STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	1315 S UNIVERSITY DR FARGO, ND 58103

(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 02/22/21 and concluded on 02/25/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/31/21

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

Electronically Signed | 03/25/2021

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to provide care for 1 of 18 sampled residents (Resident #35) in a manner and environment that maintained, enhanced, and respected the resident's dignity and individuality. Failure to speak respectfully and failure to completely cover a resident's body when returning from the bath does not preserve the residents' personal dignity or enhance their quality of life and places them at risk of embarrassment and/or emotional harm. Findings include: Review of the policy titled "Quality of Life-Dignity" occurred on 02/24/21. This policy, dated 2018, stated, "Residents shall be treated with dignity and respect at all times . . . Staff will speak respectfully to resident at all times. . . promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care. . ." Observation on 02/23/21 at 10:57 a.m., showed a staff member wheeling Resident #35 down the hall in a shower chair, water continued to run off his skin and his buttocks exposed through the	F 550	F550 Resident Rights/Exercise of Rights Corrective Action Resident #35 was interviewed to validate that he is being treated with dignity and respect. Resident encouraged to voice any concerns and educated resident on grievance process. Applicable staff educated on resident rights, including speaking respectfully and preserving resident dignity. Identification of Others Facility Advocates/designees will conduct sweep of all residents to address any concerns regarding dignity, privacy, and/or residents rights and cares are being met per resident satisfaction. Systemic Changes The Director of Nursing/designee will provide training to staff regarding resident rights to include dignity and respect and attending to identified care needs, including providing full visual privacy	

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F 550	Continued From page 2 back of the chair. Observation on 02/24/21 at 11:00 a.m., showed two CNA's [certified nursing assistants] (#1 and #2) provided personal cares for Resident #35. The CNA's (#1 and #2) assisted the resident wash his upper body and discussed negative issues about the facility. The CNA (#1) then removed the residents brief to complete perineum cares. Resident #35 was positioned on his back and completely exposed. The CNA (#2) dried the residents perineum area, prepared to apply skin protectant cream, and with the residents scrotum exposed, stated, "You are looking good" she laughed and commented, "well that was inappropriate, I bet you are uncomfortable huh?" Resident #35 did not respond. During an interview on 02/25/21 at 11:33 a.m., Resident #35 stated he "felt ok" with the cares provided by the staff. The prior day he stated, "I spasm at times and that can be uncomfortable." When asked about the comment that CNA (#2) made while doing cares, Resident #35 stated, "They tend to treat me like a friend. There are sometimes inappropriate comments made. I tend to ignore them or zone out." During an interview on 02/25/2021 at 12:34 p.m., an administrative nurse (#7) agreed, staff should have dried Resident #35 off in the bathroom, covered up when transferred to his room, and the comments made during cares failed to maintain the resident's dignity.	F 550	during cares. The Administrator/designee will provide education to department managers regarding the grievance and concerns process to include reconciliation and follow up with resident, responsible parties, and staff as applicable. Monitoring The Facility Advocates and or designee will conduct random audits to validate care needs are being met and their rights protected. Audits to be completed 3x/wk for one month, and then weekly 3 months. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		3/31/21

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F 578	Continued From page 3 §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. §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	F 578		

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F 578	Continued From page 4 appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record accurately reflected each resident's code level for 1 of 24 sampled residents (Resident #30). Failure to ensure the residents' medical record accurately reflected their wishes prevents staff from following the residents' choice in the event of a medical emergency. Findings include: Review of Resident #30's medical record occurred on all days of survey. A "Uniform Code Level Directives For Cardiopulmonary Resuscitation" form, dated 01/15/21, signed by Resident #30 stated, "Code Level 2: No intervention will be made in the event of a cardiac or respiratory arrest including defibrillation, chest compression, artificial respiration, or chemical resuscitation. Other conditions will be treated as medically appropriate." The physician's order in the resident's electronic health record dated 01/15/21 stated, "Full code." The banner in the electronic health record stated, "Full Code." During an interview on 02/25/21 at 8:30 a.m., an administrative nurse (#7), stated the physician's order and the Uniform Code Level Directives form should match the resident's choice. The facility failed to ensure Resident #30's medical record reflected resident's code level choice and the signed physician order reflected the resident's choice.	F 578	F-578 Request/Refuse/Discontinue Treatment; Formite Adv Dir Corrective Actions: The DON validated Resident #30s code status signed in the chart and corrected the order in electronic medical record to reflect the code status signed by Resident #30. Identification of Others; The DON/designee completed a sweep of all resident's code status. Validating orders in electronic medical record matched the signed code status completed by the resident/POA/guardian and facility staff. Systemic Changes; DON/Designee to complete education with Medical Records Supervisor/designee on uploading all signed code status orders into the miscellaneous section into EMR for each resident at time of admission and as needed for revised code orders. At the time of upload the medical records supervisor will review the orders to validate order matches the form signed.	

