STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 11/15/21 and concluded 11/18/21.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 1 sampled resident (Resident #44) with medications observed at the bedside. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Medications-Self Administration of Meds" occurred on 11/18/21. This policy, revised May 2013, stated, ". . . After meeting specific criteria the resident may participate in the self-administration process. A practitioner order is required. The process/set-up will be monitored daily by the nurse. The resident's self-administration ability will be reviewed quarterly, with a change of condition, prior to discharging home, or as the interdisciplinary team determines necessary. . . ."	F 554	1. Self-administration of medication assessment was completed for Resident #44. Provider order obtained to self-administer Ventolin and keep at bedside. Ventolin placed in lock-box at bedside and resident provided with a key. 2. All residents who self-administer medications have the potential to be affected. 3. These residents have been identified, an assessment completed, and physician order obtained for those deemed appropriate. Education will be provided to all staff on Eventide's Self-Administration of Medication policy. 4. Audits will be completed for five residents who are self-administering their medications to ensure that Eventide's policy is followed weekly for one month, five residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional	1/6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/2021

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

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F 554	Continued From page 1 Review of Resident #44's medical record occurred on all days of survey and showed a provider's order dated 05/06/21 for Ventolin, inhale two puffs orally every 4 hours as needed for shortness of breath (SOB) related to chronic obstructive pulmonary disease (COPD). Observation on 11/16/21 at 8:59 a.m. showed two Ventolin inhalers (used to treat wheezing and SOB) on Resident #44's bedside table. When asked about the medication, the resident indicated one inhaler was empty, held up the full inhaler, and stated, "This is a rescue inhaler. It does me no [explicative] good if it's in a drawer [in the nurse's medication cart] when I need it." Resident #44's medical record lacked a SAM assessment and a provider order stating the resident may keep the inhaler at bedside. During an interview on 11/17/21 at 5:45 p.m., an administrative nurse (#2) confirmed the record lacked a SAM assessment for Resident #44's ventolin inhaler.	F 554	audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		1/6/22

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F 578	Continued From page 2 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 2 of 21 sampled residents (Resident 59 and #320) reviewed for advance directives. Failure of staff to ensure a resident's legal representative (Power of Attorney) signed documentation regarding his/her	F 578	1. Code Level was reviewed with the POAs for Residents #59 and #320 and updated Code Level signed. 2. All residents who have a POA have the potential to be affected. 3. All Code Levels were reviewed and	

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F 578	Continued From page 3 wishes limited the facility's ability to communicate to direct care staff and emergency personnel the resident's/representative's wishes in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Directives" occurred on 11/18/21. This policy, revised December 2013, stated, ". . . Upon admission all residents/responsible parties will receive as part of the . . . admission folder information regarding Advanced Directives. . . . Documentation is made in the resident's record that information was presented or a copy of the Advance [sic] Directive was obtained." - Review of Resident #59's medical record occurred on all days of survey and showed a family member signed the code status form on file. The record lacked evidence of a discussion with the power of attorney regarding what his/her current wishes entailed regarding Resident #59's code status. - Review of Resident #320's medical record occurred on all days of survey and showed a family member signed the code status form on file. The record lacked evidence of a discussion with the power of attorney regarding what his/her current wishes entailed regarding Resident #320's code status. During an interview on 11/18/21 at 10:45 a.m., two administrative staff members (#2 and #4) agreed facility staff should contact the Power of Attorney (legal representative) regarding what his/her current wishes entailed regarding the	F 578	were signed by the POA when the resident was cognitively unable. Education will be provided to all nurses and social service staff on Eventide's CPR/AED/Code Level policy. 4. DON or designee will audit documentation to ensure that residents with POA have their Code Level signed by the POA. Audits will be completed weekly for all new/readmissions for four weeks and monthly for 9 months for adherence to the CPR/AED/Code Level policy related to appropriate execution of a resident's wishes with additional audits as recommend by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 578	Continued From page 4 resident's code status.	F 578		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		1/6/22

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F 623	Continued From page 5 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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F 623	Continued From page 6 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident and/or resident's representative of a transfer outside of the facility for 1 of 2 sampled residents (Resident #17) with a recent hospital transfer. Failure to provide a notice of transfer does not allow the resident and/or representative to make an informed choice regarding the resident's rights. Findings include: Review of Resident #17's medical record occurred on all days of survey. The record identified a transfer from the facility for admission to the hospital on 08/03/21. The record failed to include evidence of a transfer notice given to the resident and/or their representative.	F 623	1. Resident #17's representative was notified of the transfer that occurred on 08/03/2021 and provided with the written notice. 2. All residents who have had a transfer or discharge have the potential to be affected. 3. Discharges and transfers that occurred in the past 6 months have been reviewed and notice of discharge/transfers are in place. Education will be provided to all nurses and social service staff on the requirements for completion and documentation of the Notice of Transfer or Discharge.	

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F 623	Continued From page 7 During an interview on 11/17/21 at 10:05 a.m., a social services staff member (#3) agreed the facility failed to give a notice of transfer to Resident #17 and/or their representative.	F 623	4. The Director of Social Services or Designee will audit completion of the Notice of Transfer or Discharge for all residents with a transfer or discharge for one month, five residents with a transfer or discharge for three months, and five residents per quarter for a year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		1/6/22

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F 644	Continued From page 8 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 4 sampled residents (Resident #14 and #52) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASRR Provider Manual states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #14's medical record occurred on all days of survey. A Level 1	F 644	1. Updated Level 1 screening/change in status assessment completed for Residents #14 and #52. 2. Any residents with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability) have the potential to be affected. 3. Education will be provided to all nursing staff that new diagnoses must be communicated to Social Services and they will make the determination on whether an updated screening/level of care needs to be completed. Social Services will complete as needed. All current residents with appropriate diagnosis have been reviewed and updated Level 1 screening/change of condition completed as needed. 4. Audits will be completed for five residents to determine if they have a new MI, ID, and or related condition and, if so, that an updated Level 1 screening/change in status assessment was completed weekly for one month, five residents monthly for three months, and then 5 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The	

