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

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{F 697}	Continued From page 630 Interview with RN #8 on 08/05/2021 at 5:00 PM, revealed she was not aware, prior to this incident, that the facility had an emergency kit with medications available. She stated no one had ever trained her or told her about the emergency medications. Observation of the facility's medication administration pass on 08/05/2021 at 5:15 PM, revealed RN #5 administered Resident #326 a Percocet tablet from the facility's emergency kit. Resident #326 continued to rate his/her pain at an eight (8). Interview with Pharmacist #1, on 07/28/2021 4:05 PM revealed the pharmacy was unable to find any record of receiving the request for Resident #326's Percocet. However, the pharmacy was able to confirm they had not sent the Percocet to the facility for Resident #326. The pharmacy Representative stated they did maintain an Emergency Kit at the facility, which contained Percocet. However, the representative stated that the nurse requesting the medication was required to submit certain resident information to the pharmacy. Subsequently, the pharmacy would then give the nurse an electronic code to withdraw that specific dose of medication. Interview with RN #10 on 08/25/2021 at 4:28 PM, revealed it had been more difficult lately to get prescription refills for narcotics. The RN stated when the facility admitted a resident on a weekend, the resident may not have any or only some of their medications available for administration, and frequently they did not have narcotic medications available. RN #10 stated it was a "routine" problem for residents not to get	{F 697}		

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{F 697}	Continued From page 631 narcotics refilled timely. However, RN #10 did not know specifically why Resident #326 did not have medication at the facility. Interview with RN #1 on 08/05/2021 at 1:55 PM, revealed she often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or a refill for narcotic medications. The nurse stated residents "often" go multiple days without medication while waiting for a refill or arrival of the medication. RN #1 stated she did not know why Resident #326's medications were not available. Interview with Certified Medication Aide (CMA) #1 on 08/05/2021 at 1:00 PM revealed residents often run out of narcotic medications. CMA #1 stated residents must go without medication until the facility could obtain a refill. Interview with Physician #1 on 08/04/2021 at 1:05 PM, and on 08/27/2021 at 1:26 PM, revealed he was aware there were problems with obtaining narcotic pain medications for residents at the facility. However, he stated he was not aware that residents were going several days without pain medication. The physician also stated it was not acceptable for a resident to be in pain for several hours and not have medications available for administration. Continued interview revealed he expected medications to be available to residents upon admission to the facility and he expected staff to follow admission orders and implement immediate care to residents. The Physician stated he had ordered the resident's pain medication upon admission to the facility and he did not know why the facility did not have it available for administration.	{F 697}		

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{F 697}	Continued From page 632 Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (IDON) on 08/27/2021 at 12:00 PM, revealed the facility did not have a back-up pharmacy. She stated she was aware that residents were going several days without narcotic pain medications due to medications not being available. The ADON/IDON stated Physician #1 was aware that there was an issue with narcotic pain medications not being available for administration. Continued interview revealed she had "no idea why (Resident #326) didn't have pain medication" at the facility. In addition, the ADON/IDON stated she was unaware that the nurses were not aware of the facility's emergency medication kits. However, the ADON/IDON, stated she had never conducted any training in the facility regarding the emergency medication kits. The ADON/IDON stated the facility had no system in place to track medications. She stated the facility had not figured out what the problem was yet. The ADON/IDON stated she was not aware that Resident #326 was without pain medication and complained of severe pain on 08/05/2021, for approximately seven hours and fifteen minutes. The ADON/IDON stated that a resident being in pain that long without medication was not an acceptable standard of practice. Interview with Administrator on 08/10/2021 at 1:50 PM, revealed she expected the admission orders would be followed, and that medications would be available for residents prior to admission to facility. She stated the facility reviewed new admissions to ensure the facility could meet their needs prior to admitting the resident. The Administrator stated she was not aware Resident #326's pain medication was not available at facility on 08/05/2021. She further	{F 697}		

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{F 697}	Continued From page 633 stated that it was not acceptable for residents to wait several hours before receiving pain medication.	{F 697}		
{F 725} SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and review of the	{F 725}	F 725 Sufficient Nursing Staff	12/30/21

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{F 725}	Continued From page 634 facility's assessment, it was determined the facility failed to ensure sufficient staff was available to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being for seven (7) of fifty-seven (57) sampled residents (Residents #321, #65, #320, #308, #314, #311 and #3). Review of Resident #321's medical record revealed the resident had a diagnosis of Diabetes, which required staff to monitor the resident's blood glucose. However, interviews with staff revealed due to the lack of staff it was difficult to monitor the resident closely for signs/symptoms of hypoglycemia/hyperglycemia (low/high blood sugar). On 07/18/2021, Resident #321 experienced two (2) episodes of critically low blood glucose levels, requiring staff to intervene and administer emergency treatment. However, due to the facility's lack of available staff the resident's level of monitoring was not increased. On 07/19/2021, at approximately 12:30 AM, staff found Resident #321 unresponsive with a critically low blood glucose level. The facility transferred the resident to the hospital where he/she was intubated. The hospital admitted Resident #321 to the Intensive Care Unit (ICU) with diagnoses of Hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and Acute Respiratory Failure, secondary to prolonged Hypoglycemia (low blood glucose). Review of Resident #65's medical record revealed the resident was at risk for pressure ulcers and required assistance of staff for turning, repositioning, and incontinent care. Interviews with staff revealed there was not enough staff to turn and reposition residents, including Resident	{F 725}	Criteria 1: a) Resident #311, #45, #314, #65, #308, #320, and #309 was provided a shower with nail care and moisturizing lotion applied post shower, assisted with dressing in clean appropriate clothing, clean linens placed on bed on 9/11/21. b) Resident #65 was seen by the wound care physician on 8/25/21. All pressure injuries were assessed and measured, and current treatments were evaluated and reported to the primary care physician by 9/17/21. c) The residents were evaluated by social services on 9/15/21 d) Resident #321 no longer resides at the facility. E) Resident #3 was interviewed to ensure food is hot, meals are timely, call lights are answered showers are given and he feels staffing is adequate. Criteria 2: a) All residents were interviewed to obtain shower/hygiene preferences by DON or designee and new schedules implemented by nursing staff. All residents were offered a shower at this time. All resident requests for shower were honored. Resident preferences for days and type of hygiene were obtained and entered into resident care plan and CNA Kardex by Regional Nurse. b) Resident meal service for breakfast, lunch and dinner was observed on 9/11/21 all three meals were delivered on time. Criteria 3: a) Direct Care staffing has	

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{F 725}	Continued From page 635 #65. The resident developed a Stage IV (4) pressure ulcer to the sacrum that became infected and required hospitalization on 05/08/2021. According to the resident's hospital record, the pressure ulcer required debridement (removal of dead and infected tissue) down to the bone. The facility re-admitted Resident #65 to the facility on 06/09/2021. Resident #65 developed four (4) additional pressure ulcers. On 08/26/2021, the wound care clinic documented the wound had blackened tissue, blistering, erythema, fever, numbness and swelling consistent with the resident being bed ridden and having infrequent position changes. In addition, observations conducted during the survey revealed residents' hair was oily, one (1) resident had the same clothes on for three (3) days and (1) resident had body odor. Additionally, interviews with staff, residents, and resident family members revealed staff did not answer call lights timely, did not assist with toileting timely, residents were not receiving scheduled showers; and, residents' meals were late and the food was cold, due to insufficient staffing. The facility's failure to ensure sufficient staff was available to provide nursing services has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656) 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection	{F 725}	been increased through recruitment efforts with additional staffing provided through agency and travel contracts. b) 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. Nurse management team was educated on 11/1/2021. c). The process for determining staffing needs involves a baseline review of 1) the assessments and plan of care of each resident, 2) the MDS assessments, 3) the required standard of care per diagnosis of each resident, and 4) number of medication and treatments ordered for each resident. Staffing per direct care hours per patient day is measured daily and evaluated by the DON and/or designee to ensure residents needs have been met. Beginning 12/22/2021 adjustments for additional staffing are done to ensure resident needs are met in the clinical meeting where re-admissions, new physician orders and change of conditions	

