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

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{F 686}	Continued From page 471 no measurement obtained for depth. Undermining was noted at 11 o'clock at 1.9 cm with rolled edges of the wound from 12 to 4 o'clock. Per RN #4, the pressure ulcer had granulation tissue, 10% slough, eschar at 6 o'clock, and eschar and undermining at 10 o'clock to 12 o'clock. Review of the Change of Condition assessment dated 08/26/2021 at 6:39 PM revealed Resident #65 had a new Stage two (2) pressure ulcer to the left hip. The resident's physician was notified and new orders were received to cleanse the area with soap and water, pat dry, apply sure prep to area area and cover with a dressing. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the "context consists of bed ridden and infrequent position changes." "Treatment consists of changing positions frequently, debridement of necrotic tissue and Aquacel Ag". "Pertinent negatives include blackened tissue, blistering, erythema, fever, numbness and swelling". Further review of the note revealed the sacrum wound measured "13 cm (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; however, there was no evidence the faculty provided "frequent position changes". Continued interview with LPN #7 on 08/25/2021 at 7:56 PM revealed if a pressure ulcer worsened, she was required to complete a change of condition form and notify the physician. However,	{F 686}		

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{F 686}	Continued From page 472 she stated she had not identified a change in Resident #65's pressure ulcer stating, "It looked the same". The LPN further stated she was unsure what the protocol was regarding measurements of the wounds. She believed the wound care nurse usually completed wound measurements and was responsible for both the wound assessments and measurements. Interview with SRNA #1 on 8/5/2021 at 5:15 PM and with SRNA #10 on 08/27/2021 at 11:15 AM revealed they provided care for Resident #65. The SRNAs stated there was not enough staff to turn and reposition Resident #65 every two (2) hours. Interview with SRNA #11, on 08/27/2021 at 3:00 PM, revealed she could not perform rounds (turning, repositioning, check and changes) every two (2) hours when there were only one (1) or two (2) SRNAs to care for 40 residents. She stated when they were short staffed it sometimes took three (3) or four (4) hours to perform resident rounds. Interview with RN #3 on 08/27/2021 at 9:55 AM revealed staff had not been able to turn and reposition residents every two (2) hours because they were so short staffed. She stated, "It is horrible!", stating she had worked by herself for two (2) days in a row. She further stated SRNAs had notified her they could not do rounds (including turning and repositioning) every two (2) hours. She stated she directed them to notify the DON. RN #3 further stated she had completed Resident #65's wound care and she never felt that the wound was getting better (prior to the debridement in May).	{F 686}		

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{F 686}	Continued From page 473 Interview with RN #7 on 08/01/2021 at 11:40 AM and on 08/24/2021 at 3:49 PM revealed she worked the fourth floor with one SRNA. She stated there was not enough staff to turn and reposition residents as required. She further revealed skin assessments were required weekly; however, they were not always being completed because there was not enough staff and due to confusion about when skin assessments were due. RN #7 further stated she was unaware that she was responsible for measuring and assessing wounds. Interview with Registered Nurse (RN) #4/Wound Care Nurse on 08/25/2021 at 8:30 PM revealed she became the wound care nurse when she returned from maternity leave in the middle of June 2021. She stated she knew nothing about pressure ulcers and the facility provided no training. She stated the facility did not educate her regarding her responsibilities as the wound nurse. RN #4 stated she was aware wounds should be measured every week; however, she stated she worked the floor as much as she performed duties as the wound care nurse. The Wound Care Nurse stated since she could not provide wound care/assess wounds as required, staff nurses were providing wound care and assisting with assessments. However, she stated there were no systems in place to ensure the assessments were completed; subsequently, they were not being completed and it was hard to determine if a wound declined or improved. She further stated, "I'm not monitoring the wounds, I can't physically do them all." Interview with the ADON/Interim DON on 08/18/2021 at 10:00 PM revealed nursing staff were responsible for assessing wounds, including	{F 686}		

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{F 686}	Continued From page 474 measurements, a nursing assessment, and notifying the physician and family with any change of condition. She stated she and the former DON had been working the floor and no oversight was provided to ensure wounds were being managed appropriately. She further stated she was aware that Resident #65's wound had significantly declined, but she was unaware of what caused the resident to decline. Further interview with the ADON/Interim DON revealed the facility's IDT did not address wounds and there was no system in place to ensure pressure ulcers were identified and assessed. Interview with Advanced Practice Registered Nurse (APRN) #1, who worked at the Wound Care Clinic on 08/27/2021 at 3:14 PM, revealed Resident #65's pressure ulcer developed over a bony prominence. He stated the resident did not appear to be able to turn and reposition himself/herself and was unable to move on his/her own when examined. APRN #1 further stated that he evaluated Resident #65 on 07/29/2021 and assessed the wound to have slough and fibrotic tissue. He stated the wound infection could have contributed to the decline of the wound. Furthermore, APRN #1 stated if a resident had to wait more than two (2) hours to be repositioned, it could cause wound decline. APRN #1 was unable to identify any terminal illness or medical condition that would require palliative care. Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he was aware Resident #65 had a pressure ulcer to his/her bottom, but was not aware the resident had developed other pressure ulcers. He further stated he was not aware residents were not being	{F 686}		

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{F 686}	Continued From page 475 turned and repositioned every two (2) hours due to decreased staffing. He stated a pressure ulcer could develop and/or decline if a resident was not turned and repositioned, or incontinence care provided for more than two(2) hours. He stated it was reasonable to expect residents at risk for pressure ulcers and/or residents with pressure ulcers to be turned and repositioned every two (2) hours and incontinence care provided at least every two (2) hours. Furthermore, he stated he was not aware that wound measurements were not performed weekly, he stated it would be hard to determine the status of a wound without weekly measurements. Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she was responsible to ensure resident care was provided in accordance with professional standards of practice and that the facility operated within the regulatory guidelines. However, according to the Administrator she had no systems in place to monitor the care delivered to residents in the facility to ensure pressure ulcers were prevented or to ensure residents with pressure ulcers received the necessary care and services. 2. Review of Resident #45's medical record revealed the facility admitted the resident on 10/07/2020 with diagnoses of Chronic Osteomyelitis, Paraplegia, History of COVID-19, and a Right Above the Knee Amputation. Review of Resident #45's Quarterly Minimum Data Set (MDS) assessment dated 04/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident was cognitively intact. Further review of the MDS assessment revealed the resident required assistance with	{F 686}		

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{F 686}	Continued From page 476 bed mobility and transfers. The facility assessed Resident #45 to be at risk for development of pressure ulcers, but had no pressure ulcers when the assessment was conducted. Review of Resident #45's Comprehensive Care Plan initiated 01/11/2021 revealed the facility identified the resident had the potential for pressure ulcer development due to a history of ulcers, immobility, and incontinence. Interventions in place included: educate the resident/family/caregivers as to causes of skin breakdown: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. Interview with Resident #45 on 08/23/2021 at 4:50 PM revealed he/she developed a pressure ulcer to his/her left lower buttock from utilizing a sliding board to transfer himself/herself. The resident stated the area worsened because he/she liked to sit in bed and color. The resident stated he/she could not color when positioned on his/her side. Resident #45 stated he/she did not have any concerns with wound care. Review of Resident #45's Weekly Skin Assessment dated 06/01/2021 revealed a Stage III pressure ulcer was identified to the resident's left sacral area. The skin assessment noted the area had minimal drainage and the skin surrounding the wound bed was pink. According to the skin assessment, the resident had a history of a pressure ulcer in the same location. However, there was no documented evidence the wound was assessed for size, color, etc., in accordance with the Pressure Wound Assessment.	{F 686}		

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{F 686}	Continued From page 477 Review of the Situation Background Appearance Review Form (SBAR) dated 06/01/2021, stated Resident #45 had a Stage III pressure ulcer to his/her left sacral area. The SBAR stated the resident preferred to lie on his/her back and would not turn when encouraged by staff. Staff encouraged the resident to turn/reposition every two (2) hours and as needed (PRN) to relieve pressure from the affected area. New treatment orders were obtained from Physician #1 to cleanse the area with wound cleanser, pat dry, apply Aquacel to the wound bed, and cover with a dry, sterile dressing daily and, PRN if needed, for dislodgement or soiled dressing. Interview with Licensed Practical Nurse (LPN) #5 on 08/27/2021, at 10:45 AM, revealed she identified the pressure ulcer to Resident #45's left, lower buttock on 06/01/2021. She stated she should have assessed the wound and documented wound measurements. LPN #5 stated she thought the wound care nurse was measuring/assessing wounds weekly. Review of a Nurse's Note dated 06/10/2021 at 4:58 AM revealed when completing wound care to Resident #45's buttock, odor and yellowish drainage were present. The note further stated that the physician was notified. Review of a SBAR dated 06/10/2021 at 12:28 PM revealed Resident #14's physician ordered a wound culture. However, there was no further assessment of the resident's pressure ulcer. Continued review of Resident #45's medical record revealed no documented evidence the facility conducted another skin assessment until 06/12/2021, (eleven {11} days since the resident's	{F 686}		

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{F 686}	Continued From page 478 skin had been assessed). Further review of the skin assessment revealed the resident had existing skin impairment with a Stage III pressure ulcer to his/her right buttock. However, there was no documentation the facility assessed the pressure ulcer's appearance. Review of a Nurse's Note dated 06/13/2021, at 3:03 PM, revealed changes were noted to Resident #45's pressure ulcer. The wound bed had yellow/beige slough and drainage, the surrounding peri-wound tissue was blanchable and pink, and the depth was unable to determined due to the present of slough. The note stated a wound culture was pending and the physician was notified with a new order received for treatment. According to the note, Resident #45 was educated on the importance of turning and repositioning due to the resident's ability/independence to turn and reposition himself/herself, and the resident verbalized understanding. Review of Resident #45's Wound Culture report dated 06/14/2021 revealed heavy growth of MRSA (Methicillin Resistant Staphylococcus Aureus is a staph infection that is difficult to treat because of resistance to antibiotics), Enterococcus Faecalis, Streptococcus Agalactiae-Group B, Diphtheroid Bacillus, and two (2) different Gram Negative Rod (GNR) infections. According to a Nurse's Note dated 06/17/2021 at 1:28 PM, revealed Resident #45's Physician ordered Zyvox 600 mg twice daily for ten (10) days to treat the wound infection and Lactobacilli's capsule three (3) times daily for fourteen (14) days.	{F 686}		

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{F 686}	Continued From page 479 Review of a Wound Care Weekly Evaluation dated 06/16/2021, revealed the resident was seen by a wound care specialist. According to the note, Resident #45's pressure ulcer had worsened. The specialist documented the pressure ulcer had become unstageable, measuring 3.5 centimeters (cm) by 2.5 cm by 0 cm, with slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) present to the wound bed, scant serosanguinous exudate, and the surrounding skin tissue was pink with peripheral tissue edema noted to the wound edges. Review of a Head to Toe Weekly Skin Check dated 06/25/2021, (thirteen (13) days since the facility completed the last assessment of Resident #45's skin) revealed the facility identified the resident's pressure ulcer was now a Stage IV pressure injury that measured 3.3 cm long by 2.3 cm wide, and had worsened to 3 cm deep. Review of a SBAR Form dated 06/26/2021, revealed Resident #45's physician was notified of the measurements and that yellow slough was no longer present on wound bed. The note stated the peri- wound was pink and blanchable, and serosanguineous drainage was noted. The physician ordered a normal saline (NS) wet-to-dry dressing daily, and to follow-up with the wound care clinic as scheduled. Review of the Wound Clinic Progress Note dated 06/30/2021 revealed Resident #45 was assessed by the wound clinic for the assessment and treatment of a Stage IV pressure ulcer to his/her left buttock. The assessment stated the pre-debridement ulceration measured 3.5 cm x	{F 686}		

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{F 686}	Continued From page 480 2.1 cm x 3.4 cm with slough present and good granulation tissue. Documentation revealed that the resident stated he/she was utilizing a sliding board when the injury occurred and worsened over time. Review of the patient plan revealed excisional debridement to the level of the muscle was performed with removal of all non-viable tissue, biofilm, slough, and exudate from the wound bed to healthy granular borders. Wound care orders were to cleanse the wound daily with normal saline, apply Aquacel AG, and cover with a Mepilex border dressing. Further review of the Progress Note revealed recommendations for the facility to obtain a wound vac (Vacuum-assisted closure of a wound is a device placed on the wound that removes the pressure over the area to help the wound heal more quickly) for the resident's wound. Resident #45 was to follow up with the wound clinic in four (4) weeks. Review of the Head to Toe Weekly Skin Checks for Resident #45 dated 07/02/2021, 07/09/2021, 07/17/2021, and 07/23/2021, revealed no documented evidence that the facility conducted wound measurements weekly, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.). Review of a Wound Clinic Progress Note dated 07/28/2021, revealed measurements of the wound prior to debridement were 3.5 cm x 2.1 cm x 3.4 cm. Excisional debridement to the level of the muscle was performed removing all non-viable tissue, biofilm, slough, and exudate from the wound bed to healthy granular borders. Wound measurements performed after debridement were 3.5 cm x 1.0 cm x 4.2 cm. Review of the Patient Plan revealed staff were to continue with Wound Vac and Aquacel AG.	{F 686}		