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F 644	Continued From page 9 PASARR, dated 02/05/21, identified no major mental illness. A nurse's note, dated 02/08/21, stated, ". . . Did talk with [provider name] regarding Dx [diagnosis] for Seroquel [an antipsychotic] - Dx for Seroquel- Unspecified psychosis not due to a substance or known physiological condition. . . ." The record lacked evidence of an updated PASARR which included the diagnosis of unspecified psychosis (a major mental illness). During an interview on the morning of 11/18/21, a social services staff member (#3) stated she was unaware of Resident #14's diagnosis of psychosis, and confirmed she should have submitted a new Level 1 when she became aware. - Review of Resident #52's medical record occurred on all days of survey. A Level I PASARR, dated 09/07/18, identified no major illness. A physician's order, dated 08/31/21, included Zyprexa (antipsychotic medication) 2.5 milligrams related toa new diagnosis of specified schizophrenia spectrum and psychotic disorder with target behaviors of paranoia, delusions and aggression. The record lacked evidence of an updated PASARR which included the diagnosis of schizophrenia with psychotic disorder. During an interview on 11/17/21 at 3:17 p.m., a social services staff member (#3) confirmed she failed to submit an updated Level 1 screen which included the new diagnosis of schizophrenia.	F 644	results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		1/6/22

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F 677	Continued From page 10 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and resident and resident group interviews, the facility failed to provide the necessary services to 3 of 4 residents (Resident #7, #28, and #42) observed for diabetic nail care. Failure to provide diabetic nail care may result in poor personal hygiene, diabetic complications, and decreased self-esteem. Findings include: Review of the facility policy titled "Nail Care" occurred on 11/18/21. This policy, revised December 2017, stated, ". . . The resident's finger and toe nails will be kept clean and neatly trimmed. . . . A nurse will complete all diabetic resident nail care weekly on bath day and prn [as needed]. . . ." During the Group Interview on 11/16/21 at 3:00 p.m., Resident #28 stated he/she has long toenails, and when asked the CNAs to cut the toenails, he/she was told "We can't cut them because you are a diabetic," and Resident #42 stated, "Yeah. You should see mine [toenails]. They are curling down." Review of Resident #7, #28, and #42's medical records occurred on 11/17/21. All three records identified a diagnosis of Type II Diabetes Mellitus. Observations on 11/17/21 showed the following: * 8:29 a.m., Resident #42's toenails appeared	F 677	1. Residents #7, #28, and #29 had diabetic nail care provided by a nurse. 2. All residents with a diagnosis of diabetes have the potential to be affected. 3. All residents with a diagnosis of diabetes had nail care completed. Education will be provided to all nursing staff on Eventide's Nail Care policy. 4. The DON or designee will observe the fingernails and toenails of ten residents who have a diagnosis of diabetes weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 677	Continued From page 11 approximately 1/4 inch in length to both feet and curling downward. * 8:50 a.m., Resident #28's left great toenail appeared approximately 1/4 inch in length, raised, and hooked on to the resident's sock when applied. * 11:24 a.m., Resident #7's toenails appeared approximately 1/4 inch in length to both feet. During an interview on 11/18/21 at 10:37 a.m., administrative nurse (#5) stated "about three months ago we did go around and provide residents diabetic nail care."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services according to physician's orders and the current plan of care for 1 of 21 sampled resident (Resident #12). Failure to provide appropriate skin care and positioning devices placed the residents at risk for adverse health effects and physical discomfort. Findings include:	F 684	1. Chemical wipes were removed from Resident #12's room. Nursing assistant staff have been educated that: 1. A knee separator to be used when in wheelchair for leg alignment. 2. Gripper socks must be on while in bed and when not wearing shoes. 3. Proper foot wear must be worn with all transfers. 4. Mat to wall next to be to prevent rubbing toes on wall. 2. All residents who receive specialized	1/6/22

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	355069	A. BUILDING _____ B. WING _____	11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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F 684	Continued From page 12 Review of Resident #12's medical record occurred on all days of survey and identified the resident has an unstageable wound to the right foot second toe, a Stage 3 pressure sore to the coccyx, and a Stage 3 pressure sore to the left inner buttock. A physician's order, dated 09/08/21, stated, ". . . Wash peri area with warm water, pat dry. Do not use chemical wipes. . . ." Observation on 11/17/21 at 10:34 a.m., showed two CNAs (certified nurse aid) (#6 and #7) performed perineal cares for Resident #12 while in bed utilizing prepackaged chemical wipes and a nurse (#8) utilized the prepackaged chemical wipes to cleanse bowel from the coccyx and left buttock pressure ulcers prior to applying a new dressing. Review of Resident #12's care plan identified the following: * ". . . Knee separator to be used when in wheelchair for leg alignment. . . ." * ". . . Gripper socks on while in bed and when not wearing shoes. . . ." * ". . . Proper foot wear with all transfers . . ." * ". . . Mat to wall next to bed to prevent rubbing toes on wall. . . ." Observation on 11/17/21 at 10:34 a.m., showed CNAs (#6 and #7) utilized a full body mechanical lift to transfer Resident #12 from the wheelchair to the bed for cares, and back to the wheelchair without any foot protection in place. Observations showed the knee separator used only the last day of survey, and the resident without gripper socks and no mat to the wall on all days of survey.	F 684	skin care and/or positioning devices have the potential to be affected. 3. Physician orders were reviewed to ensure that skin care orders and positioning devices have been implemented. Education will be provided to all nursing staff on following physician's orders and care plan. 4. The DON or designee will observe ten residents to ensure that their care plans are up-to-date and that skin care orders and positioning orders are being implemented as ordered weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 684	Continued From page 13 During an interview on 11/18/21 at 8:23 a.m., an administrative nurse (#2) stated, "If the order is there, they [facility staff] should be doing it." The facility failed to follow physician's orders and to implement interventions outlined in Resident #12's care plan to prevent discomfort and further skin complications.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and family and staff interview, the facility failed to ensure residents received assistance with assistive devices to maintain vision for 1 of 1 sampled residents (Resident #41). Failure to locate or provide a plan for replacement of the missing glasses resulted in decreased vision and impacted the resident's ability to carry out activities of daily living. Findings include:	F 685	1. Verified that Resident #41 has glasses. 2. All residents who require glasses have the potential to be affected. 3. Verified that all residents who wear glasses currently have them in their possession. Process will be implemented and education provided to all staff on how to handle missing assistive devices.	1/6/22

