 1/19/24 at 12:04 PM: clozapine Oral Tablet 200 MG...ordered.
h. 1/28/24 at 11:39 AM: clozapine Oral Tablet 50 MG...ordered.
i. 1/31/24 at 9:29 AM: clozapine Oral Tablet 200 MG...not avail contacting harm (pharmacy).

On 2/20/24 at 2:08 PM, the facility's Director of Nursing (DON) queried about medication availability for residents. The DON explained if something not available, would be reordered in advance. The DON explained staff could either go into the computer and reorder or pull the sticker and reorder. Per the DON, if occurred in present time would notify the Nurse Practitioner (NP) medication not available and would follow guidance of NP.

When queried about Resident #3's Clozapine, the DON explained she notified, it was a difficult drug to obtain, and blood needed to be put into a repository. Per the DON, blood would be drawn, and the lab notified the repository to put in, then the drug would be sent. The DON explained herself and the person at the lab did not have

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access to the repository, when the lab was drawn, the lab value sent to other entity (repository), then needed to be entered into the databank. Per the DON, once the lab was drawn, neither party had ability to enter resident's white count. When queried as to frequency of the resident's labs, the DON acknowledged the resident's labs were not scheduled on a regular basis in the beginning, and were afterwards. The DON explained she was unaware of weekly lab draw when she worked on the floor, and after in DON role, became aware lab wasn't drawn on weekly basis and got it going.

Review of the Licensed Practical Nurse (LPN) Job Description, undated, revealed, Follow the facility's policies and procedures governing the provision of direct care to residents, including the administration of medications, treatments and other care in accordance with physician's orders and the resident's care plans.

Review of the Registered Nurse (RN) Job Description, undated, revealed, Insure that all medications and treatments are charted and signed following administration of the medication/treatment, by the administering person. Report all discrepancies noted concerning physician's orders, diet change, charting error, etc. to the Assistant Director of Nursing (ADON) or DON.

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2. The Minimum Data Set (MDS) assessment tool, dated 1/30/24, listed diagnosis for Resident #1 included: neurogenic bladder (lack of bladder control), muscle spasms, and type 2 diabetes. The MDS assessed the resident required intermittent catheterization for urine elimination. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

During an interview on 2/6/24 at 11:05 AM, Resident #1 stated his muscle spasms have been getting worse. He explained when he tries to go to sleep it feels like someone is suddenly pulling on his legs, making it difficult for him to fall asleep. The Resident stated it really helps when staff do range of motion. The resident stated staff at night will do it more than staff during the day.

The Resident also expressed concern about missing insulin several times in the last month. The resident could not report specific dates or times.

The Resident also stated the dressing on his coccyx area had been uncovered for three days in the last month. The resident could not report specific dates.

The Care Plan, dated 10/31/23, documented Resident #1 Focus Areas for:
a. Risk of pain due to diagnosis (DX) of neuropathy, osteoarthritis (OA) and spasms related to sub-acute paraplegia. The Focus Area lacked interventions addressing spasms.
b. Diabetes Mellitus (type 2 diabetes). The Intervention dated 10/31/23 documented.

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administer diabetes medications as ordered by the doctor.
c. Increased risk for pressure ulcer (PU) development. The Intervention dated 10/31/23 documented treatment as ordered.

A review of Physician Visit notes from a 12/5/23 visit with Physical Medicine and Rehab included an order for daily Passive Range of Motion (PROM).

A review of the Electronic Health Record (EHR) revealed a lack of a Physician Order for PROM.

A review of the eEHR revealed a Physician Order, dated for 10/23/23 for:
a. Insulin Glargine (long acting insulin) 20 units at bedtime for diabetes.
b. Insulin Lispro sliding scale three times daily before meals. Inject as per sliding scale if:
1. 150 -199 mg/dl (milligrames/deciliter) blood sugar = 3 units
2. 200-249 mg/dl blood sugar = 6 units
3. 250-299 mg/dl blood sugar = 9 units
4. 300-349 mg/dl blood sugar = 12 units
5. 350 - 400 mg/dl blood sugar = 15 units
c. Metformin 500 mg give 2 tablets by mouth two times a day for diabetes

A review of the January 2024 Electronic Medication Administration Record (eMAR) revealed the resident did not receive:
a. Insulin Glargine 20 units at bedtime on 1/26/24.
b. Insulin Lispro sliding scale before the supper meal on:
1. 1/2/24 with no documented blood glucose reading prior meal
2. 1/9/24 with no documented blood glucose reading prior to meal

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3. 1/25/24 with no documented blood glucose reading prior to meal
4. 1/30/24 with no documented blood glucose reading prior to meal
c. Metformin 500 mg 2 tablets evening dose not received on: 1/2/24, 1/9/24, 1/25/24, and 1/30/24.

A review of the eEHR revealed a Physician Order, dated 11/8/23, for coccyx wound. The order directed staff to remove dressing and cleanse with wound cleanser. Cover the wound bed with Hydrofera Blue (type of dressng for wound protection), cut to fit. Cover the dressing with 4x4 pad, push dressing down into the space then cover with foam dressing, change every two days.

A review of the January 2024 Electronic Treatment Administration Record (eTAR) revealed the dressing change did not occur as scheduled on:
a. 1/13/24. A review of Progress Notes revealed a lack of documentation explaining the reason for no dressing change.
b. 1/15/24. A review of Progress Notes revealed a lack of documentation explaining the reason for no dressing change.
c. 1/23/24. A Progress Note, dated 1/23/24 at 5:07PM, revealed dressing change not completed as had been completed on 1/22/24. The eTAR lacked documentation of a dressing change on 1/22/24
d. 1/25/24. A review of Progress Notes revealed a lack of documentation explaining the reason for no dressing change.

A Progress Note, dated 1/26/24, documented a dressing change not completed as dressing changes are not done on days [day shift].

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3. The Minimum Data Set (MDS) assessment tool, dated 1/17/24 , listed diagnosis for Resident #2 included type 2 diabetes, recent severe sepsis with septic shock, and peripheral vascular disease (poor circulation). The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

During an interview on 1/31/24 at 2:00 PM, Resident #2 expressed concern that nurses failed to administer heparin on multiple days since her admission. Resident #2 explained she will wait hours and then the nurse will bring her medication. The Resident stated she will not take the medication if it is too late.

A review of the EHR revealed a Physician Order, dated 1/11/24, for Heparin Sodium injection solution, injection 1.5 ml (milliliter) subcutaneously (injection beneath the skin) two times daily for anticoagulant therapy.

A review of the January 2024 eMAR revealed Resident #2 did not receive heparin as ordered on:
a. 1/24/24 AM dose, with a 2 documented. Per the eMAR chart codes a 2 indicates drug refusal.
b. 1/26/24 PM dose. A review of Progress Notes revealed a lack of documentation explaining the reason the drug was not administered.
c. 1/27/24 PM dose, with a 2 documented. Per the eMAR chart codes a 2 indicates the drug refusal

4. The Minimum Data Set (MDS) assessment tool, dated 1/1/24, listed diagnosis for Resident #19 included: cellulitis, septicemia (life threatening complication of an infection), and hypertension. The MDS listed the resident's

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Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The EHR Census report indicated Resident #19 admission occurred on 12/28/23, and discharged on 1/10/24.

The Care Plan, dated 12/29/23, included a Focus Area for Wound Management. An Intervention, dated 12/29/23, directed staff to provide wound care per treatment orders.

A review of the EHR revealed the following orders for wound care:
a. Right leg wound. Apply Mupirocin ointment and Prisma to the wound bed. Cover with small piece of soft roll drawtex (a dressing type used to draw moisture away) and secure with hypafix tape (waterproof tape for wound care). Change Monday, Wednesday and Friday. Start date of 12/29/23 , discontinued on 1/3/24.
b. Bilateral leg wounds. Apply Mupirocin 2% ointment and Prisma to wound bed. Cover with Telfa (non stick wound pad). Change every other day. May change Telfa as needed for drainage. Start date of 1/4/24.
c. Apply Silverton to left medial ankle. Rinse and cover with ABD (Abdominal pad). Secure in place with tape. Change dressing twice daily. Start date 1/3/24.

A review of the December 2023 eTAR revealed:
a. Right leg wound treatment ordered on 12/29/23 not completed on 12/29/23 as scheduled.

A review of Progress notes lacked documentation for wound treatment in December 2023.

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F 658	Continued From page 21 A review of the January 2024 eTAR revealed: a. Right leg wound treatment ordered on 12/29/23 not completed on 1/1/24 as scheduled prior to discontinuation on 1/3/24. b. Bilateral leg wound treatment ordered on 1/4/23 not completed on 1/4/24 as scheduled. c. Left medial ankle wound treatment ordered on 1/3/24 not completed on 1/4/24 as scheduled. During an interview on 2/20/24 at 2:15 PM, the Director of Nursing (DON) stated if a medication or treatment is not documented she would assume it had not been administered, or completed. The DON stated she would expect a Physician Order received during the day would be started on that day unless a specific date is included in the order. A policy, dated 10/2023, titled Medication Administration Guidelines directed staff to document signature or initial as required for medication administered on the MAR immediately following administration.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure baths/showers consistently provided for three of three reviewed for bathing (Resident #2, Resident #14, Resident #15). The facility reported a census of 24 residents.	F 677		

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Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #14 dated 11/30/23 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The MDS documented that the resident had impairment to both lower extremities, and normally used a walker for mobility. The MDS documented that the resident required set up or clean-up assistance with getting in and out of the tub/shower.

Review of Resident #14's Care Plan did not address showers.

On 2/6/24 at 11:40 AM, review of shower sheets for November 2023 lacked documentation for Resident #14.

On 2/6/24 at 11:51 AM, review of shower sheets for December 2023 lacked documentation for Resident #14.

2. The MDS assessment for Resident #15 dated 1/12/24 revealed the resident had short and long term memory problem, and moderately impaired cognition.

Review of Resident #15's Care Plan dated 10/9/23 revealed the following focus: Personalized Care. The Intervention dated 10/9/23 documented, Bathing preference: Shower.

Review of paper shower sheets for January 2024 lacked documentation of showers for Resident #15.

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Review of shower sheets for February 2024 revealed a shower sheet for Resident #15 dated 2/5/24.

On 2/13/24 at 9:31 AM, Staff I, Certified Nursing Assistant (CNA) explained second shift did not complete showers, and Staff I picked up showers from night before and the daytime showers, which was hard with two people.

On 2/14/24 at 10:30 AM when queried about showers, Staff K, CNA, explained a lot of showers were completed during the day to try to catch up from what evening shift did not do. When queried if shower sheets to be completed every shower, Staff K responded they were supposed to be, and if resident refused would get a shower sheet marked as refused. When queried about bed baths, Staff K acknowledged a shower sheet would be completed.

On 2/20/24 at 2:23 PM when queried about showers, the Director of Nursing (DON) acknowledged occasionally evening shift showers had been missed. The DON explained she had spoken with the aides and said expected to be done. The DON acknowledged the skin sheet would be used for showers, bed baths, and refusals.

On 2/20/24, the facility's Regional Director of Nursing (RNC) shared via email the facility did not have a bath policy.

3. The Minimum Data Set (MDS) assessment

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F 677	Continued From page 24 tool, dated 1/17/24 , listed diagnosis for Resident #2 included type 2 diabetes, recent severe sepsis with septic shock, and peripheral vascular disease (poor circulation). The MDS assessed the resident required substantial assistance to shower/bathe self. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition. Admission Record documented the resident's most recent admission date as 1/10/24. The Baseline Care Plan, dated 1/10/24, revealed the resident required the physical assistance of one staff to bathe. During an interview on 1/31/24 at 2:00 PM, Resident #2 reported she had not had a shower or bath since her admission. A review of the shower sheets for January 2024 revealed a shower sheet for the resident dated 1/31/24. During an interview on 2/13/24 at 10:10 AM, Staff I, Certified Nursing Assistant (CNA) stated Resident #2 refused showers, but would accept a bed bath. The CNA stated they assisted the resident with several bed baths, and a shower sheet would be completed for every bed bath given. The CNA stated if a shower sheet had not been completed, the bed bath was not completed.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring	F 678		

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such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, and facility policy review, the facility failed to follow Physician Orders to initiate Cardiopulmonary Resuscitation (CPR) for two of two residents reviewed for cardiopulmonary resuscitation status (Resident #6, and #11). Resident #6 expired on 1/18/24, and Resident #11 expired on 1/29/24. This deficient practice resulted in an Immediate Jeopardy to the health and safety of residents who resided at the facility. The facility reported a census of 24 residents.

The State Agency informed the facility of the Immediate Jeopardy (IJ) on 2/01/24 at 4:23 PM. The IJ began on 1/18/24. Facility staff removed the Immediate Jeopardy on 2/5/24 at 10:33 AM. the facility staff removed the Immediate jeopardy by implementing the following actions:

A. Education: All Nurse and Certified Nurses Aides (CNA's) (per Director of Nursing/RNC) Staff will be educated to initiate CPR per policy

NOTE: THIS PROCEDURE IS FOR ONE-RESCUER OR TWO-RESCUER CPR: ADULT

1. Determine unresponsiveness by briskly rubbing your knuckles against resident's sternum and deliver two rescue breaths to the unresponsive victim who is not breathing and start chest compressions immediately. If the resident wakes , moans then CPR is not

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necessary.
2. Call out for help
3. Delegate a specific individual to check physician orders; CPR order/DNR status; have individual call paramedics, attending physician and administrative personnel per facility policy and report back to individual as soon as possible.
4. If an AED is immediately available, deliver one shock in instructed by the device, then begin CPR.
NOTE: FOR RESIDENTS WITH PACEMAKERS AND/OR DEFIBRILLATORS

CPR and external defibrillation may be performed as usual on residents with pacemakers and defibrillator. If the implanted device delivers a shock during CPR, the responder may feel a tingling sensation on the responder.
NOTE: Advanced Directives/POLST: All residents are to have Advanced Directives obtained upon admission and then reviewed quarterly at resident care plan conference or when a change of condition requires additional review. The resident, family and physician will discuss Advance Directive status an determine. Resident POLST forms are to be completed upon admission and during any change of resident wishes regarding advanced directives. The POLST forms are to be reviewed during a significant change of condition.
CPR in Three Simple Steps
1. CALL
2. PUMP
If the victim is still not breathing normally, coughing or moving, begin chest compressions. Push down in the center of the chest 2 inches, 30 times. Pump hard and fast at the rate of 100 compressions per minute.
3. BLOW
After 30 chest compressions; tilt the head back

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and lift the shin. Pinch the nose and cover the mouth with your (may use a mouth guard if available) and blow until you see the chest rise. Give 2 breaths.
4. Continue with 30 pumps and 2 breaths until help arrives

B. Audit for Resident Code Status will be initiated; (DON/RNC)
C. Each resident will have green sticker next to name plate indicating Code Status- Green Full Code and Red- No Code (per DON/RNC)
D. Licensed Nurses checking the Code Status book before each sight and signing off with oncoming nurses about any changes. Nurses will monitor daily times 21 days, then twice weekly for 4 weeks and then monthly ongoing.
E. All audits' results will be sent to QAPI Committee for review and analysis
F. I variances in Resident Code is identified, DON will correct immediately and conduct 1:1 education as needed

The scope lowered from "J" to "D" at the time of the survey.