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{F 686}	Continued From page 481 Resident #45 was to follow up with the wound clinic in three (3) weeks. Review of a Head to Toe Weekly Skin Check dated 07/30/2021 and 08/06/2021, revealed staff documented Resident #45 had a pressure ulcer and a wound vac was in use. However, again, there was no documented evidence that facility staff assessed the pressure ulcers' size, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.) Review of an SBAR dated 08/13/2021 revealed Resident #45 had a foul-smelling odor from the wound bed. The depth of the wound had increased and had drainage. Physician #1 was present at facility. He assessed Resident #45 and transferred the resident to the emergency department (ED) for possible wound debridement. Review of the hospital record History and Physical dated 08/13/2021 revealed Resident #45 arrived at the ED due to a left buttock wound with redness and drainage. The record stated the resident had a three (3) cm decubitus ulcer that would likely need antibiotics and inpatient wound care. Review of the assessment/plan revealed the pressure ulceration extended to the level of the left ischial tuberosity (hip bone) where there was cortical irregularity of the ischial tuberosity, the finding was most compatible with a component of Osteomyelitis (infection of the bone). Resident #45 was started on Vancomycin and Cefepime (antibiotics), and had infectious disease and wound care consults. Review of Resident #45's Hospital Discharge	{F 686}		

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{F 686}	Continued From page 482 Summary dated 08/18/2021, the resident was discharged back to the facility with diagnoses of Osteomyelitis and Stage IV Pressure Ulcer. The resident had an order to continue Ceftriaxone NA (antibiotic) two (2) grams (GM) daily for 37 days and to continue local wound care. Review of the Admission/Readmission Nursing Evaluation dated 08/18/2021, revealed no documented evidence the facility assessed Resident #45's pressure ulcer upon readmission to the facility. Further review of the Head to Toe Skin Assessment forms revealed on 08/24/2021, staff documented Resident #45 had a pressure ulcer. However, again, there was no documented evidence that facility staff assessed the pressure ulcer's size, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.) Observation of wound care to Resident #45's left buttock on 08/25/2021 at 3:19 PM revealed the dressing was changed per Physician's Order. Review of a Nursing Services Basic Skin Assessment dated 08/26/2021, revealed Resident #45 had a Stage IV Pressure Ulcer to his/her left buttock fold measuring 2.9 cm x 2.6 cm x 4.6 cm, with no foul odor and moisture was within normal limits. Interview with State Registered Nurse Aide (SRNA) #11 on 08/27/2021 at 3:00 PM revealed Resident #45 often refused to turn and reposition. She stated the resident liked to sit straight up in bed so he/she could color. She stated she encouraged the resident to turn and reposition	{F 686}		

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{F 686}	Continued From page 483 often. Interview with Registered Nurse (RN) #4/Wound Care Nurse on 08/25/2021 at 8:30 PM revealed she often worked the floor as a staff nurse and could not measure/assess pressure ulcers weekly. She stated when she was working the floor, staff nurses were required to complete assessments. However, she stated there were no systems in place to ensure the assessments were completed. Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he was aware Resident #45 was noncompliant with turning and repositioning and wound vac treatment. He stated the resident wanted to stay in the same position all the time. However, he stated he was not aware wound measurements/assessments were not conducted weekly, He stated it would be hard to determine the status of a wound without weekly measurements. 3. Review of Resident #14's medical record revealed the facility admitted the resident on 05/24/2018. Resident #14 was readmitted to the facility on 05/21/2021 with diagnoses of Type II Diabetes Mellitus with Diabetic Polyneuropathy, Stage III Chronic Kidney Disease, Peripheral Vascular Disease, and a History of COVID-19. Review of Resident #14's Quarterly Minimum Data Set (MDS) assessment dated 05/27/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was cognitively impaired. The facility assessed the resident to be independent with bed mobility. Further review of the MDS assessment revealed the resident was	{F 686}		

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{F 686}	Continued From page 484 at risk for pressure ulcers, and no ulcers were present when the assessment was conducted. Review of a comprehensive care plan initiated 09/10/2020 revealed Resident #14 had the potential for pressure ulcer development related to decreased mobility, Diabetes Mellitus (DM), and a diagnosis of Peripheral Vascular Disease (PVD). The facility developed interventions that included: follow the facility's policies/protocols for the prevention/treatment of skin breakdown; and observe/document/report as needed (PRN) any changes in skin status, appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth), and stage. Observation of wound care for Resident #14 on 08/24/2021 at 2:32 PM revealed the resident had a diabetic ulcer to his/her left great toe, due to toe amputation, and a Stage II (2) pressure ulcer to his/her left hip. Observation and interview with Resident #14 on 08/25/2021 at 9:19 AM revealed the resident was sitting on the side of the bed with a bandage to his/her left foot intact. The resident stated he/she repositioned himself/herself. Resident #14 stated he/she preferred to lay on his/her left side, even though staff had educated the resident. Review of a Physician's Order dated 05/09/2021 revealed an order to wash Resident #14's left hip with soap and water, pat day, apply barrier cream, and cover with a dry protective dressing (DPD) every shift for 14 days until 05/24/2021. According to a Head to Toe Weekly Skin Checks dated 05/10/2021, revealed Resident #14 had an abrasion to his/her left hip and received barrier cream. There was no evidence that measurements or an assessment (color,	{F 686}		

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{F 686}	Continued From page 485 drainage, odor, etc) of the area was completed and documented. Review of a Physician's Order dated 05/10/2021, revealed an order to change the treatment to Resident #14's left hip to calmospetine cream every shift. Review of a Head to Toe Weekly Skin Checks dated 05/24/2021 and 05/31/2021, 06/07/2021, 06/14/2021, and 06/21/2021 revealed Resident #14 had an abrasion to his/her left hip. However, there was no documented evidence the appearance of the area was assessed. Review of a Head to Toe Weekly Skin Check dated 06/22/2021, revealed Resident #14 had new skin impairment, three (3) Stage II (two) pressure ulcers to the left trochanter (hip). The pressure ulcers measured as follows: one (1) wound was 1.4 centimeters (cm) long by 1.4 cm wide; wound #2 was 1.4 cm x 2 cm; and, wound #3 was 1 cm x 1 cm. However, there was no description of the wound's color, whether odor or drainage was present, etc. Review of a Situation Background Appearance Review Form (SBAR) dated 06/22/2021 revealed Resident #14's physician was notified of the new pressure ulcers. Review of a Physician's Order dated 06/22/2021 and 07/06/2021 revealed an order to cleanse the three (3) Stage II pressure ulcers with wound cleanser and/or soap and water, pat dry, apply Opticel, and cover with DPD daily and as needed. Review of Resident #14's Physician's Orders dated 07/23/2021, revealed an order that stated, "May" consult with wound physicians to screen,	{F 686}		

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{F 686}	Continued From page 486 evaluate, and treat as indicated and an order to measure and photo the pressure ulcers to the left hip every Monday. Review of Resident #14's Comprehensive Care Plan dated 07/23/2021, revealed the facility revised the resident's care plan to include the Stage II Pressure Injury (ulcer) to the left hip and the new Physician's Orders. Review of interventions revealed the facility was required to arrange for an evaluation at an outpatient wound clinic as needed; encourage frequent position changes when up in chair, if possible; encourage resident to lift weight from side to side while up in chair; avoid prolonged sitting; limit time out of bed; encourage the use of pillows to help with positioning off affected area; measure and monitor wound status progression or deterioration every week; notify MD and family of changes; wound care to follow up weekly and as needed; nurse to perform head to toe skin assessment weekly and as needed; weekly photo and measurement of wounds-refer to skin assessment for specific locations; and may consult with Wound Physician Clinic to screen, evaluate, and treat as indicated; and wound clinic as needed/as prescribed per physician. However, continued review of Resident #14's medical record revealed no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present; took weekly photos, nor consulted with a Wound Clinic/Physician as ordered by the physician and/or required by the resident's care plan. Review of a Weekly Head to Toe Skin Check forms dated 07/05/2021, 07/12/2021, and	{F 686}		

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{F 686}	Continued From page 487 07/19/2021, revealed the facility documented Resident #14 had skin impairment/pressure ulcers to the left hip. However, there was no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present. Review of Resident #14's Weekly Head to Toe Skin Check dated 07/26/2021 revealed the resident had one (1) Stage II (2) pressure ulcer that measured 4.0 cm long by 4.5 cm wide by 0.5 cm deep to the left hip. Further review revealed Weekly Head to Toe Skin Checks dated 08/02/2021, 08/11/2021, 08/23/2021, and 08/24/2021 revealed the facility documented the resident had existing skin impairment, a Stage II (2) to the left hip. However, there was no documented assessment of the pressure ulcer. Further review revealed the resident refused a skin assessment on 08/09/2021, and there was no documented skin assessment or pressure ulcer assessment for 08/15/2021 Review of a Nursing Services Basic Skin Assessment dated 08/26/2021, revealed RN #4/Wound Nurse completed measurements of Resident #14's left hip which measured 3.6 cm x 3.4 cm. Review of the skin assessment documentation revealed no foul odor or moisture was present. Interview with Licensed Practical Nurse (LPN) #5 on 08/27/2021 at 10:45 AM revealed she "tried" to measure Resident #14's pressure ulcer, but was told the wound nurse was responsible for weekly wound measurements. LPN #5 stated, "So, I really don't know who is responsible to measure the wounds. We have to ask the wound nurse if she is going to do treatments or not on any given	{F 686}		

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{F 686}	Continued From page 488 day." Interview with Registered Nurse (RN) #3 on 08/27/2021 at 8:30 PM revealed the Wound Care Nurse (RN #4) was responsible for completing weekly wound measurements/assessments. RN #3 stated, "I was told she would be doing the wound measurements and wound care when I was hired." Interview with RN #4/Wound Nurse on 08/25/2021 at 8:30 PM revealed she reviewed Physician #1/Medical Director's orders for 07/23/2021 and since the order stated "May" consult the wound clinic, she made the decision not to consult the clinic for Resident #14's pressure ulcer. She further stated pictures had not been taken of Resident #14's pressure ulcer. According to the RN, the Administrator was supposed to purchase a camera; however, the Administrator had not purchased one. She stated she worked the floor just as much, if not more, than performing her duties as the Wound Nurse. She stated she thought the floor nurses were performing weekly skin assessments and wound measurements when she was not. She further stated she had not received any formal education on wound care. Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he ordered weekly pictures of Resident #14's left hip pressure ulcer on 07/23/2021 to track the healing of the wound. He stated, "Pictures are a good thing." He stated he expected all wounds to be measured weekly to monitor improvement/decline of the wound. He stated a wound consult should have been completed as ordered on 07/23/2021 and he was not aware it had not been.	{F 686}		

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{F 686}	Continued From page 489 4. 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, Type 2 Diabetes, Dysphagia, Pneumonia, and Aphasia. Review of Resident #323's Admission/Readmission Nursing Evaluation dated 07/06/2021 at 5:06 PM revealed the resident had a pressure ulcer (no stage) to the coccyx measuring six (6) centimeters (cm) in length and four (4) cm in width. Review of Resident #323's hospital Discharge Summary revealed orders for the facility to continue Santyl (collagenase ointment treatment for pressure ulcers) apply a thin layer to the wound bed. However, review of Resident #323's facility Admission Orders, dated 07/06/2021, revealed the facility did not transcribe the pressure ulcer ointment to the admission orders. Continued review of Resident #323's medical record revealed on 07/10/2021, four (4) days after admission, the facility contacted the resident's physician for a treatment for the pressure ulcer. The physician ordered the pressure ulcers be cleansed with soap and water, pat dry, and apply Santyl Ointment topically to sloughed areas (dead tissue). Review of Resident #323's Treatment Administration Record (TAR) for July 2021, revealed no treatment was provided for the resident's pressure ulcers until 07/11/2021 at 12:00 PM, five (5) days after admission. Further review of the Nursing Notes dated 07/12/2021 at 10:13 AM, revealed Resident 323's pressure area had worsened to an unstageable	{F 686}		

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{F 686}	Continued From page 490 wound to both sides of the buttocks. The note stated the pressure ulcer to the right buttock measured two (2) cm by three (3) cm and the left buttock pressure ulcer measured four (4) cm by five (5) cm. Interview with Registered Nurse (RN) #6 on 07/28/2021 at 9:48 AM revealed the admitting nurse was responsible for transcribing and verifying physician's orders. She stated she was the nurse who admitted Resident #323 and was aware of the Physician's Order for Santyl ointment. RN #6 stated she wanted to evaluate the resident's pressure ulcer before the facility treated the wound with Santyl ointment. However, there was no documented evidence the RN ensured treatment was provided to the resident's pressure ulcer. Interview with the Interim Director of Nursing on 08/11/2021 at 12:05 PM revealed the assigned nurse was responsible for obtaining and verifying physician's orders for residents admitted to the facility. She stated the nurse should have notified the physician to ensure there was an appropriate treatment in place and medications ordered. Continued interview revealed she attempted to check medical records for new admissions and re-admissions to ensure physician's orders were obtained and implemented. However, she stated she worked the floor as a floor nurse preventing her from having time for DON duties. She stated she did not recall reviewing Resident #323's admission record. Interview with the Administrator on 08/11/2021 at 5:55 PM revealed nursing management was responsible for oversight of Admission Physician's Orders. She further revealed she	{F 686}		