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{F 725}	Continued From page 636 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 the facility's 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 monitors the effectiveness of systemic changes and quality assurance activities.	{F 725}	are reviewed to determine if there is an increase in clinical complexity that needs a staffing level to be changed. d) All staff were education beginning on 9/13/2021 on the call off procedure which includes In the event a person needs to call out of work for dayshift they are to notify their immediate supervisor two hours prior to the start of the shift. In the event a person needs to call off on night shift they are to notify their immediate supervisor four hours prior to the start of their shift. If appropriate staffing levels are not met the immediate supervisor and/or designee will call other qualified staff to potentially replace the person calling off. In the event 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. New hires will be educated during new hire orientation. e) Dietary staffing has been increased through recruitment efforts and appropriate staffing levels has been achieved to prepare meals and ensure timely meal delivery. Dietary Manager and Administrator began reviewing dietary staffing on 9/13/2021 weekly x four weeks then monthly x 2 months to ensure adequate staffing is maintained. f) All staff were educated on timely call light response. Direct care staff to include nurses and certified nursing assistants were educated on providing hygiene per resident plan of care, timely toileting/hygiene and ensuring residents are dressed in clean clothing of resident	

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{F 725}	Continued From page 637 The findings include: Review of the facility's policy titled "Staffing," last revised October 2017, revealed the facility would provide sufficient numbers of staff with the skills/competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. The policy stated licensed nurses and nursing assistants would be available twenty-four (24) hours a day and staffing numbers would be determined based on residents' needs and each resident's plan of care. Review of the "Facility Assessment Staffing Plan," dated 08/18/2017, revealed the facility required eight (8) to nine (9) licensed nurses, thirteen (13) to fifteen (15) State Registered Nursing Assistants (SRNA), and four (4) to six (6) dietary staff in a twenty-four (24) hour day to ensure the facility met resident needs. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed the facility's goal for staffing in the building was to have two (2) nurses and four (4) SRNAs on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses and three (3) aides for night shift (7:00 PM-7:00 AM). Review of the mealtime schedule revealed the facility scheduled breakfast at 7:00 AM, lunch at 12:00 PM and the evening meal at 5:00 PM. 1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Admission Minimum	{F 725}	choice and timely delivery of meal trays. g) Dietary staff were educated on meal service times. All education provided by DON or designee and completed on 9/14/21 staff not working or new hires will be educated. Criteria 4: a) Visual rounding of residents to assess for hygiene, toileting/incontinence/ resident repositioning to be completed by leadership staff/designee. Beginning 9/11/21 25 % of residents will be audited weekly x 4 weeks then monthly x 2 months. b) Visual monitoring and timing of call light response times, including the length of time call lights are answered, will be completed by leadership staff across all shifts: Beginning 9/11/21 ten (10) call light observations weekly x 4 weeks then monthly x 2 months c) Dietary manager or designee to time passing of meal trays to residents after arriving to the unit. Beginning 9/11/21 all three meals will be randomly observed on each unit weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. d) Beginning 12/11/21 the DON and/or designee began visual audits of resident noted to be in need of assistance with turning and positioning. Random Audits will be conduct weekly to include one resident per floor per shift to ensure turning and repositioning is done. e) Beginning 11/24/2021 The DON or designee will monitor respiratory	

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{F 725}	Continued From page 638 Data Set (MDS) assessment, dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact. Review of the Physician's Orders, dated 07/16/2021, revealed an order for staff to monitor Resident #321 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift. Review of Resident #321's baseline care plan, dated 07/16/2021, revealed the facility did not address the resident's diabetes and/or monitoring the resident's blood sugar. Review of Nursing Notes, dated 07/18/2021 at 3:20 PM, revealed Resident #321's blood glucose was sixty-seven (67) milligrams per deciliter (mg/dL). The note stated staff delivered the resident's breakfast tray (exact time unknown) and Licensed Practical Nurse (LPN) #6 obtained a repeat glucose level after breakfast which was documented as one hundred thirty-nine (139) mg/dL. Interview with Licensed Practical Nurse #6 on 07/27/2021 at 4:10 PM, revealed at approximately 7:30 AM on 07/18/2021, LPN #6 obtained a blood glucose reading for Resident #321, which was sixty-seven (67) milligrams per deciliter (mg/dL). However, there was no documented evidence LPN #6 continued to monitor the resident's condition or obtain further glucose levels for the resident. Review of a hospital record for Resident #321, revealed the resident arrived at the Emergency Department (ED) on 07/19/2021, at 1:36 AM, non-responsive and unable to follow commands.	{F 725}	assessment and SBAR communications for acute change in respiratory status and will be reviewed for MD notification and implementation of any physician order. Care plan will be reviewed and updated as needed. Audits will be weekly until substantial compliance. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 725}	Continued From page 639 The resident required intubation and was admitted to the Intensive Care Unit (ICU) with diagnoses of hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia. Interview with Resident #321's Daughter, on 08/02/2021 at 5:30 PM, revealed she arrived at the facility for a scheduled visit on 07/18/2021 at 10:45 AM. She stated Resident #321 told her his/her blood sugar had dropped to sixty-seven (67) mg/dL that morning. However, the daughter stated that she left the facility at approximately 3:00 PM that day and no staff member obtained the resident's blood glucose level during her visit. She stated Resident #321 had not received his/her lunch meal when she left the facility. Interview with Resident #321's Spouse, on 07/28/2021 at 2:19 PM, revealed his/her her daughter visited Resident #321 on 07/18/2021. The Spouse stated the daughter reported that the resident's glucose was low that morning, the facility smelled of urine and the resident's blanket and washcloths were soiled from the resident's unemptied nephrostomy bags leaking. The spouse further stated he/she had talked to Resident #321 on the telephone numerous times that day, and the resident had told him/her that he/she could tell his/her blood sugar was running low because of the way the resident felt. However, the resident told the spouse the staff had still not re-checked his/her blood sugar as of 4:00 PM, since that morning and prior to the daughter's arrival to the facility at 10:45 AM. The spouse stated at approximately 4:00 PM on 07/18/2021, was the last time he/she spoke to Resident #321 and the resident reported ringing	{F 725}		

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{F 725}	Continued From page 640 the call light (exact time unknown) and it had taken an hour before staff answered the light. Interview with State Registered Nursing Assistant (SRNA) #1, on 07/27/2021 at 4:40 PM, and on 08/03/2021 at 3:19 PM, revealed she was working on 07/18/2021 from 7:00 AM to 7:00 PM, and remembered Resident #321's blood glucose being low that morning. However, the SRNA stated she did not check on the resident again until sometime after lunch, when she found the resident non-responsive. SRNA #1 stated that she and one other SRNA were the only SRNAs on day shift for the entire floor that day, and was caring for approximately 40 residents. SRNA #1 stated that lunch had been very late arriving to the floor that day and it was probably after 4:00 PM when she found the resident. SRNA #1 stated it was difficult to check on residents multiple times during the shift because there was not enough staff to do that. The SRNA stated if a resident was able to ring the call light, staff probably checked on them less, because they could let you know if something was wrong. SRNA #1 stated she immediately notified LPN #6 of the resident's condition. Interview with Licensed Practical Nurse (LPN) #6, on 07/30/2021 at 11:30 AM, revealed she did recall Resident #321 having another hypoglycemic episode during the late afternoon on 07/18/2021 (exact time unknown). She stated SRNA #1 summonsed her to the resident's room, and she found the resident unresponsive. LPN #6 stated she obtained the resident's blood glucose level and recalled it "was around forty (40) mg/dL". The LPN stated to the best of her recollection, she had cared for the resident's nephrostomy around 1:00 PM, but had not been	{F 725}		