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F 578	Continued From page 5	F 578	The DON/designee will provide education to the license nurses regarding the requirements of entering the code status order into the electronic medical record after signature obtained and not based on orders received from hospital at time of transfer. Monitoring/QAPI; The DON/designee will conduct audits to validate the correct code status is in the orders of the electronic medical record and code status form is scanned into EMR. This audit will be completed weekly for 1 month, then monthly for three months and then quarterly. The ADON/designee will review applicable residents code status orders, signed form and order in electronic medical record, quarterly at time of care conference. Signed code status forms to be updated as needed. The DON/designee will report any identified trends to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/31/21

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F 684	Continued From page 6 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 record review, review of professional reference, and staff interview, the facility failed to ensure adequate follow up after a nephrology appointment for 1 of 4 sampled residents who received dialysis (Resident #48). Failure to ensure residents receive treatment and care in accordance with professional standards of practice may result in adverse health effects. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #48's medical record occurred on all days of survey. Diagnoses included chronic kidney disease and a history of hemodialysis. Resident #48's nurses' notes identified the following: *10/26/20 at 4:51 p.m.: ". . . Received call from nurse [name] at [dialysis center] stating that [provider name] is completely discontinuing	F 684	F684 □ Quality of Care Corrective Action The Director of Nursing/designee updated resident #48 primary care provider, while in the facility, of residents missed appointment with labs. Obtained order 2/24/21 to do labs the following morning and to not schedule appointment until resident is seen the next morning on rounds. Resident #48 was seen on rounds 2/25/21 and order to follow up with nephrology obtained. Facility staff called Nephrology department and scheduled follow up appointment. Identification of Others DON/Designee to complete a 90 day look back to validate current residents have been assisted to any ordered followed up appointments and that any provider requested labs have been obtained.	

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F 684	Continued From page 7 dialysis treatment at this time d/t [due to] resident not needing it anymore. . . ." *10/29/20 at 12:10 p.m.: ". . . Called [provider name] regarding resident follow up after stopping dialysis. New orders obtained for BMP [basic metabolic panel] on 11/4/20. . . ." *11/05/20 at 12:43 p.m.: ". . . BMP results received on 11/4, noted to be abnormal. Floor nurse updated [provider name] via phone and provider stated resident will be seen by nephrology on 11/24/20 at 1400 to follow up, no new orders at this time. . . ." *11/24/20 at 4:49 p.m.: ". . . Pt. [patient] returned from [nephrology] appointment at this time. Call also received from [interventional radiology] updating this writer that pt. perm cath [a type of catheter used for hemodialysis] was removed at that time. To keep dressing over site if drainage and to monitor site until healed. Follow-up with Nephrology in 1 month. . . ." A Nephrology Clinic Note, dated 11/24/20, stated, ". . . Assessment and Plan . . . CKD [chronic kidney disease] 5 . . . Currently off dialysis. . . . Return to clinic in 1 month with labs . . ." The "Plan of Care" from this clinic appointment identified, ". . . Instructions . . . PTH [parathyroid hormone] intact please complete by or around 12/24/20. Renal function panel please complete by or around 12/24/20. Urinalysis dipstick reflex to microscopic please complete by or around 12/24/20. . . . Return in about 4 weeks . . ." The medical record lacked evidence of a follow up appointment with the nephrology clinic or lab draws completed as ordered. During an interview on the morning of 02/25/21,	F 684	Systemic Changes The Director of Nursing/designee will provide education to applicable nursing staff related to noting physician orders including making follow up appointments and scheduling lab test. DON/Designee to complete education with Staff Development Coordinator/designee on tracking applicable residents who go out for an appointment to validate requested follow up appointments and lab test are scheduled and orders entered into electronic medical record accurately. Monitoring The Director of Nursing/designee will complete an audit for completion of physician orders after resident appointments to be completed 3x/wk for the first month, then monthly for 3 months. Any concerns will be corrected, and audits will be reported to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	