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{F 686}	Continued From page 491 was not aware of any issues related to physician's orders for Resident #323. 5. Record review revealed the facility admitted Resident #66 on 02/15/2021 with diagnoses that included Adult Failure to Thrive, Dementia, and Atherosclerotic Heart Disease without Angina Pectoris. Review of Resident #66 Minimum Data Set (MDS) Annual assessment dated 05/05/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderate cognitive impairment. The facility assessed the resident to be total assist of two (2) staff for bed mobility. Further review of the MDS revealed the resident had no rejection of care during the look back period. Review of Resident #66 Care plan, dated 04/23/2021, revealed under the Activities of Daily Living (ADL) Care Plan focus the facility identified the resident required assistance with ADL's (activities of daily living) related to decreased mobility, multiple medical conditions, and receiving Hospice services. The facility developed an intervention that stated the resident was totally dependent upon two (2) staff for repositioning and turning in bed. However, the care plan did not direct staff how often the resident was to be turned and repositioned. Review of Resident #66's Nursing Notes, revealed Registered Nurse (RN) #3 documented on 06/16/2021 at 9:04 AM, that she observed a SRNA "straightened resident up to move" the resident off his/her "right side."	{F 686}		

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{F 686}	Continued From page 492 Observation of Resident #66 on 06/16/2021 at 9:27 AM revealed a Hospice Assistant was giving the resident a bath. When the Assistant finished with care, the Assistant placed the resident on his/her right side and positioned the resident with pillows. Continued observation of the resident revealed the resident remained on his/her right side on 06/16/2021 at 11:47 AM, at 1:40 PM, at 3:13 PM, and at 4:14 PM. Observation on 06/17/2021 at 10:00 AM of Resident #66's skin revealed the resident had no skin breakdown or pressure ulcers. Attempts to interview Resident #66 on 06/16/2021 at 5:21 PM and on 06/17/2021 at 10:00 AM were unsuccessful. The resident did not respond verbally to questions. Interview with State Registered Nursing Assistant (SRNA) #5, on 06/17/2021 at 10:15 AM, revealed she had not attempted to reposition Resident #66 on 06/16/2021, because the resident "seemed comfortable". The SRNA stated the resident was unable to reposition himself/herself in bed. Interview with Registered Nurse (RN) #2, on 06/17/2021 at 10:30 AM, revealed she was not aware Resident #66 had not been turned from 9:30 AM until 4:14 PM on 06/16/2021. RN #2 stated "breakdown" could be the outcome from the resident lying on his/her side for that amount of time. Interview with the Director of Nursing (DON) on 06/19/2021 at 12:29 PM revealed all residents should be turned and repositioned every two (2) hours. She stated if residents were not repositioned, the outcome could be skin	{F 686}		

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{F 686}	Continued From page 493 breakdown. The DON stated the SRNA should have turned Resident #66 every two (2) hours. She stated the RN should have been observing to ensure the resident was turned. The DON further stated she was unaware of any concerns with turning and repositioning residents. **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	{F 686}		

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{F 686}	Continued From page 494 and #320 were bathed including a shower, nail 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,	{F 686}		

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{F 686}	Continued From page 495 lunch and dinner on 09/11/2021, all three meals 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	{F 686}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 686}	Continued From page 496 above and skin integrity reviews for residents with 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	{F 686}		

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{F 686}	Continued From page 497 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 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	{F 686}		

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{F 686}	Continued From page 498 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 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	{F 686}		

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{F 686}	Continued From page 499 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, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the	{F 686}		

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{F 686}	Continued From page 500 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, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee.	{F 686}		

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{F 686}	Continued From page 501 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 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	{F 686}		

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{F 686}	Continued From page 502 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 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,	{F 686}		

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{F 686}	Continued From page 503 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 reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate	{F 686}		

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{F 686}	Continued From page 504 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 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	{F 686}		

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{F 686}	Continued From page 505 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 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	{F 686}		

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{F 686}	Continued From page 506 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 snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director	{F 686}		

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{F 686}	Continued From page 507 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 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	{F 686}		

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{F 686}	Continued From page 508 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. 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 686}		

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{F 686}	Continued From page 509 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	{F 686}		

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{F 686}	Continued From page 510 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 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	{F 686}		

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{F 686}	Continued From page 511 (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. 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	{F 686}		

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{F 686}	Continued From page 512 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 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	{F 686}		

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{F 686}	Continued From page 513 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 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	{F 686}		

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{F 686}	Continued From page 514 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. 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	{F 686}		

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{F 686}	Continued From page 515 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 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	{F 686}		

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{F 686}	Continued From page 516 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 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,	{F 686}		

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{F 686}	Continued From page 517 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 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.	{F 686}		

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{F 686}	Continued From page 518 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, 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,	{F 686}		

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{F 686}	Continued From page 519 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 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.	{F 686}		

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{F 686}	Continued From page 520 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 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	{F 686}		

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{F 686}	Continued From page 521 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 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	{F 686}		

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{F 686}	Continued From page 522 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. 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	{F 686}		

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{F 686}	Continued From page 523 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 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	{F 686}		

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{F 686}	Continued From page 524 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 residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on	{F 686}		

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{F 686}	Continued From page 525 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 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	{F 686}		

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{F 686}	Continued From page 526 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. 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	{F 686}		

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{F 686}	Continued From page 527 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 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	{F 686}		

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{F 686}	Continued From page 528 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 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	{F 686}		

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{F 686}	Continued From page 529 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 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	{F 686}		

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{F 686}	Continued From page 530 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 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	{F 686}		

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{F 686}	Continued From page 531 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, 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	{F 686}		

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{F 686}	Continued From page 532 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. 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	{F 686}		

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{F 686}	Continued From page 533 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 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	{F 686}		

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{F 686}	Continued From page 534 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 new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resid	{F 686}		

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{F 689}	Continued From page 535	{F 689}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the environment remained as free from accident hazards as possible for one (1) of fifty-seven (57) sampled residents (Resident #12) related to medication found in resident's rooms. Observation on 06/15/2021, revealed a medication cup containing Valproic Acid two hundred and fifty (250) milligrams (mg) (antiseizure medication), Metoprolol Tartrate fifty (50) mg (blood pressure medication), and	{F 689}	F 689 Free of Accident Hazards/Supervision/Devices Criteria 1: The identified medication was removed from the room of Resident #12. Criteria 2: a) A review was completed of all resident rooms on 6/15/21 by DON/ADON to determine if there were any medications present. There were none identified. b) Medication	12/30/21

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{F 689}	Continued From page 536 Quetiapine twenty-five (25) mg (antipsychotic medication) sitting on Resident #12's overbed table. The findings include: Review of a facility policy titled,"Administering Medications", dated April 2019, revealed medications were administered in a safe and timely manner, and as prescribed. However, the policy did not address ensuring the resident had ingested the medication prior to leaving the resident. Review of Resident #12's medical record revealed the facility admitted the resident on 09/22/2017, with diagnoses which included Cerebral Infarction, Ischemic Heart Disease, Hypertension, Seizure Disorder, and Traumatic Brain Injury. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12, dated 03/10/2021, revealed the resident had been assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), which indicated the resident was interviewable. Review of Resident #12's physician's orders, dated 06/01/2021, revealed the resident was to receive Metoprolol Tartrate seventy-five (75) mg twice daily (blood pressure lowering medication); Quetiapine twenty-five (25) mg one half tablet twice daily (antipsychotic); and Valproic Acid two hundred and fifty (250) mg twice daily (antiseizure medication). Observation in Resident #12's room, on	{F 689}	administration observations on all licensed nurses working was completed by the DON/Pharmacy Consultant/Nurse Consultant/Designee on 6/15/2021 to determine that medication administration staff are not leaving medication at bedside. Criteria 3: On 6/15/21 and 6/16/21 all medication administration staff have received in-service education by the DON/Designee on the need to observed residents taking their medications before they leave the room. Criteria 4 Beginning 11/24/2021 the DON or designee will complete 5 random resident room audits, the room environment will be visually inspected to ensure no medication are kept at bedside. Audits will be weekly x 4 week then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Beginning 12/15/21 the DON/ Nurse Consultant or designee will observe at least 4 nurses passing Medications monthly x 3 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 689}	Continued From page 537 06/15/2021 at 3:34 PM, revealed a medication cup containing Valproic Acid two hundred and fifty (250) milligrams (mg) (antiseizure medication), Metoprolol Tartrate fifty (50) mg (blood pressure lowering medication), and Quetiapine twenty-five (25) mg (antipsychotic) one half tablet sitting on the resident's overbed table. Interview with Resident #12, on 06/15/2021 at 3:35 PM, revealed the nurse had set the medications on the overbed table and he/she had not taken them yet. Interview with Licensed Practical Nurse (LPN) #3, on 06/15/2021 at 3:40 PM, revealed she was supposed to observe the resident until the resident swallowed the medication. The LPN stated she did not know why she had not observed the resident taking the medications; however, she should have. The LPN stated another resident could have picked up the medication intended for Resident #12 and taken it. Interview with the Director of Nursing (DON), on 06/19/2021 at 12:00 PM, revealed she monitored medication administration randomly and had not identified any concerns. The DON stated nurses were required to ensure residents had ingested their medications prior to leaving the resident. The DON stated the resident missing a dose of medication as well as another resident picking up the medication and taking it were some of the hazards which could be caused by the resident's medication being left on the overbed table. Interview with the Administrator, on 06/19/2021 at 12:36 PM, revealed nurses were required to ensure residents had taken their medication prior	{F 689}		

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{F 689}	Continued From page 538 to leaving the resident and should never leave a medication at a resident's bedside due to the medication being missed it could be detrimental to the resident as well as another resident could pick up the medication and ingest it.	{F 689}		
{F 692} SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	{F 692}		12/23/21

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{F 692}	Continued From page 539 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure eight (8) of fifty-seven (57) sampled Residents (Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81), maintained acceptable parameters of nutritional status and/or body weight. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss as a result of the facility's failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure resident's were served adequate portions to prevent weight loss. The facility's failure to ensure residents maintained acceptable parameters of nutritional status and/or body weight, 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 692}	F 692 Nutrition/Hydration Status Maintenance Criteria 1: a) Resident #332 was discharged from the facility on 9/1/2021 b)Resident # 82 was discharged from the facility on 8/9/2021 c)Resident # 327 was discharged from the facility on 8/14/2021 d) Resident #65 was discharged on 10/31/2021 b) Residents #90, #39, #330, and #81 were weighed by 9-17-2021. c) The registered dietician completed a comprehensive nutrition assessment for the residents by 9-17-2021. The Director of Nursing or designee reviewed the comprehensive assessment recommendations by 09/17//2021, spoke with the attending MD and validated the diet orders, and recommendations were entered into PCC and matched the Dining RD tray card. Criteria 2: a) The DON and Registered Dietician reviewed weights on 9-13-2021 for all residents to identify any that had demonstrated significant weight changes. For any residents demonstrating significant weight changes, the registered dietician completed a comprehensive nutrition assessment by 9-_20_-2021. Criteria 3: a) Resident who are weighed weekly are weighed every Monday by	

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{F 692}	Continued From page 540 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 692}	CNAs. -CNAs report weights to the nurse who reviews and enters the weight into PCC -Any 5lb weight change or more will be verified by obtaining a re-weight by the next day. -Once the weight is verified, any significant change and/or 5 lbs weight loss or gain will be reported to the MD and RD for recommendations/orders. -New orders will be reflected on the care plan, with the resident and or RP notified. b) Monthly weights are obtained in the same manner the first week of each month. c) All weights are reviewed in the weekly weight meeting by the IDT which consists of: Registered Dietician, Director of Nursing, MDS, Social Services, Activities, Dietary, Therapy and Clinical Staff Representative. The DON is responsible for running this meeting/process. c) All nursing staff including CNA□s 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. d) 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. e) On 11-22-21 the Regional CDM educated the Dietary Manager and	

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{F 692}	Continued From page 541 monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled "Weight Assessment and Intervention," not dated, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. According to the policy, nursing staff would measure resident weights on admission, the next day and weekly for two weeks thereafter. According to the policy, weight changes of five (5) percent or more since the last weight assessment, would result in obtaining the weight again the next day for confirmation. If nursing staff verified the weight, they would notify the dietitian immediately and staff would document the notification. Further review of the policy revealed the dietitian would respond within twenty-four (24) hours of receipt of written notification and would review the unit weight record by the fifteenth of the month to follow individual weight trends over time. The treatment team would evaluate negative trends and determine if the resident had met the criteria for significant weight change. The policy defined significant weight change as, a five (5) percent weight loss in one month, greater than five (5) percent considered severe; seven and one-half (7.5) percent weight loss in ninety (90) days was significant and greater than seven and one-half (7.5) percent considered severe; ten (10) percent weight loss in six (6) months was significant and greater than ten (10) percent considered severe. According to the policy, the facility should base the interventions for undesirable weight loss on careful consideration of resident choices and preferences and nutritional needs of facility	{F 692}	dietary staff 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. h) By 11-22-21 the CDM educated the dietary manager and dietary staff on obtaining food preferences, Dining RD, placing order by menus for facility, stocking snack/hydration carts, snacks and hydrations, appropriate scoop sizes and/or portion sizes. i) Starting 9-16-21 newly admitted/re-admitted resident food and beverage preferences will be obtained by the dietary manager or designee within 72 hours of admission and entered in DiningRD for listing on their tray cards. Food preference will be completed bi-annually and as needed for all residents. j) Starting 9-15-21 snacks are being offered daily morning and afternoon by the restorative or activity aides or designee to all residents. Intake will be documented on snacks will be documented in the electronic medical record. Criteria 4: a) Starting 8-25-2021 the Dietician or designee will audit diet orders from PCC against orders entered in DiningRD (diet software) to ensure accuracy monthly until substantial compliance is achieved b) Starting on 9/23/2021	