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{F 725}	Continued From page 641 able to check on the resident since that time. LPN #6 stated she got Registered Nurse (RN) #1 from the other end of the unit to assist her and administered Resident #321 an injection of Glucagon (hormone injection used to treat a critically low blood glucose) and oral glucose. LPN #6 stated the resident regained consciousness and it was close to the supper meal, so she gave the resident an oatmeal pie to eat before the supper trays arrived. Review of Resident #321's medical record revealed no documented evidence the LPN documented the resident's hypoglycemic incident or any of the resident's blood glucose levels. In addition, there was no documented evidence the LPN monitored the resident's condition or blood glucose levels the remainder of her shift. LPN #6 stated it was difficult to care for all the residents and complete documentation. Review of Resident #321's Nursing Notes, dated 07/19/2021 at 12:23 AM, revealed a SRNA found the resident unresponsive and clammy. The documentation stated staff obtained the resident's blood glucose and it was thirty-two (32) mg/dL. The facility subsequently transferred the resident to the hospital. The hospital admitted the resident to the ICU. Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed she worked from 6:00 PM on 07/18/2021 until 6:00 AM on 07/19/2021, and was assigned to care for Resident #321. SRNA #4 stated she and the nurse were the only staff on the floor to care for approximately forty (40) residents. The SRNA stated at 8:45 PM, the resident was fine. She stated she did not check on the resident again. SRNA #4 stated she was about to begin her next round, when the	{F 725}		

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{F 725}	Continued From page 642 laboratory technician arrived on the floor and found Resident #321 unresponsive. Continued interview with SRNA #4 revealed she had received in report that the resident's glucose levels had been low that day. However, the SRNA stated there was no way for her to check on the residents more frequently, when she was the only SRNA on the floor. Interview with the Laboratory Technician (LT) #1, on 08/02/2021 at 4:45 PM, revealed she arrived at Resident #321's unit, on 07/19/2021 at approximately 12:15 AM, and found Resident #321 unresponsive. Interview with RN #7, on 07/28/2021 at 4:25 PM, revealed she worked on 07/18/2021 from 7:00 PM until 07/19/2021 at 7:00 AM. RN #7 stated she received in shift report that Resident #321's blood glucose levels had been low during the day. The RN stated sometime between 7:30 PM and 8:00 PM, Resident #321 rang the call light and reported he/she thought his/her blood sugar was low. The nurse stated she checked the resident's blood glucose level, and it was one hundred and six (106) mg/dL. However, RN #7 stated she failed to document the blood glucose. RN #7 stated that she and one SRNA were the only staff that worked the floor that night, and she was busy and probably forgot to document. She stated she took the resident some peanut butter and crackers, and the resident stated he/she "just felt funny". RN #7 stated at approximately 9:00 PM, she returned to check on the resident. The nurse stated Resident #321 had not eaten the peanut butter and crackers, so she offered the resident pudding or juice, but the resident declined and reported feeling better. Further interview revealed RN #7 did not re-check the resident's glucose	{F 725}		

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{F 725}	Continued From page 643 level. RN #7 stated at approximately 12:15 AM on 07/19/2021, the laboratory technician arrived on the floor, and soon after discovered that Resident #321 was unresponsive. She stated when she entered Resident #321's room, the resident was unresponsive, and she could immediately tell the resident's blood glucose was low because the resident was clammy. RN #7 stated she checked the resident's blood glucose, and it was thirty-two (32) mg/dL. RN #7 stated because it was only she and (1)SRNA that worked the entire floor, she called for staff from other floors to assist her and call the physician. 2. Review of Resident #65's medical record revealed the facility admitted the resident on 03/24/2021 and re-admitted the resident on 04/29/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia. Review of Resident 65's Admission Minimum Data Set (MDS) assessment, dated 03/30/2021, revealed the resident was totally dependent on two (2) staff with Activities of Daily Living. Further review revealed the resident was at risk for pressure ulcers based on a formal assessment. According to the MDS dated 03/30/2021, Resident #65 was not on a turning/repositioning program. Review of a Braden Scale for Predicting Pressure Sore Risk form, dated 03/23/2021, revealed Resident #65 was at risk for pressure ulcers due to being chair fast and limited mobility. Continued review of Resident #65's medical record revealed no documented evidence the facility turned/repositioned the resident at least	{F 725}		

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{F 725}	Continued From page 644 every two (2) hours. Review of a Change of Condition form, dated 05/02/2021 at 10:35 AM, revealed Resident #65 had developed a deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx. Interview with Licensed Practical Nurse (LPN) #4, on 08/25/2021 at 4:00 PM, revealed she identified the deep tissue injury to Resident #65's coccyx/sacrum area on 05/02/2021. However, the LPN stated she did not measure the area due to being "overwhelmed" with her workload due to not enough staff. Review of a Change of Condition form, on 05/11/2021 at 2:40 PM, revealed the resident's pressure ulcer to the coccyx was "worsening" and measured six and one-half (6.5) centimeters (cm) long and nine and seven tenths (9.7) cm wide. Continued review of Resident #65's medical record, including Weekly skin checks, revealed the resident's pressure ulcer continued to decline. Review of a Change of Condition form, dated 05/28/2021 at 3:54 PM, revealed Resident #65 had a "worsening wound". The form stated the physician sent the resident to the Emergency Room for further evaluation and treatment. Interview with State Registered Nurse Aide (SRNA) #4, on 08/26/2021 at 12:36 PM, revealed Resident #65's pressure ulcer had an odor for about a month and nursing staff were aware. She stated she knew the resident's wound "looked bad and smelled bad". SRNA #4 stated she provided care to Resident #65, and tried to	{F 725}		

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{F 725}	Continued From page 645 keep the resident turned and repositioned, but stated she was unable to do so every two (2) hours, because she had forty other residents to care for. SRNA #4 stated staff were not able to turn and reposition residents with pressure areas as much as needed, due to not having enough staff. Review of Resident #65's hospital record revealed the hospital admitted the resident on 05/28/2021, and diagnosed the resident as being Clinically Septic with a Pressure Wound and Associated Infection including Cellulitis and possible developing Abscess. According to the record, the pressure ulcer "smells like dead flesh". Review of an Operative report, dated 05/30/2021, for Resident #65, revealed the resident presented with a large necrotic appearing area on his/her sacrum. The operative report stated, "It was extremely extensive down to the base large amount of fat necrosis was encountered as well as necrotic tissue". The operative report further read, "Debrided all devitalized tissue down to the level of the bone". Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, who debrided Resident #65's wound, revealed he was not aware of any terminal illness or diagnosis that contributed to the resident's pressure ulcer. He stated failure to turn and reposition and improper nutrition could contribute to pressure ulcers and progression of wounds. Further review of facility records revealed the facility re-admitted Resident #65 to the facility on 06/09/2021. Per the medical record the resident's sacral wound again declined and the	{F 725}		

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{F 725}	Continued From page 646 resident developed new pressure areas to bilateral heels, a Stage I (1) to the left heel on 06/23/2021, and a deep tissue injury to the right heel on 06/26/2021. Review of Wound Care Office Visit notes for Resident #65, dated 07/29/2021, revealed the resident's wounds were consistent with the resident being bed ridden, friction, rubbing and infrequent position changes. The note further revealed the sacrum wound had increased in size since the facility's last assessment, on 07/05/2021, and measured fifteen and one-half (15.5) cm (length) by fifteen (15) cm (width) and one and eight tenth (1.8) cm (depth). Review of Head to Toe Weekly Skin Check Assessment, dated 08/12/2021 at 11:52 AM, revealed Resident #65 had developed a new pressure ulcer to the back of the left, lower leg and on 08/26/2021 the resident developed a new pressure ulcer to the left hip. Review of a Wound Care note for Resident #65, dated 08/26/2021 at 9:00 AM, revealed the circumstances resulting in the resident's wounds was consistent with the resident being "bed ridden and infrequent position changes." 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 and turn, reposition, and check/change residents,	{F 725}		

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{F 725}	Continued From page 647 including Resident #65, every two (2) hours when there was only one (1) or two (2) nursing assistants to care for 40 residents. The SRNA stated when they were short staffed it sometimes took four (4) hours to complete just one round. Interview with SRNA #14 on 07/28/2021 at 11:43 AM, SRNA #12 on 07/28/2021 at 6:08 AM, and LPN #2 on 07/28/2021 at 6:52 AM, revealed the facility did not have enough staff to turn and reposition residents every two (2) hours. Interview with Registered Nurse (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, including Resident #65, because they were so short staffed. She stated, "It is horrible!" RN #3 stated she had worked by herself for two (2) days in a row with approximately forty (40) resident assigned to her care. She further stated the SRNAs have told her they cannot do rounds every two (2) hours. She stated she directed them to notify the DON. Interview with RN #7, on 08/01/2021 at 11:40 AM and 08/24/2021 at 3:49 PM, revealed, there was not enough staff to turn and reposition residents as required. She further revealed skin assessments were required weekly; however, they do not always complete them because there was not enough staff. Interview with Registered Nurse (RN) #4/Wound Care Nurse, on 08/25/2021 at 8:30 PM, revealed she could not take care of resident wounds appropriately, because she had to work the floor more than she worked as the wound nurse because of short staffing. The Wound Care Nurse stated since she could not provide wound	{F 725}		