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F 684	Continued From page 8 an administrative nurse (#7) confirmed staff did not schedule a follow up appointment or labs.	F 684		
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 record review, resident, family and staff interviews, and review of facility policy, the facility failed to provide assistance necessary to prevent accidents for 1 of 4 sampled residents (Resident #21) with a fall. Failure to transfer Resident #21 safely placed the resident at risk of an accident and/or injury. Findings include: Information provided by the resident and family indicated staff transferred Resident #21 with assist of one, even though the care plan at the time showed Resident #21 required assist of two staff for all transfers. Review of the facility policy titled "Safety and Supervision of Residents" occurred on 02/25/21. This undated policy stated, ". . . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. . . . The care team may target interventions to reduce individual risks related to hazards in the	F 689	F 689 Free of Accident Hazards/Supervision/Devices Corrective Action The Director of Nursing/designee reassessed resident #21 for assistance needed and devices required for safe transfers, care plan updated as applicable. Applicable staff educated¿on proper transfer techniques and devices. Identification of Others DON/Designee to complete sweep of residents to validate that residents requiring assistance for transfers is appropriately documented in resident record and care plan as applicable. Any identified discrepancies will be promptly corrected. Systemic Changes	3/31/21

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F 689	Continued From page 9 environment, including adequate supervision . . . When accident hazards are identified, the QAPI [Quality Assurance and Performance Improvement]/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. . . ." Review of Resident #21's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 01/02/21, identified extensive assist of two staff for transfers. Resident #21's progress notes stated the following: * 01/27/21 at 11:58 p.m., ". . . resident was being transferred off the commode and legs gave out and slid to the floor CNAs with her and was lowered to the floor. Was (sic) Hoyer up back in chair no injuries noted wheeled self done (sic) the hall. . . ." * 1/28/21 at 5:54 a.m., ". . . Event follow up note: Type of Event: fall 1/27/21 Vitals: BP [blood pressure] 147/72 P [pulse] 88 R [respirations] 18 T [temperature] 97.6 02 [oxygen saturation] 100%. Pain Level: resident states that she is experiencing some generalized pain. 2/10 and tolerable. Level of Consciousness: Resident is alert and is able to make needs known. Treatment for injuries/pain r/t [related to] event responding to treatment or resolving: no visible injuries noted. * 1/28/21 at 9:15 p.m., ". . . Event follow up note: Type of Event: Witnesses (sic) fall - follow up. Vitals: BP = 138/76, T = 98, P = 90, R = 16. Pain	F 689	The DON/designee will provide education to all applicable staff on safe and proper transfers, including the use of gait belts. Further education will include providing necessary assistance to residents during a transfer based on the care plan. Monitoring/QAPI The DON/Designee will audit resident transfers and use of assistive devices based on the resident care plan through observation/staff and resident interview/record review 3x/wk for one month, then monthly for 3 months. Any identified trends will be reported to the Quality Assurance and Performance Committee monthly and as needed until a lessor frequency is deemed appropriate by the committee. Date of Compliance 3/31/21	

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F 689	Continued From page 10 Level: No increased pain from fall. Level of Consciousness: A/O [alert and orientated] x 4. Treatment for injuries/pain r/t event responding to treatment or resolving: No bruising noted. . . ." Resident #21's current care plan on the date of the fall stated, ". . .I am requesting to use moderate assist of 2 with all transfers and not the standing lift. But I will also ask to use the standing lift PRN [as needed]. The facility investigation showed on 01/27/21 at 10:58 a.m., a CNA (certified nurses assistant), (#12) transferred Resident #21 from the bed to the commode with a one person assist. The investigation also showed on 01/27/21 at 11:15 a.m., a different CNA (#11) was attempting to transfer Resident #21 with a one person assist from the commode to the wheelchair when the fall occurred. The investigation failed to verify the staff used the gait belt for the one person assist with transfers. During an interview on 02/25/21 at 10:40 a.m., an administrative nurse (#7) confirmed staff transferred Resident #21 incorrectly with assist of one instead of two assist per care plan.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		3/31/21

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F 692	Continued From page 11 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 1 of 2 sampled residents with a tube feeding (Resident #20). Failure to provide adequate calories/nutrition via gastrostomy tube (G-tube) and/or ensure sufficient oral intake resulted in Resident #20 experiencing severe weight loss (greater than 7.5 % in 3 months). Findings include: Review of the facility policy titled "Enteral Nutrition" occurred on 02/25/21. This policy, dated 2018, stated, ". . . Adequate nutritional support through enteral feeding will be provided to residents as ordered. . . ." Review of Resident #20's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke), aphasia (inability to understand or express speech), a G-tube, and dysphagia (difficulty swallowing).	F 692	F692- Nutrition/Hydration Status Maintenancel Corrective Action The Director of Nursing (DON)/designee updated Resident #20 orders in electronic medical record to include total volume feeding to be infused. Identification of Others The Director of Nursing (DON)/designee will conduct a review of other residents requiring enteral feedings to assess that their volumes infused documented in the electronic medical record is the correct amount to be infused per providers orders. The Registered Dietician (RD) will conduct a review of current residents' weights to validate they are being	