Findings include:

1. The Admission Minimum Data Set (MDS) assessment for Resident #6 dated 12/8/23 revealed the resident scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) score, which indicated moderate cognitive impairment.

The Care Plan for Resident #6 did not address code status for the resident.

Review of the Iowa Physician Orders for Scope of Treatment (IPOST) form for Resident #6 signed

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on 3/12/29 selected, CPR/Attempt Resuscitation.

Review of signed Physician Orders for Resident #6, signed on 12/2/23 revealed CPR.

The Physician Order dated 12/1/23 documented, CPR.

Review of a N Adv-Skilled Evaluation-V 14 dated 1/18/24 documented the following Vital Signs for Resident #6, all dated 1/18/24 at 12:01 AM: Temperature: 97.9, Blood Pressure 141/63, Pulse: 81, Respirations 21, O2 sat (oxygen: saturation) 96% on Room Air.

The Health Status Note dated 1/18/24 at 5:30 AM authored by Staff F, Registered Nurse (RN), documented, Called to Resident room by Certified Nursing Assistant (CNA). Upon Entering room observed resident lying in bed with Ashen color and absence of respirations. Head back and mouth open. No Heart sounds Auscultated or Pulses felt at Carotid. Skin Warm and dry. Nurse Practitioner, Director of Nursing (DON) and Administrator notified. Order received to Transport (release) body to Funeral Home.

On 2/1/24 at 214 PM, Staff D, Certified Nursing Assistant (CNA) explained she had worked with Staff F. Staff D explained she checked on the resident between 2:30 AM to 3:00 AM, and the resident was sleeping and dry. Per Staff D, Resident #6 was still breathing, and made gurgling noises which was normal for him. Staff D explained she elevated the head of the resident's bed a little higher than it had been. Staff D explained at 5:15 AM she found the resident, and his room light came on. Per Staff D, she thought maybe the resident was up looking at something.

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Staff D explained when she went in at 5(AM), the resident's shirt was kind of off, but not too far off. Staff D explained she touched the resident, said his name, and he did not move. Staff D explained she did not see any breathing, and she immediately went and got her nurse who assessed the resident. Staff D explained she asked the nurse if the resident was CPR, and if she needed to start it. Staff D explained she had never been put in that situation before, and was not sure if the resident was a full code or not. Per Staff D, the nurse never answered her, and then went to call the family and inform them. When queried if she or the nurse (Staff F) ever started CPR on the resident, Staff D responded no. Staff D explained the nurse helped her clean the resident up before day shift came.

The Record of Death for Resident #6 revealed the resident's date of death as 1/18/24 at 0530 (5:30 AM).

On 2/6/2024 at 12:25 PM, Staff F, RN, queried about the shift when Resident #6 expired. Staff F explained the resident received his evening (HS) medications that night through the resident's gastrostomy tube (g-tube). Staff F further explained CNAs transferred the resident into bed. Per Staff F, he believed it was CNA [First Name Matching Staff D] who worked up front, and they went in and turned and changed the resident about 3:00 AM. When queried if the resident was breathing at this time, Staff F said yes, the resident was repositioned, and the resident was doing ok. Staff F explained he did some morning medications with other people, Staff D came and got Staff F, and said to him (Staff F) needed to come to Resident #6's room because he's gone. Per Staff F, he went with Staff D and when they

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got there the resident had lack of vital signs, Resident #6's skin still warm, and it was kind of ashen/gray, with the resident's head back mouth open. Staff F explained the resident expired. Staff F queried if he tried to get vitals on the resident, and responded yes, he (Staff F) did.

When queried about Resident #6's code status, Staff F responded he was not exactly sure. Staff F explained he believed it was looked up in records afterwards and the resident was a full code, however was from 2019. Per Staff F, the resident's IPOST not updated since when the resident first admitted to the facility and was an old IPOST. Staff F said, It is still in effect, don't get me wrong on that. When queried if he, Staff F, initiated CPR on the resident, Staff F responded no, he did not. Staff F described Resident #6 was white and gray with his mouth open and pupils were fixed like it had been awhile. Per Staff F, the resident's pupils were fixed, mouth was gaping open, head was back, resident had lack of vital signs, and it was obvious resident had expired. Staff F explained he was not fully aware of the resident's code status at the time and the resident looked like obviously gone.

Per Staff F, he called and talked to the DON, a few minutes had passed, and Staff F explained the situation to the DON. Staff F explained he asked the DON if wanted him (Staff F) to start CPR and call the ambulance over the telephone because Staff F was in the middle of questioning. Per Staff F, he left the room to try to find the resident's code status to double check and make sure, and when he saw full code from 2018 that is when second guessed self and called the DON and explained what he had found out. Staff F

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reported he asked what he should do. When queried what he was told by the DON, Staff F responded told if obviously gone, to go ahead and call the family, let them know what going on, notify the Nurse Practitioner, and proceed that way.

When queried if he was CPR certified, Staff F responded yes. When queried if Emergency Medical Services/911 (EMS) called, Staff F responded, No, I didn't call 911, no. When queried if the resident's skin was warm, Staff F responded the resident's extremities were kind of cool to touch, and abdomen/chest was warm. When queried if he recalled Staff D ask about starting CPR, Staff F responded he did not believe so, no.

When queried where code status information available, Staff F responded, in part, he could not find the resident's information in the computer so he went to the paper book in the cabinet and found the form there. When queried if Resident #6 was in rigor when Staff F assessed Resident #6, Staff F responded, yeah, yeah.

On 2/14/24 at 11:36 AM when queried about the situation, the facility's Director of Nursing (DON) explained she was contacted after the fact by Staff F. When queried what Staff F told the DON, the DON explained Staff F called her (DON) to tell DON an aide had walked in and touched Resident #6 on the leg, and alerted him (Staff F) the resident had passed away. Per the DON, she was told the resident was cold to touch and gone awhile, and was told did not do CPR. The DON explained she asked if the resident was a full code, and was told he was (full code). Per the DON, she asked Staff F why CPR had not been

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done, and response given by Staff F was resident had been gone awhile. The DON further explained she asked Staff F if notified family and what needed from her (DON). When queried if Staff F asked her (DON) if CPR should be initiated, the DON responded no. Per the DON, Staff F told her the resident was a full code.

The DON explained she talked to Staff D, CNA the next day. Per the DON, Staff D just wanted the DON to know went in and touched resident on the leg and cool to touch, and had notified Staff F right away.

When queried how she felt the situation was handled for Resident #6, the DON explained she took what she received on the phone as situation under control. The DON explained she did not question because was told the resident gone awhile, and she (DON) assumed lividity set in. Per the DON, Staff D said she checked on the resident a couple hours prior to check and change, and the resident was fine. The DON explained that is what staff doing when went in around 5 and resident cool to touch. When queried about initiation of CPR, the DON explained her understanding was cool to touch and assumed lividity set in if resident gone awhile, and explained if lividity not set in and warm, CPR should be done if that was code status. The DON explained in talking to Staff D, said cool to touch, and the DON did not assume the resident would still be warm. The DON explained if was so, the obviously do CPR. The DON explained per what she was accustomed to, if lividity set in and cool to touch, do not need to do CPR. When queried if she was aware of concerns about situation, the DON responded no, she had become aware of concerns after the fact.

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The DON explained when she arrived, Staff D, Staff F, Resident #6 already gone.

The Facility Policy titled Cardiopulmonary Resuscitation (CPR), undated, revealed the following:

1. Determine unresponsiveness by briskly rub your knuckles against resident's sternum and deliver two rescue breaths to the unresponsive victim who is not breathing and start chest compressions immediately. If the resident wakes, moans or moves then CPR is not necessary.
2. Call out for help.
3. Delegate a specific individual to check physician orders; CPR order/DNR (Do Not Resuscitate) status; have individual call paramedics, attending physician and administrative personnel per facility policy and report back to individual as soon as possible.
4. If an AED (Automated External Defibrillator) is immediately available, deliver one shock if instructed by the device, then begin CPR.

2. The Minimum Data Set (MDS) assessment tool, dated, listed diagnosis for Resident #11 included: Non-Alzheimer's dementia, and hypertension. The results listed on the MDS Brief Interview for Mental Status (BIMS) as scoreless for the resident, indicating a severe cognitive impairment.

The Care Plan for Resident #11, dated 10/3/23, revealed the resident to have a full code status.

Review of the Iowa Physician Orders for Scope of Treatment (IPOST) form for Resident #11, signed

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on 2/16/21, selected a CPR/Attempt Resuscitation.

Review of Physician Orders revealed an order, dated 11/6/23, for a Full Code.

A Physician Progress note, dated 1/26/24, documented the staff reported no concerns and prior assessment remains unchanged.

A Health Status Note, dated 1/29/24 at 8:30 PM, entered by Staff G, Licensed Practical Nurse (LPN) documented Mottling (skin appears blotchy, red-purple marbling), in bilateral knees and feet and hands. Resting with eyes closed. Appears to be comfortable at this time.

A Health Status Note, dated 1/29/24 at 11:57 PM, entered by Staff G, LPN documented, When Certified Nursing Assistant (CNA) went to check in on resident at 9:55 PM. She found the resident unresponsive. Called me [Staff G] back to the room. No respirations. No pulse at 9:57 PM. Notified her guardian. Notified her daughter. Notified the funeral home listed. Notified Gale, Facility Nurse Practitioner (FNP). Ok to release the body to the funeral home. Local funeral home picked the body up at 11:30 PM. Picked up for the funeral home listed, which is out of Davenport, Iowa. No belongings went with the resident's body. P work [paperwork] completed. Notified DON of the death.

The Record of Death for Resident #11 revealed the resident's date of death as 1/29/24 at 2157 (9:57 PM).

During an interview on 2/1/24 at 3:27 PM, Staff G, LPN stated Resident #11 had deteriorated the last

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four to five days prior to her passing away on 1/29/24. Staff G stated she did not know if the resident had been seen by the facility provider, or had any new orders. Staff G reported she did not know Residents #11 code status. She stated to find out residents' code status she would look in the facilities Electronic Medical Record (EMR).

Staff G stated she did not start CPR on Resident #11. Staff G stated when the CNA called her back to the unit, Resident #11 hands and feet were purple, she had no respirations or blood pressure. Staff G stated Resident #11 did not have any signs of rigor at the time she was called back to the unit.

Staff G reported she had not assessed Resident #11 prior to her passing. Staff G stated she received a shift report from Staff R at the beginning of her shift (6:00 PM). Staff G stated the assessment of Resident #11 having a mottling appearance was made by Staff R. Staff G stated the first contact she had with Resident #11 was when the CNA (Staff O) called her back after finding the resident non-responsive.

During an interview on 2/1/24 at 3:51 PM, Staff O, CNA stated she was reassigned to the Unit at approximately 8:30 PM on 1/29/24. Staff O stated during report, Staff N, CNA informed her Resident #11 was getting ready to pass away and to keep a close eye on her. Staff O stated on initial rounds she noted the resident to have fast, rough breathing sounds. Staff O stated she did not contact the nurse.

Staff O stated when she checked on the resident again around 10:00 PM, she could not tell if Resident #11 had passed away. She stated

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placed her hand on the resident's chest and could not feel breathing. Staff O stated the resident was warm to the touch. Staff O stated she then called the nurse (Staff G, LPN). Staff O stated Staff G did not initiate CPR, nor did Staff O ask if they should start CPR. Staff O stated she did not know Resident #11 code status.

During an interview on 2/5/24 at 3:08 PM, Staff N, CNA stated she started her shift at 10:00 AM on 1/29/24. She explained she started her shift in the main area of the facility, before reassigned to the Unit (locked area of facility for residents with dementia). Staff N stated she is unsure of what time she went back to the Unit.

Staff N stated after she received a report from the previous CNA, she rounded on all the residents. Staff N reported she called the nurse (Staff R, LPN) to check on Resident #11. Staff N stated Staff R did come back to the unit and checked on Resident #11. Staff N stated Staff R asked her to call if something changes. Staff N denied Staff R taking vitals, or being directed to take vitals.

Staff N stated she last checked on Resident #11 prior to the end of her shift at 8:30 PM. Staff N stated Resident #11 appeared comfortable while she slept.

Staff N stated she gave a report to the next CNA (Staff O, CNA) working on the Unit. Staff N stated she informed Staff O the resident seemed close to passing away. Staff N stated no one told her Resident #11 was dying, but it looked like it. Staff N described Resident #11 as sleeping comfortably, with heavy breathing sounds, and her legs were splotchy purple.

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F 678	Continued From page 37 When queried about Resident #11's code status, Staff N stated she did not know the residents code status. She stated she started two to three months ago, and no one had trained her as to where to find a code status. During an interview on 2/12/24 at 1:31 PM, Staff R, LPN stated she assessed Resident #11 on 1/29/24. She stated the residents' vitals were stable. Staff R stated she asked the CNA to call her if there were any changes in the residents' respirations or skin color. Staff R stated Resident #11's color was off. Staff R stated the resident did not have traditional appearing mottling. Staff R stated she recalled hearing Resident #11 was declining, but did not hear she was actively dying. During an interview on 2/14/23 at 11:44 AM, the DON stated staff did attempt to call her on 1/29/24, but she missed the call. The DON denied being informed of changes in the resident color and respirations or that CNA staff felt the resident was close to passing away. She stated she would expect staff to inform her of this concern. The DON stated if had she known she would have contacted the legal guardian, and family to ask them how they wanted to proceed. The DON stated she would expect staff to initiate CPR if a resident with a full code order is found with no pulse, or respirations and continues to be warm, and does not have signs of rigor.	F 678		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility policy review the facility failed to ensure ongoing, timely communication with the Provider(s) regarding resident change in condition to include increased falls, post a resident's voiced resident voiced concerns about clinical condition, and upon implementation of voiding following indwelling catheter removal, failed to promptly identify and intervene upon resident change in condition, and failed to perform consistent assessment upon resident admission to the facility for three of six residents reviewed for assessment/intervention (Resident #1, Resident #4, Resident #18). The facility reported a census of 24 residents.

Findings include:

1. The Admission Minimum Data Set (MDS) assessment for Resident #4 dated 10/25/23 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMs) assessment, which indicated intact cognition. Per the assessment, Resident #4 took diuretic medication.

Review of Medical Diagnoses for Resident #4 included Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Unspecified, Essential

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(Primary) Hypertension, and Hypertensive Heart and Chronic Kidney Disease Without heart Failure.

The Care Plan dated 11/6/23, revised 1/30/24, documented as follows; I'm at risk for fluid alterations due to diuretic usage and history (HX) of renal impairments.

Interventions dated 11/6/23 included the following:
a. labs as ordered
b. medications as ordered
c. notify MD (Medical Doctor) as needed
d. observe resident for poor skin turgor, edema, pallor during care
e. Vital signs (VS) as indicated

The Physician Order dated 11/14/23, discontinued on 2/7/23, documented, Hydrochlorothiazide Oral Tablet 25 MG (milligram) with direction to give 1 tablet by mouth one time a day related to Hypertensive Heart and Chronic Kidney Disease Without Heart Failure, with Stage 1 through Stage 4 Chronic Kidney Disease, or Unspecified Chronic Kidney Disease.