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F 685	Continued From page 14 Review of Resident #41's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 06/10/21, identified Resident #41 as vision impaired without glasses. The current care plan identified, ". . . I like to watch TV (television), the news and read the newspaper . . . TV has closed caption set up . . . important to take care of her personal belongings . . . communication with nursing, staff to ensure daily needs are met . . ." Observations throughout the survey showed Resident #41 in the room without glasses on watching TV in his/her room. When interviewed about watching TV, the resident stated, "Yes I like watching TV, but I can't see it". During an interview on 11/15/21 at 03:13 p.m. a family member stated Resident #41's glasses have been missing since September. During an interview on 11/17/21 04:00 p.m. a staff member (#3) provided the following documentation regarding Resident #41's glasses: * 09/03/21, Resident #41's glasses missing. * 11/15/21, Resident #41's family inquired about the glasses to staff member (#3). Family made an eye appointment for new glasses. * 11/17/21 at 04:00 p.m., A staff member (#3) provided information that Resident #41's glasses were found, 75 days later after an initial report of the missing glasses. Family was notified and the eye appointment canceled. During an interview on 11/17/21 at 5:00 p.m., an administrative staff member (#2) confirmed she knew something about the missing glasses for Resident #41 and expected communication to be	F 685	4. The DON or designee will observe ten residents who have glasses to ensure that they have their glasses and are wearing them if they wish to and if glasses are misplaced that appropriate process was followed weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 685	Continued From page 15 more "organized" to find the glasses.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 2 of 19 sampled residents (Resident #31 and #35) who required staff assistance for transfers. Failure to use a gait belt (Resident #35) or a mechanical lift (#31) as care planned may result in falls and/or injuries. Findings include: Review of the facility policy titled "Standing Lifts" occurred on 11/18/20. This policy, revised September 2020, stated, ". . . An electronic lift (Hoyer or standing) will be used to transfer a resident whenever it is unsafe to transfer that resident due to their weight, inability to stand, or inability to cooperate. . . ." - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and osteoarthritis. The current care plan stated, ". . . requires staff assist of one for ADL's [activities of daily living]	F 689	1. Competency completed with CNA #1 on appropriate transfer technique. The CNA's responsible for not using the standing lift are no longer employed by Eventide. 2. All residents who require assistance with transfers have the potential to be affected. 3. Education will be provided to all nursing staff on following the care plan in regard to transfers (using mechanical lift if indicated) and appropriately utilizing gait belt (not lifting under the resident's arms or using clothing to lift) with all assisted transfers. 4. The DON or designee will observe ten residents during a transfer to ensure that appropriate transfer technique was used and care plan was followed weekly for one month, ten residents monthly for three months, and then 10 audits will be	1/6/22

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F 689	Continued From page 16 secondary to cognitive impairment . . . Dx [diagnosis] of CVA [stroke] . . . HX [history] of residual Left sided weakness. . . . AMBULATION/LOCOMOTION: Assist of 1 with walker and gait belt . . . TRANSFER: Assist of 1 with walker and gait belt . . ." Observation on 11/16/21 at 11:01 a.m. showed a certified nursing assistant (CNA) (#1) brought Resident #35 to her room to use the bathroom. The CNA placed a walker in front of the resident and, without using a gaitbelt, assisted her to stand by lifting under her arm. The CNA ambulated beside the resident to the bathroom. Upon completion of toileting, the CNA instructed the resident to stand and stated, "I'll help you," as she lifted under the resident's arm. The CNA ambulated beside the resident and guided her to sit in the wheelchair by grasping the back of the resident's pants. During an interview on the morning of 11/18/21, an administrative nurse (#2) indicated the CNA should use a gait belt with Resident #35. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and weakness. The current care plan stated, ". . . Res [resident] will need extensive assist with all ADLs . . . is currently not ambulatory . . . transfers with standing lift (PAL) and assist of 1 staff . . . [is] independent with [power wheelchair] in facility. . . ." Review of Resident #31's medical record occurred on all days of survey. The fall progress notes identified the following:	F 689	completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 689	Continued From page 17 * 06/11/21 at 5:40 p.m., ". . . CNA was in to transfer resident, resident stated she was able to stand up, resident is confused at times, CNA believed she could stand and helped her, when resident's legs gave out, CNA helped resident lower to the floor. . . . CNA was educated to follow care plan. . . ." * 07/22/21 at 11:45 a.m., ". . . CNA was calling for help on walkie. . . . CNA was in the bathroom attempting to transfer resident onto the toilet. . . . Resident was hanging onto bar, and legs were buckling. Writer did tell CNA to help her lower resident safely to the ground. . . . Writer did discuss following the care plan with CNA. Resident is a pal lift with assist of one. . . ." During an interview on 11/18/21 at 10:45 a.m., two administrative staff members (#2 and #4) confirmed staff should follow the care plan and utilize a stand lift to transfer Resident #31.	F 689		
F 725 SS=E	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	F 725		1/6/22

