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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

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{F 656}	Continued From page 314 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal	{F 656}		

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{F 656}	Continued From page 315 protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the	{F 656}		

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{F 656}	Continued From page 316 physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy,	{F 656}		

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{F 656}	Continued From page 317 Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds,	{F 656}		

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{F 656}	Continued From page 318 effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of	{F 656}		

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{F 656}	Continued From page 319 the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and	{F 656}		

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{F 656}	Continued From page 320 reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot	{F 656}		

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{F 656}	Continued From page 321 reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on	{F 656}		

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{F 656}	Continued From page 322 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for	{F 656}		

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{F 656}	Continued From page 323 assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking	{F 656}		

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{F 656}	Continued From page 324 snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on	{F 656}		

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{F 656}	Continued From page 325 the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline.	{F 656}		

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{F 656}	Continued From page 326 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months. 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for	{F 656}		

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{F 656}	Continued From page 327 acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or	{F 656}		

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{F 656}	Continued From page 328 designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks.	{F 656}		

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{F 656}	Continued From page 329 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the	{F 656}		

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{F 656}	Continued From page 330 electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday	{F 656}		

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{F 656}	Continued From page 331 through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications.	{F 656}		

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{F 656}	Continued From page 332 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's	{F 656}		

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{F 656}	Continued From page 333 actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the	{F 656}		

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{F 656}	Continued From page 334 DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and	{F 656}		

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{F 656}	Continued From page 335 turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean,	{F 656}		

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{F 656}	Continued From page 336 well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional	{F 656}		

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{F 656}	Continued From page 337 recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant	{F 656}		

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{F 656}	Continued From page 338 on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from	{F 656}		

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{F 656}	Continued From page 339 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift.	{F 656}		

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{F 656}	Continued From page 340 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on	{F 656}		

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{F 656}	Continued From page 341 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no	{F 656}		

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{F 656}	Continued From page 342 residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on	{F 656}		

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{F 656}	Continued From page 343 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications.	{F 656}		

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{F 656}	Continued From page 344 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement. 24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified	{F 656}		

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{F 656}	Continued From page 345 concerns with missing medications. 26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility	{F 656}		

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{F 656}	Continued From page 346 conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business	{F 656}		

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{F 656}	Continued From page 347 office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting	{F 656}		

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{F 656}	Continued From page 348 and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM,	{F 656}		

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{F 656}	Continued From page 349 Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician.	{F 656}		

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{F 656}	Continued From page 350 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of	{F 656}		

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{F 656}	Continued From page 351 turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a	{F 656}		

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{F 656}	Continued From page 352 new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and	{F 656}		

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{F 656}	Continued From page 353 Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the	{F 656}		

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{F 656}	Continued From page 354 medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and	{F 656}		

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{F 656}	Continued From page 355 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy.	{F 656}		

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{F 656}	Continued From page 356 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48	{F 656}		

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{F 656}	Continued From page 357 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed	{F 656}		

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{F 656}	Continued From page 358 they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55	{F 656}		

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{F 656}	Continued From page 359 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM,	{F 656}		

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{F 656}	Continued From page 360 SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly	{F 656}		

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{F 656}	Continued From page 361 for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts.	{F 656}		

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{F 656}	Continued From page 362 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM	{F 656}		

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{F 656}	Continued From page 363 revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician	{F 656}		

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{F 656}	Continued From page 364 notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff	{F 656}		

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{F 656}	Continued From page 365 was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each s	{F 656}		
{F 657} SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	{F 657}		12/30/21

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{F 657}	Continued From page 366 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 interview, record review, and review of the facility policies, it was determined the facility failed to revise the care plan for one (1) of fifty-seven (57) sampled residents (Resident #65); and failed to ensure three (3) of fifty-seven (57) sampled residents (Resident #57, Resident #27, and Resident #17) and/or the resident's representative was involved in developing the resident's care plan and making decisions about his/her care. Resident #65 developed five (5) pressure ulcers. The facility failed to revise the resident's care plan after the development of each pressure ulcer to	{F 657}	F 657 Care Plan Timing and Revision Criteria 1 a) Resident #65 was discharged from the facility on 10/31/2021 b) The care plan for Resident #57 has been reviewed with the resident by 10/28/2021. c) The care plan for Resident #27 has been reviewed with the resident by 11/17/2021. d) The care plan for Resident #17 has been reviewed with the resident by 10/14/2021.	

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{F 657}	Continued From page 367 address treatment for the ulcer and interventions to prevent the development of new ulcers. Resident #1 developed a Stage I (one) pressure ulcer to the left heel on 06/23/2021, a DTI (deep tissue injury) to the right heel on 06/26/2021, an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021, and two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021. The findings include: 1. Review of the facility's policy, "Care Plans, Comprehensive Person-Centered", revised December 2016 revealed assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed. Review of the facility's Prevention of Pressure Injuries Policy, revised April 2020, revealed the purpose of the policy was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy stated the facility should evaluate report and document potential changes in the skin, and review interventions and strategies for effectiveness on an ongoing basis. Review of Resident #65's medical record revealed the facility admitted the resident on 03/23/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease (COPD) and Paraplegia. Review of Resident #65's Quarterly Minimum Data Set (MDS) assessment dated 05/05/2021 revealed the facility documented the resident weighed 135 pounds and had an unhealed	{F 657}	Criteria 2: a) All current residents with wounds have had review/revision of their care plan to determine that it addresses their current skin/wound status, as completed by the MDS Coordinator/Designee on 10/27/2121. b) All residents and their representatives are invited to the scheduled care plan meetings by mail, phone, and letter. They are offered the option to attend either in person, or by phone, with their choice documented in the resident record. Criteria 3: a) On 11/24/2021 The IDT Care Plan team received in-service education by the Nurse Consultant/Designee on: the need to address all residents care plans to include skin status accurately on the care plan with the indicated interventions necessary to promote healing/prevent breakdown; and the need to invite and include all residents and their representatives in their care plan meetings to encourage their participation in care plan development. All licensed staff including new hires and agency staff will be educated prior to starting work on care plans. Beginning 11/24/2021 a post test was administered and will be graded by the DON/designee to ensure staff competency, licensed nursing staff not working will take the test on their next scheduled day . Criteria 4: a) Beginning 11/24/2021 progress notes will be reviewed weekly x	

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{F 657}	Continued From page 368 pressure ulcer, and a deep tissue injury. Review of Resident #65's care plan dated 06/16/2021, revealed the facility identified the resident had a Stage IV (4) pressure ulcer to the sacrum. The facility developed interventions to address the pressure ulcer that included turning and repositioning approximately every two (2) hours; weekly treatment documentation to include measurement of each area of skin breakdown; width, length, depth, type of tissue and exudate and any other notable changes or observation; encourage good nutrition and hydration; obtain blood work (including culture and sensitivities) of any open wounds as ordered by the physician; and, follow the facility's protocols for treatment. Review of a change of condition note for Resident #65 dated 06/23/2021 at 10:30 AM revealed the resident had acquired a new Stage one pressure ulcer to the left heel that measured 6.5 cm (centimeters) (length) by 4 cm (width). The resident's physician ordered, "Bilateral heel protectors while in bed, apply sure prep to left heel daily". However, there was no documented evidence that the facility revised the resident's care plan to reflect the new area to the left heel, and no documented evidence the care plan was revised to include the new Physician's Orders for bilateral heel protectors while in bed. Review of Resident #65's change of condition note dated 06/26/2021 at 10:10 PM revealed the resident had acquired a new deep tissue injury (DTI) pressure ulcer to the right heel. The facility received a new order for a treatment to the pressure ulcer; however, the facility failed to revise the care plan to reflect the new pressure ulcer with interventions to address healing and	{F 657}	4 weeks then monthly x 2 month by the Director of Nursing, Assistant Director of Nursing or Nursing supervisor to ensure any new areas of skin impairment and/or behaviors that are identified have a care plan implemented/ revised that includes new interventions and or treatments. Audit results will be reviewed monthly in QAPI meeting x3 months then quarterly until in substantial compliance. B) Beginning 11/24/2021 the DON/Nurse Consultant/Designee will audit the monthly Care plan calendar against residents interdisciplinary care plan meeting assessment to ensure each resident with a care plan meeting has had the meeting and the resident and/or responsible party if applicable, have attended and/or been invited.. Audits will be weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 657}	Continued From page 369 prevention of the new pressure ulcers. Continued review of Resident #65's care plan revealed on 07/14/2021, the facility implemented a new care plan for the Stage IV (4) pressure ulcer to the sacral area. The facility revised the care plan to include interventions to administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the physician; monitor dressings every shift, and as needed to ensure intact and adhering; report loose dressings to the treatment nurse; and two (2) staff were required to turn and reposition the resident at least every two (2) hours, more often as needed or requested because the resident was totally dependent on staff. However, the facility continued to fail to revise the care plan with interventions to address the Stage I pressure ulcer to Resident #65's left heel and the Deep Tissue Injury (DTI) to the right heel. Review of Resident #65's Quarterly MDS assessment dated 08/05/2021 revealed the facility identified the resident had a weight loss, and had malnutrition or was at risk. In addition, the MDS revealed the facility was aware the resident had one Stage I (1) pressure ulcer, one Stage IV pressure ulcer, and one pressure ulcer that was unstageable. However, there was no documented evidence the facility revised Resident #65's care plan with interventions to address care of the pressure ulcers to the heels and no documented evidence the facility developed interventions to prevent further pressure ulcers. Review of a Head to Toe Weekly Skin Check	{F 657}		