The eMar-Medication Administration Note dated 12/27/23 at 5:43 AM documented, Comprehensive Metabolic Panel (CMP), Hemoglobin A1C (HgvA1c), Complete Blood Count (CBC) one time only for routine lab work until 12/27/2023 23:59 (11:59 PM) Venipuncture performed to Right lateral Thumb side of wrist and Purple Top tube obtained for Complete Blood Count (CBC) and HgbA1C. Second venipuncture required to be performed from Left Lateral Thumbside of wrist for Yellow top tube for CMP. Resident tolerated procedure well. Specimens to

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be transported to [Hospital Name Redacted] laboratory for testing.

Review of Progress Notes following the lab draw lacked information about lab results for Resident #4. Review of Physician Provider Notes dated 12/29/23 and 1/2/24 also lacked information about lab results or actions taken related to lab results.

Review of a Chemistry Report, date/time collected 12/27/23 at 7:31 AM with result date/time 12/27/23 at 8:28 AM, revealed the resident's Sodium Level at 130 milliequivalents/liter (mEq/L) 9 (mEq/L), noted to be low as normal reference range 136-145. It was noted lab results uploaded to the resident's electronic health record 2/10/24.

The Behavior Note for Resident #4 dated 1/6/24 at 4:37 AM authored by Staff J, Licensed Practical Nurse (LPN) documented, resident has had complaint after complaint all shift, upset Nurse Practitioner (NP) didn't see him on rounds, upset light was not answered quick enough, upset this nurse was in UNIT when he wanted to talk to me, explained Someone has to be back there at ALL times stated" MAYBE THEY SHOULD THINK ABOUT GETTING MORE HELP< THIS IS RIDICULOUS <sic>, I ' m TIRED OF BEING IGNORED BY THE NP/MD (Medical Doctor), ignored by staff and management. States he's making a formal complaint to "THE POWERS THAT BE" about NP and facility. Resident has had emotional couple days and is frustrated, by end of talking had calmed down.

The next Progress Note for Resident #4, dated 1/6/24 at 7:48 PM also authored by Staff J, LPN

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revealed the following: Temperature (T) 99.1 Heart Rate (HR) 102, BP (Blood Pressure) 106/68 Respiration (R) 15 96% Room Air (RA), has had a drastic change in mental status, usually independent, Needing Assist times two (AX 2) and unable to walk. Usually Alert and Oriented times four-person, place, time situation (ALOx4) and is hard to stay awake, per Certified Nursing Assistant (CNA) he was on the floor 2 times today. Recent med, changes, Director of Nursing (DON) notified, NP notified. 911 called, will call report to [Hospital Name Redacted].

Review of Progress Notes for Resident #4 lacked documentation between the time period of 1/6/24 at 4:37 AM note and 1/6/24 at 7:48 PM note, which had both been authored by Staff J, LPN.

Review of Incident Reports requested for Resident #4 lacked Incident Reports for 1/6/24. Review of the Assessment tab of the resident's electronic health record (EHR) lacked assessments between the dates of 11/15/23 and 1/12/24.

Review of the Weights/Vitals tab documentation for the resident's blood pressure, temperature, pulse, respirations, oxygen saturation lacked documentation for January 2024. Pain score documentation dated 1/16/24 revealed pain level of 0 on 1/6/24 at 8:00 AM, and lacked additional pain score documentation dated 1/6/24.

The Health Status Note dated 1/6/24 at 8:12 PM authored by Staff J, LPN documented, resident just left by ambulance, not talking well, pupils sluggish, unable to stand hard to keep awake and on task, Also before 911 called about fell with assist times two (Ax2) and stated "something is

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wrong" I think I need a Doctor (DR).

The Health Status Note dated 1/6/24 at 10:13 PM documented, resident being admitted to [Hospital Name Redacted] Emergency Room (ER) for Potassium (K+) of 5.8, Chloride (CL)- 121, still running cardiac panel(troponins) and tests on kidneys, Blood Sugar(BS) remain high at hospital, report from [Name Redacted] at [Hospital Name Redacted], Director of Nursing (DON), Nurse Practitioner (NP), Administrator (Admin) notified, expected to be 2-3 day stay.

Review of Hospital Records for Resident #4 dated 1/7/24 revealed the following:

Review of Lab Results present on Hospital Records revealed the following values for Potassium and Sodium, date 1/6/24 at 8:55 PM for both values: Potassium 5.8 mEq/L (high), and Sodium 121 mEq/L (critical).

Review of the History and Physical document dated 1/7/24 included in Hospital Records revealed the following Chief Complaint: Lives at [Facility Town] nursing home. fall x 2 today due to (d/t) bilateral leg weakness. having low back pain after falls. also having left eye drainage that is new. The History of Present Illness (HPI) section revealed, Lab data showed hyponatremia, anemia, hyperglycemia and worsening renal function. Imaging was apparently nonacute...and he is referred for admission.

The Assessment/Plan section of the document revealed the following:

1. Multiple falls (Complaint of)
2. AKI (acute kidney injury)

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3. Hyperkalemia
4. Hyponatremia
5. Conjunctivitis of left eye
6. DM-Diabetes Mellitus
7. HLD-Hyperlipidemia
8. HTN-Hypertension

Review of the Discharge Summary dated 1/8/24 documented per the Hospital Course section, [Resident #4] was not in a state to be discharged from metabolic perspective in my view but he insisted on going home and went AGAINST MEDICAL ADVICE.

Review of the Census tab for the resident revealed the resident's status as active on 1/8/24. Progress Notes for Resident #4 lacked documentation about the resident's return from the hospital on 1/8/24.

The Pharmacy Note dated 1/10/24 at 7:02 AM documented, New admission review. No irregularities noted.

The Physician Progress Note dated 1/11/24 at 4:30 PM documented, in part, Was not feeling well, and was sent to the ER to be evaluated and treated on 1-6-24, electrolytes were abnormal, most likely related to his continually elevated blood glucoses, he called the facility on 1-8-24 and wanted someone to come and get him, he did not want to be at the hospital any longer.

The Infection Note dated 1/13/24 at 3:37 AM documented, cont on gent eye drops (gtts) to left (L) eye, unsure why, because he asked, per him, no swelling, no drainage, afebrile.

The Physician Progress Note dated 1/17/24 at

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3:00 PM documented, in part, Will do lab work to follow up from hospitalization that he left on his own accord, they had not planned to discharge him on the date he called and wanted to return to the facility. It was noted this Physician Progress Note added into the resident's electronic health record (EHR) on 2/12/24.

The Health Status Note dated 1/26/24 at 2:13 AM authored by Staff J documented, continue (cont) to seem out of sorts, different mentation, cont to not use walker in room, remains shaky this evening stated "I SHOULD HAVE STAYED AT HOSPITAL" i said yeah you should have. Wants to talk to NP about being sent back to be admitted, he doesn't feel great. VSS (vital signs stable) will leave in box for [Name Redacted] NP.

The Physician Progress Note dated 1/26/24 at 2:45 PM documented, in part, Will do lab work to follow up from hospitalization that he left on his own accord, they had not planned to discharge him on the date he called and wanted to return to the facility. It was noted this Physician Progress Note added into the resident's Electronic Health Record (EHR) on 2/12/24.

The Health Status Note dated 1/29/24 at 6:43 PM documented, Resident lowered himself to his knees due to got lightheaded. No injuries, [Name Redacted], NP notified of fall.

The eMar-Medication Administration Note dated 1/30/24 at 5:12 AM documented, Draw Hemoglobin A1C (A1C), Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Magnesium, and Thyroid Stimulating Hormone (TSH) one time only for 1 Day Attempted times 3. Unable to get them drawn. Spoke with DON-will

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have to send him out.

The Health Status Note dated 1/30/24 at 11:47 AM documented, Nurse called ER and spoke with [Name Redacted] Registered Nurse (RN) in the Emergency Room (ER). Gave report 89.7T 70P 155/86BP 19R SpO2 AT 96%. BS at 390 at 1130 am gave 35 units pre order. Resident is being Transferred by nursing home van with a staff member.

Review of Discharge Instructions for Visit Date 1/30/24 revealed reason for visit as hyponatremia, and included with Hospital Records revealed the following per new, changed or refilled prescriptions:
a. Nifedipine (Nifedipine 30 mg, extended release) 60 mg =2 tab(s) oral every day
b. Bumetanide (bumetanide 1 mg (milligram) 1mg=1 tab(s) Oral every day

Discharge Instructions documented, STOP TAKING the following medications:
a. Hydrochlorothiazide (Hydrochlorothiazide 25mg)

The Health Status Note dated 2/2/24 at 2:00 PM documented, Resident returned from [Hospital Name Redacted] with two new meds and faxed to pharmacy (RX), resident transferred to nursing home the by a van with a staff member.

The Physician Order dated 2/3/24 at 8:00 AM revealed, Bumetanide Oral Tablet 1 milligram (MG) (Bumetanide) with direction to give 1 tablet by mouth one time a day for fluid overload

The Physician Order dated 2/3/24 at 8:00 AM documented, Nifedipine extended release (ER)

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Oral Tablet Extended Release 24 Hour with direction to give 60 mg by mouth one time a day for acute decompensated heart failure.

It was noted the resident remained on Hydrochlorothiazide Oral Tablet 25 MG until discontinued on 2/7/24.

On the afternoon of 2/7/24, facility Regional Nurse Consultant and Director of Nursing informed the resident remained on Hydrochlorothiazide with the addition of medications per discharge instructions.

Review of the Communication with Provider Note dated 2/7/24 at 4:51 PM authored by the facility's DON documented, During medication review it was noted that resident was receiving Hydrochlorothiazide 25mg daily and it should have been discontinued on 2/2/24. Resident own responsible party notified. [Name Redacted] NP notified. Resident's behavior and locomotion unchanged. Assessment: Plan: Vitals every shift for 3 days.

Review of a N Adv-Post Fall Evaluation dated 2/8/24 at 11:02 AM revealed the resident fell in the hallway on 2/8/24 at 8:00 AM.

The Incident Note for Resident #4, dated 2/9/24 at 1:40 AM, revealed, resident had un-witnessed fall on days, cont neuros on paper...denies discomfort, does feel he is going to die, his statement.

The Incident Note dated 2/9/24 at 6:35 PM documented, resident yelling out from room, found with torso and upper body on bed, knees on floor (like he was praying) WW was not with

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him. Said he went to BR (bathroom) and just could not make it, said he landed on torso then slid to knees, vital signs stable (VSS), range of motion within normal limits (ROM WNL),denies pain, denies hitting head. Assist times three (AX3) with gait belt to get him standing, no discoloration on knees. Physical therapy (PT) screen put in yesterday, has had 2 recent hospitalizations recently, multiple issues. Has labs MON. Told him he has to use call light right now till he feels stronger. SaysI just hate asking, explained that's why we are here. Voiced understanding, TEXTED DON, that had called NP (Nurse Practitioner) with no response, so texted NP, will email her PN. Resident also had fall yesterday, denies new onset pain, ROM WNL, very shaky, and weak. neuros done at 183596.7, 140/81, 65 IR, 97% RA (room air) 16 even non-labored, HR (heart rate) distant.

The Health Status Note dated 2/10/24 at 5:52 AM documented, in part, attempted to get labs left (L) ATC, blew. Will pass on to days.

The Health Status Note dated 2/10/24 at 6:46 AM documented, Morning meds being held at this time d/t patient demeanor et blood sugar. NP is aware.

The Health Status Note dated 2/10/24 at 12:45 PM documented, according to report this shift res has not been feeling well, NP ordered labs, (BMP, BNP, et magnesium) [Name Redacted], LPN attemped to obtain multiple times, this nurse assessed for venous access which was unsuccessful. Res was then heard yelling from his room and this nurse found res on the floor by restroom. (fall has been documented in risk management) Res stated "i feel weak et dizzy" "I

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don't feel right". Res was slurring his words et his movements were uncoordinated. VS: BP 175/101, HR 61, SPO2 98%, R 16, T 98 et blood sugar 68. NP was notified of fall et the residents' demeanor. Breakfast was brought to resident so he could eat et then be reassessed et be given meds including insulin. Due to (d/t) resident feeling weak et dizzy et his being unsteady on his feet res was instructed to use call light et allow staff to assist him for his safety until he felt better et res voiced understanding. Approx. 30 mins after res had finished his am meal res was observed ambulating w/ (with) w.walker past the nurses station. When res was asked what he was doing, why he hadn't used call light, res stated, "I'm feeling better, I'm just grabbing a blanket" Went to res room to reassess et give meds et insulin at which time res was resting soundly so blood sugar was checked (318) meds except for lantus remained held at this time NP aware. Attempted to wake res for insulin et meds before mid-day meal. this nurse was unable to awaken resident (res). Certified Nursing Assistant (CNA) joined me in attempts to awaken the resident et reposition. Res was unresponsive to stimuli including sternal rub. Obtained another blood glucose et notified NP. NP gave order for res to be sent to ER (eval et treat). When Emergency Medical Technician (EMT) arrived et entered room he addressed the res et the res sat up et responded. Res was still slurring his words, his movements uncoordinated et he was confused. Told EMT to go ahead w/ transport despite being awake et NP was notified. This nurse then called report to [Hospital Name Redacted ER] to [Name Redacted].

Review of Inpatient Discharge Instructions for visit date 2/10/24 revealed diagnoses of

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hyponatremia, diabetes mellitus, and chronic kidney disease.

On 2/13/24 at approximately 10:30 AM, Staff K acknowledged he worked past weekend. Staff K explained on Saturday Resident #4 fell, and then the resident was sent out. Staff K described the resident as really out of it, looked drunk, and kind of swayed his head like he wasn't quite balanced. When queried if the resident spoke, Staff K responded the resident did, not real well, and slurred his words a little bit. Per Staff K, the resident did not want sent out until after breakfast and the resident ate a little bit. When queried how the resident appeared between after breakfast to when the resident went out, Staff K reported not a big change. Per Staff K, when [Name Redacted] CNA went in there and did a sternum rub, alcohol swab under his nose, and the resident moved his nose. Per Staff K, when EMS (Emergency Medical Services) got to facility, resident able to communicate with the Captain.

On 2/20/24 at 2:27 PM, the Director of Nursing (DON) explained when the resident returned from the hospital the nurse should have taken the hospital paperwork, done a readmit, looked at the orders to make sure orders the same, entered new orders, and if discontinued would pull the drug and send back to pharmacy. Per the DON, a section in risk management would be completed for falls. The DON acknowledged she would expect completion of a Progress Note. When queried about information in the Nurse Practitioner's (NP) notes which recommended labs (between hospital stays for resident), the DON explained if the NP gave an order, should have been entered as an order. When queried if a resident should have a Progress Note done

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upon return from hospital, the DON acknowledged should be done.

On 2/20/24 at 3:00 PM, the Director of Nursing (DON) explained if labs not at facility staff were to call and ask for them to be faxed.

2. Review of the Census for Resident #18 revealed the resident admitted to the facility on 1/26/24.

The MDS Admission assessment for Resident #18 revealed the assessment remained in progress.

On 2/7/24 review of the clinical record for Resident #18 lacked a clinical admission assessment for the resident.

On 2/20/24 at 2:25 PM, the facility's Director of Nursing (DON) confirmed she did not see a clinical admission assessment for Resident #18.