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F 692	Continued From page 12 A nutritional assessment, dated 01/14/21, stated, ". . . Nutritional review given weight loss and new pressure ulcer to ankle. Intermittent g-tube feedings continue x 16 hrs [hours] per day. Tolerating. Enteral feedings currently meeting [about] 40% of nutritional needs. Given weight loss and decrease in PO [oral] will increase enteral feedings to the following: Osmolite [an enteral feeding solution] 1.2 [calorie] 65 ml/hr [milliliters per hour] x 16 hr. This will meet [about] 70% of nutritional needs. . . ." A nutritional assessment, dated 02/22/21, stated, ". . . Nutritional review given weight loss and new pressure ulcer to ankle. Intermittent g-tube feedings continue x 16 hrs per day. Tolerating. Enteral feedings currently meeting [about] 70% of nutritional needs. Given weight loss and decrease in PO will increase enteral feedings to the following: Osmolite 1.2 95 ml/hr x 16 hr. This will meet [about] 70% of nutritional needs. . . ." Physician's orders identified Osmolite 1.2 calorie at 40 ml/hr for 16 hours (a total of 640 ml), starting at 6:00 p.m. and ending at 10:00 a.m. the next day. The physician's order began on 12/10/20 and ended on 01/21/21. The Medication Administration Record (MAR) for December 2020 and January 2021 identified Resident #20 received less than 640 ml of feeding on 13 occasions during that time period. Beginning on 01/21/21, the physician increased Resident #20's feeding to 65 ml/hr for 16 hours (a total of 1040 ml) until 02/23/21. The MAR for January and February 2021 identified Resident #20 received less than 1040 ml of feeding on 22	F 692	obtained per physician orders, accurate and that significant changes including trending are included in the Weekly Skin and Weight Meeting and applicable interventions are implemented and care plan is reflective of interventions. Any concerns will be corrected, care plan updated and physician notified. Systemic Changes The DON/designee will provide education to applicable licensed nursing staff on following physician orders for administration of enteral tube feeding. The DON/designee will provide education to applicable nursing and dietary staff on obtaining and reviewing obtained weights and requesting reweighs if a discrepancy is noted prior to recording in the resident□s medical record. The RD/designee will provide education to the Skin and Weight committee on requirements for Inter disciplinary team (IDT) review weekly for residents that have been identified with significant weight changes including trending gains and losses and applicable interventions that have been implemented to prevent undesired weight loss/gain. Monitoring The RD/designee will audit new admissions to validate an accurate baseline weight is obtained. Audits will be	

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F 692	Continued From page 13 occasions during that time period. Beginning on the evening of 02/23/21, the physician ordered Osmolite 1.2 at 95 ml/hr for 16 hours (a total of 1520 ml). Resident #20's weights (ordered weekly) showed the following: 11/18/20 237.0 pounds (Lbs) 12/12/20 236.6 Lbs 01/04/21 225.0 Lbs 01/13/21 217.0 Lbs (a 19.6 weight loss in one month [8%, i.e. severe]) 01/14/21 214.6 Lbs 01/18/21 212.4 Lbs 01/25/21 216.8 Lbs 02/01/21 213.4 Lbs 02/08/21 211.4 Lbs 02/15/21 210.1 Lbs 02/22/21 209.2 Lbs *The weights identified a 27.8 pound weight loss over three months (11%, i.e. severe weight loss). The record failed to identify weights from 12/12/20 until 01/04/21 (three weeks), and Resident experienced an 11 pound weight loss during that time. Meal intake records for February 1-24, 2021 showed Resident #20 consumed 25% or less at 61 of 70 meals documented. Meal intake records for January 2021 showed Resident #20 consumed 25% or less at 58 of 92 meals documented. Meal intake records for December 2020 showed Resident #20 consumed 25% or less at 34 of 87 meals documented. Observation on 02/23/21 at 7:40 a.m. showed Resident #20 in his room, assisted with morning cares per two certified nursing assistants, and his	F 692	conducted three times per week for four weeks, then weekly for three months, and then reassess in QAPI for changing or ceasing audits based on findings. The RD/designee will monitor weights weekly, and as needed to address weight increases/decreases, including trending and implement interventions as appropriate. The Skin and Weight Meeting will continue to be held weekly to discuss resident's weights and the need for intervention. Monitoring will be ongoing. RD/Designee will monitor residents who receive enteral feeding weights weekly for weight loss, weekly x 4 weeks then monthly and will be addressed in weekly skin weight meeting. The DON/Designee will audit volume intake of enteral feedings for applicable residents to ensure volume matches the prescribed order. Audits will be conducted three times per week for four weeks, then weekly for three months, and then reassess in QAPI for changing or ceasing audits based on findings. The DON/Designee will audit weights obtained per provider's order. Audits will be conducted three times per week for four weeks, then weekly for three months, and then reassess in QAPI for changing or ceasing audits based on findings. The DON/Designee and the RD/designee	