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{F 657}	Continued From page 370 (assessment) dated 08/12/2021 at 11:52 AM, for Resident #65 revealed the resident had developed an unstageable pressure ulcer to the back of his/her left, lower leg. The facility obtained a Physician's Order to treat the ulcer with Santyl Ointment daily. However, there was no documented evidence the facility revised the care plan to reflect the new unstageable pressure ulcer to Resident #65's lower left leg, nor did the facility revise the care plan with interventions to prevent further pressure ulcers. Review of a change of condition assessment dated 08/26/2021 at 6:39 PM for Resident #65 revealed the resident developed a Stage II (2) pressure ulcer to the left hip. The resident's physician was notified and new orders were received to treat the area with sure prep. Continued review of the resident's care plan revealed no documented evidence the facility revised the care plan to reflect the newly developed pressure ulcer nor revised the care plan to prevent new pressure ulcers. Interview with MDS Nurse #1 on 08/27/2021 at 11:10 AM revealed she was responsible for updating/revising care plans. She stated Resident #65's care plan was not revised regarding the resident's new pressure ulcers and worsening pressure ulcer until 08/16/2021. According to MDS Nurse #1, the facility did not have a system/process for communicating new and/or worsening pressure ulcers, weight loss, etc. Subsequently, residents' care plans were not being revised to accurately reflect the residents' needs. Interview with MDS Nurse #2 on 08/27/2021 at 10:43 AM revealed Resident #65's care plan	{F 657}		

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{F 657}	Continued From page 371	{F 657}		

should have been updated to reflect the resident's pressure ulcers. MDS Nurse #2 also stated the facility did not have a process/procedure to communicate this information to MDS staff. She stated if she was not aware a resident had weight loss and/or pressure ulcers she could not revise the care plan.

Interview with the Administrator on 09/03/2021 at 5:02 PM revealed the Interdisciplinary Team (IDT) reviewed comprehensive care plans weekly to ensure they were accurate and up-to-date. She stated she began reviewing care plans in mid-June 2021 and identified that care plans were not updated appropriately.

2a). Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", revised in December 2016, revealed, "Each resident's comprehensive person-centered care plan will be consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: participate in the planning process."

Record review revealed the facility admitted Resident #57 on 04/23/2021. The facility completed a Minimum Data Set (MDS) Admission Assessment dated 04/29/2021 in which the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) sore of 15 indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence the facility invited the resident to the care plan meeting.

Interview on 06/16/2021 at 10:19 AM, with Resident #57 revealed he/she had care plan

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{F 657}	Continued From page 372 meetings at another facility where he/she lived. However, the facility had not invited him/her and he/she had not attended a care plan meeting since admission to the facility. 2b). Record review revealed the facility admitted Resident #27 on 01/20/2015. Review of a Quarterly MDS Assessment dated 03/30/2021, revealed the facility assessed the resident to have a BIMS score of 15, indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence the facility invited Resident #27 the care plan meeting for this assessment. Interview on 06/16/2021 at 9:27 AM, with Resident #27 revealed the resident could not remember anyone talking to him/her about their plan of care 2c). Record review revealed the facility admitted Resident #17 on 03/15/2021. The facility completed an Admission MDS assessment dated 03/21/2021, and the facility assessed the resident to have a BIMS score of 15, indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence in the progress notes of the resident being invited to a care plan meeting. Interview on 06/16/2021 at 9:55 AM, with Resident #17 revealed he/she was not sure what a care plan meeting was and when explained, the resident stated facility staff had not discussed his/her care or care plan with him/her. Interview with the MDS Coordinator, on 06/18/2021 at 3:50 PM, revealed the facility had not had care plan meetings since December	{F 657}		

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{F 657}	Continued From page 373 2020 due to COVID-19. She stated prior to December 2020, the facility invited residents with a BIMS of eight (8) or above, or asked them if they would like to have a family member attend the care plan meeting. She stated if the resident did not wish to attend or had someone attend for them, staff was required to document the conversation in the resident's medical record. Interview with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been at the facility for two (2) weeks and was not aware whether the facility was having care plan meetings. The Administrator stated a potential problem with not having care plan meetings would be missed or unidentified problems.	{F 657}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	{F 684}		12/30/21

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{F 684}	Continued From page 374 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to ensure two (2) of fifty-seven (57) sampled residents (Resident #321 and Resident #323) received treatment and care in accordance with professional standards of practice. On the morning of 07/18/2021, before breakfast, staff obtained Resident #321's blood glucose level, which was 67 mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). Although the nurse held the resident's insulin injection, she administered the resident an oral hypoglycemic medication. The nurse stated that after breakfast she re-checked the resident's blood glucose level, which was then 139 mg/dL. However, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until sometime later that afternoon, sometime after 3:00 PM, when staff found Resident #1 unresponsive with a blood glucose level of 40 mg/dL. Interviews with staff revealed they administered Resident #321 both, injectable and oral glucose, and the resident regained consciousness. However, there was no documentation made in the resident's medical record regarding the resident's second episode of hypoglycemia, including staff finding the resident unresponsive. In addition, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until approximately 12:30 AM on 07/19/2021,when Resident #321 was found unresponsive and	{F 684}	F 684 Quality of Care Criteria 1: a) Resident #321 was discharged from this facility on 7-19-2021. b) Resident #323 was discharged from this facility on 7-20-2021. Criteria 2: a) All residents with diagnosis including COPD, Asthma, current pneumonia was assessed by licensed nurse and or respiratory therapist, no concerns were identified. Completed 8-12-2021. On 8-14-2021 a visual audit was conducted to assess all residents with diagnosis of diabetes for s/s of hypo/hyperglycemia. No concerns were observed. b) All residents with orders including glucose monitoring were reviewed by Regional Nurse and orders amended to include mandatory entry of glucose value on the MAR versus a check for completion by 7-30-21. Criteria 3: a) The Respiratory Therapist and/or designee educated Licensed nurses on identification and assessment of residents with a change in condition to include in respiratory status beginning 8-12-2021. Beginning 11/24/2021 DON/Designee will assess staff knowledge with verbal quizzing on	

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{F 684}	Continued From page 375 clammy. Interviews and record review revealed the resident's blood glucose was 32 mg/dL. Staff again administered the resident injectable glucagon and oral glucose. Resident #321 remained unresponsive and developed difficulty breathing. The facility transferred Resident #321 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit (ICU). In addition, the facility admitted Resident #323 on 07/06/2021 after being on a ventilator at the hospital. At approximately 7:30 AM on 07/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. Although interview with a nurse revealed she administered the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Upon Resident #323's arrival to the hospital, the resident required high flow oxygen, and was diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus atelectasis (lung collapse). The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42	{F 684}	identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, notification of physician and following physician orders. Staff will be quizzed randomly across all shifts; 5 staff will be quizzed weekly x4 then monthly x 2. b) The DON/Designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of physician and following physician orders beginning 8-12-2021. Criteria 4: c) On 9/19/2021 The DON/designee completed an SBAR communication Form audit to assess for documented blood sugar results outside of normal range. Beginning on 11/24/2021 SBAR Audits will be completed weekly x 4 weeks then monthly x 2 months or until substantial compliance. Beginning 11/24/2021 all new staff will be educated on Change in condition and diabetic protocol. Random visual audits of residents noted to have change in condition per SBAR□s will be conducted weekly x 4 weeks then monthly x 2 months to monitor accuracy of SBAR documentation. d) Beginning 11/24/2021 The DON or designee will monitor respiratory assessment and	