The Facility Policy titled Change in Condition/Incident Reporting dated August 2021 revealed the following:

a. When a resident displays a change in condition, Licensed Nurse will complete an assessment or Situation, Background, Assessment, Recommendation (SBAR) to determine symptomology and clinical results.
b. Licensed Nurse to check physician orders to address.
c. If there is an actual change in condition, the resident's physician is notified promptly and validated as to information. Family/Responsible Party notified promptly.
d. Document the date/time of contacts and with

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whom you spoke. Document any new physician orders if indicated. Document resident condition and change in condition in nursing notes/SBAR. Continue monitoring of resident's vital signs and pain level until determination made of potential delayed injury.
e. Immediately enter new orders on the resident's medical record and/or medication administration record if indicated.

3. The Quarterly Minimum Data Set (MDS) assessment tool, dated 1/30/24, listed diagnosis for Resident #1 included: neurogenic bladder (lack of bladder control), muscle spasms, and type 2 diabetes. The MDS assessed the resident required intermittent catheterization for urine elimination. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The review of the Electronic Health Record (EHR) census revealed Resident #1 admitted to the facility on 10/23/23.

The Care Plan, dated 10/31/23, included a focus area related to a Foley catheter. Interventions for the focus area included:
a. Cath care as indicated during care/and per MD (medical doctor) orders, dated 10/31/23.
b. Labs as ordered, dated 10/31/23.

A review of Physician Orders revealed an order, dated 10/25/23, directing staff to change urinary drainage bag and label bag with date. Use strap/securement device to stabilize tubing as

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requested/needed.

A Physician Order, dated 11/17/23, directed staff to use a 18 french (catheter size)/10 milliliter (ml) of saline for an internal balloon to hold tubing in place.

A Physician Progress note, dated 12/18/23, from Urology provider included an order to attempt a voiding trial at next catheter exchange in three weeks.

A Progress Note, dated 1/16/24, revealed a nurse pulled residents catheter due to his bed being soaked.

A review of Physician Orders revealed an order, dated 1/20/24, indicated the resident urinated, but with bladder palpation or patient uncomfortable, may straight cath (one time use catheter to empty bladder) every six hours and to continue to straight catheterization until resident is void spontaneously. The order directed staff to update Urology on 1/22/24 to see how to proceed.

A review of the January and February 2024 Electronic Medication Administration Record (eMAR) revealed documentation for urine elimination results occurring at midnight, 6:00 AM, 12:00 PM, and 6:00 PM. The documentation did not specify if it results from a spontaneous void by resident or the need for a straight catheterization.

The January and February 2024 eMAR documentation for urine elimination revealed elimination amounts ranging from 150 cc's (cc stands for cubic centimeter. 1 cc is equal to 1 milliliter (ml) to 1000 cc's.

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The Electronic Health Record (EHR) lacked documentation of a 1/22/24 update with the Urology Provider.

A Progress Note, dated 2/6/24 at 2;13 AM, revealed the resident required a straight catheterization with a return of 1000 cc's of urine on 2/5/24 at 10:00 PM.

A Progress Note, dated 2/6/24 at 2:45 PM, revealed the resident required a straight catheterization with a return of 1350cc's of urine.

A Progress Note, dated 2/9/24 at 11:09 PM, indicated the resident experienced a taut abdomen with spasms. A straight catheterization was not able to be performed.

During an interview on 2/9/24 at 1:05 PM, the Urology provider the facility has not contacted their office to provide an update on the void trial. The Provider stated Resident #1 had an appointment on 1/22/24 and was a no call, no show. The appointment has not been rescheduled. The Provider reported if the resident had straight catheterization results of 1000 cc's the void trial should have been stopped and a Foley catheter restarted.

During an interview on 2/12/24 at 1:31 PM, Staff R, Licensed Practical Nurse (LPN) stated she asked about a void trial protocol but has yet to see one. Staff R reported the documentation on the eMAR is difficult to follow as it is unclear if the resident needed a straight catheterization, spontaneously urinated in a urinal or had been incontinent.
Staff R stated when she used a straight cath,

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F 684	Continued From page 54 Resident #1 had not a return of more than 300 cc ' s. Staff R stated if she had gotten 1000 cc's or more she would have called the provider. During an interview on 2/22/24 at 2:30 PM, the Director of Nursing (DON) stated she would expect the documentation of a void trial to include if the resident had urinary output spontaneously, had been incontinent or required a straight catheterization. The DON stated she did not know Resident #1 had a straight catheterization return of 1000 cc's more than once. She stated had she known she would have directed staff to call the Urologist for direction. The facility did not provide a catheterization policy, or a void trial protocol when requested.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

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Based on clinical record review, facility policy, and resident, staff and provider interviews the facility failed to accurately assess, treat and monitor a pressure ulcer present on admission for 1 of 1 residents (Resident #2). The facility reported a census of 24.

Findings include:

The Minimum Data Set (MDS) assessment tool, dated 1/17/24 , listed diagnosis for Resident #2 included type 2 diabetes, recent severe sepsis with septic shock, and peripheral vascular disease (poor circulation). The MDS documented the resident admitted with one pressure ulcer. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A review of hospital discharge records, dated 1/10/24, revealed the resident had the following wounds:
a. Friction injury on right buttock
b. Intertriginous dermatitis gluteal cleft (inflamed, reddened skin area between buttocks)
c. Abrasion inside of left ankle

The Clinical Admission note, dated 1/10/24, indicated the following skin issues for Resident #2:
a. Pressure injury on left buttock. No measurements, or appearance documented
b. Pressure injury on left ankle. Documented measurements: 1.5 centimeters (cm) x 0.75 cm. The wound bed described as having slough (shedded dead skin cells), with no odor or exudate (no fluid present) present.

The Electronic Health Record (EHR) revealed the

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Director of Nursing (DON) completed the 1/10/24 Clinical Admission note.

The Baseline Care Plan, dated 1/10/24, indicated current skin integrity issues due to severe pain limiting repositioning.

The MDS, dated 1/17/24, revealed one Stage 2 pressure ulcer on admission.

A Physician's Order, dated 1/10/24, directed staff to complete a weekly skin assessment on Thursday.

A review of the January and February 2024 Medication Administration and Treatment Administration records lacked weekly skin assessment documentation.

A review of the EHR for skin and wound assessment, and progress notes revealed a lack of documentation for the left ankle, and the left buttock pressure ulcers.

On 2/1/14 at 11:15 AM, when queried about pressure ulcers at the facility, the DON stated currently there are no residents with pressure ulcers.

During an interview on 2/7/24 at 2:15 PM, the residents community based primary care provider stated during the 1/29/24 appointment she observed two pressure ulcers. The first, on the resident's left ankle she described as a Stage 2 ulcer measuring 1 cm. The provider stated the pressure ulcer on the resident's ankle did not surprise her due to the resident's poor circulation.

The second, on the resident's left buttock, the

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provider described as alarming due to the size and open skin. The provider described the area of the left buttock as a new Stage 2 pressure ulcer measuring 3 cm x 3 cm and shallow.

The provider stated she referred the resident to a Wound Clinic.

A review of Physician Progress note from the 1/29/24 revealed:
a. The resident did not have a dressing on the left buttock pressure ulcer.
b. The Assessment/Plan for pressure ulcer, included starting Mupirocin (antibiotic ointment) twice daily.

A review of the EHR revealed a Physician Order dated 2/1/24 for A & D (non medicated protective barrier) to buttocks covered with a boarder [border] dressing every shift and as needed (PRN).

A review of the January and February 2024 Medication Administration and Treatment Administration Records (MAR and TAR) lacked documentation of Mupirocin application twice daily, and A&D ointment with boarder [border] dressing every shift and PRN.

During an interview on 2/13/24 at 10:55 AM, Staff K, CNA, stated Resident #2 had a big area on the right side of her buttock that did not get better. The CNA stated at first a gel pad had been applied on the area, and it would tear the residents skin. The CNA stated they started to apply a border gauze dressing with triple antibiotic ointment on the area, and the area improved.

During an interview on 2/20/24 at 2:38 PM, the

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F 686	Continued From page 58 DON stated she believed she knew Resident #2 had a referral to the wound clinic due to pressure ulcers after the General Practictioner (GP) appointment on 1/29/24. The DON stated weekly skin checks should have been done, and documentation of skin concerns should be entered into the EHR. The DON stated the resident did have an order for wound care, and completion of wound care should have been documented on the TAR. The DON stated it is not appropriate for a CNA to apply ointment and a dressing to a resident's wound. The CNA should have notified a nurse. The undated policy, titled Skin Management Standards, addressed Routine Preventative Care, directing staff to complete a systematic skin inspection at least once a week. The facility requires a minimum of skin check daily during morning care and incontinence care by a CNA, and a minimum skin check of at least weekly by a licensed nurse. Findings documented in the medical record would include information from the weekly wound reports.	F 686		
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 interview, and record review, and	F 689		

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facility policy review the facility failed to thoroughly investigate falls, implement fall interventions following resident falls, and determine root cause analysis for falls for two of four residents reviewed for accidents (Resident #4, Resident #21). The facility reported a census of 24 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #4 dated 1/25/24 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMs) assessment, which indicated intact cognition. Per this assessment, the resident did not have any falls since admission, entry, re-entry, or the prior assessment, whichever more recent.

The Resident had a Care Plan to address falls dated October 2023 with all interventions dated in October 2023.

The Care Plan dated 11/15/23, revised 1/17/23, documented, Risk for Falls. Review of Interventions per the Care Plan documented the following:

a. Date initiated 1/8/24 created on 1/17/24: Asst. with ambulation as needed when returning to facility due to medical appointments/hospitalizations.
b. Date initiated and created 11/15/23: Determine Residents ability to transfer
c. Date initiated and created 11/15/23: Evaluate fall risk on admission and as needed (PRN)
d. Date initiated and created 11/17/23: I will ask for help when feeling weak

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The Care Plan dated 2/9/24 documented, Risk for Falls. All interventions per the Care Plan were initiated and created on 2/9/23 as follows:

a. Assist Resident with ambulation and transfers, utilizing therapy recommendations
b. If fall occurs, alert provider
c. If Resident is a fall risk, initiate fall risk precautions

Review of Fall Risk Evaluations for Resident #4 lacked evaluations completed between 11/15/23, when the resident scored 11 (at risk), and 2/9/24 when the resident scored 22 (at risk). Per Evaluation instructions, a score of 10 or greater indicated high fall risk.

Review of the resident's Care Plans to address falls lacked interventions between the intervention created on 1/17/24, initiated on 1/8/24, and the Care Plan interventions dated 2/9/24.

Review of the Health Status Note dated 1/6/24 at 7:48 PM documented, in part, per Certified Nursing Assistant (CNA) he was on the floor 2 times today. Review of Incident Reports received for Resident #4 lacked documentation for falls which occurred 1/6/24.

The Incident Report dated 1/8/24 at 3:00 PM documented, resident (res) was on the sidewalk by his walker, "my leg isn't working right" res was returning to the facility from being in the (hospital (hosp.) res had no complaints of(c/o) pain and (et) a small abrasion on his right knee. Progress Notes lacked documentation of the resident's fall on 1/8/24.

The Health Status Note dated 1/29/24 at 6:43 PM

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documented, Resident lowered himself to his knees due to got lightheaded. No injuries, [Name Redacted], Nurse Practitioner (NP) notified of fall. Review of Incident Reports received for Resident #4 lacked documentation for the fall on 1/29/24.

The N Adv-Post Fall Note dated 2/4/24 at 4:13 PM documented the following date and time of fall: 2/4/24 at 3:10 PM. The Note also documented, Fall was witnessed. Fall occurred in the Resident's room. Resident was attempting to self toilet at time of the fall. Review of Incident Reports received for Resident #4 lacked documentation for the fall on 2/4/24.

The N Adv- Post Fall Evaluation Note dated 2/8/24 at 11:02 AM documented the following date and time of fall: 2/8/24 at 8:00 AM: Fall was witnessed. Fall occurred in the hallway. Activity at the time of fall: Headed to the shower room to shower. The reason for the fall was not evident. Review of Incident Reports received for Resident #4 lacked documentation for the fall on 2/8/24.

The Incident Note dated 2/9/24 at 6:35 PM documented, resident yelling out from room, found with torso and upper body on bed, knees on floor (like he was praying) wheeled walker (WW) was not with him. Said he went to bathroom (BR) and just could not make it, said he landed on torso then slid to knees. The Incident Report dated 2/9/24 at 6:29 PM documented the same incident description.

The Incident Report dated 2/10/24 at 6:20 AM documented, called to room by res calling out, he was on the floor by the bathroom. Res c/o dizziness et unsteadiness. Res had no c/o pain et no apparent injuries noted.

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The Late Entry Health Status Note dated 2/10/24 at 12:45 PM documented, According to report this shift res has not been feeling well, NP ordered labs...[Name Redacted] Licensed Practical Nurse (LPN) attp to obtain multiple times, this nurse assessed for venous access which was unsuccessful. Res was then heard yelling from his room et this nurse found res on the floor by restroom. (fall has been documented in risk management) Res stated "i feel weak et dizzy" "I don't feel right". Res was slurring his words et his movements were uncoordinated.

Review of Post Fall Assessments in Resident #4's clinical record lacked an assessment dated 2/10/24.

On 2/20/24 at 2:27 PM, the Director of Nursing (DON) explained a section in risk management would be completed for falls. The DON acknowledged she would expect completion of a Progress Note. When queried if root cause analysis would occur without an Incident Report done, the DON responded probably not.

Review of the Facility Policy titled Falls Standard, revised 8/2021, revealed the following: Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. The Facility Policy also documented, the following per the Procedure-Post Fall section:

7. Nursing to complete:

a. Fall Risk Assessment form

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b. Incident report, to include vital signs, with lying and standing blood pressure...Incident report and accident/event management protocol to be completed per nurse. Start investigation process to determine root cause of the fall. Fall Scene Investigation Report (used to identify the root cause analysis)
c. Change of Status Review
d. Resident Event Documentation-per guidelines for alert charting
e. Pain assessment to be completed as appropriate.

10. Accident/Incident report, Post Fall Investigation report, clinical record, and care plan to be reviewed within 24 hours for complications and at next morning meeting.

2. The Minimum Data Set (MDS) assessment tool, dated 11/15/23 , listed diagnosis for Resident #21 included traumatic brain injury, aphasia (impaired communication skills), dementia. The MDS assessed the resident required substantial assistance to transfer from bed to a chair, and due to medical and safety concerns does not walk. The MDS listed the resident ' s Brief Interview for Mental Status (BIMS) score as 01 out of 15, indicating severely impaired cognition.

A Fall Risk Evaluation, dated 12/30/23, assessed the resident scored a 13. A score of 10 or greater indicated a high fall risk.

A review of the Electronic Health Record (EHR) revealed four falls occurring 1/12/24, 1/14/24, 1/17/24, and 2/11/24.

The Care Plan, with a revision date of 1/30/24,

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F 689	Continued From page 64 included a focus area for risk of falls due to poor safety awareness, and dementia. The Care Plan included updated interventions for the falls that occurred on 1/12/24,and 1/14/24. The document lacked interventions for falls on 1/17/24, and 2/11/24. During an interview on 2/20/24 at 2:43 PM, the Director of Nursing (DON) stated Resident #21 puts himself on the floor frequently. She stated if the staff find the resident on the floor and did not witness the event, it is considered a fall. The DON stated she would expect the care plan would be revised with new interventions in an effort to prevent future falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		

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as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy, provider and staff interviews the facility failed to provide appropriate treatment and services to restore continence to the extent possible after the use of a foley catheter for 1 of 2 residents (Resident #1) in the sample. The facility reported a census of 24 residents.