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F 692	Continued From page 14 tube feeding turned off. A nurse (#8) stated she shut the feeding off about 10 minutes prior for morning cares. At 08:22 a.m., staff assisted Resident #20 to eat breakfast in the dining room. Observation showed Resident #20 refused all food and fluids. At 8:26 a.m., staff brought Resident #20 to the hallway, and the nurse restarted the feeding at 65 ml/hour. At approximately 10:30 a.m., the nurse shut the feeding off, and noted the total volume to be 945 ml. Review of the MAR for 02/23/21 showed staff charted a volume of 950 ml. Observation on 02/24/21 from 7:50 a.m. until approximately 8:30 a.m. showed Resident #20 in his wheelchair with his feeding pump turned off. At 10:00 a.m., a nurse (#6) shut the feeding pump off for the day and charted a total volume of 1883 ml of feeding. Further inspection of the feeding pump identified a rate of 95 ml/hr and 1883 ml of total fluid given, with 500 ml of water flush (i.e., 1383 ml of feeding). During an interview, a charge nurse (#13) confirmed the total volume of feeding was 1383 ml, and not 1883 ml as the nurse (#6) had charted. Failure to ensure Resident #20 receives the full volume of enteral feeding and accurately chart intakes of enteral feedings misrepresents Resident #20's actual intakes and may delay implementation of additional interventions to prevent weight loss. Failure to provide adequate calories/nutrition via G-tube and/or ensure sufficient oral intake resulted in Resident #20 experiencing severe, avoidable weight loss (greater than 7.5 % in 3 months).	F 692	will track and trend audit findings and report to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed. The QAPI Committee will evaluate the effectiveness of each plan based on the trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3 months, and then reassess the need for continued monitoring based on compliance. Date of Compliance 3/31/21	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		3/31/21

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F 695	Continued From page 15 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, staff and resident interview, the facility failed to provide respiratory care consistent with standards of practice and physician orders for 1 of 2 sampled residents (Resident #27) receiving oxygen. Failure to ensure oxygen staff administered, assessed, and monitored as ordered may complicate a resident's respiratory status and result in inappropriate use of oxygen. Findings include: Review of the facility policy titled "Oxygen Administration" occurred on 02/22/2021. The policy, updated, 2020, stated, "The purpose of this procedure is to provide guidelines for safe oxygen administration. . . . Verify that there is a physician's order . . . Review the resident's care plan to assess for special needs. . ." Review of Resident #27's medical record occurred on all days of the survey. The physician's order, dated 01/12/2021, stated, "O2 [Oxygen] at 2LPM [Liters per Minute] per NC [Nasal Canula] at bedtime every night shift for OSA [Obstructive Sleep Apnea].	F 695	F695- Respiratory/Tracheostomy Care and Suctioning Corrective Action The Director of Nursing (DON)/designee notified residents # 27 provider and new oxygen order obtained from NP. Applicable staff provided with education on following physicians orders as it relates to oxygen administration. Resident #27 has since been discharged. Identification of Others DON/designee will review applicable residents who have orders for Oxygen administration to verify it is being administered per MD orders. Any concerns identified were promptly corrected. Systemic Changes The Director of Nursing/designee will	

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F 695	Continued From page 16 Observations showed the following: - 02/23/21 at 10:48 a.m., in bed continuous oxygen in place at 1.5 liters - 02/24/21 at 08:30 a.m., in bed continuous oxygen in place at 1.5 liters - 02/24/21 at 1:45 p.m., returning from appointment with portable oxygen in place at 2.0 liters During an interview, on 02/24/21 at 8:30 a.m., Resident #27 stated, " I don't use oxygen when I leave the building. I don't need it. I'm not supposed to wear it all the time, but I do. It should be set on 2 liters." During an interview on 02/25/21 at 12:30 p.m., an administrative nurse (#7), agreed staff failed to follow physicians orders. Resident #27's oxygen is only ordered at night.	F 695	provide education to applicable nursing staff on following physicians orders in regards to oxygen administration. Monitoring The Director of Nursing/designee will complete an audit to monitor oxygen use and validate oxygen is being used appropriately per MD orders 3x/wk for the first month, then weekly for 3 months. Any concerns will be corrected, and audits will be reported to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/16/2019 Based on record review, review of facility policy, and staff interview, the facility failed to provide care and services for the provision of hemodialysis consistent with professional	F 698	F698- Dialysis Corrective Action Resident #12 continues with dialysis treatment, assessed for bleeding and potential complications post-dialysis. No	3/31/21