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{F 725}	Continued From page 648 care and assess the wounds as required, she was not monitoring the wounds and she physically could not assess them all. Interview with the 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 self. Continued interview revealed if resident #65 had to wait more than two (2) hours to be repositioned, it could cause wound decline. 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 staff were not able to turn and reposition residents 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 not provided for more than two (2) hours. 3. Review of Resident #320's medical record revealed the facility admitted the resident on 09/30/2015 with diagnoses including Hemiplegia and Hemiparesis. Review of Resident #320's Annual MDS assessment, dated 06/17/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15), indicating the resident was moderately cognitively impaired. The MDS stated the resident required extensive assistance with personal hygiene.	{F 725}		

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{F 725}	Continued From page 649 Observations of Resident #320, on 07/27/2021 at 11:20 AM, revealed the resident was wearing black jogging pants and a blue t-shirt. Observation on 07/28/2021 at 9:00 AM revealed the resident was wearing the same clothes as on 07/27/2021. Observation of Resident #320, on 07/29/2021 at 9:15 AM, revealed the resident continued to wear the same clothes as on 07/272021 and 07/28/2021. Continued observation revealed an unpleasant odor was noticeable when close to the resident and the resident's hair had an oily appearance. Interview with Resident #320, on 07/28/2021 at 9:00 AM, revealed the resident frequently had to ask staff to change his/her clothes. Resident #320 stated, "I usually have to ask two (2) or three (3) times before they will help me." The resident denied getting a shower twice weekly as scheduled, stating, there was "not enough help here". Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, revealed the facility had no shower record for Resident #320. 4. Review of Resident #308's medical record revealed the facility admitted the resident on 11/29/2019 with diagnoses that included a Lack of Coordination and Abnormal Gait/Mobility. Review of Resident #308's Quarterly MDS assessment, dated 07/26/2021, revealed the facility assessed the resident to have a BIMS score of twelve (12) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the resident required staff assistance with transfers and toileting.	{F 725}		

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{F 725}	Continued From page 650 Observation of Resident #308, on 07/27/2021 at 11:10 AM, revealed the resident was in his/her room in bed or chair. Continued observation revealed the resident's hair was oily and uncombed. Interview with Resident #308, on 07/27/2021 at 11:10 AM, revealed staff had not assisted him/her with a bath in nine (9) days. The resident stated, "For about a year it's been hard to get anyone to help you around here." Resident #308 stated meals were late and the food was "cold and not worth eating most of the time". Resident #308 stated it took up to an hour for staff to answer a call light. The resident reported complaining to everyone about not enough help and not being taken care. However, the resident stated nothing had been done to correct the problems. Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #308. 5. Review of Resident #314's medical record revealed the facility admitted the resident on 06/03/2021 with diagnoses that included Lack of Coordination. Review of Resident #314's Quarterly MDS assessment, dated 07/30/2021, revealed the facility assessed the resident to have a BIMS score of ten (10) out of fifteen (15), indicating the resident was moderately cognitively impaired. The facility assessed Resident #314 to require staff assistance with bathing. Interview with Resident #314, on 07/27/2021 at 12:50 PM, revealed the resident reported he/she	{F 725}		

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{F 725}	Continued From page 651 had received only one (1) bath each week since admission to the facility. Continued interview revealed the facility did not have enough help especially at night. Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #314. 6. Review of Resident #311's medical record revealed the facility admitted the resident on 06/28/2021 with diagnoses that included Abnormalities of Gait. Review of Resident #311's Admission MDS assessment, dated 07/04/2021, revealed the facility assessed the resident to have a BIMS score of eight (8) out of fifteen (15), indicating the resident had mild cognitive impairment. Resident #311 required assistance of one (1) staff member for bathing and dressing. Interview with Resident #311, on 07/27/2021 at 12:40 PM, revealed the resident reported he/she only received three (3) showers since admission to the facility twenty-three (23) days go. Resident #311 stated the facility didn't have enough workers and he/she had stopped using the call light shortly after admission, because "no one ever came anyway." Interview with the DON/IDON on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #311. 7. Review of Resident #3's medical record revealed the facility admitted the resident on 01/27/2014, with diagnoses that included Parkinson's Disease and Diabetes Mellitus.	{F 725}		

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{F 725}	Continued From page 652 Review of Resident #3's Quarterly MDS assessment, dated 07/22/2021, revealed the facility assessed the resident to have a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed the resident required assistance with dressing and extensive assistance with toileting and personal hygiene. Interview with Resident #3, on 07/28/2021 at 10:00 AM, revealed the resident routinely attended resident council meetings. The resident stated every meeting he/she attended the residents always voiced concerns over cold food, meals served late, call lights not answered, showers not given, and not enough staff to provide care. However, the resident stated, "Nothing has been done." 8. Observation on 08/05/2021 of the lunch meal service, revealed the first fourth floor meal cart arrived on the unit at 1:59 PM (approximately two hours later than scheduled) with twenty (20) trays on the cart. Further observation revealed RN #8 was the only staff passing meal trays from 1:59 PM until 2:04 PM. Staff passed the last tray at 2:16 PM. Observation of the test tray food temperatures, on 08/05/2021 at approximately 2:16 PM, revealed the pureed meat was ninety (90) degrees Fahrenheit, potatoes ninety-two (92) degrees Fahrenheit , pureed green beans ninety (90) degrees Fahrenheit , pureed bread eighty (80) degrees Fahrenheit and cold chocolate pudding was sixty (60) degrees Fahrenheit . Observation on 08/05/2021 revealed the second	{F 725}		

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{F 725}	Continued From page 653 fourth floor meal cart arrived on the unit at 2:10 PM (approximately 2 hours and 10 minutes later than scheduled) with fifteen (15) trays. Observation revealed only one (1) staff person was passing trays. Staff delivered the last resident tray at 2:35 PM. Observation of the second meal cart test tray food temperatures, on 08/05/2021 at approximately 2:35 PM, revealed chicken fried steak with gravy was one hundred and four (104) degrees Fahrenheit, whole kernel corn one hundred twelve (112) degrees Fahrenheit, mashed potatoes one hundred twenty-four (124) degrees Fahrenheit, two (2) percent milk was fifty-eight (58) degrees Fahrenheit, coffee one hundred eight (108 degrees Fahrenheit and cold chocolate pudding was sixty-eight (68) degrees Fahrenheit. Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed especially at night. The SRNA stated there should be three (3) SRNAs for night shift. However, for months there had only been one (1) SRNA scheduled to care for forty (40) residents. SRNA #16 stated meal service was always late and at times, it was 8:00 PM before the kitchen delivered trays to the floor. The SRNA stated there was no way one (1) staff could pass trays and assist forty (40) residents, some of which required total feeding. Interview with Registered Nurse (RN) #9, on 07/29/2021 at 9:30 PM, revealed the RN confirmed the facility was short staffed. RN #9 stated there should be three (3) SRNAs working on the fifth floor for the night shift 6:00 PM until 6:00 AM. However, RN #9 stated most of the time	{F 725}		

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{F 725}	Continued From page 654 there was only one (1) SRNA. The RN stated she had reported staffing concerns to the ADON/IDON and the Administrator on multiple occasions. RN #9 also stated she reported resident call light complaints and shower complaints, but she had never received feedback or a resolution. Further interview revealed RN #9 recalled an incident which occurred a few weeks ago. RN #9 stated the Administrator directed her to provide 1:1 supervision to a resident. However, RN #9 stated she informed the Administrator that there were forty-seven (47) residents on the floor and that she and one SRNA were the only staff on the unit to care for them, and that level of resident supervision was not possible. RN #9 stated the Administrator directed her to do the best she could and did not attempt to find additional staff to provide assistance on the floor to ensure the resident's safety. Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides since she had been there. The ADON/IDON stated she had worked the floor as a staff nurse more than she had been able to complete her administrative nursing tasks. The ADON/IDON stated she had worked the last six (6) of seven (7) nights on the floor due to short staffing. She stated she was aware that residents were not getting showers, not getting timely incontinent care, not being turned and re-positioned, and not receiving appropriate feeding assistance due to the lack of staff. The ADON stated she was also aware that meals were served consistently late, which made it difficult for staff and residents at	{F 725}		