Findings included:

The Minimum Data Set (MDS) assessment tool, dated 1/30/24, listed diagnosis for Resident #1 included: neurogenic bladder (lack of bladder control), muscle spasms, and type 2 diabetes. The MDS assessed the resident required intermittent catheterization for urine elimination. The MDS listed the resident ' s Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The Care Plan, dated 10/31/23, included a focus area related to a Foley catheter.

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A Physician Progress note, dated 12/18/23, from Urology provider included an order to attempt a voiding trial at next catheter exchange in three weeks.

A Progress Note, dated 1/16/24, revealed a nurse pulled the residents catheter due to his bed being soaked.

The January 2024 Electronic Medication Administration Record (eMAR) documentation for urine elimination started on 1/20/24.

A review of Physician Orders revealed an order, dated 1/20/24, indicated the resident is urinated, but with bladder palpation or patient uncomfortable, may straight cath (the one time use of a catheter to empty bladder) every six hours and to continue to straight catheterization until resident is void spontaneously. The order directed staff to update Urology on 1/22/24 to see how to proceed.

A review of the January and February 2024 Electronic Medication Administration Record (eMAR) revealed documentation for urine elimination results occurring at midnight, 6:00 AM, 12:00 PM, and 6:00 PM. The documentation did not specify if it results from a spontaneous void by resident or the need for a straight catheterization.

The January and February 2024 eMAR documentation for urine elimination revealed elimination amounts ranging from 150 cc's (cc stands for cubic centimeter. 1 cc is equal to 1 milliliter) to 1000 cc's.

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A Progress Note, dated 2/6/24 at 2;13 AM, revealed the resident required a straight catheterization with a return of 1000 cc's of urine on 2/5/24 at 10:00 PM.

A Progress Note, dated 2/6/24 at 2:45 PM, revealed the resident required a straight catheterization with a return of 1350 cc's of urine.

A Progress Note, dated 2/9/24 at 11:09 PM, indicated the resident experienced a taut abdomen with spasms. A straight catheterization was not able to be performed.

During an interview on 2/9/24 at 1:05 PM, the Urology provider reported that the facility had not contacted their office to provide an update on the void trial. The Provider stated Resident #1 had an appointment on 1/22/24 and was a no call, no show. The appointment had not been rescheduled.

The Provider stated if the resident had straight catheterization results of 1000 cc's the void trial should have been stopped and a Foley catheter restarted.

During an interview on 2/12/24 at 1:31 PM, Staff R, Licensed Practical Nurse (LPN) stated she asked about a void trial protocol but has yet to see one. Staff R stated the documentation on the eMAR is difficult to follow as it is unclear if the resident needed a straight catheterization, spontaneously urinated in a urinal or had been incontinent.

Staff R stated when she used a straight cath, Resident #1 had not a return of more than 300 cc's. Staff R stated if she had gotten 1000 cc's or

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F 690	Continued From page 68 more she would have called the provider. During an interview on 2/22/24 at 2:30 PM, the Director of Nursing (DON) stated she would expect the documentation of a void trial to include if the resident had urinary output spontaneously, had been incontinent or required a straight catheterization. The DON stated she did not know Resident #1 had a straight catheterization return of 1000 cc's more than once. She stated had she known she would have directed staff to call the Urologist for direction. The facility did not provide a catheterization policy, or a void trial protocol when requested.	F 690		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse	F 712		

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practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy, and staff interviews the facility failed to ensure initial visits for skilled nursing services were completed by a Physician prior to being delegated to a Nurse Practitioner for 5 of 7 residents. The facility reported a census of 24 residents.

Findings include:

A review of the Electronic Health Record revealed the following residents were admitted for Skilled Nursing (SN) services:
a. Resident #6 admitted on 12/1/24
b. Resident #13 admitted on 11/17/23
c. Resident #14 admitted on 11/16/23
d. Resident #19 admitted on 1/1/24.
e. Resident #22 admitted on 1/3/24.

The EHR revealed a Nurse Practitioner (NP) completed all visits for each resident on the following dates:
a. Resident #6 seen by a NP on 12/2/23, 12/5/23, 12/14/23, 12/15/23, 12/20/23, 12/21/23, 12/29/23, 1/2/24, 1/5/24, 1/11/24, and 1/17/24.
b Resident #13 seen by a NP on 11/21/23, 11/28/23, 12/2/23, 12/5/23, 12/14/23, 12/15/23, 12/20/23, 12/21/23, 12/29/23, 1/2/24, and 1/5/23.
c. Resident #14 seen by a NP on 11/16/23, 11/28/23, and 12/2/23
d. Resident #19 seen by a NP on 1/2/24, and 1/5/24.
The EHR revealed Resident #22 ' s initial visit completed by the NP on 1/5/24. The Physician visit completed on 1/6/24.

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F 712	Continued From page 70 During an interview on 2/15/24 at 11:00 AM, the Regional Nurse Consultant (RNC) stated the contracted physician and NP are aware residents receiving SNF services must have a Physician complete the first visit. The RNC stated the usual pattern of visits for SNF services is for the Physician to do an initial visit and then the NP does the next visit. This pattern continues until the resident is discharged from SNF services. The undated policy, titled Physician Services, indicated the standard for residents of the facility to be visited by their attending physician in accordance with State and Federal Regulations and facility policy and procedures.	F 712		
F 727 SS=C	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 facility schedule review, policy review, and staff interview, the facility failed to consistently utilize the services of a Registered Nurse for at least 8 consecutive hours a day, 7	F 727		

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F 727	Continued From page 71 days a week. The facility reported a census of 24 residents. Findings include: Review of the facility nursing schedule for the period of 1/4/24 to 2/4/24 revealed a lack of RN coverage for the following days: 1/6/24, 1/20/24, 2/3/24, and 2/4/24. During an interview on 2/14/24 at 1:07 PM, the Director of Nursing (DON) stated the schedule was correct and no other nurses worked. She looked at the schedule and confirmed the facility did not have RN coverage for the above dates. The Job Description for the Director of Nursing, Personal Functions sections included the task of assigning a sufficient number of licensed practical nurses and/or registered nurses for each tour of duty to ensure that quality care is maintained. Evaluate care needs continuously and adjust staffing as indicated.	F 727		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not	F 741		

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limited to, knowledge of and appropriate training and supervision for:

§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].

§483.40(a)(2) Implementing non-pharmacological interventions.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure sufficient staff with appropriate qualifications to meet the needs of cognitively impaired residents who resided on the dementia area of the facility for five of five residents who resided on the dementia unit (Resident #9, Resident #15, Resident #16, Resident #17, Resident #18). The facility reported a census of 24 residents.

Findings include:

Observations conducted on the dementia unit of the facility included the following:

Observation conducted on 1/31/2024 at 2:18 PM revealed four residents present in the common area of the dementia unit. A staff member not observed to be present, as the staff member was assisting down the hall.

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Observation on 1/31/24 at 3:04 PM revealed Resident # 18 opened upper cabinets near the table by the nursing station. Resident #15 ambulated without her walker in the dining area, and pushed on the lock on the freezer. Resident #18 ambulated down the hallway.

On 1/31/24 at approximately 2:00 PM, Staff B, CNA explained they were the only aide for the night for the dementia area.

On 1/31/24 at 3:06 PM, Resident #15 near the set of upper and lower cabinets near the table next to the nursing station on the dementia unit. Resident #15 had clothing present on her walker. Resident #9 approached Resident #15 and said, "If that is my clothes I'm gonna beat your butt...you are not supposed to be playing with these..." Staff not present at time of observation between Resident #9 and Resident #15. Resident #9 then had the outfit present next to her at the recliner chair where Resident #9 was sitting.

Observation then revealed Resident #15 walked without her walker and tried a door. Staff not observed to be present.

On 2/1/24 at 9:39 AM, Resident #17 opened up an upper cabinet by the table next to the nursing station, removed a drink out of the cabinet. Resident # 16 and Resident #9 observed in recliner chairs in the common area. A staff member not present at time of observation.

Observation on 2/1/24 at 11:23 AM revealed Resident #9 said they had to go the bathroom. Staff A went with Resident #9. Staff C, Licensed Practical Nurse (LPN) present at the medication cart. Resident #18, Resident #15, and Resident

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#16. Resident #18 left the dining area, and Staff A in the nursing office in the dementia unit. Resident #18 approached a door with a stop sign banner across it and touched the handle of the door and the stop sign banner. Resident #17 walked into the dining room and tried to open the locked refrigerator in the dining room. Resident #17 observed to walk into Resident #18's room in front of Resident #18's sink. When queried, Resident #17 talked about going to restroom.

Observation on 2/1/24 at 11:28 AM revealed Resident # 16 up and ambulatory, Resident #17 attempted to open the refrigerator, and Resident #15 walking in the dining room without her walker in the dining room. Staff C heard to tell Resident #17 he could not drink an item out of the garbage, and Resident #17 had a supplement drink container in hand, and observed to bring the bottle to his mouth. Resident #16 present at the exit door to the dementia unit, Resident # 15 went through the cabinets in the dining room without her walker, and Resident #17 continued to walk with the supplement container in had. Resident #15 opened the cabinets, and Staff C gave Resident #17 a new drink to drink.

On 2/1/24 at 11:32 AM, Resident #17 again went into Resident #18's room. Staff A and Staff C observed in the dining room at the time. On 2/1/24 at 11:24 AM, the cart with lunch trays brought onto the dementia unit, and Resident #17 observed to leave Resident #18's room and enter Resident #16's room. Staff A observed in dining room with Resident #9. Resident #15, Resident #16, and Resident #18. Staff C, LPN, observed at the medication cart near the table by nursing desk.

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1. The Minimum Data Set (MDS) assessment for Resident #9 dated 11/8/23 revealed the resident scored 11 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition.

Review of Medical Diagnoses for Resident #9 included other frontotemporal neuroccognitive disorder.

The Care Plan for Resident #9 dated 1/29/24 documented, I have a memory impairment and is at risk for changes due to triggering delirium. DX (diagnosis) of dementia.

2. The MDS assessment for Resident #15 dated 1/12/24 revealed the resident had short and long term memory problem, and moderately impaired cognition.

Review of Medical Diagnoses for Resident #15 included unspecified dementia.

The Care Plan for Resident #15 dated 10/7/23 revealed, Risk for Wandering / Elopement Identified.

3. Review of the clinical record for Resident #16 revealed the resident did not have an MDS completed yet.

Review of Medical Diagnoses for Resident #16 included Alzheimer's Disease.

The Care Plan for Resident #16 documented, Risk for Wandering / Elopement.

4. The MDS assessment for Resident #17 dated 12/27/23 revealed the resident scored 11 out of

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15 on a BIMs exam, which indicated moderate cognitive impairment. Per this assessment, the resident had other behaviors which occurred daily that significantly interfered with the resident's care. Per the assessment, the resident wandered daily.

Review of Medical Diagnoses for Resident #17 included unspecified dementia, mild, and anxiety disorder.

The Care Plan for Resident #17 dated 12/28/23 revealed, I am a wanderer r/t Resident wanders aimlessly, significantly intrudes on the privacy of others.

5. Review of the clinical record for Resident #18 revealed the resident did not have an MDS completed yet.

Review of Medical Diagnoses for Resident #18 included vascular dementia without behavioral disturbance and anxiety disorder.

On 2/1/24 at 9:05 AM, Staff A, Certified Nursing Assistant (CNA) present on the dementia unit. Staff A explained they had six residents on the dementia unit. Per Staff A, the nurse up front would come back to the dementia unit. When queried about staffing, Staff A explained they felt like they needed more supervision. When queried about residents who required assistance with toileting, Staff A responded pretty much all of the residents except for one. Per Staff A, for the rest of the residents she would need to lead the residents to the bathroom. Staff A explained, If I'm in a room, who is out here? When queried about residents who wandered, Staff A responded pretty much all. Per Staff A, if residents fidgeted she

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would walk them to the bathroom.

On 2/1/24 at 1:50 PM, Staff E, CNA explained she normally worked the front of the facility, and had worked the dementia unit. Per Staff E, she complained of being back there (dementia unit) because there was no help. Staff E explained usually when working the dementia unit there was one CNA, and usually one to two up front. Per Staff E, there was absolutely no communication up there, and no way to get ahold of anyone without opening the door and yelling to get ahold someone. Staff E explained if one resident needed care, how did that work with other residents? Staff E explained need to hurry and do what doing and go back out there. Staff E explained sometimes could get someone to come back and watch the others while doing cares, and explained it was very rare. Per Staff E, it was very hard with one CNA back there, which was why so many staff refused to go back there.

Observations and interviews conducted 2/20/24 revealed the following:

On 2/20/20/24 at 12:57 AM, Staff A, CNA observed at nursing desk at front of building (outside of the facility's dementia unit). When queried about aides present 2/20/24, Staff A responded only her.

On 2/20/2024 at approximately 1:00 PM, the Maintenance Supervisor and Staff Q, Physical Therapy Assistant (PTA) present on dementia unit. When queried if he received training to work with the residents, the Maintenance Supervisor explained he watched a video about dementia, and acknowledged he was not a CNA. The Maintenance Supervisor explained if there was a

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fall or someone needed changed, he would get on his phone or yell down the hall.

The Maintenance Director explained on Friday, he was present on the dementia unit from 4:00 PM to 7:30 PM. When queried how he completed dining, the Maintenance Supervisor explained food brought back, he fed Resident #16, and the Maintenance Supervisor did not know who could eat and who could not eat.

Per the Maintenance Director, the Housekeeping Supervisor had been on the dementia unit since 6:00 (AM), and he had been on the dementia unit for approximately an hour. The Maintenance Supervisor explained he explained he had asked the Housekeeping Supervisor if she wanted to go to lunch as she had been on the dementia unit with no break all morning.

After speaking with the Maintenance Supervisor, Staff P, Housekeeper, observed present at a table on the dementia unit. On 2/20/24 at 1:07 PM during an interview with Staff P, Staff P explained helping today (2/20/24), and further explained she just came back to dementia unit to help them out, and to help Resident #9. Staff P explained she knew they were busy, and she helped when she could. Staff P explained she could do a puzzle or something, anything that she could help with that didn't involve lifting. When queried if she was a CNA, Staff P responded she was a housekeeper.

On 2/20/2024 at 1:20 PM, the Regional Nurse Consultant (RNC) informed the Housekeeping Supervisor, PTA, and Housekeeper present on the dementia unit. The RNC sent a corporate staff back to dementia unit.

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On 2/20/24 at 1:21 PM, the Housekeeping Supervisor explained they were Housekeeping Supervisor, did Medical Records, and was a Feeding Assistant. When queried if she was a CNA, the Housekeeping Supervisor responded she was not. The Housekeeping Supervisor explained she was on the dementia area from 7:00 AM until went to lunch about 12:45 PM. When queried if anyone came to help her, the Housekeeping Supervisor explained [CNA Name Redacted] kept coming and checking. Per the Housekeeping Supervisor, she was told to go back to dementia unit the AM to relieve the DON. When queried about if resident had to go to the bathroom, the Housekeeping Supervisor explained she had a walkie, and would walkie staff. When queried if she felt comfortable working like that back there, the Housekeeping Supervisor responded she did not like to be the only one back there, no, and didn't usually go back there, not by herself anyway.