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{F 692}	Continued From page 542 residents. 1. Review of Resident #65's medical record revealed the facility admitted him/her on 03/23/2021 with diagnosis that included Cerebral Infarction, Dysphagia, Polyarthritis and Paraplegia. Review of Resident 65's Admission MDS assessment, dated 03/30/202,1 revealed the facility assessed the resident weighed one hundred and seventy-nine (179) pounds, and was totally dependent on two (2) staff with Activities of Daily Living, including eating. Further review revealed the resident had no weight loss/gain or his/her weight loss/gain history was unknown and had no pressure ulcers. The MDS revealed Resident #65 had complaints of difficulty or pain when swallowing and had malnutrition or was at risk for malnutrition. Review of Resident #65's weight record revealed on 04/06/2021, the resident's weight was one hundred forty-two and seven tenths (142.7) pounds, a weight loss of thirty-six and six tenths (36.6) pounds since admission to the facility on 03/23/2021. Review of the medical record revealed there was no documented evidence the RD evaluated Resident #65 after the weight loss and no documented evidence the facility addressed the weight loss. 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 facility on 4/29/2021 with diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure, and Urinary Tract Infection. The record revealed there was no documented evidence the facility	{F 692}	Dietary Manager or designee will ensure and audit meals leaving the kitchen and reaching the units timely, audits will be conducted for random meals monthly until substantial until substantial compliance is achieved c) Starting 9-11-21 the Dietary Manager or designee will time passing of meal trays to residents after arriving to the unit. All three meals will be observed monthly until substantial compliance is achieved. d) Starting 9-13-21 MD ordered snack intake will be audited by Dietary Manager monthly until substantial compliance is achieved. e) Beginning on 12/1/21 Weights are reviewed in the Clinical Meetings Monday □ Friday reviews any recommendations from the RD/MD for residents are addressed at that meeting. Dietary Manager reports any nutrition concerns of residents with the group. Minutes of the meetings are maintained in the DON□s office. The Dietary Manager conducts visits with resident to address their preferences weekly and if issues will visit daily. Also, Starting on 9/23/21 the Dietary Manager audits portion control, recipe followed, and forfeited foods. Interviews with residents to ensure they are getting enough food and are not hungry is done and recorded on the preference audit form. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance:	

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{F 692}	Continued From page 543 weighed the resident upon readmission to the facility. Review of the Situation, Background, Assessment and Recommendation (SBAR) Communication form, dated 05/02/2021 at 5:29 PM, revealed the Resident #65 had developed a deep tissue injury (DTI) to the coccyx. Review of the medical record revealed Resident #65 weighed one hundred and thirty-five (135) pounds on 05/04/2021, another seven and seven tenths (7.7) pound weight loss from the previous weight on 04/06/2021. Approximately one (1) month after the resident's initial weight loss, the RD assessed Resident #65. Review of a Nutrition Data Collection assessment, dated 05/06/2021, revealed the resident's weight was 135 pounds, and the RD calculated the resident's weight was down five and four tenths (5.4) percent in thirty (30) days and twenty-four and seven tenths (24.7) percent in sixty (60) days. According to the RD's assessment, Resident #65 had severe malnutrition related to weight loss. The RD recommended fortified foods three (3) times a day and a frozen cup at dinner. There was no documented evidence the RD identified the resident had a DTI and addressed whether the resident needed anything for wound healing. Interview with the RD, on 08/26/2021 at 12:16 PM, revealed the facility had not been notifying her of resident skin breakdown and weight loss. She stated she was unaware that Resident #65 had a pressure ulcer when she assessed the resident on 05/06/2021. She stated had she known she would have increased the resident's	{F 692}	12/30/2021	

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{F 692}	Continued From page 544 protein to aide in pressure ulcer healing. She stated ideally she would like to be notified weekly of new pressure ulcers. Review of a change of condition form for Resident #65, dated 05/11/2021 at 2:40 PM, revealed the pressure ulcer to the resident's coccyx was "worsening". Continued review revealed the deep tissue injury (DTI) was now an unstageable pressure ulcer (full thickness tissue loss (death) in which the base of the ulcer was covered by slough (yellow, tan, green or brown) and/or eschar (tan, brown, or black) in the wound bed) that measured six and one-half (6.5) centimeters (cm) long and nine and seven tenths (9.7) cm wide. Review of a Nutrition Progress Note, dated on 05/18/2021 at 10:46 PM, revealed Resident #65's weight was one hundred forty-two and six tenths (142.6) pounds, a significant weight loss of three (3) percent in seven (7) days, twenty and one-half (20.5) percent in ninety (90) days. Further review revealed the RD was aware the resident had an unstageable pressure ulcer to the sacrum. Based on the progress note, the resident was receiving fortified foods three (3) times a day and a frozen nutrition cup at dinner. The resident's ideal body weight (IBW) was one hundred forty-eight (148) pounds. The RD had no recommendations. Continued interview with the RD, on 08/26/2021 at 12:16 PM, revealed she was unaware Resident #65's pressure ulcer was worsening when she assessed the resident on 05/18/2021. She stated, had she known she would have implemented new interventions to address the pressure ulcer decline.	{F 692}		

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{F 692}	Continued From page 545 Further review of Resident #65's weight record revealed the resident weighed one hundred fifty-one and one-half (151.5) pounds on 5/27/2021. Review of a Nutrition Data Collection assessment, dated 06/13/2021, revealed the resident had a twelve and two tenths (12.2) percent weight gain in thirty (30) days and had sustained a fifteen and one-half (15.5) percent weight loss in ninety (90) days. Further review revealed the resident's intake was greater than his/her needs; however, the resident was at risk for malnutrition due to a weight loss in ninety (90) days, a pressure wound, and the resident required a therapeutic diet. Continued review revealed no nutritional recommendations were made. Review of a change of condition form, dated 05/28/2021 at 3:54 PM, revealed Resident #65 had a "worsening wound". The physician ordered a wound culture and laboratory testing. However, per the change of condition form, "MD later called back and decided to send resident to Emergency Room for evaluation and treat for possible debridement of area". Review of Resident #65's hospital record, revealed he/she was admitted to the hospital on 05/28/2021. Review of the resident's Emergency Department (ED) nurse's notes, dated 05/28/2021 at 5:36 PM, revealed the resident had a "large decubitus (pressure) ulcer approximately fifteen (15) cm by eight (8) cm with central skin sloughing and underlying necrosis, the wound had surrounding erythema with mild purulent drainage to bandage". Review of a progress	{F 692}		

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{F 692}	Continued From page 546 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 an Infectious Disease Consult note, dated 06/01/2021, the resident "underwent debridement on 05/30/2021, per operative note, all necrotic tissues were removed and the excision was down to the bone". Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed he debrided the large stage four-(4) pressure ulcer to Resident #65's sacrum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be debrided down to the bone. He stated the pressure ulcer measured ten (10) cm in length by six (6) cm in depth prior to debridement, and post debridement the area measured fifteen (15) cm in length by ten (10) cm in width and was very extensive. Surgeon #1 stated, "Nutrition is a big key" in the development/worsening of pressure ulcers. Further review of the hospital record revealed, on 05/28/2021 at 11:38 PM, Resident #65's Albumin (low albumin can indicate malnutrition) was "low" at one and three tenths (1.3) gram per deciliter (g/dL) with normal range of three and four tenths (3.4) to five (5.0) g/dL. Further review revealed the resident's Total Protein (measures the total amount of albumin and globulin in blood) was "low" at five and six tenths (5.6) g/dL with normal range of six and four tenths (6.4) to eight and four tenths (8.4) g/dL (low protein levels can be seen in severe malnutrition). Resident #65 was discharged back to the facility on 06/09/2021. Continued Review of Resident #65's weight record revealed no readmission weight was	{F 692}		

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{F 692}	Continued From page 547 documented for the resident. The resident weighed one hundred fifty-two and two tenths (152.2) pounds on 06/15/2021, one hundred fifty and six tenths (150.6) pounds on 06/22/2021 and one hundred forty-three and one tenth (143.1) pounds on 06/29/2021. Review of a Nutrition Progress Note, dated 06/29/2021 at 9:52 PM, revealed Resident #65 had sustained a significant weight loss of six (6) percent in less than thirty (30) days and twenty and two tenths (20.2) percent weight loss in ninety (90) days. The resident's ideal body weight (IBW) was one hundred forty-eight (148) pounds. Further review revealed the resident had developed a Deep Tissue Injury (DTI) to the right and left heels and continued to have a Stage IV (4) pressure ulcer to the coccyx. According to the progress note, the resident continued to receive fortified foods three (3) times a day; however, the current intake was inadequate to meet the resident's protein needs for healing. The RD recommended adding large protein portions at breakfast and dinner to better meet energy needs for healing. Continued review of Resident #65's medical record revealed on 07/08/2021, the resident weighed one hundred forty-two and seven tenth (142.7) pounds. Review of the resident's Nutrition Progress Note, dated 07/13/2021, revealed the resident had a significant weight loss of six and three tenths (6.3) percent in thirty (30) days and twenty and one-half (20.5) percent in less than one hundred eighty (180) days. The resident also had a DTI to the right heel, two (2) stage one (1) pressure ulcers to left heel, and stage four (4) to coccyx.	{F 692}		

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{F 692}	Continued From page 548 The note revealed the resident received fortified foods three times a day and large protein portions at breakfast and dinner. According to the RD, the resident's intake greatly exceeded the resident's needs and no nutritional recommendations were made. Review of Resident #65's tray card revealed the resident was to receive large protein portions and fortified foods with meals. Observation of Resident #65 dinner tray, on 08/05/2021 at 7:50 PM, revealed no evidence the resident received large protein portions. Review of Resident #65's weight record revealed the resident was not weighed again until approximately one (1) month later on 08/06/2021. The resident weighed one hundred thirty three and two tenths (133.2) pounds, a six and six tenths (6.6) percent weight loss in less than thirty (30) days. There was no documented evidence the RD assessed the resident and no documented evidence that the facility addressed the resident's weight loss. Continued review revealed the resident weighed one hundred thirty one and four tenths (131.4) pounds on 08/11/2021, a seven and nine tenths (7.92) percent loss in approximately five (5) weeks. There was no documented evidence the RD assessed the resident until 08/22/2021. Review of Resident #65's Nutrition Progress note, dated 08/22/2021 at 2:41 PM, revealed the resident's weight was one hundred thirty-seven and eight tenths (137.8) pounds, which was a significant loss of nine (9) percent in ninety (90) days and twenty-three and one tenth (23.1) percent in one hundred eighty (180) days.	{F 692}		

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{F 692}	Continued From page 549 According to the progress note, the resident continued to have a DTI to right heel, a stage one-(1) pressure ulcer to left heel, a stage four-(4) pressure ulcer to sacrum, and had developed an unstageable pressure ulcer to left lower extremity. Review of the note revealed the resident had a desired weight gain of four and six tenths (4.6) pounds over the "past few weeks" and no recommendations were made. Further review of Resident #65's weight record revealed the resident continued to lose weight. The resident weighed one hundred thirty-two (132) pounds on 08/23/2021, one hundred thirty-one and seven tenths (131.7) pounds on 08/24/2021 and one hundred thirty-one and four tenths (131.4) pounds on 08/25/2021. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she was not aware the facility was not fortifying foods, nor providing large protein portions as recommended. She stated if the facility had fortified Resident #65's foods and added large protein portions as recommended, the on-going significant weight loss that occurred for this resident would have been prevented. Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed he debrided the large stage four-(4) pressure ulcer to Resident #65's sacrum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be debrided down to the bone. He stated the pressure ulcer measured ten (10) cm in length by six (6) cm in depth prior to debridement, and post debridement the area measured fifteen (15) cm in length by ten (10) cm in width and was very extensive. Surgeon #1 stated, "Nutrition is a big key" in the	{F 692}		