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F 725	Continued From page 18 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 resident and family interviews and review of the Resident Council minutes, the facility failed to ensure sufficient nursing staff to meet resident needs for 2 of 21 sampled residents (Resident #17 and #44), one supplemental resident (Resident #63), eight confidential residents (Residents A, B, C, D, E, F, G, and H) and one confidential family member (Family I) who needed staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote the resident's rights and physical, mental, and psychosocial well-being. Findings include: The facility failed to provide a call light policy. Review of the Resident Council minutes, dated June-November 2021, occurred on 11/23/21. The meeting minutes identified residents voiced the following concerns: * June, ". . . Call light times seems to be slower lately on all shifts-mornings are the worst. . . ."	F 725	1. Nurse Manager spoke with Residents #17 and #44 assured them that their needs are important to staff and that staff would be leaving the call light on until their needs were met. 2. All residents have the potential to be affected. 3. The facility has hired replacement staff members as well as additional travel staff. Nursing leadership and staffing coordinator will meet daily to develop a staffing plan for the following day, ensuring that all positions are filled. All staff will be educated on the expectation that it is everyone□s responsibility to answer call lights. All staff will be educated that call lights should remain on until the resident□s need has been met. Daily rounds on all residents will be initiated by the leadership team. 4. Audits will be completed to ensure that	

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F 725	Continued From page 19 * July, ". . . Call light times are slow/all shifts. . . ." * August, ". . . Discussed long call light times . . ." * November, ". . . Resident's expressed some slow call light times . . ." During the Resident Council interview on 11/16/21 at 3:00 p.m., the residents made the following statements regarding staffing/call light wait times: * Resident A, "It's bad at night and they [facility staff] get mad when I have an accident," and "The bathroom pull light, it takes a long time [for staff] to come." * Resident B, "A lot of times they [staff] do not answer it [the call light]. I wonder, 'What if I was dying?'" * Resident C, "Evenings it [delayed call light response times] happens." * Resident D, "Nights are bad. I wait one to one and a half hours [for staff to answer the call light.]" * Resident E, "I waited two and a half hours to get my light answered. I peed the bed," and "I don't use the call light often, so when I do use it, it is something serious." * Resident F, "I have it [the call light] on. They [staff] come in and shut it off. I need to hit it [the call light] again," and "It's [call light wait times] bad any time of day. I do not abuse the call light. After supper, when I wanted to go to bed, I waited and waited one and a half hours." * Resident G, "It's [call light response times] bad at and after supper. I put my light on. It goes for 45 minutes to one hour. I often need to hit it [the call light] three to four times [because staff turns the call light off] before I get help." * Resident H, "Last Friday or Saturday night, I looked at my clock when I put on my [call] light at	F 725	call lights are being answered in a timely manner and resident□s needs are being met in a timely manner. The DON or designee will observe ten residents weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 725	Continued From page 20	F 725		

1:30 a.m. and no one came until 3:30 a.m.," and "I go to the bathroom myself, but I can't get up by myself. I have waited up to one and a half hours on the toilet [for staff to answer the call light and assist.]"

Resident interviews on 11/15/21 identified the following:
* 2:10 p.m., Resident #17 indicated he/she has waited for 30 minutes to an hour for staff to answer the call light and stated, "They [staff] go and help other people who don't even have their light on first and make me wait."
* 3:12 p.m., Resident C stated he/she often waits 30 minutes to an hour or longer for staff to answer the call light when needing the bathroom. Longer call light wait times occur on evenings and weekends, and staff often enter the resident's room, turn off the call light, and never return.
* 3:45 p.m., Resident #63 stated he/she often has waited up to an hour for staff to answer the call light when needing the bathroom, and the call light wait time is worse on evenings and weekends.
* 4:18 p.m., Resident B stated, "I put it [the call light] on for help to the bathroom and it takes so long for them [the staff] to answer, I don't need the toilet anymore." Resident B further stated, "They [the staff] will be disgusted with me and say they won't help me anymore."

Resident and Family/Representative interviews on 11/16/21 identified the following:
* 8:38 a.m., Resident D stated he/she has waited up to an hour for staff to answer the call light, and the call light wait time has caused incontinence.
* 8:59 a.m., Resident #44 indicated the facility is

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F 725	Continued From page 21 short staffed, has waited up to one and a half hours for assistance, and stated, "I pushed my call light five times [because staff turns the call light off] until I finally got help. After the fifth time, they answered it." * 9:50 a.m., Resident I's family member stated, "Staffing is a problem at night. My mom called me last night, because staff did not come back to the room to take her off the bed pan. She said there [was] one staff on the unit, and she waited an hour. I had to call staff to get her off the bed pan."	F 725		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and group and staff interviews, the facility failed to reassess behaviors, and develop, implement, and monitor the effectiveness of individualized interventions for 1 of 4 sampled residents (Resident #49) with wandering behaviors. Failure to reassess and monitor Resident #49's continued behaviors, limited the facility's ability to meet his needs and negatively impacted multiple residents within the facility. Findings Include: Review of the facility policy titled "Behavior Monitoring" occurred on 11/18/21. This policy, revised June 2021, stated, ". . . behavior changes will be identified by social services and nursing . . . the interdisciplinary team [will] determine	F 745	1. Behaviors for Resident #49 were re-assessed and PCP and NP were updated on 11/18/2021. Discussion regarding resident moving to a group home is in progress. Current interventions were reviewed. Additional intervention of stocking snacks in resident's room implemented along with staff offering to play board games with resident and put together puzzles. Will re-assess interests related to activities and implement these as needed. 2. All residents, aside from those in the memory care unit, have the potential to be effected. 3. Behavior Monitoring policy reviewed	1/6/22