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{F 684}	Continued From page 376 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility	{F 684}	SBAR communications for acute change in respiratory status and will be reviewed for MD notification and implementation of any physician order. Care plan will be reviewed and updated as needed. Audits will be weekly until substantial compliance. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance e) Beginning 12/18/2021 the DON/ADON or designee will conduct visual audits on 2 random residents a week to ensure that the plan of care is being implemented as written. Audits will be weekly x 4 then monthly x 2 month or until substantial compliance is achieved. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 684}	Continued From page 377 monitors the effectiveness of systemic changes and quality assurance activities. Findings include: Review of the facility's policy titled, "Acute Condition Changes-Clinical Protocol", dated March 2018, revealed if a resident had a change in condition, the nursing staff would collect pertinent details to report to the physician, such as the history of present illness and previous and recent test results for comparison. Further review, revealed the nurse would assess, document, and report baseline information including, vital signs, neurological status, current pain level, level of consciousness, cognitive and emotional status, onset, duration and severity of illness, recent labs, history of psychiatric disturbances, mental illness or depression, all active diagnoses, and all current medications. Review of the facility's policy titled, "Management of Hypoglycemia", dated November 2020, revealed the facility had adopted a hypoglycemia protocol that classified hypoglycemia as follows. Level 1 hypoglycemia was a blood glucose level below 70 mg/dL, but above 54 mg/dL, Level 2 hypoglycemia- was a blood glucose level below 54 mg/dL, and a Level 3 hypoglycemia- was altered mental and/or physical status requiring assistance for treatment of hypoglycemia. Further review of the protocol revealed, if a resident had Level 3 hypoglycemia and was unresponsive staff should call 911, administer glucagon, notify the provider immediately, remain with the resident, place resident in a comfortable safe place and monitor vital signs. 1. Review of Resident #321's medical record	{F 684}		

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{F 684}	Continued From page 378 revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicating the resident was cognitively intact. Review of Resident #321's Baseline Care Plan dated 07/16/2021, revealed the care plan did not include the resident's diagnosis of Diabetes Mellitus. Review of Physician's Orders dated 07/16/2021, revealed an order for staff to monitor Resident #321 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift. Review of Nursing Notes dated 07/18/2021 at 3:20 PM, and interview with Licensed Practical Nurse (LPN) #6 on 07/27/2021 at 4:10 PM, revealed at approximately 7:30 AM on 07/18/2021, LPN #6 obtained a blood glucose reading for Resident #321, which was 67 mg/dL (milligrams per deciliter). The note further stated staff delivered the resident's breakfast tray (exact time unknown) and LPN #6 obtained a repeat glucose level after breakfast which was documented as 139 mg/dL. However, there was no further documentation or evidence found to indicate LPN #6 continued to monitor the resident's condition or obtain further glucose levels for the resident. Continued review of Resident #321's Nursing Note revealed at approximately 1:30 PM, Resident #321's Spouse	{F 684}		

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{F 684}	Continued From page 379	{F 684}		

called the facility and spoke to LPN #6. The note stated the Spouse was upset related to information his/her daughter, who was at the facility visiting the resident at the time, was calling and reporting to him/her. LPN #6 documented the Spouse requested to speak with someone regarding getting the resident out of the facility and transferred to another facility. The LPN documented she gave the Spouse the contact information for the Administrator and Director of Nursing (DON) and made the DON aware of the Spouse's call.

Interview with Resident #321's Daughter (Family Member #3) on 08/02/2021 at 5:30 PM, revealed she arrived at the facility for a scheduled visit on 07/18/2021 at 10:45 AM. She stated Resident #321 was awake, alert, and talking to her normally during the visit. The Daughter stated Resident #321 told her that his/her blood sugar had dropped to 67 mg/dL that morning. However, Family Member #3 stated that she left the facility at approximately 3:00 PM that day and no staff member obtained the resident's blood glucose level during her visit. She stated the resident had not received a lunch meal when Family Member #3 left the facility. Continued interview with Family Member #3 revealed when she came for the visit on 07/18/2021, she brought Resident #321 a mobile phone and left it with the resident to use. She stated she left the phone because when the family attempted to call and check on the resident, the facility's phone would frequently go unanswered.

Interview with Resident #321's Spouse on 07/28/2021 at 2:19 PM, revealed his/her her daughter visited Resident #321 on 07/18/2021. The Spouse stated the daughter reported that the

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{F 684}	Continued From page 380 resident's glucose was low that morning, the facility smelled of urine, the resident's blanket and washcloths were soiled from the resident's unemptied nephrostomy (bags that collected urine drained from the kidney) bags were leaking, and the daughter was told the facility had no clean blankets/washcloths to give the resident. The Spouse further voiced talking to Resident #321 on the telephone numerous times that day. Continued interview revealed the resident had told the spouse that he/she could tell his/her blood sugar was running low because of the way he/she felt. However, the resident told the Spouse that as of 4:00 PM, the staff still had not re-checked his/her blood sugar since that morning prior to the daughter's arrival to the facility at 10:45 AM. The Spouse confirmed speaking with LPN #6 on 07/18/2021 but, he/she did not contact the DON or Administrator because the resident was sent to the hospital that night. Further interview revealed the spouse stated at approximately 4:00 PM on 07/18/2021, was the last time he/she spoke to Resident #321. The spouse stated, that at that time, the resident reported that he/she had rang the call light (exact time unknown) and it had taken an hour before staff answered the light. The Spouse stated they had only admitted Resident #321 to the facility for short-term rehabilitation and the resident had planned to return home. Interview with State Registered Nursing Assistant (SRNA) #1, on 07/27/2021 at 4:40 PM, and on 08/03/2021 at 3:19 PM, revealed she was working on 07/18/2021 from 7:00 AM to 7:00 PM, and remembered Resident #321's blood glucose being low that morning. She stated she took the resident some juice. The SRNA stated she later entered Resident #321's room sometime after	{F 684}		

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{F 684}	Continued From page 381 lunch in the late afternoon (exact time unknown) and found the resident non-responsive. SRNA #1 stated she immediately notified LPN #6, who summonsed Registered Nurse (RN) #1 from the other end of the unit, and both nurses were working with the resident. SRNA #1 stated she did not recall what the resident's blood sugar was at that time. However, SRNA #1 stated the resident was "better" prior to shift change, which was between 6:00 PM-6:30 PM. Continued interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed she did recall Resident #321 having another hypoglycemic episode during the late afternoon on 07/18/2021 (exact time unknown). She stated when she entered the resident's room, she found the resident unresponsive. LPN #6 stated she obtained the resident's blood glucose level and recalled it "was around 40 mg/dL". She stated she then got Registered Nurse (RN) #1 from the other end of the unit to assist her and administered Resident #321 an injection of glucagon (Hormone injection used to treat a critically low blood glucose). LPN #6 stated she also administered the resident oral glucose also after the resident began to respond. The LPN stated the best she could recall, the resident's blood glucose increased to "around 139 mg/dL" but, she could not recall exactly. Continued interview with LPN #6 revealed by that time it was nearing time for the supper meal, so she gave the resident an oatmeal pie to eat before the supper trays arrived. Review of Resident #321's medical record revealed no evidence the LPN documented the resident's hypoglycemic incident or any of the resident's blood glucose levels. In addition, there was no evidence the LPN monitored the	{F 684}		

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{F 684}	Continued From page 382 resident's condition or blood glucose levels the remainder of her shift. Further interview, on 07/30/2021 at 11:30 AM, with LPN #6 revealed it was standard nursing practice to document when staff found a resident unresponsive, when a resident had a hypoglycemic episode, and when a resident was administered emergency Glucagon. However, the LPN was unable to explain why she had not documented all these occurrences for Resident #321. LPN #6 stated that it was difficult to care for all the residents and complete documentation. Interview with RN #8, on 07/30/2021 at 10:54 AM, revealed she was worked on 07/18/2021, and recalled LPN requesting her assistance with Resident #321, due to the resident being unresponsive and having a blood glucose level of 40 mg/dL. She stated she could not recall the exact time the incident occurred but, it was late afternoon sometime probably between 4:00 PM and 5:00 PM. She stated LPN #6 administered the resident a glucagon injection and the resident began to wake up. However, RN #8 stated the resident's blood glucose remained low, (unable to recall exact reading) and LPN #6 administered the resident oral glucose. RN #8 stated following the oral glucose administration, the resident's blood glucose increased to 111 mg/dL. She stated she stayed with the resident until he/she was fully awake. RN #8 stated she called down to the kitchen and requested orange juice with sugar be brought up to the floor for the resident. However, RN #6 stated she returned to her side of the unit and did not know if the kitchen delivered the juice to the resident. Review of Resident #321's Nursing Notes revealed an entry dated 07/19/2021 at 12:23 AM,	{F 684}		