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{F 692}	Continued From page 550 development/worsening of pressure ulcers. 2. Review of Resident #90's medical record revealed the facility admitted the resident on 10/07/2016 with diagnoses including Dementia, Unspecified Protein-Calorie Malnutrition and Dysphagia. Review of Resident #90's Minimum Data Set (MDS) assessment dated 02/19/2021, revealed the facility assessed the resident to have a BIMS score of eight (8) out of fifteen (15), indicating the resident had moderate cognitive impairment. The MDS also revealed the resident was totally dependent on staff for eating. The assessment stated the resident weighed ninety-seven (97) pounds and was at risk for malnutrition. Review of Resident #90's weight record revealed the resident weighed ninety-seven (97) pounds on 02/02/2021. Review of Resident #90's comprehensive care plan in place on 02/19/2021, revealed the facility identified on 11/20/2020 that the resident had a potential for weight concerns and was at risk for malnutrition due to dependence on staff for eating, diagnosis of dysphagia and Vitamin B12 deficiency. Review of Resident #90's weight record revealed on 03/06/2021, the resident weighed eighty-six and eight tenths (86.8) pounds, a loss of ten (10) pounds in thirty-two (32) days. However, there was no documented evidence the facility notified the RD of the resident's weight loss as required by policy. Continued review of Resident #90's weight record revealed on 04/04/2021, the resident weighed	{F 692}		

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{F 692}	Continued From page 551 eighty-six and six tenths (86.6) pounds. Review of RD documentation, dated 04/09/2021, revealed the RD noted Resident #90 had sustained an eight and eight tenths (8.8) percent weight loss in thirty (30) days, and ten and one-half (10.5) percent in one hundred eighty (180) days. The documentation stated the RD recommended serving the resident fortified foods with meals, ice cream with lunch and supper, whole milk with meals and administer the resident Med Pass (nutritional supplement) one hundred twenty (120) milliliters (ml), three (3) time per day. However, review of Resident #90's medication administration records (MAR), dated April 2021 through July 2021, revealed staff continued to administer the resident ninety (90) ml of the House Supplement three (3) times a day, instead of one hundred twenty (120) ml as recommended by the RD on 04/09/2021. Continued review of Resident #90's weight record revealed on 05/04/2021, the resident had gained weight and weighed ninety-three and six tenths (93.6) pounds. However, there was no documented evidence the facility re-weighed the resident the next day to ensure the increased weight was accurate as required by the facility's policy. Review of Resident #90's weight record revealed on 06/08/2021, the resident's weight was eighty-four and seven tenths (84.7) pounds, and on 06/15/2021, the resident's weight was eighty-two and one-half (82.5) pounds. Review of Resident #90's RD documentation, on 06/16/2021, revealed the RD noted an eleven and	{F 692}		

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{F 692}	Continued From page 552 nine tenths (11.9) percent weight loss in thirty (30) days, a twelve and nine tenths (12.9) percent weight loss in ninety (90) days, and an eleven and one-half (11.5) percent weight loss in one hundred eighty (180) days. However, the RD documented the resident's intake "greatly exceeds the resident needs yet continues to lose weight". The RD recommended increasing the resident's Med Pass to four (4) times per day. Review of Resident #90's Medication Administration Records, for June 2021 and July 2021, revealed the Med Pass continued to be administered to the resident three (3) times per day. Review of Resident #90's weight record revealed on 06/29/2021, the resident weighed eight-two and three tenths (82.3) pounds. Review of RD documentation dated 07/07/2021, revealed the RD documented Resident #90 had lost thirteen and one tenth (13.1) percent in ninety (90) days and eleven and seven tenths (11.7) percent loss in one hundred eighty (180) days. However, the RD made no new recommendations. Further review of Resident #90's weight record revealed on 07/08/2021, the resident's weight was eighty and two tenths (80.2) pounds. Review of Resident #90's meal tray card on 07/27/2021, revealed the card listed fortified foods at meals and ice cream with lunch and supper meals. Observations of Resident #90 during the lunch meal services, on 07/27/2021 and 07/28/2021,	{F 692}		

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{F 692}	Continued From page 553 revealed the resident's tray did not include ice cream on either day. Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, reveled Resident #90 weighed eighty-one and one tenth (81.1) pounds. However, there was no documented evidence the facility notified the RD that the resident was continuing to lose weight. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if the facility had fortified Resident #90's foods as recommended and provided the resident with the recommended supplements and snacks, it would have prevented the on-going significant weight loss that occurred for this resident. The RD stated she assumed if she made a recommendation the facility implemented it, unless she was notified otherwise. The RD stated she did not conduct any type of monitoring to ensure residents were getting the recommendations she had made, such as meal observations. The RD stated the facility did not routinely notify her if a resident had experienced weight loss, and the only way for her to obtain that information was to run a report when she came to the facility. 3. Review of Resident #327's medical record revealed the facility admitted the resident on 03/15/2021 with diagnoses including Dementia, Anemia, and Hyperlipidemia. The facility documented the resident's admission weight as two hundred one and one-half (201.5) pounds. Review of Resident #327's admitting physician orders, dated 03/15/2021, revealed staff were to provide the resident with a mechanical soft diet	{F 692}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 692}	Continued From page 554 with thin liquids and provide the resident with Med Pass four (4) times per day. Review of RD documentation, dated 03/17/2021, for Resident #327 revealed she recommended staff to provide fortified foods with all meals, snacks three (3) times a day and finger foods when available. Review of Resident #327's Admission MDS assessment, dated 03/22/2021, revealed the facility assessed the resident to be severely cognitively impaired. The assessment also stated the resident complained of difficulty or pain with swallowing, and was independent with meals requiring set up help only, and the resident weighed two hundred and five (205) pounds. Review of Resident #327's baseline care plan, initiated on 03/15/2021, revealed the plan failed to address nutritional status. Review of a RD evaluation, dated 03/26/2021, revealed Resident #327 weighed one hundred ninety-four and two tenths (194.2) pounds, and the RD documented the resident had sustained a five (5) percent weight loss in one week. The RD recommended adding whole milk and ice cream to the resident's lunch and supper meals. Review of a RD documentation, dated 04/09/2021, revealed on 04/06/2021, Resident #327 weighed one hundred eighty-four and two tenths (184.2) pounds, a significant weight loss of ten (10%) percent in thirty (30) days. Further review of the report revealed the RD recommended referring the resident to the physician for a medication review due to the facility's documentation that the resident's intake	{F 692}		

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

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{F 692}	Continued From page 555 was "fair", but continued to experience weight loss. However, there was no documented evidence in the resident's medical record to indicate the facility implemented the recommendation and no documented evidence the staff notified the resident's physician of the weight loss or that a medication review was completed. Review of RD documentation, dated 05/07/2021, revealed she evaluated Resident #327 on 05/07/2021, because the resident weighed one hundred eighty-two and one-half (182.5) pounds on 04/27/2021. The RD documented the resident had lost six (6) percent of body weight in the past thirty (30) days and ten and eight tenths (10.8) percent of body weight in the past ninety (90) days. However, the RD made no further recommendations, stating the resident's intake was likely adequate, because the resident's weight was stable since the last review. Review of Resident #327's care plan, developed on 05/09/2021, revealed the facility documented the resident was at risk for impaired nutrition related to dementia and chronic medical problems. The resident's care plan also stated that although the resident had sustained weight loss, the resident was still above ideal body weight. The interventions on the resident's care plan included assisting the resident with meals as needed, RD consults as needed, obtain weights, and administer the resident the House Supplement as ordered. Review of RD documentation revealed on 06/06/2021, the RD evaluated Resident #327 because the resident weighed one hundred seventy-eight and one-half (178.5) pounds on	{F 692}		

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{F 692}	Continued From page 556 06/01/2021, a significant weight loss of eleven and four tenths (11.4) percent in ninety (90) days. However, the RD made no recommendations for Resident #327. Review of RD documentation revealed on 07/07/2021, the RD evaluated Resident #327, who weighed one hundred seventy-nine and nine tenths (179.9) pounds on 07/06/2021. The RD made no new recommendations stating the resident's weight had remained stable in the past thirty (30) days. Observation of Resident #327 during the lunch meal, on 07/27/2021 at approximately 2:00 PM, revealed the resident was not served ice cream with the meal, per the RD recommendation. Continued review of Resident #327's record revealed the resident weighed one hundred seventy (170) pounds on 08/03/2021, which was a five and one-half (5.5) percent weight loss in thirty (30) days, however, there was no evidence the RD re-evaluated the resident. Observation of staff weighing residents in the facility on 08/05/2021, from 2:00 PM until 5:00 PM, revealed Resident #327 weighed one hundred seventy and three tenths (170.3) pounds. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed in her opinion, if the facility had consistently followed the resident's diet orders and recommendations, the resident would not have experienced on-going significant weight loss. The RD stated the facility's failure to provide fortified foods, snacks, and supplements such as ice cream could have all	{F 692}		

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{F 692}	Continued From page 557 contributed to the resident's continued weight loss. The RD stated facility staff had never informed her of Resident #327's weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. Therefore, the RD stated she was not aware that the resident had sustained additional significant weight loss from 07/06/2021 to 08/03/2021. 4. Review of Resident #82's medical record revealed the facility admitted the resident on 05/12/2021 with diagnoses including Parkinson's Disease, Alzheimer's Disease, Insomnia and Vitamin D Deficiency. Further review of the admission data revealed the resident's weight was one hundred fifty-three and six tenths (153.6) pounds on 05/12/2021. Review of the Physician Admission orders, revealed Resident #82 was to receive a mechanical soft diet with thin liquids, and on 05/18/2021 the physician ordered the house supplement to be provided to the resident four (4) times per day and on 07/27/2021 the physician ordered Periactin (appetite stimulant) to be administered every six (6) hours. Review of Resident #82's Admission MDS assessment, dated 05/18/2021, revealed the resident was severely cognitively impaired, but was independent with eating, requiring set up only. The assessment also stated the resident's weight was one hundred forty-eight (148) pounds, a five and six tenths (5.6) pound weight loss in one (1) week. Review of Resident #82's baseline care plan, initiated on 05/12/2021, revealed no information	{F 692}		

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{F 692}	Continued From page 558 related to nutritional status was on the care plan. Review of Resident #82's weight record revealed on 06/01/2021, the resident weighed one hundred forty-five and one tenth (145.1) pounds, a five and one-half (5.5) percent weight loss in less than thirty (30) days. However, there was no documented evidence the RD evaluated Resident #82 until 06/05/2021, twenty-four (24) days after admission and eighteen (18) days after the resident sustained a weight loss. Review of the RD assessment, dated 06/05/2021, identified Resident #82 had sustained a five and one-half (5.5) percent weight loss in thirty (30) days, and a thirteen and four tenths (13.4) percent loss in ninety (90) days. The RD recommended to add a nighttime snack and fortified foods to the Resident's diet. Continued review of Resident #82's weight record revealed on 06/08/2021, the resident weighed one hundred forty-three and two tenths (143.2) pounds. Review of Resident #82's nutritional care plan, developed on 06/17/2021, revealed the facility identified the resident had a potential for weight loss, and was at risk for malnutrition due to Alzheimer's Disease and a history of weight loss. Interventions implemented on 06/17/2021, included honoring the resident's food requests/preferences, the RD to evaluate and make dietary changes/recommendations as needed, obtain weights as ordered, and monitor and report and signs/symptoms of malnutrition to the physician. The facility identified malnutrition signs/symptoms as significant weight loss of three (3) or more percent in one a week, a five (5)	{F 692}		

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{F 692}	Continued From page 559 percent weight loss in one (1) month, a seven and one-half (7.5) percent weight loss in three (3) months and a ten (10) percent weight loss in six (6) months. Further review of Resident #82's record revealed the resident weighed one hundred forty-two and one-half (142.5) pounds on 07/13/2021, one hundred thirty-nine and one tenth (139.1) pounds on 07/20/2021, one hundred thirty-seven and three tenths (137.3) pounds on 07/27/2021 and 132.9 pounds on 08/03/3021, a significant weight loss of 13.4% in the last 90 days. However, there was no evidence the RD re-evaluated the resident after 06/05/2021, and no evidence the facility notified the resident's physician of the weight loss. Observation of staff weighing residents on 08/05/2021 from 2:00 PM thru 5:00 PM, revealed Resident #82 weighed 140 pounds. Interview with the RD on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed in her opinion, if the facility had fortified Resident #82's foods as recommended and provided the resident with an adequate amount of food and snacks, it would have prevented the resident's on-going significant weight loss. The RD stated facility staff had never informed her of Resident #327's weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. However, the RD stated she did not always run that report and at times, staff failed to enter the resident's weights into the system, so a weight loss would not trigger. Therefore, the RD stated she was not aware that the resident had sustained additional significant weight loss since 06/05/2021.	{F 692}		

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{F 692}	Continued From page 560 5. Review of Resident #330's medical record revealed the facility admitted the resident on 03/11/2020 with diagnoses including Cerebral Infarction, Diabetes Mellitus, Hemiplegia and Aphasia. Review of Resident #330's physician orders for May 2021, revealed the resident was to receive a mechanical soft diet with thin liquids. Review of Resident #330's Annual MDS assessment, dated 05/12/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15), indicating the resident was cognitively impaired, had swallowing difficulties and held residual food in mouth. Further review of the assessment revealed the facility assessed the resident to require limited assistance of one (1) staff member at meals. The assessment stated the resident's weight was two hundred thirty-nine (239) pounds. Review of Resident #330's care plan, in place on 05/12/2021, revealed the resident was at risk for potential weight concerns/malnutrition because of the resident's diagnosis of dysphagia. However, the facility identified the resident was above ideal body weight and was obese. The note indicates the resident had a feeding tube, not utilize for nutrition. Interventions initiated on the care plan included RD consults as needed, obtain weights and monitor/report any signs/symptoms of malnutrition to the physician. The facility identified signs/symptoms of malnutrition to report included weight loss of three (3) pounds in a week, five (5) percent of body weight in one month, seven and one-half (7.5) percent of body weight in three (3)	{F 692}		