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F 698	Continued From page 17 standards of practice for 3 of 3 sampled residents (Resident #12, #23, and #42) receiving hemodialysis. Failure to assess and monitor the resident's condition after dialysis and obtain blood pressure in the extremity with a fistula may result in bleeding, loss of access site, or other complications. Findings include: Review of the facility policy titled "Hemodialysis Access Care" occurred on 02/25/21. This undated policy stated, ". . . Vascular access may be accomplished in one of three ways: a.) Arterio-venous fistula (AVF) b.) Arterio-venous graft (AVG) c.) Central Catheter. . . Care of AVFs and AVGs. . . e.) Do not use the access arm to take blood pressure. . . . Documentation: The general medical nurse may document in the resident's medical record every shift as follows:. . . . 5.) Observations post dialysis." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included end stage renal disease. Record review identified Resident #12 received dialysis three days per week via a left forearm AVF. Resident #12's pre and post dialysis form from 02/01/21 until 02/24/21 showed staff failed to complete the pre dialysis assessment on two occasions and the post dialysis assessment on four occasions. - Review of Resident #23's medical record occurred on all days of survey. Diagnoses included end stage renal disease. Record review identified Resident #23 received dialysis three days per week via a left forearm AVF. Resident #23's pre and post dialysis form from 01/25/21	F 698	concerns assessed. Resident #23 and resident #42 have since been discharged. Identification of Others DON/designee to review all residents receiving hemodialysis services, and those with an AVF, to verify orders for monitoring and appropriate treatment of access sites are in place. Systemic Changes The Director of Nursing/designee will provide education to applicable nursing staff related to pre and post-dialysis assessments and monitoring including assessment of AVF/Central Catheter. The Director of Nursing/designee will provide education to applicable nursing staff regarding the limitations related to care for residents with dialysis fistulas, such as blood draws, IV sticks, and obtaining blood pressure. Monitoring The Director of Nursing/designee will complete an audit of documentation/monitoring/assessments and care plan interventions for pre and post-dialysis bleeding/complications for residents receiving dialysis 3x/wk for the first month, then monthly for 3 months. Director of Nursing/designee will monitor	

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F 698	Continued From page 18 until 02/22/21 showed staff failed to complete the post dialysis assessment on six occasions. Resident #23's blood pressure records from February 06, 2021 to February 23, 2021 showed staff took his/her blood pressure on his/her left arm (the site of the AVF) on four different occasions. A physician's order, dated 11/10/20, stated, "No BP [blood pressure] or Blood Draws to left AVF extremity." - Review of Resident #42's medical record occurred on all days of survey. Diagnoses included end stage renal disease. Record review identified Resident #42 received dialysis three days per week via a right forearm AVF. Resident #42's pre and post dialysis form from 02/01/21 until 02/24/21 showed staff failed to complete the post dialysis assessment on seven occasions. Resident #42's blood pressure records from 01/01/21 to 02/11/21 showed staff took his/her blood pressure on his/her right arm (the site of the AVF) on five different occasions. During an interview on 02/25/21 at 12:22 p.m., an administrative nurse (#5) her expectations she stated, "I would expect the post assessment would be completed by the nurse and the resident monitored with documentation . . . I would expect physician's orders to be followed by staff." The administrative nurse (#5) confirmed the staff failed to document post assessments and follow physician orders.	F 698	compliance with limiting access of limbs or restricted access for blood draws, vital signs, Intravenous access 3x/wk for the first month, then monthly for 3 months. Any concerns will be corrected, and any identified trends will be reported to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		3/31/21

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F 727	Continued From page 19 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's nursing staff schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for two days of the 36 day period from 01/17/21 to 02/21/21. Failure to ensure sufficient, qualified nursing staff are available daily has the potential to affect all the residents residing in the facility. Findings Include: The facility provided a copy of the nurses' schedule for the time period of 01/17/21 to 02/21/21. A review of the schedules showed the facility lacked the required RN coverage on 02/06/21 and 02/07/21. During an interview on 02/24/21 at 4:30 p.m., an administrative nurse (#9) confirmed the facility lacked eight consecutive hours of RN coverage on 02/06/21 and 02/07/21.	F 727	F 727 RN 8hrs per day 7 days per week Corrective Action: The Administrator/designee provided written education to the Director of Nursing related to regulations surrounding requirements of having a registered nurse to work for 8 consecutive hours a day, 7 days a week. Identifications of Others: The Director of Nursing/designee conducted a 7 day look back on the staffing schedule to validate a RN was scheduled/worked 8 consecutive hours 7 days a week, if concerns were identified the Director of Nursing/designee reviewed 24-hour reports to validate that resident care needs were promptly assessed, physicians notified, and interventions	