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{F 725}	Continued From page 655 meal times. The ADON/IDON stated when the food cart did not arrive on the floor until 7:00 or 8:00 PM in the evening, it was difficult to serve and assist residents because there was only one (1) SRNA and the nurses were administering medications at that time and could not help. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed and did not have enough nurses or nurse aides. The Administrator stated optimally a "good ratio" was ten (10) residents per nursing assistant, and that was the goal for staffing in the facility. The Administrator stated there should be two (2) nurses and four (4) nurse aides on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses and three (3) aides for night shift (7:00 PM-7:00 AM). However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. The Administrator stated she was aware there was only one (1) SRNA and one (1) nurse providing care to approximately forty (40) residents because the facility was short staffed. However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. The Administrator stated when staff called in and was unable to come, there was no one to cover the shift resulting in short staffing. However, the Administrator stated she continued to accept new resident admissions, even though there was an inadequate number of staff to care for them. The Administrator stated that although she was aware that one (1) nurse and (1) SRNA were routinely caring for approximately forty (40) patients, she denied knowledge that residents were not receiving showers as scheduled or that residents were complaining of call light wait times.	{F 725}		

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{F 725}	Continued From page 656 **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail 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.	{F 725}		

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{F 725}	Continued From page 657 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts.	{F 725}		

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{F 725}	Continued From page 658 Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with 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	{F 725}		

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{F 725}	Continued From page 659 residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative 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	{F 725}		

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{F 725}	Continued From page 660 implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in 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	{F 725}		

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{F 725}	Continued From page 661 requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval 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,	{F 725}		

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{F 725}	Continued From page 662 entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim 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	{F 725}		

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{F 725}	Continued From page 663 Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse 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	{F 725}		

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{F 725}	Continued From page 664 reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting	{F 725}		

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{F 725}	Continued From page 665 beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the	{F 725}		

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{F 725}	Continued From page 666 Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how 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,	{F 725}		

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{F 725}	Continued From page 667 Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood 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	{F 725}		

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{F 725}	Continued From page 668 of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the	{F 725}		

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{F 725}	Continued From page 669 Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021.	{F 725}		

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{F 725}	Continued From page 670 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given 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	{F 725}		

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{F 725}	Continued From page 671 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. 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	{F 725}		

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{F 725}	Continued From page 672 Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. 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	{F 725}		

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{F 725}	Continued From page 673 completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) 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	{F 725}		

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{F 725}	Continued From page 674 with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be 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.	{F 725}		

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{F 725}	Continued From page 675 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will 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	{F 725}		

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{F 725}	Continued From page 676 meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional 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.	{F 725}		

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{F 725}	Continued From page 677 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the 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	{F 725}		

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{F 725}	Continued From page 678 adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments 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,	{F 725}		

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{F 725}	Continued From page 679 #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 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	{F 725}		

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{F 725}	Continued From page 680 deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the 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	{F 725}		

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{F 725}	Continued From page 681 in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service 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	{F 725}		

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{F 725}	Continued From page 682 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM 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	{F 725}		

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{F 725}	Continued From page 683 with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's 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.	{F 725}		

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{F 725}	Continued From page 684 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, 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	{F 725}		

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{F 725}	Continued From page 685 #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed 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,	{F 725}		

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{F 725}	Continued From page 686 and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 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	{F 725}		

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{F 725}	Continued From page 687 Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 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	{F 725}		

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{F 725}	Continued From page 688 staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly 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	{F 725}		

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{F 725}	Continued From page 689 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the 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	{F 725}		

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{F 725}	Continued From page 690	{F 725}		

medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement.

24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility.

25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications.

26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical 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

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{F 725}	Continued From page 691 administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control 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,	{F 725}		

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{F 725}	Continued From page 692 effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 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	{F 725}		

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{F 725}	Continued From page 693 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of	{F 725}		

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{F 725}	Continued From page 694 Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the 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	{F 725}		

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{F 725}	Continued From page 695 meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and 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	{F 725}		

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{F 725}	Continued From page 696 further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding 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	{F 725}		

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{F 725}	Continued From page 697 Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 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	{F 725}		

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{F 725}	Continued From page 698 Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10.55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 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	{F 725}		

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{F 725}	Continued From page 699 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 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	{F 725}		

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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 725}	Continued From page 700 #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 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	{F 725}		

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{F 725}	Continued From page 701 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received	{F 725}		

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{F 725}	Continued From page 702 education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 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	{F 725}		

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{F 725}	Continued From page 703 SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident	{F 725}		

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{F 725}	Continued From page 704 #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each	{F 725}		

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{F 725}	Continued From page 705 medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of	{F 725}		

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{F 725}	Continued From page 706 weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had	{F 725}		

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{F 725}	Continued From page 707 been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326	{F 725}		

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{F 725}	Continued From page 708 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday	{F 725}		

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{F 725}	Continued From page 709 through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and	{F 725}		

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{F 725}	Continued From page 710 following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time	{F 725}		

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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

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{F 725}	Continued From page 711 per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to	{F 725}		

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{F 725}	Continued From page 712 be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin.	{F 725}		

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{F 725}	Continued From page 713 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM. 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including	{F 725}		

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{F 725}	Continued From page 714 likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to	{F 725}		

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{F 725}	Continued From page 715 review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining sc	{F 725}		
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	{F 755}		11/30/21

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{F 755}	Continued From page 716 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide pharmaceutical services to meet the needs of five (5) of fifty-seven (57) sampled residents (Resident #321, Resident #326, Resident #351, Resident #9, and Resident #324). The facility failed to acquire and administer prescribed medications to meet the needs of Resident #326, Resident #351, Resident #9 and Resident #324. In addition, the facility admitted Resident #321 on 07/16/2021 with the diagnoses of Urosepsis and Invasive Bladder Cancer with Physician's Orders to receive an antibiotic to treat the Urosepsis. The pharmacy required the facility to "cost over-ride" the medication before it could be dispensed. However, the facility failed to address the cost over-ride and Resident #321 did not receive the physician ordered antibiotic. The facility's failure to ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	{F 755}	F755PharmacySrvcs/Procedures/Pharmacist/Records Criteria 1: a) Resident #9, and Resident #324 had a medication review by the MD on 09-23-21 to validate if ordered medications should continue and to validate appropriate administration times. b) Resident #351 had a medication review by the MD on 09-24-2021 to validate if ordered medications should continue and to validate appropriated administration times. c) Resident #321 was discharged from the facility on 7-19-2021 d) Resident # 326 was discharged from the facility on 9-3-2021 .Criteria 2: a) Between 11/20/21 and 11/22/2021 all residents current medication orders were compared to medications present in the medication cart to ensure residents ordered medication	

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{F 755}	Continued From page 717 the needs of each resident, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. 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	{F 755}	was available. The pharmacy and MD were notified of any medication not available to be administered as ordered and new orders received from the MD will be followed. b)On9.27.21 DON/ADON/Designee reviewed all residents on narcotics with the pharmacy to ensure that an active script is on file. Any renewals needed; the MD was be notified and a new script was obtained. Criteria 3: a) Beginning 11/22/2021 all licensed nursing staff have been re-educated on: " 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.	