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{F 684}	Continued From page 383 stating a SRNA found the resident un-responsive and clammy. The documentation stated staff obtained the resident's blood glucose and it was 32 mg/dL. Staff administered the resident a glucagon, and the resident's blood glucose came up to 52 mg/dL. The documentation then stated staff administered Resident #321 the oral glucose, and the resident's blood glucose dropped to 48 mg/dL. Continued review revealed staff administered a second glucagon injection and the resident's blood glucose came up to 110 mg/dL. However, the resident remained un-responsive and experienced labored breathing. Review of the Nursing Notes revealed at 1:00 AM, Emergency Medical Services (EMS) arrived at the facility and transported Resident #321 to the hospital. Further review of the documentation revealed staff notified the resident's family that the facility had transferred the resident to the hospital. Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed she worked from 6:00 PM on 07/18/2021 until 6:00 AM on 07/19/2021, and was assigned to care for Resident #321. SRNA #4 stated when she came on shift at 6:00 PM on 07/18/2021 she was told in report that the resident's blood glucose level had dropped to 50 mg/dL earlier in the day but was "good" the remainder of day shift. SRNA #4 stated supper trays were late on 07/18/2021 and she did not come out of the kitchen until sometime after 6:00 PM. However, SRNA #4 stated she had checked on the resident, emptied the nephrostomy bags and changed the resident's clothes prior to supper. She stated she observed Resident #321 at approximately 8:45 PM, and the resident was fine. SRNA #4 stated she was about to begin her next round sometime after 11:00 PM, when the	{F 684}		

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{F 684}	Continued From page 384	{F 684}		

laboratory technician arrived on the floor to begin drawing labs. SRNA #4 stated soon after the laboratory technician arrived, she came and found SRNA #4, to report that Resident #321 was not responding. SRNA #4 stated she found RN #7, and the nurse went to check on Resident #321.

Interview with RN #7 at 4:25 PM, on 07/28/2021, revealed she was working on 07/18/2021 from 7:00 PM until 07/19/2021 at 7:00 AM. RN #7 stated she received in shift report that Resident #321's blood glucose levels had been low during the day. RN #7 stated sometime between 7:30 PM and 8:00 PM, Resident #321 rang the call light and reported he/she thought his/her blood sugar was low. The nurse stated she checked the resident's blood glucose level, and it was 106 mg/dL. However, RN #7 stated she did not document that she obtained the resident's blood glucose or the result in the resident's medical record. RN #7 stated that she and and one SRNA were the only staff working the floor that night, and she was busy and probably forgot to document. Continued interview revealed she took the resident some peanut butter and crackers, and the resident stated that he/she "just felt funny". RN #7 stated at approximately 9.00 PM, she returned to check on the resident. The nurse stated Resident #321 had not eaten the peanut butter and crackers, so she offered the resident pudding or juice, but the resident declined and reported feeling better. The RN stated she did not re-check the resident's glucose level.

Continued interview with RN #7 at 4:25 PM, on 07/28/2021 revealed she completed her medication pass and sat down to chart at approximately 10:45 PM-11:00 PM. RN #7 stated

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{F 684}	Continued From page 385 the laboratory technician arrived on the unit. She stated although she did not look at the clock, the technician usually arrived around 12:00 AM. RN #7 stated she had gone into another resident's room, when SRNA #4 came in the room and told her Resident #321 would not wake up. She stated when she entered Resident #321's room, the resident was unresponsive, and she could immediately tell the resident's blood glucose was low because the resident was clammy. RN #7 stated she checked the resident's blood glucose, and it was 32 mg/dL. RN #7 stated she administered a glucagon injection to the resident, waited fifteen (15) minutes, and rechecked the blood sugar, which was then 52 mg/dL. She stated the resident was still not responding so she attempted to give the resident oral glucose under the tongue. RN #7 stated that she and SRNA #4 worked the entire floor, so she called for staff from other floors to assist her and call the physician. Continued interview revealed the physician directed her to administer the resident a second glucagon injection and call an ambulance to send the resident to the hospital for further evaluation. RN #7 stated she administered the second Glucagon injection, while waiting for the ambulance to arrive. She stated Resident #321 remained non-responsive and developed agonal breathing (gasping for air). RN #7 stated they tried to obtain an intravenous access (IV) on Resident #321, because they thought the resident was going to code (require cardiac resuscitation). RN #7 stated when EMS arrived to transport the resident to the hospital, the resident's blood sugar was "around 67 mg/dL". Interview with the Laboratory Technician (LT) #1, on 08/02/2021 at 4:45 PM, revealed she arrived at Resident #321's unit on 07/19/2021, at	{F 684}		

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{F 684}	Continued From page 386 approximately 12:15 AM. She stated she went into Resident #321's room to obtain labs and the resident would not respond to her. She stated she found the SRNA on the floor and asked if the resident was hard of hearing. She stated the SRNA accompanied her back into the resident's room and stated the resident was not acting normal and went to find the nurse. The LT stated the resident did not respond at any time while she was present, and the nurse stated she thought the resident's blood glucose was low. LT #1 stated she left the facility before EMS arrived. Interview with the Emergency Department (ED) Physician on 07/19/2021, and review of Resident #321's ED record dated 07/19/2021, revealed resident #321 arrived at the emergency room at 1:36 AM, was non-responsive and unable to follow commands. Further review revealed hospital staff intubated Resident #321 at 1:50 AM and admitted the resident to the Intensive Care Unit (ICU) with diagnoses of hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia. Interview with Administrator, on 08/10/2021 at 1:50 PM, she was not aware that staff found Resident #321 unresponsive on the afternoon of 07/18/2021. She stated staff had never notified her that the resident's family was upset. The Administrator stated staff should have documented all hypoglycemic incidents in the resident's medical record. In addition, the Administrator stated staff should have re-assessed Resident #321 on 07/18/2021, after the resident's blood glucose level was low that morning and continued to re-assess the resident and call the physician as warranted.	{F 684}		

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{F 684}	Continued From page 387 2). Review of Resident # 323's medical record revealed the facility admitted the resident on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Admission MDS assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition and rarely/never understands. In addition, the assessment stated Resident #323 utilized oxygen therapy and a Positive Airway Pressure machine (Bi-pap/C-pap). Further review revealed Resident #323 did not exhibit shortness of breath with exertion, at rest, sitting, or when lying flat. Interview with SRNA (State Registered Nurse Aide) #14 on 07/28/2021 at 11:43 AM, revealed on the morning of 07/20/2021 at approximately 7:00 AM to 7:30 AM, she found Resident #323 sweaty, clammy, and having difficulty breathing. SRNA #14 stated she notified Registered Nurse (RN) #6 of the change in the resident's condition, and the nurse administered the resident a breathing treatment. However, SRNA #14 stated the resident continued to have difficulty breathing, and she was "worried" about the resident, who was "breathing pretty hard". SRNA #14 stated she did not see RN #6 go back into the resident's room to check on the resident after the breathing treatment was administered, until the resident's family came to visit the resident around 10:30 AM. The SRNA stated when the family arrived and observed the resident, they insisted the facility send the resident to the hospital. Interview with SRNA #15 on 07/28/2021 at 2:35	{F 684}		

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{F 684}	Continued From page 388 PM revealed on 07/20/2021 at approximately 7:00 AM to 7:30 AM, she observed that Resident #323 was having trouble breathing and the resident's face was red. SRNA #15 stated RN #6 administered the resident a breathing treatment, however, the resident still appeared to be having difficulty breathing. Continued interview revealed that RN #6 administered a second breathing treatment to the resident "a couple hours later." However, SRNA #15 stated the resident continued with labored breathing, but to her knowledge, RN #6 took no further action. SRNA #15 stated she did not visualize any staff go back in the room to assess Resident #323 until the family came in to visit at approximately 10:30 AM, and requested the facility send Resident #323 to the hospital. Interview with RN #6 on 07/28/2021 at 3:45 PM revealed on 07/20/2021 at approximately 7:00 AM to 7:30 AM, one of the nursing assistants notified her that Resident #323 was "congested". She stated she was not the nurse assigned to care for Resident #323; however, she went to the resident's room. She stated when she entered the room, she could hear the resident wheezing and observed the resident using accessory muscles to breathe (having to use more muscle than just the diaphragm muscle to breathe). RN #6 stated she had last seen Resident #323 at approximately 6:15 AM. The RN stated the resident having difficulty breathing was "new" for the resident. RN #6 stated she administered a breathing treatment to the resident at 7:43 AM, and it initially improved the resident's breathing. However, RN #6 stated the improvement did not last long and the resident's status declined. She stated she thought LPN #3, the resident's assigned nurse, notified the resident's physician	{F 684}		