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F 745	Continued From page 22 person-centered care plan goals and approaches based on the comprehensive assessment . . . behavior status will be reviewed by the interdisciplinary team . . . to determine trends and the effectiveness of care plan interventions. . . ." Observations on all days of survey showed Resident #49 wandering throughout the building. On the afternoon of 11/16/21, Resident #49 repetitively entered and exited the activity room during the group interview. He also walked around the tables and grabbing items from the room. Several of the residents were visibly upset and voiced their concerns regarding Resident #49's behaviors: * Resident B stated, "He has come to my room once or twice. I yell at him and ask him to leave." * Resident D stated, "He doesn't belong here. He belongs in the unit. He walked into my room once when I was on the commode, and there was no curtain or anything." Resident D reported the door was closed prior to him entering. * Resident E stated, "He has been in my room several times. He always looks for food items. He has eaten my grapes, cherries, and drank my cranberry juice. He has taken [the] quarter I won in Bingo off of my table." * Resident F stated, "Every time I leave my room, I close my door. Put up the chain, so he doesn't go in my room. But he will still take down the chain and go in." * Resident G stated, "[He] took my candy." * Resident H stated, "He took candy [out of] my drawer." * Resident J stated, "He opens [my room] door and looks in, and leaves." * Residents B, D, E, F, and G all reported Resident #49 frequently disrupts activities. They	F 745	and no changes are required. Reviewed concerns identified regarding Resident #49 with the team. Education provided to all staff regarding implementing appropriate and individualized interventions. Education provided to nurses on keeping provider updated on resident status/behaviors. 4. Daily leadership rounds will include questions on whether the residents feel safe, if their privacy is being maintained, and if they have concerns with missing items. The DON or designee will interview ten residents regarding if they feel safe, if their privacy is being maintained, and if they have concerns with missing items weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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	355069	A. BUILDING _____ B. WING _____	11/18/2021

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also voiced concerns that Resident #49 will get hurt one day or will hurt someone else. The residents made comments like, "He will run into you. He will run you over. He will fall over you."

Review of Resident #49's medical record occurred on all days of survey. The current behavior care plan identified, "Noted to hit staff. . . . Dx [diagnosis] of Schizophrenia, can have impulsive behavior . . . Noted to eat uneaten food off of other residents' food trays they left at the table . . . Follow resident's . . . routine as able, Keep resident separated from [Resident NN] due to [Resident NN] having increased agitation with resident, Medications as ordered, Monitor for side effects . . . behavior monitoring . . . Offer emotional support and encourage family involvement . . . Provide 1:1 visits for conflict resolution . . . redirection as needed, Provide consistent caregivers as able, Provide support . . . as needed when resident appears . . . frustrated, Psych [psychology] consult . . . Report changes in mood to practitioner . . . Wanderguard to L) ankle."

The behavior progress notes identified the following:
* 05/31/21 at 1:00 p.m., "Resident [#49] was seen . . . coming out of [Resident AA's] room . . . Resident had handful of candy . . . Resident did not have any candy in his own room. . . ."
* 05/31/21 at 1:20 p.m., "Writer . . . [was] charting, was hit in back. Writer turned around and resident [#49] said 'where's my medicine?' . . ."
* 05/31/21 at 10:00 p.m., ". . . resident [#49] was roaming the halls trying to take pudding off the treatment cart . . . He was following the kitchen

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[staff] when they were picking up trays from the rooms and trying to take food off the trays. He was in the activity room rummaging in the cupboards looking for food. . . ."
* 06/3/21 at 8:35 a.m., ". . . resident [#49] was seen in hallway by [Resident BB's] room . . . with large bag of Cheetos and eating from it. . . ."
* 06/03/21 at 11:07 a.m., "Resident [#49] was seen . . . taking pudding off of med [medication] cart and eating it . . . did discuss with resident he cannot be taking things off of med cart. . . ."
* 06/08/21 at 7:20 a.m., "Resident [#49] was seen ambulating . . . with large container of cheeto puffs. Cheeto puffs . . . did not belong to him. . . . Did discuss with resident that he cannot be taking things out of others rooms . . ."
* 06/08/21 at 10:00 a.m., "Resident [#49] was seen going by Med Cart and taking a . . . supplement . . . he kept walking back to room . . . [and] tried to drink it . . . Again discussed that he cannot be taking things off of Med cart and that he has specific diet."
* 06/12/21 at 5:54 p.m., ". . . resident [#49] had taken [Resident CC's] room . . . tray out of room and was eating from it . . . Writer did talk to resident and told him he needs to stop entering other residents rooms and taking their food."
* 06/13/21 at 9:22 p.m., "Resident [#49] was . . . in and out of residents' rooms on the pm shift . . . and . . . drank three [supplements] from the medication cart . . ."
* 06/15/21 at 11:48 p.m., "Resident [#49] was . . . wandering the first part of the pm shift and did go into [Resident DD's] room . . . and eat all of his watermelon and later . . . all of his supper in front of him, and continued to eat it when resident stated that it was not his, resident stated 'I know' and finished before exiting his room. Email will be