On 2/20/24 at 2:45 PM the facility's Director of Nursing (DON) queried about staffing for the dementia unit. When queried how the dementia unit normally staffed, the DON explained a CNA, and one nurse who covered the building. The DON acknowledged staffing with one CNA for all shifts for the dementia area. When queried about non-clinical staff present for the dementia area, the DON acknowledged it had occurred when they did not have a staff member. The DON acknowledged it had occurred in current week and during the ice storm.

Per the DON, she was on the dementia until approximately 6AM/7AM the morning of 2/20/24, came out of unit to count narcotics with [Name

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F 741	Continued From page 80 Redacted] and then they went down and asked [Housekeeping Supervisor] to step in for a moment. The DON explained she checked on [Housekeeping Supervisor] the minute done, and residents were not up. Per the DON, she had [CNA Name Redacted] go back, the DON alerted there was one staff member, a staffing meeting occurred, and the DON asked the plan for the AM. Per DON, response given was trying to get someone in here. When queried how she (DON) felt about maintenance, housekeeping, and Physical Therapy Assistant staffing, the DON explained the way she put it was if needed something holler out and would help them. The DON further explained lack of staffing agency available, everyone contacted with no response, and sister facilities asked as well. When queried further about non-clinical staff who worked the dementia unit, the DON explained occurred on Friday and current day (2/20/24), as trying to get through and no staff. Review of the Facility Assessment Tool, last updated 10/17/23, revealed the facility needed one DON, RN (Registered Nurse) for full time days, one RN or LPN (Licensed Practical Nurse) Charge Nurse for each shift, 3 CNAs for days, 3 CNAs for evenings, and 2 CNAs for nights.	F 741		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		

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Based on clinical record review, interview, and facility policy review, the facility failed to discontinue the diuretic medication hydrochlorothiaze upon a resident's return from the hospital per hospital discharge medication reconciliation prior to initiating new medications, including a diuretic medication, per discharge medication reconciliation and failed to discontinue two antibiotic medications per Infectious Disease for two of two resident reviewed for significant medication errors (Resident #1, Resident #4). The facility reported a census of 24 residents.

Findings include:

The Minimum Data Set (MDS) assessment for Resident #4 dated 10/25/23 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMs) assessment, which indicated intact cognition. Per the assessment, Resident #4 took diuretic medication.

Review of Medical Diagnoses for Resident #4 included Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Unspecified, Essential (Primary) Hypertension, and Hypertensive Heart and Chronic Kidney Disease Without heart Failure.

The Care Plan dated 11/6/23, revised 1/30/24, documented, I'm at risk for fluid alterations due to diuretic usage and HX (history) of renal impairments.

Interventions dated 11/6/23 included the following:
a. labs as ordered
b. medications as ordered
c. notify MD (Medical Doctor) as needed

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d. observe resident for poor skin turgor, edema, pallor during care
e. VS (vital signs) as indicated

Review of Discharge Instructions for Visit Date 1/30/24 included with Hospital Records revealed the following per new, changed or refilled prescriptions:

a. Nifedipine (Nifedipine 30 mg, extended release) 60 mg =2 tab(s) oral every day
b. Bumetanide (bumetanide 1 mg (milligram) 1mg=1 tab(s) Oral every day

Discharge Instructions documented, STOP TAKING the following medications:

a. Hydrochlorothiazide (Hydrochlorothiazide 25mg)

Review of the Internal Medicine Progress Note dated 2/1/24 at 1:21 PM documented, in part, the following per the Assessment/Plan section:

a. Hyponatremia; aysmptomatic-improving Secondary to fluid overload in the setting of CHF (Congestive Heart Failure) exacerbation and potentially hctz (hydrochlorothiazide)...Holding hctz.

The Health Status Note dated 2/2/24 at 2:00 PM documented, Resident returned from [Hospital Name Redacted] with two new meds and faxed to RX (pharmacy), resident transferred to nursing home the by a van with a staff member. The Health Status Note did not address discontinuation of hydrochlorothiazide.

The Physician Order dated 2/3/24 at 8:00 AM

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revealed, Bumetanide Oral Tablet 1 MG (milligram) with direction to give 1 tablet by mouth one time a day for fluid overload.

Review of the resident's Medication Administration Record (MAR) dated February 2024 revealed Bumetanide (Bumex) charted as administered on 2/3/24, 2/4/24, 2/6/24, and 2/7/24.

The Physician Order dated 2/3/24 at 8:00 AM documented, Nifedipine ER (extended release)Oral Tablet Extended Release 24 Hour with direction to give 60 mg by mouth one time a day for acute decompensated heart failure.

Review of the resident's MAR dated February 2024 revealed Hydrochlorothiazide Oral Tablet 25 MG charted as administered on 2/3/24, 2/4/24, 2/6/24, and 2/7/24.

On the afternoon of 2/7/24, facility Regional Nurse Consultant and Director of Nursing informed the resident remained on Hydrochlorothiazide with the addition of medications per the resident's hospital discharge instructions.

Review of the Communication with Provider Note dated 2/7/24 at 4:51 PM documented, During medication review it was noted that resident was receiving Hydrochlorothiazide 25mg daily and it should have been discontinued on 2/2/24. Resident own responsible party notified. [Name Redacted] NP notified. Resident's behavior and locomotion unchanged. Assessment: Plan: Vitals every shift for 3 days.

Per Resident #4's clinical record,

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hydrocholorothiazide medication discontinued for the resident on 2/7/24.

On 2/20/24 at 2:27 PM, the Director of Nursing (DON) explained when the resident returned from the hospital the nurse should have taken the hospital paperwork, done a readmit, looked at the orders to make sure orders the same, entered new orders, and if discontinued would pull the drug and send back to pharmacy.

The Facility Policy titled Medication Administration Guidelines, revised 10/2023, revealed the following: Readmissions: a) Compare transfer orders with information on the previous medical record and clarify any discrepancie Verify orders with physician.

2. The Minimum Data Set (MDS) assessment tool, dated 1/30/24, listed diagnosis for Resident #1 included: neurogenic bladder (lack of bladder control), muscle spasms, and type 2 diabetes. The MDS assessed the resident required intermittent catheterization for urine elimination. The MDS listed the resident ' s Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

The Care Plan, dated 10/31/23, included a Focus Area of antibiotic treatment to treat a spinal abscess which occurred prior to admission. An Intervention, dated 10/31/23, direct staff to administer antibiotics as ordered.

A Record Review on 2/13/24 of Physician Orders revealed the following orders for antibiotics:

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F 760	Continued From page 85 a. Doxycycline 100 mg 1 capsule by mouth twice daily no stop date, start date 10/23/23 b. Metronidazole 500 mg 1 tablet by mouth three times a day, start date 10/23/24 A review of Physician Progress notes, dated 12/19/23, from the Infectious Disease provider revealed: a. Doxycycline 100 mg BID (two time daily) to continue for two more weeks. b. Metronidazole 500 mg TID (three times daily) discontinued on 10/18/23. A review on 2/13/24 of the February 2024 electronic Medication Administration Record (eMAR) revealed the the last dose of Doxycycline administered on 2/13/24 during the 8:00 AM medication pass and the last dose of Metronidazole administered on 2/13/24 during the 1:00 PM medication pass. On the afternoon of 2/13/24 the facility Regional Consultant informed the resident remained on Doxycycline, and Metronidazole. During an interview on 2/20/24 at 2:57 PM, the Director of Nursing (DON) stated the residents antibiotics were discontinued on 2/13/24 after being informed of their continuation past the physician ordered stop dates. . The DON stated the medication error occurred as the facility had not obtained the Physician Progress notes from the Infectious Disease provider. The DON stated she expects staff to follow up after each medical appointment to ensure progress notes are received timely.	F 760		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results	F 773		

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F 773	Continued From page 86 CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure prompt communication with the Provider regarding resident laboratory test results for one of four residents reviewed for labs (Resident #4). The facility reported a census of 24 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 10/25/23 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMs) assessment, which indicated intact cognition. The Physician Order dated 12/27/23 documented, CMP (Comprehensive Metabolic Panel), HgbA1c (Hemoglobin A1C), CBC (Complete Blood Count) one time only for routine lab work until 12/27/2023 23:59 (11:59 PM). The eMar-Medication Administration Note dated	F 773		

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12/27/23 at 5:43 AM documented, CMP, HgbA1c, CBC one time only for routine lab work until 12/27/2023 23:59 Venipuncture performed to Right lateral Thumb side of wrist and Purple Top tube obtained for CBC and HgbA1C. Second venipuncture required to be performed from Left Lateral Thumbside of wrist for Yellow top tube for CMP. Resident tolerated procedure well. Specimens to be transported to [Hospital Name Redacted] laboratory for testing.

Review of Progress Notes following the lab draw lacked information about lab results for Resident #4. Review of Physician Provider Notes dated 12/29/23 and 1/2/24 also lacked information about lab results or actions taken related to lab results.

Review of the resident's clinical record revealed lab results from 12/27/23 added to the resident's electronic health record on 2/10/24.

Review of a Chemistry Report, date/time collected 12/27/23 at 7:31 AM with result date/time 12/27/23 at 8:28 AM, revealed the resident's Sodium Lvl at 130 mEq/L (milliequivalents/liter), noted to be low as normal reference range 136-145.

On 2/8/24 at 306 PM during an interview with the Nurse Practitioner (NP) when queried about results reported, the NP explained she would have to look in her notes, things written down, and faxes received. When queried what actions would be taken for a Sodium level of 130, the NP explained she would start the resident on sodium chloride if not already on it, and if already on it increase it, then recheck the labs. When queried as to timeframe for recheck, the NP responded

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probably a week later.

Review of Resident #4's Physician Orders lacked an order for sodium chloride or repeat labs in one week. Review of the resident's Medication Administration Record (MAR) dated December 2023 and January 2024 lacked administration of sodium chloride.

On 2/14/24 at approximately 11:20 AM when queried who received lab results, the Regional Nurse Consultant explained if labs were drawn, the facility got the labs.

On 2/14/24 at 11:31 AM, the Director of Nursing (DON) explained changes implemented to highlight the bottom of the requisition to include fax number which went to the back of the building and to the DON's email. Per the DON, the information was not faxed to the Provider, so it was the facility's responsibility once got it to make sure the Provider saw it. The DON explained she spoke to the lab, and unless highlighted the lab did not do anything with the report. When queried which lab she spoke to, the DON explained the lab name which matched that used by Resident #4's labs done on 12/27/23. The DON explained new processes had been recently implemented.

On 2/19/24 at approximately 9:40 AM, the Regional Nurse Consultant explained the facility did not have a lab contract.

On 2/20/24 at 3:00 PM, the Director of Nursing (DON) explained if labs not at facility staff were to call and ask for them to be faxed. When queried if anyone had brought up process concerns, the DON responded no.

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F 825	Continued From page 89	F 825		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews the facility failed to provide approved Skilled Physical Therapy services in a timely manner for 1 of 5 residents in the sample (Resident #2). The facility reported a census of 24 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 1/17/24 , listed diagnosis for Resident #2 included type 2 diabetes, recent severe sepsis with septic shock, and peripheral vascular disease (poor circulation). The MDS assessed	F 825		

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the resident required The MDS listed the resident ' s Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

During an interview1/31/24 at 2:00 PM, Resident #2 stated she did not have therapy for the first 10 days of her admission.

The Electronic Health Record (EHR) census history revealed an admission date of 1/10/24.

The facility contracted therapy services provided initial evaluation and treatment sessions records for Occupational, and Physical Therapies.

A review of the records for Occupational Therapy (OT) revealed an evaluation completed on 1/11/24. The evaluation indicated Resident #2 has a certification period from 1/11/24 to 3/10/24 for 5 times per week, for 8 weeks.

The Occupational Therapy Treatment records revealed sessions occurred on: 1/12/24, 1/15/24, 1/16/24, 1/18/24, 1/19/24, 1/20/24, 1/22/24, 1/23/24, 1/25/24, 1/26/24, 1/27/24, 1/29/24, 1/30/24

A review of the records for Physical Therapy (PT) revealed an evaluation completed on 1/11/24. The evaluation indicated Resident #2 had a certification period from 1/11/24 to 3/10/24 for 20 times per period, with a duration of 4 weeks.

The Physical Therapy Treatment records revealed sessions occurred on 1/18/24, and 1/29/24. The note indicated the 1/18/24 session as the first skilled visit since the 1/11/24 evaluation.

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F 825	Continued From page 91 During an interview on 2/5/24 at 3:20 PM, the Rehabilitation Supervision explained a lack of PT staff caused the delay in Resident #2 PT treatment sessions. During an interview on 2/15/24 at 3:00 PM, the Director of Nursing (DON) stated the facility lacked therapy staff needed to provide approved skilled physical therapy services. The facility lacked a policy related to Skilled Nursing services.	F 825		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure effective administration to ensure the provision of high quality healthcare and nursing services for 24 of 24 residents who resided at the facility. The facility reported a census of 24 residents. Findings include: 1. On 2/13/24 at 9:31 AM when queried about training for new employees, Staff I, Certified Nursing Assistant (CNA) explained there was not a written document to follow. When queried if Staff I had trained staff on first shift at the facility, Staff I explained she had done so. Staff I	F 835		

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explained the following process: Usually first day let staff member watch and learn the residents, then the second day more hands on, then third day staff would do it and she would watch to make sure doing it right.

On 2/13/24 at 10:30 AM, Staff K, CNA explained there was not a set program for new staff training and also not a paperwork portion which would go along with training for new CNAs.

Review of a Facility Policy titled Clinical Employee Orientation Standard dated September 2023 included a Skills Competency Validation Checklist Certified Nursing Assistant which included a column for competency/skills, a column for competent, a column for needs experience, and a column for comments/remediate. The Checklist included an area at the bottom of the form where the employee, preceptor, and Nursing Supervisor were to sign and date.

On 2/20/24 at 3:02 PM when queried about a written component for CNA training, the facility's Director of Nursing (DON) referenced a check off sheet. When queried who would complete it, the DON responded herself, or would be provided to the CNA who did orientating.

2. On 2/12/24 at 3:25 PM, Staff J, Licensed Practical Nurse (LPN) explained she would write notes to the former and current Director of Nursing (DON) regarding concerns, and response provided was that's the way corporate did it. Staff J further explained the facility needed its own identity with policies and procedures specific to people they took care of. Staff J explained she was unable to find policies and procedures, the facility had three different fall

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packets, two different neuro sheets, and she did not know what assessments to do. Staff J explained she did not have a job or shift description although she had asked for them.

Per Staff J, she put a book into place for pharmacy recommendations, the facility did not have a communication book in place or place that physical therapy went, charting was very vague, and she did not have progress notes from the Nurse Practitioner or specialists. When queried if she felt information was acted upon in her absence, Staff J responded no. Staff J explained when she went to the policy/procedure book for fall interventions it talked about restraints and alarms, which could not be used.

Review of Care Plans for Resident #3 and Resident #4 revealed the following revised or added by Staff J:

a. On 2/13/24, review of the Care Plan for Resident #3 revealed a Care Plan Focus to address CPAP/BIPAP (continuous positive airway pressure/bilevel positive airway pressure) and Interventions added to the resident's Care Plan by Staff J on 2/15/23.

b. On 2/13/24, review of the Care Plan for Resident #4 revealed multiple interventions to address falls were added to Resident #4's Care Plan by Staff J. All interventions added by Staff J were dated 2/9/24. Staff J had also input interventions to the resident's Care Plan for pain.