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{F 684}	Continued From page 389 while she gave the resident a second breathing treatment. Interview with LPN #3 revealed she was the nurse assigned to Resident #323 on 07/20/2021. She stated at approximately 6:30 AM on 07/20/2021, Resident #323 "seemed ok". However, at approximately 7:30 AM she realized "something was going on" with the resident. She stated the resident was breathing fast and using accessory muscles to aide in breathing. LPN #3 stated she notified the resident's physician, Physician #1, around 8:15 AM, and received a new order to obtain a chest x-ray for the resident. LPN #3 stated following the breathing treatments administered by RN #6, Resident #323's condition "stayed about the same". LPN #3 stated Resident #323's family arrived at the facility at approximately 10:30 AM, and insisted the facility send the resident to the ED. The LPN stated she notified Physician #1 of the family's request and the facility sent the resident to the hospital at approximately 12:30 PM (approximately five hours after the resident began having trouble breathing). Interview with Resident #323's family member on 08/02/2021 at 8:50 AM, revealed she arrived at the facility on 07/20/2021 at approximately 11:00 AM. She stated that upon arriving to the unit, she could hear the resident trying to breathe from the hallway approximately two (2) doors down. She stated the breathing was a high-pitched sound, as if the resident was trying to breathe through a straw. The family member stated it sounded as if the resident had a narrow or partially blocked airway. Continued interview revealed she insisted the facility send the resident to the hospital for evaluation.	{F 684}		

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{F 684}	Continued From page 390 Further review of Resident #323's medical record for 07/20/2021, revealed after the family arrived at the facility and requested the resident be sent to the hospital, staff documented the resident was having shortness of air, abnormal lung sounds, rapidly labored breathing, and cough. In addition, staff completed a change of condition form at 12:12 PM, which stated they notified Physician #1 at 11:45 AM of the resident's assessment and received new orders to send the resident to the ED. Review of Resident #323's ED record revealed the ED staff assessed the resident to have audible stridor, increased respiratory effort, was using accessory muscles to breathe and had mild wheezing to bilateral lungs. Continued review of Resident #323's hospital record revealed the resident was admitted to the Intensive Care Unit at 10:54 PM, and diagnosed with Acute Hypoxic Respiratory Insufficiency, Left Lower Lobe Pneumonia versus Atelectasis (collapsed lung), and an elevated Lactate level (results from low flow of oxygen level). Interview with Physician #1 on 08/04/2021 at 1:00 PM revealed he could not recall if he spoke to LPN #3 about Resident #323 once or twice on 07/20/2021. However, he stated he expected staff to assess a resident when a change in their condition occurred. He further stated that if a resident was experiencing respiratory distress, he would expect staff to increase monitoring and assessment of the resident and monitor for further decompensation of respiratory status. Interview with the Administrator on 08/10/2021 at 1:48 PM, and the Interim Director of Nursing on	{F 684}		

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{F 684}	Continued From page 391 08/11/2021 at 12:05 PM, revealed they expected staff to immediately assess a resident when a change in condition occurred. Further interview revealed that they expected the staff to document nursing assessments in the medical record. **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail	{F 684}		

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{F 684}	Continued From page 392 care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals	{F 684}		

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{F 684}	Continued From page 393 were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with	{F 684}		

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{F 684}	Continued From page 394 BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative	{F 684}		

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{F 684}	Continued From page 395 aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in	{F 684}		

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{F 684}	Continued From page 396 droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval	{F 684}		

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{F 684}	Continued From page 397 for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim	{F 684}		

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{F 684}	Continued From page 398 Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse	{F 684}		

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{F 684}	Continued From page 399 Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the	{F 684}		

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{F 684}	Continued From page 400 medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and	{F 684}		

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{F 684}	Continued From page 401 complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how	{F 684}		

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{F 684}	Continued From page 402 to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood	{F 684}		

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{F 684}	Continued From page 403 sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and	{F 684}		

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{F 684}	Continued From page 404 reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary	{F 684}		

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{F 684}	Continued From page 405 Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given	{F 684}		

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{F 684}	Continued From page 406 outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months.	{F 684}		

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{F 684}	Continued From page 407 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed.	{F 684}		

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{F 684}	Continued From page 408 Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4)	{F 684}		

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{F 684}	Continued From page 409 weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be	{F 684}		

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{F 684}	Continued From page 410 completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will	{F 684}		

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{F 684}	Continued From page 411 be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional	{F 684}		

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{F 684}	Continued From page 412 Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the	{F 684}		

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{F 684}	Continued From page 413 Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments	{F 684}		

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{F 684}	Continued From page 414 revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed.	{F 684}		

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{F 684}	Continued From page 415 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the	{F 684}		

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{F 684}	Continued From page 416 observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service	{F 684}		

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{F 684}	Continued From page 417 Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM	{F 684}		

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{F 684}	Continued From page 418 revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's	{F 684}		

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{F 684}	Continued From page 419 orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers,	{F 684}		

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{F 684}	Continued From page 420 turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed	{F 684}		

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{F 684}	Continued From page 421 no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39,	{F 684}		

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{F 684}	Continued From page 422 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on	{F 684}		

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{F 684}	Continued From page 423 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly	{F 684}		

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{F 684}	Continued From page 424 following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the	{F 684}		

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{F 684}	Continued From page 425 facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement. 24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. 26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical	{F 684}		

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{F 684}	Continued From page 426 Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control	{F 684}		

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{F 684}	Continued From page 427 and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on	{F 684}		

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{F 684}	Continued From page 428 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40	{F 684}		

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{F 684}	Continued From page 429 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the	{F 684}		

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{F 684}	Continued From page 430 Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and	{F 684}		

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{F 684}	Continued From page 431 timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding	{F 684}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 684}	Continued From page 432 turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021	{F 684}		

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{F 684}	Continued From page 433 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31	{F 684}		

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{F 684}	Continued From page 434 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55	{F 684}		

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{F 684}	Continued From page 435 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021	{F 684}		

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{F 684}	Continued From page 436 at 3.04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with	{F 684}		

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{F 684}	Continued From page 437 established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on	{F 684}		

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{F 684}	Continued From page 438 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged	{F 684}		

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{F 684}	Continued From page 439 on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3.00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed	{F 684}		

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{F 684}	Continued From page 440 they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021	{F 684}		

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

(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 684}	Continued From page 441 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns.	{F 684}		

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{F 684}	Continued From page 442 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in	{F 684}		

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{F 684}	Continued From page 443 respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for	{F 684}		

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{F 684}	Continued From page 444 completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and	{F 684}		

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{F 684}	Continued From page 445 assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further	{F 684}		

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{F 684}	Continued From page 446 review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on	{F 684}		

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{F 684}	Continued From page 447 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin	{F 684}		

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{F 684}	Continued From page 448 assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM.	{F 684}		

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{F 684}	Continued From page 449 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random	{F 684}		

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{F 684}	Continued From page 450 shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns. 75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts,	{F 684}		

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{F 684}	Continued From page 451 including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and the DON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interim Administrator on 09/30/2021 at 5:05 PM revealed daily audits had been conducted daily from 09/11/2021. A review of the audits revealed no identified concerns. 80). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed observations on different shifts to identify any change in resident condition. Further	{F 684}		

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{F 684}	Continued From page 452 interviews revealed if a change in condition was identified, staff would complete a stop and watch. An audit review revealed no concerns with the change of conditions not being addressed by facility staff. 81). Review of interviews performed on 09/25/2021 for residents with a BIMS score of 8 or greater revealed no identified concerns. A review of the questionnaire completed during interviews revealed residents were asked: Is everyone treating you well? Do you feel safe here? Do you have any concerns? Interview with the Medical Records Staff on 09/29/2021 at 8:34 AM revealed she completed the interviews with residents on 09/25/2021, and she stated she identified no concerns.	{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.	{F 686}		12/30/21