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{F 692}	Continued From page 561 months and ten (10) percent of body weight in six (6) months. The care plan also directed staff to "Explain and reinforce to (the resident) the importance of maintaining the diet ordered. Explain consequences of refusal, obesity/malnutrition risk factors", despite the resident being severely cognitively impaired and requiring staff assistance with meals. Review of Resident #330's weight record revealed on 06/08/2021, the resident's weight was two hundred thirteen and six tenths (213.6) pounds. However, there was no documented evidence the RD evaluated the resident until 06/28/2021, twenty (20) days after the resident sustained a ten and six tenths (10.6) percent weight loss in approximately thirty (30) days. Review of a RD assessment, dated 06/28/2021, revealed the RD documented Resident #330 had lost ten and six tenths (10.6) percent of his/her body weight in one hundred eighty (180) days, but made no dietary recommendations. Continued review of Resident 330's weight on 07/06/2021, revealed the resident weighed two hundred fifteen and one-half (215.5) pounds. Review of a nurse's note, dated 07/18/2021 at 4:15 PM, revealed staff took Resident #330 down to the third floor for an in-person visit with spouse. The note stated within ten (10) minutes, the third floor staff were calling up to the resident's floor, stating the resident's spouse was very upset. The noted stated the spouse told staff "they were starving the resident". The nurse's note indicated the writer went to the third floor and found the resident crying, and the spouse stating the "resident was hungry and facility was starving	{F 692}		

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{F 692}	Continued From page 562 (him/her)". The spouse stated the resident had "visibly lost weight." The note further stated the resident says he/she was not hungry. Interview with Resident #330's spouse, on 08/03/2021 at 7:30 PM, confirmed the spouse was visiting the resident on 07/18/2021. The spouse stated the resident all of a sudden wanted to come home and was crying. The spouse stated the resident had never acted that way on prior visits and the resident looked like he/she had lost weight. The spouse reported caring for the resident at home after the stroke, which had left the resident unable to speak. The spouse stated when the resident was home, they had learned to communicate through actions and symbols. The spouse stated when the resident made a "gnawing motion" on the arm it meant the resident was hungry. The spouse stated when he/she realized during the visit on 07/18/2021, that the resident was crying, the spouse reported asking the resident what was wrong. The spouse stated the resident immediately began making a gnawing motion on his/her arm. The spouse reported asking the resident are you hungry and stated the resident answered yes by shaking his/her head. The spouse then told the resident that he/she had purchased a "pop and bag of chips" on the way to the facility and asked the resident if he/she wanted it. The Spouse reported giving the food to the resident who immediately ate the chips and drank the soda. The spouse began to cry during the interview and voiced trying to arrange to care for the resident at home or finding another facility to transfer the resident to, because the resident was "going hungry." Review of Resident #330's weight on 08/03/2021, revealed the resident weighed two hundred and	{F 692}		

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{F 692}	Continued From page 563 ten (210) pounds, a five and one-half (5.5) pound weight loss since 07/06/2021. However, there was no documented evidence the RD re-evaluated the resident after 06/28/2021. In addition, there was no documented evidence staff notified Resident #330's physician that the resident had sustained significant weight loss in the facility. Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, revealed Resident #330 weighed two hundred and ten (210) pounds. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed although Resident #330 had sustained a significant weight loss on 06/28/2021, when she evaluated the resident, the resident still remained significantly above ideal body weight, so therefore the RD stated no interventions were warranted. However, the RD stated facility staff had never informed her of Resident #330's continuing weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. However, the RD stated she did not always run that report and at times, staff failed to enter the resident's weights into the system, so a weight loss would not trigger. Therefore, the RD stated she was not aware that the resident had continued to lose weight. 6. Review of Resident #39's medical record revealed the facility admitted the resident on 11/25/2011, and re-admitted the resident to the facility on 04/03/2018 with diagnoses including Diabetes Mellitus, GERD, and Chronic Diastolic Heart Failure.	{F 692}		

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{F 692}	Continued From page 564 Review of Resident #39's Quarterly MDS assessment dated 03/01/2021 revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. The assessment also revealed the resident was independent with eating, weighed two hundred ninety-six (296) pounds, and was not on a physician ordered weight loss plan. Review of Resident #39's weight record revealed the resident weighed two hundred ninety (290) pounds on 04/04/2021, and refused to be weighed in May 2021. Review of Resident #39's comprehensive care plan, dated 06/17/2021, revealed the facility identified the resident was at risk for impaired nutrition related to receiving a mechanical soft diet and the diagnosis of Diabetes. Interventions implemented on 06/17/2021 included staff honoring the resident's food requests/preferences, monitoring the residents weight and providing the resident with diet as ordered. Review of Resident #39's weight record revealed the resident weighed two hundred fifty-three and three tenths (253.3) pounds on 06/22/2021, representing a fourteen (14) percent weight loss in approximately one hundred eighty (180) days. Review of an RD assessment, dated 06/22/2021, revealed the RD recommended to honor the resident's dietary preferences and serve the resident fortified foods at meals. Further review of Resident #39's weight record revealed documentation that the resident refused	{F 692}		

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{F 692}	Continued From page 565 to allow staff to obtain weight in July 2021. Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, revealed Resident #39 weighed two hundred sixty-one and seven tenths (261.7) pounds. Interview with Resident #39, on 07/27/2021 at 10:45 AM, revealed the facility had no snacks available for residents and the facility served the same food several times a week, especially for the supper meal. Resident #39 also stated, "You hardly get anything at supper to eat anyway". The resident stated the facility never passes snacks and stated, "I get hungry". Interview with Resident #39 and during the lunch meal, on 08/17/2021 at 1:20 PM, revealed the resident preferred salads for lunch, and liked to eat Fruit Loops cereal. However, the facility had not served the resident a salad for the meal. The resident stated, "I've lost a lot of weight in the past year because the food here is always late and cold". The Resident stated he/she had requested salads for lunch but had never received a salad for lunch. The resident reported asking staff in the past, why he/she never received salads, and stated, "It's always a different excuse, they forgot, or they're out of lettuce." Resident #39 also stated he/she had requested Fruit Loop cereal, stating that was his/her favorite cereal before admission into the facility. However, Resident #39 stated, "they won't give me that here either." The resident stated, "Why would someone ask me what I liked or wanted to eat, if they're not gonna give it to me, makes no sense." The resident stated breakfast was frequently cold and he/she remains hungry until lunch. However, the resident stated "but if I	{F 692}		

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{F 692}	Continued From page 566 could get some cereal I could eat that, I could make it myself." Resident #39 also denied ever refusing to allow staff to weigh him/her. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if Resident #39's food preferences had been honored, the resident would most likely not have experienced a significant weight loss. The RD stated a gradual weight loss would have been beneficial for the resident, but a sudden significant weight loss was not desirable. 7. Review of Resident #332's medical record revealed the facility admitted the resident on 03/12/2021 with diagnoses including Diabetes, Chronic Kidney Disease, Gastro-Esophageal Reflux Disease, Hypertension, Atrial Fibrillation, and Femoral Neck Fracture. Review of Resident #332's diet orders, dated 03/12/2021, revealed the resident was to receive a two thousand (2000) calorie ADA (American Diabetes Association) and Renal Diet. Review of a Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed Resident #332's weight was one hundred ninety-nine and nine tenths (199.9) pounds and the resident's intake was inadequate to meet the resident's needs. Further review of the assessment revealed a recommendation to add fortified foods to the resident's meals to meet energy needs. Review of Resident #332's Quarterly MDS assessment, dated 03/19/2021, revealed the facility assessed the resident to have a BIMS score of fourteen (14) out of fifteen (15),	{F 692}		

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{F 692}	Continued From page 567 indicating intact cognition. Further review of the assessment revealed the resident was independent with eating, and weighed two hundred (200) pounds. Review of Resident #332's weight record revealed the resident weighed one hundred eighty-two and six tenths (182.6) pounds on 04/05/2021. Review of the Nutrition Progress Note by the RD, dated 04/11/2021, revealed Resident #332 had sustained a nine (9) percent weight loss in thirty (30) days. Further review revealed the resident's intake remained inadequate to meet the resident' needs. The progress note stated the resident was receiving fortified foods, large protein portions at dinner, and a snack at bedtime. Review of Resident #332's weight record revealed the resident weighed one hundred eighty-four and nine tenths (184.9) pounds on 05/04/2021. Review of a Nutrition Progress Note for Resident #332, dated 05/27/2021, revealed the resident had a seven and six tenths (7.6) percent weight loss in ninety (900 days. However, according to the note the resident's "current intake exceeds needs, yet (he/she) has remained weight stable". Further review of the RD evaluations revealed the RD evaluated Resident #332 on 06/29/2021 and noted the resident received two (2) bologna sandwiches with tomato and mayonnaise at lunch and dinner per the resident's request. However, the RD again notes "has a history of weight stability despite exceeding (his/her) needs so do not recommend adjusting interventions at this	{F 692}		

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{F 692}	Continued From page 568 time". Review of a subsequent RD evaluation for Resident #332, on 07/25/2021, revealed there was "no new weight since 05/04/2021". The RD documented "current intake exceeds needs", so the RD made no new dietary recommendations. Review of the Restorative Weight Record Book revealed staff weighed Resident #332 on 06/07/2021, 07/05/2021, and 08/03/2021. However, staff failed to enter the weights into the resident's electronic medical record. Review of the weights revealed Resident #332 continued to lose weight, weighing one hundred eighty-three and six tenths (183.6) pounds on 06/07/2021, one hundred eighty-two and nine tenths (182.9) pounds on 07/05/2021 and one hundred seventy-nine and nine tenths (179.9) pounds on 08/03/2021. Observation of staff weighing residents on 08/05/2021, from 2.00 PM thru 5:00 PM, revealed Resident #332 weighed one hundred and eighty (180) pounds. Observation of Resident #332's supper meal tray, on 08/05/2021 at 7:28 PM, revealed the resident did not have bologna sandwiches or large protein portions on the meal tray. Interview with Resident #332, on 7/27/2021 at 11:00 AM, revealed the food was always cold, and the resident reported losing weight since admission. The resident stated he/she was supposed to get a bologna sandwich on the meal tray at lunch and supper. However, the resident stated he/she never got the sandwiches at lunch or supper. The resident further stated when	{F 692}		

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{F 692}	Continued From page 569 asked about where the sandwich were, staff would usually state the kitchen was out of bologna. In addition, Resident #332 stated the facility never had snacks especially at night and reported going to sleep hungry. The resident stated staff would tell me I have to wait till in the morning when the kitchen opens. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed the facility was out of bologna, and had been out for weeks. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if the facility had fortified Resident #332's foods, added large protein portions, provided the resident with two (2) bologna sandwiches at lunch and supper, and provided a nightly snack, it would have prevented the resident's on-going significant weight loss. In addition, the RD stated, "most likely the resident would have gained weight". The RD stated she only looks at weights documented in the resident's electronic medical record, and denied having knowledge of a "weight book". The RD stated she could only assume the facility was providing the resident with the diet he/she was ordered and the recommendations she made. However, the RD stated she had never discussed the resident's weight or diet with the resident. The RD stated when she was at the facility she reviewed records and weights, but did not physically observe or talk to residents. 8. Review of Resident #81's medical record revealed the facility admitted the resident on 10/12/2015, and re-admitted the resident on 09/30/2019 with Dementia, Anemia, Anxiety and Major Depressive Disorder.	{F 692}		

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{F 692}	Continued From page 570 Review of Resident #81's Quarterly MDS assessment dated 05/18/2021, revealed the facility assessed the resident to have a BIMS score of six (6) out of fifteen (15), indicating the resident was cognitively impaired. Further review of the MDS assessment revealed the resident required extensive assistance for eating, and the resident weighed one hundred and seventeen (117) pounds. Review of Resident #81's comprehensive care plan, in effect on 05/18/2021, revealed the resident had a history of unplanned weight loss and poor nutritional intake and was at risk for malnutrition. Review of Resident #81's weight record revealed on 06/01/2021, the resident weighed one hundred nine and two tenths (109.2) pounds. Review of a RD assessment for Resident #81, completed on 06/05/2021, revealed the resident sustained a six and one-half (6.5) percent weight loss in thirty (30) days and an eight and nine tenths (8.9) percent weight loss in ninety (90) days. Further review of the assessment revealed the resident's current intake was inadequate to meet resident needs. The assessment further stated the resident met criteria for severe malnutrition due to weight loss. The assessment stated Resident #81 was "already supposed" to get fortified foods, whole milk and sandwiches with meals, and an ice cream cup with dinner. The RD recommended discontinuing the ice cream cup and adding a frozen nutrition cup with dinner. Review of a Nutrition Progress Note for Resident #81, dated 07/07/2021, revealed on 07/06/2021,	{F 692}		