When queried about Care Plan revision for falls, Staff J explained the was not told the assessment she completed updated a care plan, explained what she completed said clinical suggestions,

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and to her that was a suggestion for someone to try to figure out. Staff J explained a lack of orientation.

On 2/20/24 at 3:03 PM when queried about policy and procedures, the facility's Director of Nursing (DON) explained manuals present on shelf by nurses cart. When queried if there was ever a time they were not available, the DON responded no. When queried about a fall packet, the DON explained today first time brought to her attention. The DON explained neuro sheets were in the med room in the cabinet, and she was unaware of more than one. When queried how staff aware of which assessments to complete, the DON explained they popped up red under the UDA (user defined assessment), and generated in [Electronic Health Record]. When queried if floor nurses altered Care Plans, the DON responded she did not think they were currently doing that.

3. On 2/15/24 at 9:31 during an interview with Staff I, CNA, Staff I explained the following when she would come in and do rounds, resident to resident to check them: Staff I explained she had to roll the residents because things were hidden under the chux pad. Staff I explained if urine present, she found another chux had been put down instead of a bed change. Staff I explained the following example involving Resident #22: Per Staff I, on the morning of 2/15/23, the resident had his fitted sheet with a chux pad under the fitted sheet and another on top of the fitted sheet because the resident's bed was wet. Staff I explained she came in to five to six bed changes a day. Staff I explained when she got the resident up in the morning and pulled the chux under the fitted sheet was wet, and top of the fitted sheet was dry. When queried if she thought

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staff changed the resident and not the bed, Staff I nodded her head yes. The resident was dry and top chux dry, and the sheet underneath described with dried yellow stain.

When queried about other residents, Staff I mentioned Resident #3 (former resident) and explained times she came in in the morning with the mattress soaked through to the floor. When queried about other similar findings in the past month, Staff I mentioned Resident #12 and Resident #20. When queried about Resident #1, Staff I explained times when resident completely soaked up to the shoulders, not this week, last week or the week before. Per Staff I, there were days Staff I and Staff K came in, and Resident #22 had four chux pads present. Staff I explained Resident #22 could be taken to the restroom or urinal, and there was no reason for bed changes like that if checked on regularly.

On 2/13/24 at 10:30 AM, Staff K, CNA, explained Resident #22 urinated frequently, and the resident's bed got stripped a lot. Staff K explained too many chux put for the resident, present from shoulder to knees, described as 3 to 4 chux a night. Staff K described it as excessive. When queried if the chux were wet when he (Staff K) came into facility, Staff K responded sometimes, and further explained the sheet underneath was wet with a brown ring around, and the chux on top was dry. When queried as to timeframe this occurred, Staff K explained a few weeks ago for Resident #22, and in general, occurred last week. Per Staff K, in the week prior he came in, Resident #24 had the same thing, brown ring underneath with dry chux on top. Per Staff K, the resident did not have a brief on. When queried if Resident #24 normally wore a brief, Staff K

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F 835	Continued From page 96 responded yes, more times than not. Per Staff K, the former DON and current DON notified. When queried about changes since Staff K brought it up, Staff K responded it occurred a little less frequently, and still happened. On 2/20/24 at 3:08 PM, the DON queried about concerns from midnight shift to days. Per the DON, a concern brought to her involving a current staff on night shift. The DON explained she was asked to come down to see, and saw a wet chux with a dry chux on top of it. The DON acknowledged the concern brought to her just recently. Review of the Licensed Nursing Home Administrator Job Description, undated, revealed the following per the Job Duties and Responsibilities section: Oversee that nursing services, social service programs, activity programs, food service programs and medical services are planned, implemented and evaluated to meet resident needs to maximize resident quality of life and quality of care. Review of the Director of Nursing Job Description, undated, revealed the following per the Job Summary: The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times.	F 835		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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unauthorized use.

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure complete and accurate medical records present and accessible in the residents' clinical records for eight of eleven residents reviewed for records (Resident #1, Resident #2, Resident #4, Resident #6, Resident #11, Resident #13, Resident #14, Resident #19). The facility reported a census of 24 residents.

Findings include:

1. Review of Physician Progress Notes for Resident #4 revealed, in part, Physician Progress Notes effective for the following dates were

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added to the resident's electronic health record on 2/12/24:

a. 10/18/23
b. 10/22/23
c. 11/16/23
d. 12/15/23
e. 1/5/24
f. 1/11/24
g. 1/17/24
h. 1/26/24
i. 2/5/24

The Physician Order dated 12/27/23 for Resident #4 documented, CMP (Comprehensive Metabolic Panel), HgbA1c (Hemoglobin A1C), CBC (Complete Blood Count) one time only for routine lab work until 12/27/2023 23:59 (11:59 PM). Further review of the resident's clinical record revealed lab results from 12/27/23 added to the resident's electronic health record on 2/10/24.

2. Review of Physician Progress Notes for Resident #6 revealed the resident resident expired on 1/18/24. The clinical record for Resident #6 revealed, in part, Physician Progress Notes effective for the following dates were added to the resident's electronic health record on 2/12/24:

a. 12/5/23
b. 12/14/23
c. 12/15/23
d. 12/29/23
e. 1/2/24
f. 1/17/24

The Facility Policy titled Health Information Management Manual, revised 2021, revealed the

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following: All records, including active, overflow, and discharge records, will be readily accessible, assembled, and maintained in uniform chart order.

3. During an interview on 2/6/24 at 1:17 PM. Staff J, Licensed Nurse Practitioner (LPN) stated R#1 informed her one of his doctors ordered passive range of motion (PROM) to help with muscle spasms. Staff J stated physician notes were unavailable in the Electronic Health Record (EHR). STaff J stated the resident used his phone to pull up the records from the providal portal to show her the order. Staff J stated she entered the orders in the EHR, and started PROM.

On 2/6/24 a EHR record review revealed a lack of Physician Progress notes from the facility nurse practitioner and outside specialists.

On 2/8/24 at 8:10am, via email requesting the facility Nurse Practitioner(NP) and outside specialist notes for Residents #1, Resident #2, Resident #4 , and Resident #14 sent to the Director of Nursing (DON).

On 2/8/24 at 1:56 PM, the DON stated she contacted the NP and the Physician Progress notes will be available on the morning of 2/9/24. When asked if the delay in getting notes has presented a problem the DON stated no. She stated the NP visits once or twice a week, gives orders, she puts the orders in [EHR] and then the NP signs the orders during the next visit. When asked how nurses get this information she stated it is the EHR or they call the NP.

On 2/11/24, the facility NP entered Physician Progress notes in Resident #1 EHR for visits that

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F 842	Continued From page 101 occurred on: a. 10/23/23 b. 10/31/23 c. 11/2/23 d. 11/5/23 e. 11/6/23 f. 11/21/23 g. 12/5/23 h. 12/20/23 i. 1/11/24 j. 1/17/24 k. 1/26/24 l. 1/30/24 m. 2/5/24 On 2/13/24 at 10:08 AM, the DON provided specialist Physician Progress notes for visits that occurred on: a. 11/1/23 from Urology b. 11/6/23 from Infectious Disease. c. 12/5/23 from Physical Medicine and Rehab d. 12/19/23 from Infectious Disease The 12/5/23 note from Physical Medicine and Rehab included an order for daily Passive Range of Motion (PROM). Further review of the EHR revealed a lack of a Physician Order for PROM 4. On 2/6/24 an EHR review revealed a lack of Physician Progress notes for Resident #2 appointments on 1/29/24 with her preferred provider. On 2/8/24 at 2:48 PM, the DON provided Physician Progress notes from Resident#2 preferred provider. The note, with a fax date of 1/30/24 consisted of a Medication list with changes noted. The note lacked a Physician Progress narrative.	F 842		

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On 2/13/24 at 10:08 AM, the DON provided a Physician Progress note with narrative and orders for Resident #2 1/29/24 appointment.
Staff J stated the

5. On 2/6/24 an EHR review revealed a lack of Physician Progress notes for Resident #11 from the facility NP.

On 2/11/24, the facility NP entered Physician Progress notes in the EHR for visits that occurred on:
a. 10/6/23
b.10/13/23
c. 10/15/23
d. 11/2/23
e. 11/28/23
f. 12/2/23
g. 1/2/24
h. 1/26/24

6. On 2/6/24 an EHR review revealed a lack of Physician Progress notes for Resident #13 from the facility Physician.

On 2/12/24, the facility Physician entered Physician Progress notes in the EHR for visits that occurred on:
a. 11/21/23
b. 11/28/23
c. 12/2/23
d. 12/5/23
e. 12/14/23
f. 12/15/23
g. 12/20/23
h. 12/21/23
i. 12/29/23
j. 1/2/24

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F 842	Continued From page 103 k. 1/5/24 7. On 2/6/24 an EHR review revealed a lack of Physician Progress notes for Resident #14 from the facility NP. On 2/12/24, the facility Physician entered Physician Progress notes in the EHR for visits that occurred on: a. 11/16/23 b. 11/28/23 c. 12/2/23 8. On 2/6/24 an EHR review revealed a lack of Physician Progress notes for Resident #19 from the facility NP. On 2/19/24, the facility NP entered Physician Progress notes in the EHR for visits that occurred on: a. 12/29/23 b. 1/2/24 c. 1/5/24	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF DONNELLSON	901 STATE STREET DONNELLSON, IA 52625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 104	F 880		

a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 880	Continued From page 105	F 880		

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure residents were tested for tuberculosis (TB) upon admission to the facility for four of four residents reviewed for TB testing (Resident #16, Resident #17, Resident #18, Resident #20).The facility reported a census of 24 residents.

Findings include:

On 2/7/24 at 1:03 PM at 11:21 AM, TB testing requested for residents Resident #16, Resident #17, Resident #18, and Resident #20 via email to the Regional Nurse Consultant and Director of Nursing (DON).

Review of Census information for Resident #16, Resident #17, Resident #18, and Resident #20 revealed the following admission dates to the facility:

a. Resident #16: 1/23/24
b. Resident #17: 12/18/23
c. Resident #18: 1/26/24

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F 880	Continued From page 106 d. Resident #20: 2/1/24 On 2/7/24 at 1:03 PM, the facility's Director of Nursing (DON) explained the she did not have them, and would get them today. The DON explained it was her fault, she did the admissions and did not get them. When queried if the floor nurses could have done them, she acknowledged they could, and said it did not get done. Per the DON, it was a miscommunication whether it was included or not in the batch order. Per the DON, either it needed to be entered in order, or needed to be put into batch order, or the DON would do it when did the admit. The DON explained she just started doing admits, and was working together with another staff member who had been doing the admits. The Facility Policy titled Tuberculosis Prevention and Management revised 9/2023 documented, Residents, routine volunteers, and health care workers will be given a two-step Mantoux skin test upon admission/hire.	F 880		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by:	F 940		

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F 940	Continued From page 107	F 940		

Based on staff interview and facility policy review, the facility failed to ensure employee training completed to address communication, resident rights, abuse, neglect, and exploitation, Quality Assurance Performance Improvement (QAPI), infection control, compliance and ethics, and behavioral health training for five of five staff reviewed for training requirements (Staff A, B, I, N, O). The facility reported a census of 24 residents.

Findings include:

On 2/14/24 at 9:26 AM, training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC) for the following topics:

a. Effective Communication
b. Resident Rights and Responsibilities of the Facility
c. Abuse, Neglect, and Exploitation Training
d. Behavioral Health Care Needs
e. Infection Control Program
f. QAPI
g. Compliance and Ethics Program

On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices.

Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked

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F 940	Continued From page 108 communication training, QAPI, and behavioral health.	F 940		
F 941 SS=E	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed communications training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, communications training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices. Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 941		
F 942	Resident Rights Training	F 942		

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F 942 SS=E	Continued From page 109 CFR(s): 483.95(b)	F 942		

§483.95(b) Resident's rights and facility responsibilities.
A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility policy review, the facility failed to ensure staff completed resident rights training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents.

Findings include:

On 2/14/24 at 9:26 AM, resident rights and responsibilities of the facility training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC).

On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices.

Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.

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F 943	Continued From page 110	F 943		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed abuse, neglect, and exploitation training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, abuse, neglect, and exploitation training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices. Review of the Facility Policy titled Clinical	F 943		

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F 943	Continued From page 111 Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 943		
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed Quality Assurance Performance Improvement (QAPI) training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, QAPI training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices.	F 944		

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F 944	Continued From page 112 Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 944		
F 945 SS=E	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed infection control training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, infection control training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices.	F 945		

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F 945	Continued From page 113 Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 945		
F 946 SS=E	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed compliance and ethics training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, compliance and ethics	F 946		

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F 946	Continued From page 114 training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices. Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 946		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to ensure staff completed behavioral health care needs training for five of five employees reviewed (Staff A, B, I, N, O). The facility reported a census of 24 residents. Findings include: On 2/14/24 at 9:26 AM, behavioral health care	F 949		

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F 949	Continued From page 115 needs training for Staff A, B, I, N, and O requested via email to the Director of Nursing (DON), Administrator, and Regional Nurse Consultant (RNC). On 2/19/24 at 9:46 AM, the RNC explained she could not find the inservices. Review of the Facility Policy titled Clinical Employee Orientation Standard, dated September 2023, included, in part, the following topics as part of general orientation: corporate compliance program, resident rights/confidentiality, freedom of abuse/neglect, exploitation, and infection control/handwashing/PPE (personal protective equipment). The list of topics lacked communication training, QAPI, and behavioral health.	F 949		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0911	A. BUILDING: _____ B. WING _____	C 02/20/2024

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L 189	58.10(3) General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: This Statute is not met as evidenced by: Based on employee file review, staff interview and facility policy review, the facility failed to ensure employees screened/tested for tuberculosis upon hire for one of five staff members reviewed for TB testing (Staff D). The facility reported a census of 24 residents. Findings include: On 2/6/2024 at 7:57AM, Staff H, Human Resources queried about employee TB testing, and explained TB test would be done with the drug test, usually a one step was done, and the employee would come in and get it read. On 2/6/24 at 9:31 AM, TB testing for employees, including Staff D, requested via email from the Director of Nursing (DON) and Regional Nurse Consultant. On 10:26 AM, the Regional Nurse Consultant explained the facility did not have the information requested, and was doing a performance improvement plan. During the course of the survey, a book for TB testing provided by the facility's Director of Nursing (DON), however lacked information for TB testing for Staff D. The Facility Policy titled Tuberculosis Prevention and Management revised 9/2023 documented,	L 189		

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 189	Continued From page 1 Residents, routine volunteers, and health care workers will be given a two-step Mantoux skin test upon admission/hire.	L 189		

Aspire of Donnellson
901 State Street
Donnellson, Iowa 52625

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F555
The facility strives to ensure that the resident has the right to choose his or her attending physician.

Corrective action taken for residents found to have been affected by deficient practice
Resident #2 no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Resident files were audited to ensure the residents and/or their responsible party received and signed a copy of the Resident Rights.
- Education was completed with Department Heads and Director of Business Development on the resident's right to choose their own physician.
- Director of Nursing or Designee will audit new admissions x4 weeks to ensure they were given the ability to choose their own physician.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

3/21/2024

Aspire of Donnellson
901 State Street
Donnellson, Iowa 52625

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F656
The facility strives to ensure that it develops and implements a comprehensive person-centered care plan for each resident consistent with resident rights, and 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.