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sent to SS [social services] for . . . suggestion."
* 07/05/21 at 9:29 p.m., "CMA [medication aide] had to go get resident [#49] out of the courtyard. He was crouching by a bush eating candy. . . ."
* 07/27/21 at 9:47 a.m., ". . . resident [#49] was seen in courtyard eating something . . . Resident was found with cup of instant dry rice, several small chocolate candy bars, bag of half eaten potato chips, and plastic zip lock bag with some dog treats, and blue army lanyard . . . did again discuss with resident that it is not ok to taken food that is not his. Also discussed that he has special diet to prevent choking . . . items had come from Activities room, and cupboards had been pulled hard enough to open . . ."
* 07/27/21 at 6:20 p.m., "A resident notified staff that [Resident #49] was in her room. The bag of food that was on her bedside table now rests open on the floor. . . ."
* 08/02/21 at 8:59 p.m., "Resident [#49] wandering the halls naked. . . ."
* 08/05/21 at 8:11 a.m., "Resident [#49] was seen in the courtyard, tipping head back as if drinking something . . . Resident had 3 small packets of flavored water drink mix, had [a] string of tickets and small orange psalm and testament book . . . Discussed with resident not taking things that are not his . . . Objects brought to . . . social services."
* 08/05/21 at 12:35 p.m., ". . . resident [#49] in courtyard . . . trying to drink something . . . found various candy wrappers, powdered drink mixes, and bag of dog treats. Staff also found dirty brief and that resident had pooped in courtyard. . . ."
* 08/08/21 at 8:00 a.m., "Resident [#49] was seen out in courtyard with small box in his hand . . . In box was silver [watch], with clearance tag . . . appearing brand new. Resident told writer 'I

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bought it.' Resident had not previously had watch in [his] room, had not been on shopping trip recently . . . given to Social Services . . ."
* 08/08/21 at 10:28 a.m., ". . . CNA found $1.50 in [Resident #49's] pockets . . . Quarters taken back to Activities room."
* 08/09/21 at 6:13 p.m., "Resident [#49] has been wandering into other resident rooms and taking their food. . . ."
* 08/12/21 at 11:25 a.m., ". . . CNA found several . . . small candy bars in pocket and batteries. Call placed to activities, believe that resident [#49] did take this as some cupboard locks were pulled off. . . ."
* 08/16/21 at 7:00 p.m., ". . . resident [#49] . . . [took] whole food off another resident's plate on dietary cart . . . no coughing or choking noted or reported at that time."
* 08/26/21 at 5:50 p.m., "Resident [#49] has been going in and out of rooms stealing food. Resident did go into [Resident DD's] room . . . to steal flavored water and mints. Resident seen little bit later going into [Resident EE's] room . . . and eating banana bars."
* 09/18/21 at 5:55 a.m., "Notified by Housekeeping staff . . . resident [#49] walking by with butcher knife and can of beans, but could not get it from resident. Resident was seen by writer walking with knife and beans. Resident did give it when asked too . . . Resident was told to not do it again . . ."
* 9/18/21 at 6:39 a.m., "Resident [#49] was . . . in diner shoving container in pockets . . . was large packet of gum . . . discussed . . . not taking things from other residents' rooms."
* 10/02/21 at 4:00 p.m., "Resident . . . saw [Resident #49] go into [Resident DD's] room . . . Writer saw [Resident #49] coming out of the

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room, appeared to be chewing on something . . . [Resident #49] was told he needs to stay out of other residents' rooms. Door to [Resident DD's] room . . . was shut and yellow chain put up."
* 10/16/21 at 1:35 p.m., ". . . resident [#49] carrying large bag of candy and eating from it . . . Resident hands full of melted chocolate and trying to open candy and shove [it] in [his] mouth . . . Resident was told it is not appropriate to take things from other residents rooms and to eat their food."
* 10/21/21 at 11:52 a.m., "Resident [#49] . . . went into multiple residents rooms: [FF, GG, and HH]. Resident [FF] stated that this resident went into her room and does not know if he took anything. Writer did contact . . . Social services . . . Resident [GG] was hollering . . . she [saw] . . . resident [#49] in her room x 3 and . . . [the] third time this resident did take a muffin and cups of candy. Resident also seen searching room [HH] drawers, resident was . . . reminded that he should not be in other peoples rooms without permission. . . ."
* 10/23/21 at 12:10 p.m., ". . . [Resident #49 had] at least 4 little bottles of coke . . . in the diner. Cokes came from another resident's room. . . ."
* 10/25/21 at 1:49 p.m., "Resident [#49] did walk into [Resident II's] room . . . while the door was closed and [Resident II] was on the commode . . . resident [#49] would not get out [of her room] and did try to take her food from her tray . . . resident [#49] did go into several other rooms in that hallway after leaving."

A grievance report, dated 10/25/21, identified, "Resident [#49] entered [Resident II's] room while she was on the commode and took food off of her tray . . . Writer followed up with [Resident II] after

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incident . . . [Resident II] stated she was still a little upset and shook up about it . . ."

The behavior progress notes identified the following:
* 10/28/21 at 4:06 p.m., "Resident [JJ] . . . seen [Resident #49] come into his room and take his chicken from his tray and walked out."
* 10/29/21 at 3:33 p.m., "Resident [#49] was walking so fast he was almost running and we had daycare kids in the activity room . . . He went outside and back in quickly and ran over a little girl and knocked her down and almost fell on her . . . Resident has no impulse control."
* 10/31/21 at 10:28 a.m., "Resident [#49] was seen walking to med cart and grabbing nutritional . . . drink . . . Resident then took off walking fast to his room, slammed the door . . . resident was drinking it in [his] bathroom . . . Resident was told that he cannot be taking things off of the med cart and to not take things that don't belong to him."
* 11/6/21 at 8:12 p.m., ". . . [Resident #49] came in and grabbed a sandwich off a resident [sic] plate and . . . then took a bite of it."
* 11/07/21 at 12:04 p.m., "Resident [#49] has been wandering . . . was noted by [Resident KK] . . . to be in her room . . . [Resident KK] was upset he was in there . . ."
* 11/12/21 at 12:53 p.m., "Resident [LL] stated that resident [#49] was in her room and stole 2 . . . bottles of pop and a bag of cheetos . . ."
* 11/12/21 at 1:44 p.m., "Resident [#49] . . . pulled out a box of junior mints and started eating them . . . Writer asked if he took them from another resident's room, he stated, 'yea' and continued to shove them in his mouth."