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{F 692}	Continued From page 571 the resident's weight was one hundred eight and seven tenths (108.7) pounds, representing a nine and four tenths (9.4) percent weight loss in ninety (90) days. However, the RD also documented the resident's weight was stable for thirty (30) days, and implemented no new recommendations. Review of Resident #81's weight on 08/03/2021, revealed the resident weighed one hundred seven and one tenth (107.1) pounds. Observation of staff weighing Resident #81, on 08/05/2012, revealed Resident #81 weighed one hundred seven and nine tenths (107.9) pounds. Observation of Resident #81's lunch tray, on 08/05/2021 at 3:10 PM, revealed the resident received two (2) percent milk with the meal and received no sandwich. Review of a Nutrition Progress note for Resident #81, dated 08/22/2021, revealed the resident had sustained a significant weight loss of eight and three tenths (8.3) percent in ninety (90) days and ten and seven tenths (10.7) percent in less than one hundred eighty (180) days. The note stated the resident's weight had remained stable for sixty (60) days. However, the note also stated the resident's body mass index (BMI) was below normal limits for the resident's age and body weight of one hundred seven and one tenth (107.1) pounds. In addition, the note stated the resident's current nutritional intake greatly exceeded the resident's need to maintain weight and nutritional status. Further interview with the RD, on 08/11/2021 at 4:10 PM, and 08/18/2021 at 10:30 AM, revealed when she documented that a resident's current	{F 692}		

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{F 692}	Continued From page 572 intake greatly exceeded the resident needs, that was saying, "We have a problem". The RD went on to explain that if the resident was receiving what was ordered and the resident's intake was documented correctly, then the resident would not be losing weight. Review of Resident #40's progress note, dated 08/26/2021 at 2:33 PM, revealed staff had notified the resident's daughter of the resident's weight loss. The progress note stated the resident's appetite was improving, and the resident required cueing for meals. The note further stated the caller told the daughter the RD was assessing the resident and the resident received nutritional supplements. Observations of the snack refrigerator and snack storage areas on the third floor, on 07/27/2021 at 11:30 AM, revealed no snacks, drinks or juices were available for the residents. Observations of the snack refrigerator and snack storage areas on the fourth floor, on 07/27/2021 at 11:45 AM, , revealed no snacks, drinks or juices were available for the residents. Observations of the snack refrigerator and snack storage areas on the fifth floor, on 07/27/2021 at 12:05 PM, , revealed no snacks, drinks or juices were available for the residents. Interviews on 07/27/2021, at 4:40 PM, with SRNA #1, and at 5:00 PM with SRNA #2, and on 07/28/2021 at 5:10 PM, with SRNA #4, revealed the facility did not provide enough snacks for the residents. In addition, the SRNAs stated they had all had resident's tell them they were hungry, but had nothing to give them.	{F 692}		

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{F 692}	Continued From page 573 Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed the facility's residents complain of being hungry and stated it had been an ongoing problem at the facility. RN #9 stated she routinely works from 6:00 PM until 6:00 AM, and at times, resident supper trays do not arrive on the floor until 7:30 or 8:00 PM. Per interview the facility staffed with only one SRNA to pass all the trays and assist/feed all residents who required assistance, stating, "It's impossible for the residents to get adequate nutrition. The RN stated she assisted the aide with meal service the best she could; however, she was the only nurse for approximately forty (40) residents, and she had to pass evening medications at that time. Review of the menu for the lunch meal on 08/05/2021, revealed the residents should have received three (3) ounces of protein, 1/2 cup of mashed potatoes, and ½ cup of vegetable. In addition, the "Diet Roster" provided by the facility indicated forty-two (42) residents required fortified foods, including Residents #90, #327, #82, #39, #332, #81, and #65. Observation of the lunch meal, on 08/05/2021, revealed staff served the residents 1/3 cup of mashed potatoes and 3/8 cup of vegetable. In addition, when staff was asked to weigh the protein to ensure it was adequate, there was no functioning scale in the kitchen to weigh the meat. In addition, there was no food prepared and designated as "fortified". Continued observation revealed three (3) residents were supposed to get sandwiches with meals including Residents #332 and #81, and three (3) other residents were supposed to get salads for the lunch meal including Resident #39. However, continued	{F 692}		

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{F 692}	Continued From page 574 observation and interview with dietary staff revealed the facility did not have lunchmeat, lettuce, or other sandwich ingredients available. In addition, observations revealed that although the meal was scheduled to be served to residents at approximately 12:00 PM, the last food tray did not exit the kitchen until 2:45 PM. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full time at the facility for approximately one (1) year. Cook #2 stated no one had ever trained her or directed her to fortify foods for facility residents. She stated she worked five (5) days a week and cooks all three (3) meals on the days she works, and had never seen "a recipe" or had instruction on how to fortify foods. Therefore, Cook #2 stated she had never prepared or served fortified foods for the residents. Cook #2 also stated she had never received instruction or training on scoop sizes or appropriate portions to serve residents. In addition, Cook #2 stated she never knew she was supposed to weigh meat or protein. She stated the facility was frequently out of food items. The cook stated two (2) residents continuously asked for Fruit Loop cereal, but the Administrator refused to order the food item. The cook also stated the dietary department should prepare and send out snacks for residents, especially those at risk for weight loss. However, the cook stated, "we haven't sent out snacks in six months or longer." She stated there was not an adequate amount of food items purchased to fulfill the menu, and "definitely not enough" purchased at the facility to provide snacks. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed the facility was always out of multiple items that the residents	{F 692}		

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{F 692}	Continued From page 575 wanted and required to fulfill dietary interventions. DA #1 also stated the facility rarely had bologna, lettuce, ice cream and other food items that were on resident tray cards. Interview with Dietary Manager (DM) #1, on 08/18/2021 11:40 AM, revealed the facility did not have a Dietary Manager at this time, but she was the DM at a sister facility and had placed some food orders for the facility. The DM stated she conducted no monitoring of resident weights or was involved in meetings or discussions related to resident weight loss. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year and had never been provided a list of resident to evaluate. The RD stated she ran her own reports in the system and formulated her own list of residents to evaluate. The RD stated she had many ongoing concerns in the facility. The RD stated she had identified concerns with weight loss for the residents, concerns that her recommendations were not being implemented, resident choice/preference not honored, and communication with nursing staff. The RD stated she had discussed the concerns on multiple occasions with the Administrator; however, the facility had taken no action to correct the problems. The RD stated meals were always late and there was not enough food purchased to provide snacks to the residents. The RD stated she was not aware staff did not know how or did not have "instruction" on fortifying foods. The RD stated not fortifying foods, not utilizing the correct scoop size to portion out residents servings, failing to provide snacks, not weighing protein	{F 692}		

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{F 692}	Continued From page 576 portions, not supplying supplements she had recommended such as ice cream, and not serving residents their preferences, could all lead to weight loss and malnutrition for the residents. According to the RD, the dietary department was also frequently out of food items to follow the menu. The RD stated nursing staff had never notified her that any of the resident had a sustained a weight loss. The RD stated the only way she knew as much as she did, was by running reports and investigating on her own. The RD also stated she believed for each of the resident's reviewed, if the facility had implemented her recommendations, provided the residents with the planned meals, and offered the resident's snacks, the majority, if not all the residents would not have sustained significant weight loss. The RD also stated in the year the facility had contracted her services, she had never been invited or attended a nutrition meeting to discuss weight loss or any nutritional concerns for facility residents. The RD stated she could evaluate residents on a daily basis, however, if the facility did not implement recommendations, buy enough food to feed residents or ensure menus were followed, it would not prevent weight loss and malnutrition from occurring in the facility. Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year, and was placed in the IDON position a few weeks ago when the Director of Nursing (DON) resigned from the facility. The ADON/IDON stated since she had been at the facility, there had been very few morning clinical meetings conducted, because there was no staff available to participate. The	{F 692}		

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{F 692}	Continued From page 577 ADON/IDON stated her and the former DON worked as floor nurses more often than not. The ADON/IDON stated she had never monitored weights in the facility, and stated the facility had not conduct weekly Nutrition At Risk (NAR) meetings since she had been at the facility. The ADON/IDON stated she was not sure who was responsible to monitor or ensure staff was implementing RD recommendations. The ADON/IDON Stated the RD sent her recommendations to the DON, ADON and the Administrator after her visits, but she did not have time to follow-up on them because she was working the floor. The ADON/IDON stated she had never provided the RD with a list of residents to evaluate and was not sure who was responsible to monitor residents for weight loss in the facility and who was responsible to notify the RD when a resident lost weight. Per interview, the facility had no unit managers to track weights. In addition, the ADON/IDON, stated she conducted no monitoring to ensure residents received meal trays timely, the food was palatable, that snacks were available and served, that staff implemented RD recommendations, and that staff were able to get meals passed and residents requiring assistance were assisted timely. She stated, "I just don't have time to monitor that". Interview with the Administrator, on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator denied having knowledge that staff were not fortifying foods, that the facility did not have snacks to provide residents, that staff was not weighing food/protein portions, that nursing was not communicating nutritional /weight loss concerns with the RD, or	{F 692}		

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{F 692}	Continued From page 578 that recommendations were not being implemented. The Administrator stated the facility had no systems in place to monitor resident weight loss or nutritional needs. The Administrator stated she received e-mails from the RD after she conduced visits. However, the Administrator stated she was not sure what information was in them, because she had not read them. The Administrator acknowledged that resident preferences could not always be honored at the facility, and stated she had planned on talking to the RD about all the items on the resident's tray cards that the facility did not provide. The Administrator stated that the RD should be able to make recommendations to prevent weight loss with items the facility routinely ordered. The Administrator confirmed the facility had not conducted NAR meetings since she had been the Administrator, but stated she was working on getting those established. The Administrator could not voice any monitoring or tracking she did to ensure the facility was doing everything possible to prevent resident weight loss. **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	{F 692}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 692}	Continued From page 579 #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 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	{F 692}		

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{F 692}	Continued From page 580 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 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	{F 692}		

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{F 692}	Continued From page 581 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 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	{F 692}		

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{F 692}	Continued From page 582 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 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.	{F 692}		

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{F 692}	Continued From page 583 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 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	{F 692}		

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{F 692}	Continued From page 584 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 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	{F 692}		

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{F 692}	Continued From page 585 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 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	{F 692}		

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{F 692}	Continued From page 586 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 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,	{F 692}		

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{F 692}	Continued From page 587 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 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	{F 692}		

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{F 692}	Continued From page 588 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 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	{F 692}		

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{F 692}	Continued From page 589 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 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	{F 692}		

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{F 692}	Continued From page 590 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 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	{F 692}		

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{F 692}	Continued From page 591 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 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.	{F 692}		

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{F 692}	Continued From page 592 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 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.	{F 692}		

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{F 692}	Continued From page 593 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 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	{F 692}		

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{F 692}	Continued From page 594 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. 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.	{F 692}		

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{F 692}	Continued From page 595 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. 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,	{F 692}		

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{F 692}	Continued From page 596 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) 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	{F 692}		

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{F 692}	Continued From page 597 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 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	{F 692}		

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{F 692}	Continued From page 598 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 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	{F 692}		

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{F 692}	Continued From page 599 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 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	{F 692}		

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{F 692}	Continued From page 600 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 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	{F 692}		

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{F 692}	Continued From page 601 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 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.	{F 692}		

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{F 692}	Continued From page 602 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. 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	{F 692}		

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{F 692}	Continued From page 603 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 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	{F 692}		

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{F 692}	Continued From page 604 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 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	{F 692}		

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{F 692}	Continued From page 605 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 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	{F 692}		

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{F 692}	Continued From page 606 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 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	{F 692}		

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{F 692}	Continued From page 607 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, 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.	{F 692}		

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{F 692}	Continued From page 608 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 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.	{F 692}		

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{F 692}	Continued From page 609 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, 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	{F 692}		

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{F 692}	Continued From page 610 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 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	{F 692}		

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{F 692}	Continued From page 611 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 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	{F 692}		

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{F 692}	Continued From page 612 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 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	{F 692}		

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{F 692}	Continued From page 613 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 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	{F 692}		

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{F 692}	Continued From page 614 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 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,	{F 692}		

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{F 692}	Continued From page 615 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 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	{F 692}		

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{F 692}	Continued From page 616 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 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	{F 692}		

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{F 692}	Continued From page 617 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 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,	{F 692}		

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{F 692}	Continued From page 618 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 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	{F 692}		

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{F 692}	Continued From page 619 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 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,	{F 692}		

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{F 692}	Continued From page 620 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 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	{F 692}		

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{F 692}	Continued From page 621 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SR	{F 692}		
{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide respiratory care for one (1) of fifty-seven (57) sampled residents (Resident #323), a resident that required a bilevel positive airway pressure (BiPAP) machine (a machine that provides non-invasive ventilation via a mask, usually with added oxygen, under positive pressure). Resident #323 was admitted by the facility on 07/06/2021 with a diagnosis of Acute Respiratory Failure and required the use of a BiPAP machine when sleeping. The facility failed to obtain physician orders for the machine and set up a machine for the resident's use until 07/14/2021, eight (8) days after admission. The findings include:	{F 695}	F 695 Respiratory/Tracheostomy Care and Suctioning Criteria 1: Resident #323 no longer resides at the facility. Criteria 2: An audit was conducted by DON/ADON/RT or designee on 10/1/21 for all residents admitted within the last 30 days to determine if admitting information indicated the need for a BiPAP/CPAP machine while sleeping. Any residents requiring this equipment had review to verify orders were in place, and the equipment in use. Criteria 3: a) Inservice education was provided by the DON/Respiratory	11/30/21