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{F 686}	Continued From page 453 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy review, it was determined the facility failed to ensure two (2) of five (5) sampled residents (Resident #65 and Resident #66) received care to prevent pressure ulcers and failed to ensure care and treatment was provided for four (4) of seven (7) residents with pressure ulcers (Resident #65, Resident #45, Resident #14, and Resident #323) to promote healing, prevent infection and/or prevent new pressure ulcers from developing. The facility admitted Resident #65 on 03/23/2021 without pressure ulcers. The facility failed to turn and reposition the resident. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements, appearance, drainage, odor, etc.). Subsequently, the facility also failed to identify the pressure ulcer had worsened. On 05/28/2021, Resident #65 was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer and was "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent debridement on 05/30/2021, when all necrotic tissue was removed the "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65; and, failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure	{F 686}	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Criteria 1: a) Resident #65 was discharged from the facility on 10-31-2021 b) Resident #66 was discharged from the facility on 6-19-2021 c) Resident # 323 was discharged from the facility on 7-20-2021 c) Resident #14 and ,#45 continue to receive wound care services through Vohra wound care and have their assessed and treatment provided per orders. Criteria 2: a) On 9-11-21 head to toe skin assessments were completed on all residents. Braden Scale was completed on all residents by facility nurses 8-28-2021. Using both the head-to-toe skin assessment and Braden scale, comprehensive care plans were reviewed to ensure residents with pressure injuries had a care plan by 9-17-21. b) On 11/24/2021 residents with pressure injuries were assessed by the DON/ designee to ensure that the pressure injuries were receiving treatment per physician order. c) Beginning 08-28-2021 registered dietitian reviewed all residents diets. She made recommendations for meal changes or supplements to promote healing and to address any weight loss	

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{F 686}	Continued From page 454 ulcers and the resident's sacral pressure ulcer worsened. In addition, the facility identified Resident #45 had a Stage III (3) pressure ulcer on 06/01/2021 to the left sacrum. However, there was no documented evidence the wound was assessed in accordance with the facility's wound assessment form, including measurements, appearance, etc. On 06/30/2021, a wound care specialist assessed Resident #45 and noted the pressure sore to the left buttock was a Stage IV (four) and required excisional debridement to the level of the muscle. The facility failed to assess the resident's pressure ulcer during weekly skin assessments from 07/02/2021 through 08/08/2021. On 08/13/2021, a foul-smelling odor and increased depth and drainage from the wound bed was noted. The resident was transferred to the ED where he/she required antibiotics and inpatient wound care. The pressure ulcer extended to the level of the left ischial tuberosity (hip bone). Resident #45 was diagnosed with Osteomyelitis (infection of the bone). Review of Resident #14's medical record revealed the facility identified three (3) Stage II pressure ulcers on the resident's left trochanter (hip) on 06/22/2021. The facility failed to assess the resident's skin and the pressure ulcers weekly as required. Further, the facility admitted Resident #323 on 07/06/2021 with Physician's Orders to treat his/her pressure ulcer with Santyl ointment (collagenase). The facility failed to provide the treatment to the resident's pressure ulcer until	{F 686}	issues. Criteria 3: a) Beginning 9-17-21 upon admission a skin assessment and Braden Scale will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer, a comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcer and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. b) All nursing staff were educated beginning 9-17-21 by the Director of Nursing, MDS coordinator or designee on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. c) On 9-13-21 the Dietary Manager was educated by the Regional CDM on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. d) Therapy or designee in-serviced all nursing staff on turning and positioning, range of motion and transfer of resident from bed to chair and chair to bed beginning 8-19-2021. e) Additional staff has been added through recruitment and agency contract to ensure the there are enough staff to turn and reposition all residents who are unable to reposition themselves. f) Beginning 11-24-21 all nursing staff were educated by the Regional Director of Nursing, Regional	

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{F 686}	Continued From page 455 07/11/2021, five (5) days after admission to the facility. In addition, the facility failed to turn and reposition Resident #66 on 06/16/2021 from 9:27 AM until after 4:14 PM. The facility's failure to ensure residents received care to prevent pressure sore development and failure to ensure a resident with pressure ulcers received the necessary care and treatment to promote healing and prevent infection has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.	{F 686}	Nurse consultant or Director of nursing or designee on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, and providing treatments per physician orders. This will be added to the new hire orientation. Staff not working will be educated on their next scheduled shift. A post test will be administered and graded by the DON or designee to ensure staff competency. g) Beginning 9-25-21 licensed nurses were additionally educated on how to complete and document a head-to-toe skin assessment in EMR, measuring and staging of pressure injuries per EPUAP (wound assessment are completed with identified pressure areas from the head-to-toe assessment) and how to notify the registered dietician, MD, and RP of a new skin impairment. With any change to skin impairment the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident□s representative. New or worsening wounds/pressures that are identified either by the Weekly Wound Care rounding by the Wound Care Nurse and Wound Care Doctor and/or by nursing staff during turning/repositioning and/or showers requires the notification to the MD and RP, intervention/treatment, update of the care plan, along with weekly updates and review by the Weight Loss IDT which includes (Dietary Manager, Social Services, Activity Director, DON/ADON, Wound Care Nurse, Administrator, Dietician) for updates	

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{F 686}	Continued From page 456 A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's Prevention of Pressure Injuries Policy, revised April 2020, revealed the purpose of the policy was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy stated a risk assessment should be completed upon admission, weekly, and with any changes in condition. A skin assessment was also required upon admission and with each risk assessment, as indicated according to the resident's risk factors. Further review of the policy revealed staff were required to keep the skin clean and hydrated, clean promptly after episodes of incontinence, reposition all residents with or at risk of pressure ulcers on an	{F 686}	and/or recommendations. Criteria 4: a) Beginning 11/24/2021 the DON or designee will audit weekly head to toe skin assessments that are completed by staff nurses to ensure they have been completed weekly on each resident and any new skin impairment that has been identified has had the MD, RD and RP notified and confirm any new interventions have been put in place to prevent decline and new intervention is care planned Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance b)) Beginning 12/11/21 the DON and/or designee began visual audits of resident noted to be in need of assistance with turning and positioning. Random Audits will be be conducted weekly x 4 weeks then monthly x 2 months to include one resident per floor per shift to ensure turning and repositioning is done. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 686}	Continued From page 457 individualized schedule as determined by the Interdisciplinary Team (IDT), choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. The policy further stated the facility should evaluate, report and document potential changes in the skin, and review interventions and strategies for effectiveness on an ongoing basis. Review of the facility's policy titled, "Repositioning", dated May 2013, revealed, "Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief." Further review of the policy revealed, "Residents who are in bed should be on at least an every two hour (q 2 hour) repositioning schedule". Interview with the Assistant Director of Nursing (ADON)/Acting Director of Nursing (DON) on 08/11/2021 at 12:05 PM revealed the facility did not have a policy regarding pressure ulcer assessment, but the expectation was for staff to assess pressure ulcers upon admission and weekly, including measurements and to assess for changes in status. According to the ADON, all residents should be turned and repositioned at least every two (2) hours; and, incontinent care should be provided every two (2) hours. Further interview with the ADON, on 08/11/2021 at 12:05 PM, revealed staff should conduct a weekly skin assessment and document the assessment on a Head to Toe Weekly Skin Check form. In addition, if a resident had a pressure ulcer, staff should assess the wound, document the findings, and notify the resident's physician/family when required.	{F 686}		

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{F 686}	Continued From page 458 Review of the "Weekly pressure wound note" form revealed staff were required to document the location and stage of a pressure ulcer; wound bed appearance and percentage of wound tissue coverage; whether drainage was present and the amount; whether an odor or tunneling/undermining was present; a description of the wound edges; whether there were signs of infection; the progress of the wound (improved, unchanged, worsening, etc.); notifications for any changes in condition or new orders; whether the care plan was reviewed and updated; and any other pertinent progress notes. 1. Review of Resident #65's medical record revealed the facility admitted the resident on 03/24/2021 and re-admitted the resident on 04/29/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia. Review of Resident 65's Minimum Data Set (MDS) admission assessment dated 03/30/2021 revealed the resident was totally dependent on two (2) staff with Activities of Daily Living, was occasionally incontinent of bowel, had a indwelling catheter, and had no pressure ulcers. Further review revealed the resident was at risk for pressure ulcers based on a formal assessment instrument (Braden) and clinical assessment. According to the MDS dated 03/30/2021, Resident #65 did not have a pressure reduction device for the chair, was not on a turning/repositioning program, and did not have nutrition or hydration interventions to manage skin problems. Review of a Braden Scale for Predicting Pressure	{F 686}		

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{F 686}	Continued From page 459 Sore Risk form dated 03/23/2021 revealed Resident #65 was "at risk" for pressure ulcers with a score of eighteen (18), due to being chair fast; slightly limited mobility; and, problems with adequate nutrition, friction, and shearing. Review of the Admission/Readmission Nursing Evaluation on 04/29/2021 at 6:00 PM revealed a Braden Scale assessment was completed for Resident #65. The resident scored a fourteen (14), indicating the resident was at "high risk" for pressure ulcers. The risk was due to slightly limited sensory problems; occasionally moist; confined to bed (bedfast); very limited mobility; potential problems with adequate nutrition; and, friction, and shearing. Review of Resident #65's Baseline Care Plan dated 03/23/2021 at 11:00 AM revealed even though the resident was at high risk for pressure ulcers, the facility did not implement any pressure ulcer prevention interventions. Further review of Resident #65's medical record revealed no documented evidence the facility completed a comprehensive care plan for the resident with interventions to address the resident's high risk for pressure ulcers in an attempt to prevent pressure ulcers in March, April, or May 2021. Subsequently, there was no documented evidence the IDT determined an individualized turning and repositioning schedule, as required by the facility's policy, and based on the resident's risk factors. Continued review of Resident #65's medical record review revealed Resident #65 was discharged to the hospital on 04/08/2021 for shortness of breath and was re-admitted to the	{F 686}		