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{F 755}	Continued From page 718 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, "Provider Pharmacy Requirements", revised 01/2021, revealed regular and reliable pharmaceutical services were available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. Further review revealed the provider agreed to perform routine and timely pharmacy services, and emergency pharmacy services twenty-four (24) hours per day, seven (7) days a week. In, addition, the pharmacy would assist the facility in determining the appropriate acquisition, receipt, dispensing and administration of all medications and biologicals to meet the medication needs of the residents, accurately dispense prescriptions based on authorized prescriber orders, and provide, maintain, and replenish emergency medication in a sealed and properly labeled container in a timely manner. Review of the facility's policy titled, "Medication Ordering and Receiving from Pharmacy," dated as revised on 01/2021 revealed emergency pharmacy services were available on a 24-hour basis. Staff will obtain emergency medications by using the facility's approved emergency	{F 755}	Licensed nursing staff not working will be educated on their next scheduled shift. Education will be added to new hire orientation. b) On 9-24-21 the Co-owner/President of ETPS Pharmacy has agreed to providing a 3-day supply of meds that require a cost authorization to be sent to the facility while pending cost review. Criteria 4: Beginning 11/24/2021 5 random residents medication orders will be audited by the DON and/or designee to ensure medication is available as ordered in the medication cart. If medication is not available as ordered the pharmacy, MD/NP will be notified for new orders. The audit will be weekly x 4 weeks then monthly until substantial compliance is achieved Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance 11/ 30 /2021	

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{F 755}	Continued From page 719 medication supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities, in the emergency kit in compliance with applicable state regulations. Further review revealed telephone/fax (facsimile) numbers for emergency pharmacy services were posted at the nurses stations and/or medication storage rooms, physician on call 24/7 and telephone numbers were posted at the nurses stations and/or medication storage rooms. Continued review revealed the pharmacy supplied emergency or "stat" medications according to the pharmacy agreement, and if available, should be obtained from the emergency kit until the provider pharmacy delivered the appropriate medications. Review of the facility's policy titled, "Administering Medications", dated as revised on 04/2019 revealed medications were administered in a safe and timely manner, as prescribed. Further review revealed medications were administered in accordance with prescriber orders, including any required time-frames and medications were administered within one (1) hour of their prescribed time, unless otherwise specified, such as before or after meals. 1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021 with diagnoses of Urosepis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Minimum Data Set Discharge assessment dated 07/19/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score	{F 755}		

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{F 755}	Continued From page 720 of thirteen (13), indicating the resident was cognitively intact. Continued review of Resident #321's medical record revealed the facility transferred the resident to the hospital on 07/20/2021 related to Hypoglycemia (low blood sugar). Review of Resident #321's admission Physician's Orders, dated 07/16/2021, revealed an order for the staff to administer Fosfomycin Thromethamine (antibiotic) by mouth every Saturday to treat the resident's diagnosis of Urosepsis. Staff was to administer the medication for three (3) months, starting on 07/17/2021 and ending on 10/17/2021. Review of Resident #321's Medication Administration Record (MAR), dated 07/17/2021, revealed the Fosformycin Thromethamine medication was due at 9:00 AM on 07/17/2021, but was not administered because the medication was not available. Further review of the MAR revealed a "cost approval" was pending for the medication. Interview with Licensed Practical Nurse (LPN) #6, on 07/27/2021 at 4:10 PM, revealed she contacted the pharmacy on 07/17/2021 in an attempt to obtain Resident # 321's medication. However, the pharmacy stated the antibiotic required cost approval from the facility before they could send it to the facility. She further stated she notified Physician #1 that the medication was not available and asked if he could order a substitute antibiotic. However, the physician instructed her that he could not substitute the medication, and the resident needed the medication as ordered. LPN #6 stated she	{F 755}		

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{F 755}	Continued From page 721 notified the Director of Nursing/Interim Director of Nursing (DON/IDON) of the need for a cost approval. However, when she provided care for the resident the next day, on 07/18/2021, the medication was still not available for the resident. According to LPN #6, someone should have identified the medication required a cost approval prior to the resident's admission to the facility. Interview with the Admission Coordinator, on 07/28/2021 at 11:34 AM, revealed before the facility admitted a resident from the hospital, the facility's Admission Coordinator met with the hospital's Case Manager for the referral, and she checked the resident's needs, bed availability, etc. She further stated staff faxed the resident's admission medication orders to the pharmacy prior to the resident's admission and the cost of each medication was reviewed. According to the Admission Coordinator, she had not had any issues with cost approvals, though she had only been at the facility for three (3) months. She stated the facility has knowledge of a resident's admission date and therefore, the resident's medications should be available and ready for the resident upon arrival to the facility. Interview with Pharmacist #1 on 07/28/2021 at 4:05 PM, revealed the pharmacy received Resident #321's medication list on 07/16/2021 at 6:57 PM. She stated the pharmacy had not sent the medication to the facility because they were waiting cost approval from the ADON/IDON. She further stated any medication, which was non-formulary, expensive, or not approved by insurance, required a cost approval from the facility prior to delivery. She stated the pharmacy had a note on file that they attempted to reach the facility via telephone for a cost approval for	{F 755}		

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{F 755}	Continued From page 722 Resident #321's antibiotic on 07/16/2021 at 11:25 AM, and then followed-up with an email to the ADON/IDON, requesting the cost approval. Interview with Physician #1, on 08/04/2021 at 1:05 PM, revealed he expected medications to be available for residents upon admission to the facility and admission orders to be followed to provide immediate care to residents. He stated he recalled the nurse notifying him that Resident #321's antibiotic for Urosepsis was not available to administer on 07/17/2021. Physician #1 stated he told the nurse the resident needed the medication and he did not change the order. However, he did not recall the facility making him aware that Resident #321's antibiotic did not arrive for administration on 07/18/2021, nor that the medication was never administered to the resident. Interview with the ADON/IDON, on 08/11/2021 at 12:05 PM, revealed that when the facility received a new admission, the Admission Coordinator reviewed the case to ensure the facility could meet the resident's needs. The ADON/IDON the Admission's Coordinator should have already handled any cost approvals during the pre-admission process. She further stated she did recall anyone notifying her that Resident 321's antibiotic medication needed a cost approval. The ADON/IDON stated she was unaware the medication was not sent or given to the resident. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. She stated she expected staff to follow admission orders and medications to be available for the resident prior	{F 755}		

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{F 755}	Continued From page 723 to admission to the facility. She stated she was not aware Resident #321's antibiotic was not available following his/her admission due to a cost approval issue. She stated the Admissions Coordinator should have resolved any issue related to cost approval prior to Resident #321's arrival to the facility. 2. Record review revealed the facility admitted Resident #9 on 11/01/2013 with diagnoses that included Multiple Sclerosis, Muscular Dystrophy, and Dementia. Review of Resident #9's Annual MDS assessment, dated 06/09/2021, revealed the facility assessed the resident to be severely cognitively impaired. Review of Resident #9's Comprehensive Care Plan, dated 07/09/2020, revealed the resident was at risk for decline related to Intellectual Disabilities and Muscular Dystrophy with a goal to maintain the highest level of comfort possible. Further review revealed Resident #9 had the potential for alteration in comfort and was at risk for pain related to Muscular Dystrophy and muscle spasms with a goal to keep the resident as comfortable as possible. Interventions included administering the resident's medications as ordered, notifying the physician of new onset pain, and if the pain medication was ineffective. Review of Resident #9's Physician's Orders dated 10/13/2020, revealed staff were to administer the resident Gabapentin by mouth three (3) times daily and Norco by mouth two (2) times daily, and Diazepam by mouth three (3) times daily beginning on 06/17/2021, for treatment of Multiple Sclerosis, Muscular Dystrophy, muscle	{F 755}		

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{F 755}	Continued From page 724 spasms, restlessness and agitation. Review of Resident #9's MAR, from 06/23/2021 thru 08/04/2021, revealed on 06/23/2021, 06/24/2021, and 07/27/2021, the facility failed to administer Resident #9's Diazepam three (3) times daily as prescribed and documented the medication was not available from pharmacy. On 08/02/2021, 08/03/2021 and 08/04/2021, the facility failed to administer Resident #9's Gabapentin three (3) times daily and documented the medication had not arrived from pharmacy. Further review of the MAR revealed, on 08/03/2021 the facility also failed to administer Resident #9's Norco pain medication two (2) times daily as prescribed and staff documented the medication was not in from pharmacy. Interview with Registered Nurse (RN) #1, on 08/05/2021 at 1:00 PM, revealed Resident #9 had been out of Gabapentin medication for several days. She stated she had notified the pharmacy and Physician #1 multiple times, but the pharmacy had not delivered the medication until 08/04/2021. RN #1 stated obtaining refills on medications sometime took a long time. RN #1 stated often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or refill for narcotics for a resident. RN #1 stated nurses notified the physician and pharmacy when there were three (3) days of medication remaining, but often residents had to go without medication for several days while awaiting a refill or arrival of the medication. Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 1:00 PM, revealed Resident #9 had been out of Gabapentin for several days, and she had notified RN #1. CMA #1 stated she	{F 755}		