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{F 695}	Continued From page 622 Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON), on 08/11/2021 at 12:05 PM, revealed the facility did not have a policy regarding BiPAP machines. She stated the facility used a respiratory company to supply and maintain residents' BiPAP machines and had machines available at the facility for use. She stated they should be utilized per physician's order. Review of Resident #323's medical record revealed the resident was admitted by the facility on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Type 2 Diabetes, Dysphagia, Pneumonia and Aphasia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/13/2021, revealed Resident #323 was rarely/never understood. Continued review of the MDS revealed the resident was coded to utilize a non-invasive mechanical ventilator (BiPAP/CPAP) while a resident in the facility. However, further review of Resident #323's medical record revealed the facility failed to obtain a physician's order for the BiPAP machine until 07/14/2021. Review of the Physicians order, dated 07/14/2021, revealed Resident #323 required "BiPAP at 12/5, 18, 50% QHS [at night]" for diagnosis of Respiratory Failure. Review of the resident's Medication Administration Record (MAR) revealed there was no documented evidence Resident #323's BiPAP was applied until 07/14/2021.	{F 695}	Therapist for all licensed nursing staff and Admission Review Team beginning 11/24/21 on BiPAP/CPAP machine use, including but not limited to: verifying orders upon admission; notifying the respiratory therapist for any needed assistance/set-up; ensuring BIPAP/CPAP equipment is put in place on admission for immediate use. b) The admissions coordinator was educated by the DON or designee on 11/24/2021 on the need to review pre-admission information to identify residents that will need BiPAP/CPAP equipment and will notify the unit of the need to prepare for the admission orders and arrangements to put this equipment into use upon admission. Criteria 4: The DON/ ADON or designee will review all new admissions/readmission beginning 11-1-2021 weekly x 4 weeks then monthly x 2months to determine that all indicated equipment, including BiPAP/CPAP machines, were ordered and implemented upon admission. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/ 30 /2021	

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{F 695}	Continued From page 623 Interview with Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed she notified the nursing staff at the facility, approximately 07/11/2021, that Resident #323 required a BiPAP to be worn at night. She stated Resident #323 wore BiPAP well at home with no problems. She further revealed she felt Resident #323 not wearing BiPAP contributed to the re-hospitalization of the resident. Interview with State Registered Nurse Aide (SRNA) #13, on 07/28/2021 at 6:28 AM, revealed she worked on the unit where Resident #323 resided on 07/07/2021, 07/08/2021, 07/13/2021, 07/16/2021, 07/17/2021 and 07/18/2021, and she never observed Resident #323 wearing BiPAP during the night. Interview with SRNA #16, on 07/28/2021 at 8:00 PM, revealed she worked night shift and provided care for Resident #323 on 07/07/2021, 07/08/2021, 07/12/2021, 07/13/2021 and multiple other shifts prior to the resident leaving the facility. She stated she never observed Resident #323 wear his/her BiPAP. Interview with SRNA #18, on 07/28/2021 at 9:54 PM, revealed he provided care for Resident #323 on 07/06/2021, 07/09/2021, 07/10/2021 and the resident did not wear a BiPAP that night. He stated after those dates, (exact date unknown), he did recall the resident wearing BiPAP at night. Interview with Licensed Practical Nurse (LPN) #3, on 07/28/2021 at 4:16 PM, revealed she was working on 07/06/2021 when Resident #323 was admitted to the facility. She stated she was aware Resident #323 required a BiPAP machine; however, there was no order from the hospital.	{F 695}		

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{F 695}	Continued From page 624 She stated she and Registered Nurse (RN) #6 got a BiPAP machine from facility stock on 07/06/2021; however, they did not set up the machine because they did not have an order for machine settings for Resident #323. She stated she reported to the oncoming nurse, LPN #8, that orders were needed for the settings for the resident's BiPAP. However, LPN #3 stated the facility did not place the resident on BiPAP until 07/14/2021, when Respiratory Therapist (RT) #1 identified no setting orders had been obtained. Interview with LPN #8, on 07/28/2021 at 9:29 PM, revealed she was not notified Resident #323 needed orders for his/her BiPAP. She stated the resident should have had orders for the BiPAP if he/she required one for breathing. She further revealed not wearing a BiPAP could have negative impact on breathing. Interview with Registered Nurse (RN) #9, on 07/29/2021 at 9:17 PM, revealed Resident #323 did not wear his/her BiPAP for several nights after admission. She stated the family notified her the resident required a BiPAP; however, she was unable to obtain a physician's order for BiPAP machine settings. She stated a physician's order was not obtained until the Interim Director of Nursing/Assistant Director of Nursing (ADON) obtained an order on 07/14/2021. RN #9 stated the resident should have had an order for the BiPAP prior to 07/14/2021 because not wearing BiPAP could have a negative impact on breathing. Interview with RN #6, on 07/28/2021 at 9:48 AM and 3:45 PM, confirmed she assisted with getting Resident #323 a BiPAP machine from the facility stock on admission on 07/06/2021; however, the	{F 695}		

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{F 695}	Continued From page 625 facility did not have the settings for the resident's machine and treatment was not initiated. On 07/14/2021, the Respiratory Therapist (RT) #1 came to the unit to determine any residents who required respiratory equipment. RN #6 stated she notified RT #1 about Resident #323; however, the RT did not have a physician order for the equipment. RN #6 revealed at that time, she identified the resident had went several nights without the BiPAP machine. She stated Resident #323 should have had the BiPAP before 07/14/2021. She stated not wearing BiPAP could have potential negative impacts on breathing. Interview with Respiratory Therapist (RT) #1, on 08/04/2021 at 8:28 AM, revealed she was new to the facility and was unaware Resident #323 did not have settings for his/her BiPAP machine until 07/14/2021. She stated she entered the resident's room on 07/14/2021 and resident was not wearing BiPAP and did not notice whether the resident had a machine in the room. Interview with Emergency Room Physician #1, on 08/03/2021 at 10:47 AM, revealed Resident #323 presented to the Emergency Department (ED) on 07/20/2021, exhibiting stridor. He stated his medical assessment revealed the resident had an upper airway problem. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (ADON), on 08/11/2021 at 12:05 PM, revealed she was aware there were concerns with obtaining Resident #323's BiPAP. She revealed she was unable to recall how the order was obtained, however, she expected staff to obtain orders for new admissions timely (within 24 hours) including those orders for BiPAP machines. She stated a	{F 695}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 695}	Continued From page 626 resident not having a BiPAP could result in decline in respiratory status. Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she had been at the facility since June 2021, and had not developed any systems to monitor to ensure resident's received respiratory care as required.	{F 695}		
{F 697} SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure pain management was provided for one (1) of fifty-seven (57) sampled residents (Resident #326) who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Observations and record review revealed Resident #326 complained of severe pain in his/her head and back, from 10:01 AM until 5:15 PM on 08/05/2021 (approximately 7.25 hours) before staff administered the resident pain medication, because the resident's prescribed medication was not available in the facility.	{F 697}	F 697 Pain Management Criteria 1: Resident #326 was discharged from the facility on 9-3-2021. Criteria 2: a) On 11/22/2021 all residents were audited to ensure they receive their pain medication as ordered. Residents noted to be outside parameters or with any medication not available to be administered as ordered had he pharmacy and MD/NP made aware. Criteria 3 a) Beginning 11/24/2021 all licensed nursing staff have been re-educated on:	11/30/21

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{F 697}	Continued From page 627 The findings include: Review of the facility's policy titled, "Pain Assessment and Management", dated March 2020, revealed the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices. Further review revealed the facility defined "pain management" as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Review of Resident #326's medical record revealed the facility admitted the resident on Friday 07/30/2021, with diagnoses that included Rhabdomyolysis, Respiratory Failure with Hypercapnia, Myocardial Infarction, and Spinal Compression Fractures. Review of Resident #326's Minimum Data Set (MDS) assessment dated 08/06/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9), indicating the resident was moderately cognitively impaired. Review of Resident #326's care plan revealed the only care developed for the resident as of 08/05/2021, was the resident's Baseline Care Plan, which had been initiated on admission (six days prior). The Base Line Care Plan did not contain any information related to the resident's pain or pain management. Review of Resident #326's Physician's Orders dated 07/30/2021, revealed the only ordered pain medication for the resident was Oxycodone	{F 697}	" The 5 rights of medication administration including right □ medication, patient, dose, time, and route. " The process to follow when a medication is not available to be given as ordered, which includes □ check the e-kit to determine if the medication is available in the e-kit; if not available in the e-kit call the pharmacy to obtain the medication and the anticipated medication delivery time, notify the MD/NP that an ordered medication will either be omitted or given outside of the ordered medication time, follow new orders given by the MD/NP, document the conversation and new orders from the MD/NP in PCC. " The process to obtain a narcotic that is not available from the e-kit includes- obtain an order for the narcotic, fill out the pharmacy form for removal of narcotics from the e-kit. Fax a copy of the form to pharmacy. Call the pharmacy and request a code. Enter the code into the box and remove the narcotic. Licensed nursing staff not working will be educated on their next scheduled shift. Education will be added to new hire orientation. All new admissions, re-admissions that include weekend and after normal business hours discharge orders are submitted to pharmacy □ medications are entered into PCC and submitted to pharmacy through pharmacy integration, if medications are not received in a timely manner the pharmacy is notified, as well as use of the E-kit. If an emergency would arise for needed medication while awaiting on pharmacy	

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{F 697}	Continued From page 628 Acetaminophen (Percocet) to be administered by mouth every six (6) hours as needed for moderate/severe pain. The order start date was 07/31/2021. Review of the Nurse's Notes dated 08/05/2021 at 10:01 AM, revealed Resident #326 was complaining of head and back pain, and rated the pain as an eight (8) out of ten (10) on a pain scale with one (1) representing minimal discomfort and ten (10) representing severe pain. However, further review of the note revealed no pain medication was available to administer to the resident. The note stated staff notified the pharmacy and requested a "STAT" (urgent) delivery of the medication. Observation and interview with Resident #326 on 08/05/2021 at 11:09 AM, revealed the resident stated he/she was "hurting all over", and was waiting on pain medication. The resident voiced he/she had been in pain "all morning" and rated it an eight (8) on the pain scale. Review of Resident #326's admission Medication Administration Record (MAR) revealed the Percocet medication was on the MAR to be administered every six (6) hours, as needed, for pain. However, none of the medication was documented as being administered to the resident. Interview with Licensed Practical Nurse (LPN) #4 on 08/05/2021 at 11:11 AM, revealed Resident #326 did not have any pain medication at the facility and they were waiting on the medication from pharmacy. She further stated that Resident #326 was not her resident, but she was assisting RN (Registered Nurse) #8 with trying to get the	{F 697}	the MD is notified for substitution and/or new orders. License nursing staff not working will be educated on the next day scheduled to work. Education will be added to the new licensed nurse orientation . A post test will be administered and will be graded to validate competency. b) On 9-23-21 the Co-owner/President of ETPS Pharmacy has agreed to providing a 3-day supply of meds that require a cost authorization will be sent to the facility while pending cost review Criteria 4: a) Starting 9.25.21, 5 random med pass audits on random shifts using the CMS medication administration observation form, will be conducted by the Regional Nurse Consultant, Pharmacy, Director of Nursing or designee weekly x 4 weeks and monthly until substantial compliance is achieved. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance b) Starting 11/24/2021 5 random residents with a BIMS of 8 or greater will be interviewed to ensure pain medication is administered as requested, 5 random residents with a BIMS of 7 or less will be visually assessed for observable s/s of pain; such as facial grimacing, crying, restlessness, etc. If visual indicators of pain are observed the MD/NP will be made aware for new orders. Audits will be weekly x 4 week and then monthly until substantial compliance is achieved. Audits will be reviewed monthly in QAPI x3 months then quarterly	

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{F 697}	Continued From page 629 medication for the resident. LPN #4 stated she had no idea why Resident #326 did not have pain medication at the facility, six (6) days after the physician had ordered it. Interview with RN #8 on 08/05/2021 at 11:57 AM, revealed they were attempting to get Resident #326's medication from the pharmacy and was unaware of any emergency medication kit in the facility. RN #8 stated she did not know why Resident #326's pain medication was not available. Observation and interview with Resident #326 on 08/05/2021 at 1:42 PM, revealed the resident still had not received the pain medication. Resident #326 stated, "My head is still killing me". The resident continued to rate the pain as an eight (8) on a scale of one (1) to ten (10). Continued interview with RN #8 on 08/05/2021 at 1:50 PM, revealed the nurse had not administered pain medication to Resident #326, because "there is nothing in the building to give (him/her)". The nurse stated she knew the resident needed something for pain, because the resident was in severe pain. Further interview revealed she did not know how to get the resident's medication any sooner. Observation and interview with Resident #326 on 08/05/2021 at 4:45 PM, revealed the resident was still in pain, and continued to rate it as an eight (8). Interview with RN #8 on 08/05/2021 at 4:47 PM, revealed the pharmacy had just directed her to pull the medication from the facility's emergency kit and administer it to the resident.	{F 697}	until in substantial compliance. Criteria 5; Date of compliance: 11/30/2021	