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{F 686}	Continued From page 460 facility on 04/29/2021 with diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure, and Urinary Tract Infection. Review of an Admission/Readmission Nursing Evaluation for Resident #65 dated 04/29/2021 at 6:00 PM revealed the resident had "scratches" to his/her bilateral buttocks upon readmission from the hospital, with no other impaired skin integrity noted. Continued review of Resident #65's medical record revealed no documented evidence the facility turned/repositioned the resident at least every two (2) hours as the ADON stated was a requirement. Review of a change of condition form dated 05/02/2021 at 10:35 AM revealed Resident #65 had developed a deep tissue injury (DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx. A Physician's Order was obtained to "clean coccyx with soap and water, pat dry, apply zinc oxide and cover with border gauze every day". There was no documented evidence the facility assessed the pressure ulcer (measurements, appearance, etc.) and completed a Weekly Pressure Wound Note on 05/02/2021, when the DTI was identified. Interview with Licensed Practical Nurse (LPN) #4 on 08/25/2021 at 4:00 PM revealed she identified the deep tissue injury (DTI) to Resident #65's coccyx/sacrum area. She stated that the area was reddened, round, and approximately the size of a quarter. LPN #4 stated she should have measured the area but she was "probably overwhelmed" related to not enough staff. She	{F 686}		

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{F 686}	Continued From page 461 further stated that no one had ever provided her education regarding measuring and/or assessing a pressure ulcer. Continued interview revealed prior to the "new company" taking over the facility, the wound care nurse assessed and measured all pressure ulcers. However, she was unsure of the protocol for assessing, measuring pressure ulcers. Review of a Head to Toe Weekly Skin Check (skin assessment) for Resident #65 dated 05/08/2021 at 3:38 PM, revealed the facility measured the resident's 'Suspected Deep Tissue Injury" as 6.5 centimeters (cm) in width by 9.3 cm deep, and 0 cm in depth. However, there was no documented evidence the facility assessed the wound per the Weekly Pressure Wound Note (assessment of the pressure ulcer including the wound bed appearance, a description of the wound edges; the progress of the wound [improved, unchanged, worsening, etc.]). Review of a "Change of Condition" form on 05/11/2021 at 2:40 PM revealed Resident #65's pressure ulcer to the coccyx was "worsening". The deep tissue injury (DTI) was now an unstageable pressure ulcer (full thickness tissue loss [death] in which the base of the ulcer is covered by slough [yellow, tan, green or brown] and/or eschar [tan, brown, or black] in the wound bed) that measured 6.5 cm long and 9.7 cm wide. According to the note, the resident's physician was contacted and new orders were obtained to clean the coccyx with soap and water, pat dry, apply calcium alginate (Ag) and cover with a dressing every day. Review of a Head to Toe Weekly Skin Checks for Resident #65, revealed the next day, 05/12/2021	{F 686}		

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{F 686}	Continued From page 462 at 3:17 PM, the unstageable pressure ulcer to the resident's coccyx had increased in size to 10 cm long by 10 cm wide. Seven (7) days later, on 05/19/2021, the pressure ulcer to the coccyx/sacrum measured 9.5 cm in length and 10 cm in width. Continued review of the Head to Toe Weekly Skin Checks dated 05/26/2021 at 5:37 PM revealed the resident's pressure ulcer to the sacrum increased in size, measuring 16.5 cm long and 17.7 cm wide. Further review revealed there was no documented evidence the facility assessed the wound's appearance, or whether drainage or odor was present for any date. The facility continued to treat Resident #65's wound with calcium alginate. However, there was no documented evidence the resident's physician was notified that the pressure ulcer had increased in size. Interview with Licensed Practical Nurse (LPN) #6 on 08/25/2021 at 7:45 PM revealed Resident #65's wound "progressed rapidly". She stated she worked the fourth floor and provided care for Resident #65. However, she was unable to recall if she notified the physician of the decline in the resident's pressure ulcer. She stated the wound care nurse was responsible for measuring and monitoring pressure ulcers; therefore, she "assumed" the wound care nurse was contacting the physician. LPN #6 stated if she noticed a change in a pressure ulcer or a new pressure ulcer she would notify the wound care nurse, who should notify the physician. Review of a Change of Condition form on 05/28/2021 at 3:54 PM revealed Resident #65 had a "worsening wound". Review of the form revealed the physician ordered a wound culture and laboratory testing. However, per the Change	{F 686}		

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{F 686}	Continued From page 463 of Condition form, "MD later called back and decided to send resident to Emergency Room for evaluation and treat for possible debridement of area." Interview with State Registered Nurse Aide (SRNA) #4 on 08/26/2021 at 12:36 PM revealed Resident #65's pressure ulcer had an odor for about a month and nursing staff was aware. She stated she knew the resident's wound "looked bad and smelled bad". SRNA #4 stated she provided care to Resident #65 and approximately 40 other residents until August 2021. She stated Resident #65 and other residents who had pressure ulcers, were turned and repositioned, but not every two (2) hours because there was not enough staff. Interview with Registered Nurse (RN) #7 on 08/24/2021 at 3:49 PM revealed she had seen Resident #65's pressure ulcer prior to the resident being sent to the hospital on 05/28/2021. She stated that she had identified that the resident's pressure ulcer had declined quickly and felt "lack of nutrition" could be contributing to the pressure ulcer. Review of Resident #65's hospital record, revealed he/she was admitted to the hospital on 05/28/2021. Review of a Progress Note dated 05/28/2021 at 9:24 PM revealed Resident #65 was "clinically septic with large decubitus [pressure] ulcer with associated infection including cellulitis and possible developing abscess". According to the record, the pressure ulcer "smells like dead flesh". Review of Resident #65's Emergency Department (ED) Nurse's Notes dated	{F 686}		

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{F 686}	Continued From page 464 05/28/2021 at 5:36 PM revealed the resident had a "large decubitus (pressure) ulcer proximally 15 cm by 8 cm with central skin sloughing and underlying necrosis, the wound has surrounding erythema with mild purulent drainage to bandage". According to the record, the pressure ulcer "smells like dead flesh". Review of the wound pictures dated 05/29/2021 at 5:40 AM revealed the resident's sacrum was black with red wound edges. The pressure ulcer measured 14 cm long by 15 cm wide. Review of Resident #65's Operative Report dated 05/30/2021 revealed the resident presented with a large necrotic appearing area on his/her sacrum. The operative report stated, "It was extremely extensive down to the base large amount of fat necrosis was encountered as well as necrotic tissue". The Operative Report further read, "debrided all devitalized tissue down to the level of the bone". Interview with Surgeon #1 on 08/31/2021 at 1:30 PM revealed Resident #65 had a large Stage IV (4) pressure ulcer to the sacrum. He debrided the slough, necrotic and non-viable tissue in the pressure ulcer on 05/30/2021 to bone depth. Based on the operative report, Surgeon #1 stated the pressure ulcer measured 6 cm in depth prior to debridement. He further revealed that post debridement the area measured 15 cm in length by 10 cm in width and that the wound was very extensive. Surgeon #1 stated he was unaware of any terminal illness or diagnosis that contributed to the pressure ulcer. He stated failure to turn and reposition, improper nutrition and an improper mattress could have contributed to the pressure ulcers and the progression of the wound.	{F 686}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 686}	Continued From page 465 Record review revealed the facility readmitted Resident #65 on 06/09/2021. Upon return to the facility, staff documented the resident had a pressure ulcer to the "coccyx" and a treatment order for calcium AG to the wound. Review of a Weekly Pressure Wound Note dated 06/11/2021, revealed the facility assessed the pressure ulcer to Resident #65's coccyx/sacrum for the first time utilizing this form since the pressure ulcer developed on 05/02/2021. According to the note, the pressure ulcer measured 17 cm (length) by 12 cm (width) and 1.3 cm (depth), with undermining between three (3) and nine (9) o'clock from 2 cm to 2.3 cm. Further review revealed the facility staged the wound as a Stage IV (4), described as full-thickness skin and tissue loss with slough tissue present covering 50% of the wound, with epithelializing wound edges. The facility assessed the resident's pressure ulcer to be free of drainage, odor, and signs of infection. The treatment to the pressure ulcer was changed to apply a wet to dry kerlix to the wound twice daily. However, there was no documented evidence the facility assessed the pressure ulcer and completed a Weekly Pressure Wound Note until 06/11/2021 at 2:00 PM, approximately six (6) weeks after the pressure ulcer developed. Review of Resident #65's Change of Condition note dated 06/23/2021 at 10:30 AM revealed the resident had acquired a new Stage I (1) pressure ulcer to the left heel. Review of the note revealed the pressure ulcer measured 6.5 cm long by 4 cm wide. The facility received a new order for "bilateral heel protectors while in bed, apply sure prep to left heel daily".	{F 686}		