Corrective action taken for residents found to have been affected by deficient practice
Care plans for Resident #17 and #21 were audited and revised to ensure comprehensive.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' care plans were audited to ensure accurate and comprehensive.
- Education was completed with the Interdisciplinary Team on completion of comprehensive care plans.
- Education was completed with the Director of Nursing on revising care plans with any changes of condition.
- Director of Nursing or Designee will randomly audit 3 resident care plans per week for 4 weeks to ensure they are comprehensive.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

3/21/2024

Aspire of Donnellson
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F657
The facility strives to ensure that a comprehensive care plan is developed within 7 days of completion of the comprehensive assessment, prepared by an interdisciplinary team, and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

Corrective action taken for residents found to have been affected by deficient practice
Resident #1, #4, and #17's care plans were reviewed and revised to ensure accurate and comprehensive.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' care plans were reviewed to ensure accurate and comprehensive and were revised if needed.
- The Interdisciplinary Team was educated on completing comprehensive care plans and revising of the residents' care plans after a change in condition.
- Director of nursing or designee will randomly audit 3 resident care plans per week for 4 weeks to ensure the care plan is accurate and comprehensive.

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F658
The facility strives to ensure that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.

Corrective action taken for residents found to have been affected by deficient practice.
Resident #1 was screened by therapy for range of motion needs and orders for physical therapy to evaluate and treat were received on 3/15/2024.
Resident #1 is receiving medications and treatments as per the Physician Orders.
Residents #2, #3, and #19 no longer reside in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' physician orders were audited to ensure implemented and being received as ordered.
- Licensed nurses were educated on following physician orders for including but not limited to: medications, treatments, and range of motion.
- Licensed nurses were educated on proper procedure to follow if a medication is unavailable.
- Director of Nursing or Designee will randomly observe 3 med passes per week for 4 weeks to ensure medications are administered per physician orders.
- Director of Nursing or Designee will randomly observe 3 treatments per week for 4 weeks to ensure completed per physician orders.
- Director of Nursing or Designee will randomly audit 3 resident medical records per week for 4 weeks to ensure physician orders received were noted and implemented as per the order.

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F677
The facility strives to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Corrective action taken for residents found to have been affected by deficient practice
Resident #2 and #14 no longer reside in the facility
Resident #15 is being offered and receiving showers at least 2 times per week.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Resident records will be audited to ensure they are scheduled to be offered and receive at a minimum 2 showers per week.
- Nursing staff were educated on offering and providing showers to residents 2 times per week.
- Director of nursing or designee will randomly audit 3 residents per week for 4 weeks to ensure showers were offered and received.

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F678
The facility strives to ensure that personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

Corrective action taken for residents found to have been affected by deficient practice
Resident #6 and #11 no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Resident medical records were audited to ensure that each resident's code status is correct in PCC and that they have the corresponding sticker on their name plate by their room. Any new admission will be monitored for accurate code status and corresponding sticker.
- Licensed nurses were educated on CPR and responding to emergencies. Any new licensed nurses hired will be educated on CPR and responding to emergencies.
- Director of Nursing or Designee will randomly audit 3 resident records per week for 4 weeks to ensure their code status is in PCC correctly and the correct sticker is on their name plate by their room.
- Director of Nursing or Designee will randomly query 2 licensed nurses per week for 4 weeks on where a resident's code status can be located and what to do during an emergency.

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3/7/2024

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F684
The facility strives to ensure that based on the comprehensive assessment of a resident, that they receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Corrective action taken for residents found to have been affected by deficient practice
Resident #1's physician was notified of volume of urine obtained during straight cathing.
Resident #4's physician was notified of lab results and diuretic not being discontinued when ordered.
Resident #18 has had a comprehensive assessment completed since admission.
Residents #1, #4, and #18 are being assessed when there is a change in condition, receiving prompt intervention, and their physicians are being notified of such.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' charts were audited for lab results and physician notification of such results.
- Residents' charts were audited to ensure any physician orders received in the last 30 days had been implemented.
- Residents' charts were audited to ensure that any changes in condition in the last 30 days had been assessed, communicated to the physician, and an intervention implemented if appropriate.
- Charts were audited of any resident who had admitted/readmitted to the facility in the last 30 days to ensure an admission assessment had been completed.
- Licensed nurses were educated on following physician orders, completion of admission assessments with any new admission or readmission to the facility, assessing of changes in condition and intervening as appropriate, notifying the physician of changes in condition, and notifying the physician of lab results.
- The Director of Nursing or designee will randomly audit 3 residents per week for 4 weeks to ensure labs are completed per order and results are communicated to the physician.

- The Director of Nursing or designee will randomly audit 3 residents per week for 4 weeks to ensure physician orders are in place and being followed and that any changes in condition are assessed appropriately, intervened upon as appropriate, and are communicated to the physician timely.
- The Director of Nursing or designee will audit new admissions and readmissions for 4 weeks to ensure an admission assessment is completed.

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F686

The facility strives to ensure that based on the comprehensive assessment of a resident, that they receive care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable; and that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Corrective action taken for residents found to have been affected by deficient practice

Resident #2 no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility with wounds have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- A skin assessment was completed for residents and any new wounds were assessed, documented on, and the physicians notified.
- Licensed nurses were educated on completing a skin assessment for new admissions and readmissions, including assessment of wounds, documenting the assessment of the wounds, notification of the physician, obtaining orders for treatment, and monitoring of such wounds weekly.
- Director of nursing or designee will audit new admissions and readmissions for 4 weeks to ensure a skin assessment was done and any wounds were assessed, that the assessment was documented, treatment orders received and implemented, and that the physician was notified of the wound.
- The Director of nursing or designee will randomly audit 3 residents with wounds per week for 4 weeks to ensure the wounds are assessed weekly, treatments are in place as per physician orders, and that any decline in the wound was communicated to the physician.

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F689
The facility strives to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.

Corrective action taken for residents found to have been affected by deficient practice.
Resident #4 and #21's care plans and falls were reviewed to ensure interventions are in place to reduce the risk of falling related to the root cause of their falls.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents that had fallen in the past 30 days were reviewed to ensure that their falls had been investigated and a root cause identified, along with an intervention being implemented and placed on the care plan to prevent future falls related to the root cause of the fall.
- Nursing staff were educated on fall management and ensuring that fall interventions are in place.
- Licensed nurses were educated on completion of Incident Reports and progress notes with falls.
- Interdisciplinary Team was educated on investigating falls, root cause analysis of falls, and implementation of interventions that are related to the root cause.
- Director of nursing or designee will audit falls for 4 weeks to ensure the incident report is complete, a progress note completed, a root cause analysis completed after the fall is investigated fully, and an intervention put into place that correlates with the root cause of the fall.

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F690

The facility strives to ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain; and that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and that a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

Corrective action taken for residents found to have been affected by deficient practice.

Resident #1's urologist was notified of straight catheterization results and new orders received on 3/13/2024.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility with catheters have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Charts were audited for residents who have had a foley catheter in the past 30 days to ensure that physician orders for the catheter, discontinuation of the catheter, and/or voiding trial were implemented and documented on accordingly.
- Licensed nurses were educated on following physician orders for and documentation of discontinuation of foley catheters, voiding trials, and insertion of foley catheters.
- The Director of Nursing or designee will randomly audit the charts of 3 residents who have or had a foley catheter per week for 4 weeks to ensure physician orders for the catheter and/or voiding trial are implemented and proper documentation is in place.

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F712
The facility strives to ensure that the resident is seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter; that the physician visit is considered timely if it occurs not later than 10 days after the date the visit was required; and that all required physician visits are made by the physician personally unless at the option of the physician, after the initial visit, required visits may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist.

Corrective action taken for residents found to have been affected by deficient practice
Residents #6, #13, #14, and #19 no longer reside in the facility.
Resident #22 was seen by his physician on 3/1/2024.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Resident charts were audited for documentation of last physician visit and if lacking, were seen by a physician and documentation obtained.
- Medical Director and attending physicians were educated on requirements for physician to see the resident initially and then every other visit thereafter.
- Director of Nursing or designee to randomly audit 3 charts per week for 4 weeks to ensure physician visits are occurring as required.

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F727
The facility strives to ensure that it uses the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Nursing schedule was reviewed to ensure an RN is staffed for 8 hours a day, 7 days a week.
- Director of nursing and Administrator educated on requirements for an RN to be staffed for 8 hours every day.
- Administrator to audit staffing daily for 4 weeks to ensure an RN is staffed for 8 hours daily.

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F741
The facility strives to ensure that it has sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population.

Corrective action taken for residents found to have been affected by deficient practice
Residents #9, #15, #16, #17, and #18 receive services to meet their needs from qualified and sufficient staffing.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility on the CCDI unit have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staffing assignments for the CCDI unit were reviewed and revised to ensure staffing is adequate and that the staff are qualified and trained in providing care to residents with cognitive impairments.
- Director of Nursing and Administrator were educated on staffing requirements for the CCDI unit.
- Administrator or designee to monitor staffing on the CCDI unit daily for 4 weeks to ensure staffing is appropriate.

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F760
The facility strives to ensure that its residents are free of any significant medication errors.

Corrective action taken for residents found to have been affected by deficient practice
Resident #1's antibiotics were discontinued.
Resident #4's HCTZ was discontinued.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' charts were audited to ensure any antibiotic orders had a stop date and that the stop date was entered correctly in PCC.
- Residents' charts were audited to ensure any orders received in the last 30 days to discontinue medications were followed through with.
- Licensed nurses were educated on transcribing physician orders when received and ensuring that medications are being given as prescribed.
- Director of Nursing or designee will randomly audit 3 residents' physician orders per week for 4 weeks to ensure any new orders to start or discontinue medications are completed as ordered.

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F773
The facility strives to ensure that it provides or obtains laboratory services only when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws; and that it promptly notifies the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.

Corrective action taken for residents found to have been affected by deficient practice
Resident #4's physician is aware of lab results that were drawn on 12/27/2023.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' charts were audited for lab results and physician notification of such results for the last 30 days.
- Licensed nurses were educated on ensuring timely receipt of lab results from the lab and notifying the physician of the lab results.
- The Director of Nursing or designee will randomly audit 3 residents per week for 4 weeks to ensure labs are completed per order and results are communicated to the physician.

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F825
The facility strives to ensure that if specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity are required in resident's comprehensive plan of care, that it provides the required services or obtains the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs.

Corrective action taken for residents found to have been affected by deficient practice
Resident #2 no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents with orders for physical and occupational therapy in the last 30 days were audited to ensure they are receiving therapy as per physician orders.
- The Director of Rehabilitation was educated on ensuring that residents with orders for therapy are scheduled to receive such services timely and as per orders.
- The Administrator or designee will randomly audit 3 residents with therapy orders weekly for 4 weeks to ensure receiving therapy as per physician orders.

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F835
The facility strives to ensure that it is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- An audit was completed of employees that were hired in the last 30 days to ensure that they had received general orientation training and job specific training, and if they hadn't, the required training was completed.
- The Director of Nursing and Administrator were educated on their job responsibilities per their job descriptions, including ensuring that grievances brought forth from staff are investigated and followed up on timely.
- Licensed nurses were educated on the correct fall packet, neuro check form, and where to locate policies and procedures.
- Job descriptions were reviewed with, and a copy given to staff.
- Administrator or designee will audit new hires for 4 weeks to ensure general orientation training and job specific training is completed, as well as ensuring that the appropriate job description was reviewed with the new hire.
- The Director of nursing or designee will audit falls for 4 weeks to ensure the correct fall packet and neuro check forms are completed.
- The Regional Nurse Consultant or the Regional Vice President of Operations will randomly question 3 staff members per week for 4 weeks to ensure any grievances brought forth were followed up on.

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F842
The facility strives to ensure that in accordance with accepted professional standards and practices, the facility maintains medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized.

Corrective action taken for residents found to have been affected by deficient practice
Residents #2, #6, #11, #13, #14, and #19 no longer reside at the facility.
Residents #1 and #4's medical records are complete and up to date.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Residents' medical records were audited for provider progress notes for any visits completed in the last 30 days.
- Licensed nurses were educated on ensuring receipt of provider progress notes timely.
- Primary providers were educated on need to complete progress notes and deliver them to the facility timely.
- Director of nursing or designee will randomly audit 3 resident charts per week for 4 weeks to ensure provider progress notes are available for any visits completed.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

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F880
The facility strives to ensure that it has established and maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Corrective action taken for residents found to have been affected by deficient practice
Residents #16, #17, #18, and #20 have been tested for tuberculosis.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Resident charts were audited to ensure residents had been tested for tuberculosis or that a chest x-ray was completed if indicated.
- Licensed nurses were educated on administering a TB test to residents upon admission to the facility and scheduling a second TB test to be given.
- The Director of Nursing or designee will audit new admissions to ensure a TB test was administered upon admission and that a second TB test is scheduled to be given on the MAR.

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F940
The facility strives to ensure that it has developed, implemented, and maintained an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles; and that it determines the amount and types of training necessary based on a facility assessment.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Effective Communication; Resident Rights and Responsibilities of the Facility; Abuse, Neglect, and Exploitation; Quality Assurance and Performance Improvement (QAPI); Infection Control; Compliance and Ethics Program; and Behavioral Health Care Needs.
- The Employee General Orientation policy for new staff members includes all required aspects of training including communication training, QAPI, and behavioral health.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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F941
The facility strives to ensure that it has included effective communications as a mandatory training for direct care staff.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Effective Communication.
- The Employee General Orientation policy for new staff members includes all required aspects of training including communication training.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F942
The facility strives to ensure that staff members are educated on rights of the resident and the responsibilities of a facility to properly care for its residents.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Resident Rights and Responsibilities of the Facility.
- The Employee General Orientation policy for new staff members includes all required aspects of training including Resident Rights and Responsibilities of the Facility.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F943
The facility strives to ensure that it provides training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and Dementia management and resident abuse prevention.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Abuse, Neglect, and Exploitation.
- The Employee General Orientation policy for new staff members includes all required aspects of training including Abuse, Neglect, and Exploitation.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F944
The facility strives to ensure that it includes as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Quality Assurance and Performance Improvement (QAPI).
- The Employee General Orientation policy for new staff members includes all required aspects of training including QAPI.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F945
The facility strives to ensure that it includes as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Infection Control.
- The Employee General Orientation policy for new staff members includes all required aspects of training including Infection Control.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F946
The facility strives to ensure that it includes as part of its compliance and ethics program an effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains requirements under the program.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on the Compliance and Ethics Program.
- The Employee General Orientation policy for new staff members includes all required aspects of training including Compliance and Ethics Program.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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F949
The facility strives to ensure that it provides behavioral health training consistent with the requirements and as determined by the facility assessment.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Staff were educated on Behavioral Health Care Needs.
- The Employee General Orientation policy for new staff members includes all required aspects of training including behavioral health.
- The Administrator or designee will audit new staff members orientation for 4 weeks to ensure all education listed in the Employee General Orientation policy was completed.

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L189
The facility strives to ensure that there are written personnel policies for each facility.

Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Personnel files were audited to ensure tuberculosis testing had been completed for staff as per policy.
- The interdisciplinary team was educated on ensuring tuberculosis testing is completed for all new hires to the facility as per policy.
- The Administrator or designee will audit new staff members for 4 weeks to ensure that tuberculosis testing is completed.

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