During an interview on 11/18/21 at 10:45 a.m.,

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F 745	Continued From page 29 two administrative staff members (#2 and #4) reported Resident #49 was hospitalized with pressure ulcers prior to admission. After his physician reduced his medications, Resident #49 "was up walking and talking again." The two administrative staff members (#2 and #4) stated, "We've tried several things with him. We've tried bigger portions [and] his diet was changed to give him more options." A grievance report, dated 11/19/21, identified, "Resident [MM] stated resident [#49] came into [her] room and after he left she had candy bars missing. . . ." Facility staff failed to: * reassess Resident #49's behaviors including walking the hallways unclothed, defecating in the courtyard, entering rooms uninvited, and stealing food, money, and other personal items from medication carts, the activity room, and multiple resident rooms, * monitor the effectiveness of current interventions, * contact the physician in an effort to develop/implement new interventions addressing those behaviors, and * address multiple residents' concerns regarding Resident #49 invading their privacy and/or their fears regarding Resident #49 posing a significant safety risk.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		1/6/22

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F 756	Continued From page 30 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to promptly	F 756	1. Resident #3: labs were completed, albeit late, provider has been contacted	

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F 756	Continued From page 31 act upon the pharmacist's recommendations and ensure the consultant pharmacist reported drug regimen irregularities for 2 of 5 sampled residents (Resident #3 and #24) selected for drug regimen review. Failure to report drug regimen irregularities and act upon recommendations may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Medication Regimen Review" occurred on 11/18/21. This policy, revised September 2017, stated, ". . . Irregularities include, but are not limited to: . . . excessive duration . . . Irregularities identified will be documented on the Consultant Pharmacist's Medication Regimen Review form and provided to the Director of Nursing or designee for follow up as indicated. . . . The attending physician will document on the Consultant Pharmacist's Medication Regiment [sic] Review form that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If the physician chooses not to act upon the consultant pharmacist's recommendation they must document rationale as to why the change is not indicated. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance. Pharmacy reviews, dated November 5, 2020 and	F 756	regarding gradual dose reductions for Zoloft and Ativan. Resident #4: Ativan was discontinued, Oxycodone order was addressed, albeit late. 2. All residents have the potential to be affected. 3. All outstanding Drug Regimen Reviews for the past 6 months will be completed. Education will be provided to consultant pharmacist that prn psychotropic medications without an end date need to identified and reported on the drug regimen review. Education will be provided to Dr. Downs on Drug Regimen Review regulations. 4. All drug regimen reviews will be audited x 3 months, then 10 drug regimen reviews per month x 3 months, then 10 drug regimen reviews per quarter x 2 quarters with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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March 3, 2021, stated, ". . . I was unable to find recent, relevant labs in the resident's chart for medication(s) including CMP [comprehensive metabolic panel], A1C [a measure of average blood sugar levels], and TSH [thyroid-stimulating hormone]. . . . Please update the resident's chart with these lab(s); if it has been completed within the last year. If labs have not been completed within the last year, consider a repeat lab at next lab draw . . . Nursing staff to address ASAP [as soon as possible] but no later than 30 days . . ." The record lacked evidence the facility/physician followed up with the pharmacist's recommendations until 03/29/21, when Resident #3 had labwork completed.

Pharmacy reviews, dated November 2020 and March 2021, stated, ". . . LORAZEPAM [an antianxiety medication] 0.5 MG [milligrams] TABLET [one tablet] PO [by mouth] QD [daily] FOR ANXIETY/AGITATION . . . This medication was initiated 11/19. Please assess whether a dose reduction is appropriate at this time. Please provide CLINICAL RATIONALE if a dose reduction would not be appropriate for this resident at this time . . . Physician to address ASAP but no later than 60 days . . ." The record lacked evidence the facility/physician acted upon these recommendations.

During an interview on the afternoon of 11/17/21, an administrative nurse (#2) identified Resident #3 remained on the same dose of Ativan, and the physician had not attempted a gradual dose reduction.

- Review of Resident #24's medical record occurred on all days of survey. Diagnoses

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F 756	Continued From page 33 included generalized anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance. A physician's order, dated 02/28/21, stated, ". . . Renew PRN [as needed] Lorazepam [Ativan] order [for] 14 days. Use remains appropriate for agitation/behaviors . . ." The current order identified Ativan 0.5 mg every 8 hours as needed, instructed staff to discuss with the provider prior to administration, and lacked an end date. Monthly pharmacy reviews failed to identify/report the irregularity regarding a PRN order beyond 14 days without an end date. Pharmacy reviews, dated February 2021 and July 2021, stated, ". . . Oxycodone [an opioid] 2.5 mg PRN . . . Consider discontinuing the above order due to lack of use/need . . . Physician to address ASAP but no later than 60 days . . ." The record lacked evidence the facility/physician followed up with the pharmacist's recommendations until 10/26/21, when the physician wrote an order continuing/clarifying the PRN oxycodone. During an interview on the morning of 11/18/21, an administrative nurse (#4) confirmed the facility staff failed to follow up with the pharmacist's recommendations in a timely manner.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		1/6/22

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	355069	A. BUILDING _____ B. WING _____	11/18/2021