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{F 686}	Continued From page 466 Continued review of Resident #65's assessments revealed no documented evidence the facility assessed the resident's sacrum until fifteen (15) days later, 06/26/2021. Review of the Head to Toe Weekly Skin Check assessment dated 06/26/2021 at 10:03 PM and a Weekly Pressure Wound Note dated 06/26/2021 at 10:25 PM, revealed the Stage IV (4) pressure ulcer to the resident's sacrum measured 11 cm long by 15 cm wide by 1.3 cm deep. The left heel measured 5.8 cm (length) by 4.4 cm (width) and 0 cm (depth). Continued review of the assessment revealed the resident had a new deep tissue injury (DTI) to the right heel that measured 3.1 cm (length) by 3 cm (width) and 0 cm (depth). The physician was notified and an order was obtained for treatment for the right heel. Review of the Wound Note revealed the pressure ulcer to Resident #65's sacrum was noted to have slough tissue covering 50% of the wound with a small amount of serosanguinous drainage. Further review revealed the note stated the wound edges were rolled, wound progress was improving, and all three (3) areas were free of odor and signs of infection. The facility continued to provide wet to dry kerlix dressings to the resident's sacral wound. Continued review of Resident #65's Head to Toe Weekly Skin Checks and Weekly Pressure Wound Notes revealed no documented evidence the facility assessed the resident's skin and pressure ulcers until 07/05/2021, nine (9) days later. On 07/05/2021 at 7:10 AM, the facility documented the pressure ulcer to the sacrum measured 11 cm (length) by 14 cm (width) and 1.5 cm (depth). The "left heel deep tissue injury appears to be healing and has went from one large DTI to two smaller DTI's" on the left inner	{F 686}		

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{F 686}	Continued From page 467 and outer heel. The left inner heel measured 3.2 cm (length) by 2.8 cm (width) by 0 cm (depth) and the left outer heel measured 1.8 cm (length) by 1.3 cm (width) by 0 cm (depth). Further review revealed the pressure ulcer to the right heel measured 3 cm (length) by 2.5 cm (width) and 0 cm (depth). According to the Weekly Pressure Wound Note dated 07/05/2021 at 7:23 AM, Resident #65's pressure ulcer to the sacrum had an odor, moderate amount of serosanguinous drainage, and signs of infection. Review of a Change of Condition form dated 07/05/2021 at 7:33 AM, revealed the resident's physician was notified and a new order was obtained for a wound culture with the next dressing change. Review of the Resident #65's Treatment Administration Record (TAR) for July 2021, revealed the resident's next dressing change was to be completed on 07/06/2021 at 12:00 PM. However, review of the Progress Notes for Resident #65 revealed on 07/06/2021 at 9:43 AM, the resident's family requested the resident be sent to the ED for evaluation of the sacral pressure ulcer. Review of the Emergency Room record revealed Resident #65 arrived to the hospital on 07/06/2021 at 11:09 AM for "wound check". The record revealed the resident "complained of mild pain on (his/her) buttocks but states it is no worse than normal". Review of the Physical Exam Notes revealed the resident had a "15 cm in diameter wound on buttocks that goes to the bone, appears to be healing, no drainage, no surrounding cellulitis had packing inside." The resident was transferred back to the facility on 07/06/2021.	{F 686}		

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{F 686}	Continued From page 468 Further review of the Progress Notes dated, 07/06/2021 at 2:45 PM revealed a wound care appointment was made for Resident #65 on 07/15/2021 at 8:30 AM with Wound Care Advanced Practice Registered Nurse (APRN) #1. Review of the wound culture report for 07/07/2021 revealed the facility obtained a wound culture of Resident #65's sacral pressure ulcer on 07/07/2021. However, the laboratory noted the swab had been "expired since 02/28/2021." The laboratory was unable to complete the wound culture. Further record review revealed there was no documented evidence the facility obtained a culture of the pressure ulcer as ordered by the resident's physician. Record review revealed that on 07/08/2021 at 3:15 PM, the facility completed a Head to Toe Weekly Skin Check assessment. The pressure ulcer to Resident #65's sacrum measured 14.5 cm (length) by 11 cm (width) and 1.5 cm (depth), the right heel measured 2.8 cm (length) by 2.5 cm (width) and 0 cm (depth), the left inner heel measured 3 cm (length) by 2.5 cm (width) and 0 cm (depth) and the left outer heel measured 1.2 cm (length) by 1.5 cm (width) and 0 cm (depth). However, there was no documented evidence the facility assessed the pressure ulcers per the Weekly Pressure Wound Note. The Weekly Pressure Note required staff to document the stage of a pressure ulcer; wound bed appearance and percentage of wound tissue coverage; whether drainage was present and the amount; whether an odor or tunneling/undermining was present; a description of the wound edges; whether there were signs of infection; and the progress of the wound (improved, unchanged, worsening, etc).	{F 686}		

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{F 686}	Continued From page 469 Further review of Resident #65's medical record revealed no documented evidence the facility assessed the resident's skin from 07/08/2021 until 08/12/2021; and no documented evidence the facility assessed Resident #65's pressure ulcers and completed a Weekly Pressure Wound Note from 07/05/2021 to 08/25/2021. Review of the Wound Care Office Visit notes for Resident #65 dated 07/29/2021 revealed the "context consists of bed ridden, friction/rubbing and infrequent position changes." The note further revealed the sacrum wound had increased in size since the facility's last assessment on 07/05/2021, and measured 15.5 cm (length) by 15 cm (width) and 1.8 cm (depth). Further, the note revealed moderate serosanguinous exudate with no foul odor. The wound was assessed to have 67%-100% granulation and 34%-66% necrosis of muscle, with bone exposed. The physician conducted an "Excisional debridement to the level of the muscle, removing all non-viable tissue, biofilm, slough and exudate from the wound bed to healthy granular borders". The physician changed the wound care to treat with Aquacel Ag daily and cover with a mepilex border Review of the Head to Toe Weekly Skin Checks assessment dated 08/12/2021 at 11:52 AM, (the first skin assessment since 07/08/2021); revealed Resident #65 had developed an unstageable pressure ulcer to the back of the left, lower leg. However, there was no documented evidence the facility assessed the new pressure ulcer and no evidence the facility notified the resident's physician that the resident had developed a new pressure ulcer.	{F 686}		

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{F 686}	Continued From page 470 Interview with LPN #7 on 08/25/2021 at 7:56 PM revealed if a new pressure ulcer was identified, she was required to complete a change of condition form and notify the physician. However, she stated she was never notified that she was responsible for measuring wounds. LPN #7 stated she should have notified the physician on 08/12/2021, when the pressure ulcer was identified to the back of Resident #65's left leg. Review of Resident #65's Head to Toe Weekly Skin Checks assessment revealed the facility completed another skin assessment on 08/19/2021 at 11:02 AM. This assessment revealed the resident continued to have a pressure ulcer to the left heel (Stage I), the right heel (deep tissue injury), the sacrum (Stage IV), and an unstageable ulcer to the left lower leg (rear). However, there was no documented evidence the facility measured or assessed the pressure ulcers. Observation of wound care on 08/25/2021 at 1:33 PM (the facility had not completed a pressure ulcer assessment since 07/05/2021) with RN #4 (Wound Care Nurse) and the ADON/Acting DON, revealed the skin to Resident #65's left heel was intact. RN #4 stated the area was healed; however, the heel remained "boggy". Continued observation revealed the right heel measured 0.4 cm (length) by 0.3 cm (width) and 0 cm (depth). RN #4 (Wound Care Nurse) stated the area was a "scabbed area." RN #4 measured the resident's left inner leg to be 3.2 cm (length) by 1.8 cm (width) and 0 cm (depth). The RN stated the wound had pink edges with slough and eschar in the center of the wound. Further observation revealed the sacral pressure ulcer measured 13 cm (length) by 13.3 cm (width) with	{F 686}		