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F 727	Continued From page 20	F 727	implemented timely as applicable. Systemic Changes: The Administrator/designee provided education to the DON on steps to take and who to notify if RN coverage is insufficient to meet minimum requirements of 8 consecutive hours a day, 7 days a week. Monitoring/QAPI: The Administrator/designee will conduct a review 3 x a week for 4 weeks, then weekly to validate that the RN coverage has been sufficient to meet minimum requirements of 8 consecutive hours 7 days a week. The Administrator/designee will report any identified trends to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate. Date of Compliance 3/31/21	
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	F 755		3/31/21

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F 755	Continued From page 21 §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 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 facility policy, record review, staff and resident interviews, the facility failed to obtain routine, regularly scheduled medication for 2 of 18 sampled residents (Resident #21 and #48). Failure to ensure each resident receives routine, regularly scheduled medications has the potential for residents to suffer unnecessary pain and other adverse effects.	F 755	F-755 Pharmacy Services/Procedures- ¿Corrective Action¿ Director of nursing verified resident #21 medication available, and no concerns identified.	

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F 755	Continued From page 22 Findings include: Review of the facility policy titled "Medication and Treatment Orders" occurred on 02/25/21. This policy, dated 2018, stated, ". . . Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) dates prior to the last dosage being administered to ensure that refills are readily available. . . ." -Review of Resident #21's medical record occurred on all days of survey and included the diagnosis of chronic pain syndrome. Resident #21's current physician orders included; Oxycodone HCl (an opioid medication used for moderate to severe pain) Tablet 10 MG [milligrams]. Give 10 mg by mouth every 8 hours for Chronic pain syndrome. The electronic medication administration record (EMAR) identified the following: * 02/12/21 at 7:00 a.m., ". . .Oxycodone HCL [hydrochloride] Tablet 10 MG every 8 hours for chronic pain syndrome. Out of supply et [and] no medication available in cubex [automated medication dispensing system]. Writer called pharmacist et they will have sent a new card out to be received in am. . . ." * 02/13/21 at 12:00 a.m., showed Resident #21's scheduled Oxycodone was not administered. * 02/13/21 at 8:00 a.m., ". . .Oxycodone HCL 10 MG Give every 8 hours for chronic pain syndrome. Out of stock. . . ." Resident #21's controlled substance record for Oxycodone HCL 10 MG tablets on 02/11/21 at	F 755	Director of nursing verified resident #48 medication available, and no concerns identified. Identification of Others Director of Nursing/designee validated that medications were readily available to all residents, any concerns were promptly corrected. Systemic Changes¿ Director of nursing/designee met with pharmacy representatives to verify appropriate stocking of medications in Nexsys. Director of Nursing/designee will maintain ongoing communication with the Pharmacy and representatives to assure routine stocking of Nexsys is maintained. Director of Nursing/designee will complete education with nursing staff on appropriate measure to follow when medication is needing to be reordered or is not available at time of dispensing. Monitoring Director of Nursing/Designee will perform audit 3 times a week x 4 weeks then weekly of medication carts through observation, chart review, and interview to verify availability of all medications for residents. ¿	

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	355024	A. BUILDING _____ B. WING _____	02/25/2021

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F 755	Continued From page 23 4:00 p.m., showed a zero amount remaining. When requested the facility failed to provide the controlled substance record for 02/12/21 and 02/13/21. The controlled substance record on 02/14/21 showed six Oxycodone 10 MG tablets added. -Review of Resident #48's medical record occurred on all days of survey. Diagnoses included chronic kidney disease and a history of hemodialysis. Current medications included Renvela (a phosphorus-binding agent). Nurses' notes identified the following: *10/24/20 at 12:19 p.m.: ". . . Called pharmacy to get re-fill on powdered Renvela. Pharmacy will not be able to re-fill prescription until next week. . . ." *10/24/20 at 2:47 p.m.: ". . . Called [dialysis provider] to inform them we are unable to administer Renvela since pharmacy is out of stock. [dialysis RN] will not write hold order because they want the patient to get the medication. . . ." *10/26/20 at 3:38 p.m.: ". . . Updated [nurse practitioner] re: [regarding] renvela order and not having supply from pharmacy. . . ." An order received on 10/26/20 at 3:40 p.m. identified: ". . . Ok to hold Renvela until received from pharmacy. One time only until 10/28/2020 d/t [due to] no current supply . . ." *12/01/20 at 1:43 p.m.: ". . . Pt [patient] did not receive Renvela powder med d/t no supply. Ordered from pharmacy. . . ." *12/02/20 at 3:15 p.m.: ". . . New order: 1)HOLD Renvela until supply arrives . . ." The medication administration record (MAR) for December 2020 identified staff held the medication (due to	F 755	The Director of Nursing/designee will report any identified trends to the Quality Assurance and Performance Improvement Committee monthly and as need until a lesser frequency¿is¿deemed¿appropriate.¿¿ Date of Compliance 3/31/21	