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{F 755}	Continued From page 725 documented the medication was unavailable. 3. Review of Resident #326's medical record revealed the facility admitted the resident on 07/30/2021 with diagnoses of Rhabdomyolysis, Respiratory Failure with Hypercapnia and Myocardial Infarction. Review of Resident #326's Admission MDS assessment, dated 08/06/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status score of nine (9), indicating the resident was moderately cognitively impaired. Review of Resident #326 Comprehensive Care Plan, dated 08/12/2021, revealed the resident was care planned for pain management and interventions included administering medications as ordered. Review of Resident #326's Physician's Orders, dated 07/31/2021, revealed an order for Percocet (pain medication) to be administered by mouth every six (6) hours as needed for moderate/severe pain with a start date of 07/31/2021. Review of Electronic Medication Administration Record (E-Mar), dated 08/05/2021, revealed Resident #326 received Percocet Tablet 5-325 mg (milligram), one (1) tablet by mouth for head and back pain at 5:14 PM, approximately six (6) hours after requesting pain medication and voicing severe pain to staff. Review of a Nursing Note, dated 08/05/2021 at 10:01 AM, revealed Resident #326 complained of head and back pain and rated the pain as eight	{F 755}		

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{F 755}	Continued From page 726 (8) of ten (10) on the pain scale. Further review revealed no pain medication was available for the resident, and staff requested a "STAT" (now) delivery of the medication. Observation of Resident #326 on 08/05/2021, at 11:09 AM, revealed the resident was lying in bed holding his/her head. 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 stated he/she had been in pain "all morning" and rated his/her pain as an eight (8) on the pain scale. Interview with Licensed Practical Nurse (LPN) #4, on 08/05/2021 at 11:11 AM, revealed Resident #326 did not have pain medication and they were awaiting the medication from pharmacy. LPN #4 stated RN #8 was the nurse assigned to the resident. Interview with RN #8, on 08/05/2021 at 11:57 AM, revealed Resident #326 had no pain medication and they were attempting to get the medication from the pharmacy. The RN stated she was unaware of an emergency medication kit. Interview with Resident #326, on 08/05/2021 at 1:42 PM, revealed he/she had not yet received his/her pain medication. Resident #326 stated, "My head is still killing me". Interview with RN #8, on 08/05/2021 at 1:50 PM, revealed she had not provided Resident #326 with any medication for pain because there was nothing in the building. However, the resident needed something for pain. She further stated she was unaware of how to obtain the resident's	{F 755}		

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{F 755}	Continued From page 727 medication any sooner. Interview with Resident #326, on 08/05/2021 at 4:45 PM, revealed the resident still had not received any pain medication and was still in pain. Interview with RN #8, on 08/05/2021 at 4:47 PM, revealed, she had spoken to the pharmacy and they had instructed her on the facility's emergency medication kit and how to obtain Resident #326's pain medication from the kit. Observation of a medication pass, on 08/05/2021 at 5:15 PM, revealed RN #5 administered Resident #326 a Percocet tablet from the emergency kit. Interview with Physician #1, on 08/27/2021 at 1:26 PM, revealed he was aware there were issues with obtaining narcotic pain medications for residents at the facility. However, the physician stated he was unaware residents including Resident #326, were going days without pain medications. Interview with ADON/IDON, on 08/27/2021 at 12:00 PM, revealed she was aware residents were going several days without narcotic pain medications due to medications not being available. The ADON/DON stated the facility had no designated back-up pharmacy to supply medications. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. The Administrator stated she expected residents' medications to be	{F 755}		

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{F 755}	Continued From page 728 available and administered as ordered. The Administrator stated she was not aware Resident #326's pain medication was not available following admission. 4. Record review revealed the facility admitted Resident #351 on 10/28/2002 with diagnoses that included Diffuse Traumatic Brain Injury, Hypertension, and Quadriplegia. Review of Resident #351's Quarterly MDS assessment, dated 05/26/2021 revealed the facility assessed the resident to have a BIMS score of three (3), indicating the resident was severely cognitively impaired. Review of Resident #351's the Comprehensive Care Plan, dated 09/04/2020, revealed Resident #351 had potential for alteration in comfort related to pain due to muscle spasms and chronic pain due to a motor vehicle accident. Further review revealed the goal for the resident was to be as comfortable as possible with interventions to administer medications as ordered, notify physician of new onset of pain, and notify the physician if pain medication was ineffective. Review of the Physician's Orders for Resident #351 dated 10/06/2020, revealed an order for Oxycodone-Acetaminophen (pain medication) by mouth every eight (8) hours, prescribed for intracranial injury without loss of consciousness. Review of Resident #351's MAR from 04/01/2021 thru 08/06/2021, revealed the facility failed to administer Resident #351's Oxycodone tablet as prescribed on 04/01/2021, 04/02/2021, 08/02/2021, 08/03/2021, 08/04/2021 and 08/05/2021. Further review revealed the facility	{F 755}		

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{F 755}	Continued From page 729 documented the medication was not available from pharmacy to administer to the resident. Interview with Certified Medication Technician (CMT) #1, on 08/05/2021 at 1:00 PM, revealed Resident #351 had been without Oxycodone for several days. The CMT stated she notified RN #1 and documented the medication was unavailable. She stated sometimes medications were not available to administer and she notified the nurse, and the nurse would notify the physician and the pharmacy. She further stated residents often run out of narcotic medication when waiting for a refill or the facility did not have the medication available to administer. Interview with RN #1, on 08/05/2021 at 1:55 PM, revealed she often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or refill for narcotics for a resident. The RN stated the nurse notified the physician and pharmacy when three (3) days were remaining of medication, and often residents would go multiple days without medication while awaiting a refill or arrival of the medication. 5. Record review revealed the facility admitted Resident #324 on 03/24/2021 with diagnoses including Quadriplegia, Gastro-Esophageal Reflux Disease (GERD), and Chronic Pain Syndrome. Review of Resident #324's Quarterly MDS assessment, dated 07/06/2021, revealed the facility assessed the resident to have a BIMS score of fourteen (14), indicating the resident was cognitively intact. Review of Resident #324's Comprehensive Care	{F 755}		

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{F 755}	Continued From page 730 Plan, dated 06/18/2021, revealed Resident #324 had chronic pain with a goal to remain free of complications or discomfort. Further review revealed interventions included administering the resident medications as ordered and pain management as needed. Review of Resident #324's admitting Physician Orders, dated 03/24/2021, revealed Resident #324 was prescribed Sertraline HCl daily, Lactulose Solution two (2) times daily, Gabapentin three (3) times daily, and Baclofen three (3) times daily. Further review of Physician Orders revealed on 03/28/2021, an order for Clonazepam (3) times a day and on 07/03/2021, revealed an order for Fentanyl via transdermal patch applied/changed every seventy-two (72) hours. Review of Resident #324's MAR revealed that on 03/26/2021 the facility failed to administer Resident #324's Sertraline, Lactulose, Gabapentin, and Baclofen as ordered. The facility documented the medications were not available to administer to the resident. Additionally, on 03/29/2021, 06/04/2021, 06/05/2021, 06/06/2021 and 06/07/2021, the facility failed to administer the resident's Clonazepam and documented the medication was not available from pharmacy. Further, the facility failed to administer Resident #324's Baclofen from 07/02/2021-07/03/2021 and staff failed to change the resident's Fentanyl patch on 07/09/2021 and 07/12/2021. Staff documented both the Baclofen and Fentanyl medications were not available from pharmacy. Interview with Certified Medication Aide #1, on 08/05/2021 at 1:00 PM, revealed sometimes	{F 755}		