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F 758	Continued From page 34 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 35 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 5 sampled residents (Resident #3 and #24) selected for medication regimen review. Failure to attempt a gradual dose reduction (GDR) (or identify contraindications for a GDR) and ensure as needed (PRN) psychotropic drug orders are limited to 14 days (or provide a rationale to extend the order beyond 14 days) may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance. Current physician's orders included Zoloft (an antidepressant) 75 milligrams (mg) daily with a start date of 10/09/19, and Ativan (an antianxiety medication) 5 mg daily with a start date of 04/29/20. The record lacked evidence of a GDR attempt (or contraindications for a GDR) within the last year. During an interview on 11/17/21 at 4:37 p.m., an administrative nurse (#2) stated she was unable to find physician documentation regarding a recommendation or contraindication for a GDR.	F 758	1. Resident #3's provider contacted regarding gradual dose reduction for Zoloft and Ativan. Resident #24's prn Ativan was discontinued. 2. All residents receiving psychotropic medication have the potential to be affected. 3. Chart review has been completed for all residents receiving prn psychotropic medications to ensure physician renewal after 14 days. Chart review will be completed for all residents receiving psychotropic medications to ensure that gradual dose reductions/attempts are current. Education will be provided to all nurses that prn orders for psychotropic medications are limited to 14 days unless the provider believes that it is appropriate to extend beyond this and documents their rationale. Education will be provided to all nurses that all residents who receive psychotropic medications must receive gradual dose reductions/attempts. 4. The DON or designee will observe ten residents receiving psychotropic medications to ensure that gradual dose reductions have been completed and to ensure that orders for prn psychotropic medications do not exceed beyond 14	

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F 758	Continued From page 36 - Review of Resident #24's medical record occurred on all days of survey. Diagnoses included generalized anxiety disorder, major depressive disorder, and unspecified dementia without behavioral disturbance. A physician's order, dated 02/28/21, stated, ". . . Renew PRN Lorazepam [Ativan] order [for] 14 days. Use remains appropriate for agitation/behaviors . . ." The current order identified Ativan 0.5 mg every 8 hours as needed, instructed staff to discuss with the provider prior to administration, and lacked an end date. During an interview on 11/17/21 at 4:48 p.m., an administrative nurse (#2) identified the current PRN order is considered a one time order because staff call the provider before administering, and confirmed the order lacked an end date.	F 758	days weekly for one month, ten residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Compliance date will be January 6, 2022.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/6/22

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F 761	Continued From page 37 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store and discard expired medications medications in 1 of 3 medication rooms. Failure to safely store and discard medications increases the risk of residents receiving outdated medications with reduced efficacy and staff utilizing outdated medical supplies. Findings include: Review of the facility policy titled "Medication Administrative Information" occurred on 11/17/21. This policy revised 04/21, stated, ". . . expired medications will be disposed of via a slurry . . . two nurses or a nurse and a MA [medical aide] will count the medications to be destroyed/returned . . . the nurse will document in a progress note . . . list each medication and the amount . . . if unopened it may be returned to the pharmacy . . ." Review of the facility policy titled "Refrigerator-Medication Temperature Checks" occurred on 11/17/21 at 8:41 a.m. This policy, revised 06/21, stated, ". . . Medication	F 761	1. The following expired medications were removed from the Front medication storage area: Benadryl, Aspercream lotion, Muscle Rub lotion, Voltaren ointment, Albuterol nebulizers, and Lasix. 2. All residents have the potential to be affected. 3. Under the direction of the DON all medication carts and rooms have been audited for expired medications and any expired medications were discarded. Education will be provided to all nurses/MAs regarding appropriate disposal of expired medications. New temperature logs have been implemented. Education will be provided to all nurses/MAs regarding checking/documenting medication/vaccine refrigerator temperature daily. 4. The DON or designee will audit all medication rooms/carts for expired medications weekly x 4 weeks, monthly x	

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F 761	Continued From page 38 refrigerators will be checked daily . . .to provide safe medication storage . . . the medication refrigerator operating temperature will be checked on every nursing unit on a daily basis . . . the actual temperature will be recorded on the temperature log . . ." Observation of the Front medication storage area occurred on 11/15/21 at 2:05 p.m. with a nurse (#8) and showed the following on the medication cart: * Benadryl 25 mg (milligram) tabs, expired 10/21/21. * Aspercream lotion, expired 10/21. * Muscle Rub lotion, expired 8/21. * Voltaren 1% ointment, expired 10/21. * Albuterol Nebulizers 2.5 mg/3 ml (milliliter) vials, expired 10/07/21. * Lasix 40 mg vial, expired 11/01/21. During an interview on 11/15/21 at 2:09 p.m., an nurse (#8) confirmed the medications were expired and should be removed from the medication cart. -A tour of the Front medication refrigerator containing medications occurred on 11/17/21 at 8:41 a.m., with a staff nurse (#8). The refrigerator temperature logs showed staff failed to record temperatures as follows: * May 2021, 13 out of 31 days. * June 2021, 17 out of 31 days. * July 2021, 11 out of 31 days. * August 2021, 6 out of 31 days. * September 2021, 9 out of 30 days. * October 2021, 18 out of 31 days. -Observation of vaccine medication fridge at the	F 761	3 months, quarterly x 3 quarters with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. The DON or designee will audit all medication/vaccination refrigerators for completion of temperature checks weekly x 4 weeks, monthly x 3 months, quarterly x 3 quarters with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Date of correction: January 6, 2022.	

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F 761	Continued From page 39 nurses station in the Front room on 11/17/21 at 8:50 a.m., with a staff nurse (#9), showed staff failed to complete the temperature log as follows: * August 2021, 1 out of 31 days. * September 2021, 7 out of 30 days. * October 2021, 10 out of 31 days. During an interview on 11/18/21 at 10:04 a.m., an administrative nurse (#2) confirmed "Staff are responsible to check the refrigerator temperatures and record them, daily".	F 761		