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{F 755}	Continued From page 731 medications were not available to administer. She stated she notified the nurse, and the nurse called the physician and the pharmacy. Further interview revealed the facility often ran out of residents' narcotic medications when they were waiting on a refill or they did not have the medication available to administer. She stated when medications were not available to administer she notified the nurse, and the nurse called the physician and pharmacy. She further stated the facility ran out of residents' narcotic medications and the residents had to go without pain medicine for several days while waiting for a refill. Interview with RN #10, on 08/25/2021 at 4:28 PM, revealed it had been more difficult to get prescription refills for narcotics. The RN stated when there was a three (3) day supply of medication remaining; the nurse would notify the physician and the pharmacy. RN #10 stated the pharmacy's "cut off time" was 4:00 PM to fax orders for prescriptions, and the pharmacy would not fill anything received after 4:00 PM until the next day. In addition, RN #10 stated if the facility admitted a resident on the weekend, none of the resident's medications might be available. RN #10 stated there were frequent issues with residents not getting narcotic refills on time. She stated staff could remove medication from the emergency kit on the floor if there was an order for the medication. However, RN #10 stated if the medication needed was a narcotic, the process was different. RN #10 stated to obtain a medication from the emergency kit, staff faxed an order for the medication to the pharmacy along with specific resident information, and then a pharmacist would call the nurse at the facility and relay an electronic code to enter into the	{F 755}		

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{F 755}	Continued From page 732 emergency kit, and obtain the narcotic. RN #10 stated she was unsure how the facility maintained the emergency kits to ensure medications were available. RN #10 stated she had never received training on the emergency kit, stating she just "figured it out". Interview with RN #7, on 08/24/2021 at 4:28 PM, revealed there were issues with medications not being available to residents. She stated if a medication was not available, the nurse should check the emergency kit first and call the physician if the medication was not in the kit. She stated if it was narcotic medication needed, then nurse should call the pharmacy to find out if the medication was not available due to needing a refill. If the medication did require a refill, the nurse should call the physician and get an order so staff could get the medication from the facility's emergency kit until the medication arrived from pharmacy. RN #7 further stated the nurse was responsible to pull the sticker from the medication's container when there was seventy-two (72) hours of medication remaining for the resident. The staff then faxed the sticker to the pharmacy to obtain a refill of the medication. If there was no sticker available, because the medication required a refill, they would contact Physician #1's Nurse and she notified the physician to refill the medication. RN #7 stated the facility had not trained her on utilizing the kits, but she leaned it from other staff. RN #7 stated to access a narcotic from the emergency kit, the nurse would fax a physician's order to the pharmacy, and then the pharmacy would call and give the nurse a code to open the box. Interview with Physician #1's Nurse on 08/27/2021 at 10:29 AM, revealed when a	{F 755}		

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{F 755}	Continued From page 733 resident needed a medication refill, facility staff would notify the physician's office, and she would enter the medication into the electronic medication record (EMAR) for Physician #1 to electronically authorize the pharmacy to refill the medication. She further stated the office had no specific process in place to ensure medications were refilled, but if a medication did not arrive to the facility or the resident was completely out of a medication, the facility would call the office. She stated there have been issues with the pharmacy and having to resend prescriptions for medications because they said they did not have them, only to later find out they had them and did not see them. Interview with Physician #1, on 08/04/2021 at 1:05 PM, revealed he expected medications to be available to residents upon admission to the facility and expected staff to follow the admission orders and implement care to residents immediately. Continued interview with the physician #1, on 08/27/2021 at 1:26 PM, revealed he was aware there were issues with obtaining narcotic pain medications for residents at the facility. He stated he requested the facility send him a refill request when the resident's supply of medication was down to a ten (10) day supply. The physician stated he was not aware residents were going several days without pain medications. Continued interview with Physician #1, revealed he was aware there were issues with obtaining narcotic pain medications for residents at the facility. However, the physician stated he was unaware residents were going several days without pain medication. The physician stated residents in pain should have their needs addressed and	{F 755}		

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{F 755}	Continued From page 734 treated as soon as possible. Interview with the ADON/IDON, on 08/27/2021 at 12:00 PM, revealed she expected nursing staff to notify the physician when a resident's narcotic pain medication was down to a three (3) day supply. The ADON/IDON stated the facility did not have a designated back-up pharmacy to obtain residents' medications. She stated she was aware residents were going several days without narcotic pain medications due to medications not being available and stated this was not acceptable. She stated Physician #1 was aware there was an issue with narcotic pain medications getting to the facility timely. Further interview reviewed that staff notified the physician and pharmacy in advance for refills. The ADON/IDON stated it was not standard practice to allow a resident to be in pain for several hours before administering a prescribed pain medication. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed she expected resident medications to be filled, available and administered as ordered. She stated the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. The Administrator stated it was not acceptable for residents to wait several hours for pain medication. **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	{F 755}		

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{F 755}	Continued From page 735 were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail 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	{F 755}		

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{F 755}	Continued From page 736 plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals 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	{F 755}		

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{F 755}	Continued From page 737 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 directcare staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with 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	{F 755}		

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{F 755}	Continued From page 738 identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative 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	{F 755}		

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{F 755}	Continued From page 739 in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in 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	{F 755}		

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{F 755}	Continued From page 740 common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval 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	{F 755}		

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{F 755}	Continued From page 741 the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim 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	{F 755}		

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{F 755}	Continued From page 742 QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse 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,	{F 755}		

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{F 755}	Continued From page 743 grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the 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	{F 755}		

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{F 755}	Continued From page 744 minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and 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	{F 755}		

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{F 755}	Continued From page 745 Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how 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,	{F 755}		

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{F 755}	Continued From page 746 timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood 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	{F 755}		

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{F 755}	Continued From page 747 copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and 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	{F 755}		

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{F 755}	Continued From page 748 electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary 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	{F 755}		

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{F 755}	Continued From page 749 educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given 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	{F 755}		

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{F 755}	Continued From page 750 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. 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,	{F 755}		

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{F 755}	Continued From page 751	{F 755}		

incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM.

58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks.

59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. 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

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{F 755}	Continued From page 752 Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) 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.	{F 755}		

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{F 755}	Continued From page 753 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be 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	{F 755}		

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{F 755}	Continued From page 754 interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will 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)	{F 755}		

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{F 755}	Continued From page 755 weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional 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	{F 755}		

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{F 755}	Continued From page 756 identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the 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	{F 755}		

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{F 755}	Continued From page 757 President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments 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	{F 755}		

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{F 755}	Continued From page 758 with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 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.	{F 755}		

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{F 755}	Continued From page 759 No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the 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	{F 755}		

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{F 755}	Continued From page 760 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service 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	{F 755}		

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{F 755}	Continued From page 761 obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM 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	{F 755}		

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{F 755}	Continued From page 762 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's 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	{F 755}		

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{F 755}	Continued From page 763 scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, 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;	{F 755}		

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{F 755}	Continued From page 764 SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed 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	{F 755}		

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{F 755}	Continued From page 765 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 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	{F 755}		

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{F 755}	Continued From page 766 tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 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	{F 755}		

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(F 755)	Continued From page 767 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly 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,	(F 755)		

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{F 755}	Continued From page 768 Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the 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	{F 755}		

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{F 755}	Continued From page 769 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. 26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical 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	{F 755}		

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{F 755}	Continued From page 770 Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control 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	{F 755}		

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{F 755}	Continued From page 771 reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 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.	{F 755}		

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{F 755}	Continued From page 772 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 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	{F 755}		

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{F 755}	Continued From page 773 he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the 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	{F 755}		

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{F 755}	Continued From page 774 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and 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	{F 755}		

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{F 755}	Continued From page 775 addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding 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,	{F 755}		

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{F 755}	Continued From page 776 SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 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	{F 755}		

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{F 755}	Continued From page 777 timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns.	{F 755}		

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{F 755}	Continued From page 778 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan	{F 755}		

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{F 755}	Continued From page 779 with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6	{F 755}		

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{F 755}	Continued From page 780 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound	{F 755}		

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{F 755}	Continued From page 781 Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had	{F 755}		

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{F 755}	Continued From page 782 received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN)	{F 755}		

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{F 755}	Continued From page 783 #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20	{F 755}		

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{F 755}	Continued From page 784 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party	{F 755}		

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{F 755}	Continued From page 785 notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident	{F 755}		

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{F 755}	Continued From page 786 repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on	{F 755}		

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{F 755}	Continued From page 787 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated.	{F 755}		