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F 755	Continued From page 24 unavailability) for over a week. During an interview on 02/25/21 at 10:40 a.m., an administrative nurse (#7) stated nursing staff should have called for medication refills sooner to avoid a delay in administration.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 4 of 7 sampled residents observed during medication administration (Resident #20, #30, #48, and #50). Fourteen medication errors occurred during staff administration of 39 medications, resulting in a 35% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility competency titled "Insulin Pen Preparation Competency" occurred on 02/25/21. This undated competency stated, ". . . 3. Wipe the rubber seal on the . . . pen with alcohol, then remove the protective seal from a new needle. 4. Push the capped needle straight onto the pen and twist the needle on until it is tight. 5. Take off and keep the outer needle cap,	F 759	F759- Free of Medication Error Rts 5 Prcnt or More Corrective Action Resident # 30 was assessed for signs and symptoms of hypo/hyper glycemia with no concerns identified. Resident # 50 was assessed for signs and symptoms of hypo/hyper glycemia with no concerns identified. Resident # 48 was assessed for concerns related to insufficient flushing (occluded tubing, efficacy of medication) between medications administered through g-tube with no concerns identified. Resident # 20 was assessed for concerns related to insufficient flushing (occluded tubing, efficacy of medication) between	3/31/21

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F 759	Continued From page 25 then remove the inner needle cap and discard it. 6. Select a dose of 2 units by turning the dosage selector. 7. Hold the pen with the needle pointing upwards and tap the insulin reservoir so that any air bubbles rise up towards the needle. 8. Press the injection button all the way in and check if insulin comes out of the needle tip. If no insulin comes out, repeat the process until you see a drop of insulin - a max of 6 times. . . ." Review of the facility policy titled "Administering Medications through an Enteral Tube" occurred on 02/25/21. This policy, dated 2018, stated, ". . . Administering each medication separately and flushing between medications is considered standard of practice. . . . Confirm placement of feeding tube . . . Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. . . . When correct tube placement and acceptable GRV have been verified, flush tubing with 15-20 mL [milliliters] warm sterile water. . . ." -Review of Resident #30's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2. Observation on 02/23/21 at 8:30 a.m., showed a staff nurse (#5) failed to remove the inner and outer caps from the needles when priming the Novolog and Lantus insulin pens for Resident #30 prior to administration. -Review of Resident #50's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2 with hyperglycemia (high blood sugar). Observation on 02/23/21 at 8:50 a.m., showed a	F 759	medications administered through g-tube with no concerns identified. DON/Designee educated applicable staff who administered insulin and medication via g-tube during the survey on proper medication administration for medications administered via g-tube and those by insulin pen. Identification of Others The Director of Nursing/designee will conduct a 7 day look back on resident who receive insulin via insulin pen to validate any concerns related to hypo/hyper glycemia were promptly addressed and physician notified if applicable. The Director of Nursing/designee will conduct a 7 day look back on residents who receive medication via gastric tube to validate any concerns related to insufficient flushing (occluded tubing, efficacy of medication) between medications were promptly addressed and physician notified if applicable. Systemic Changes The¿Director¿of Nursing/designee will provide training to license nurses on medication administration via g-tube. The Director of Nursing/designee will	

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F 759	Continued From page 26 staff nurse (#5) failed to remove the inner and outer caps from the needles when priming the Novolog and Lantus insulin pens for Resident #50 prior to administration. - Review of Resident #48's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) and a gastrostomy tube (G-tube) placement. Observation on 02/23/21 at 8:46 a.m. showed a nurse (#8) administered the following medications to Resident #48 via G-tube: aspirin, liquicel (a protein supplement), and metoprolol and amlodipine (blood pressure medications). The nurse failed to check placement/GRV and flush the tubing between these medications. - Review of Resident #20's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) and a gastrostomy tube (G-tube) placement. Observation on 02/23/21 at 10:30 a.m. showed a nurse (#8) administered the following medications to Resident #20 via G-tube: Liquicel, amlodipine, aspirin, carvedilol (a blood pressure medication), vitamin D, sodium chloride, and ezetimibe and rosuvastatin (cholesterol medications). The nurse failed to flush the tubing between these medications. During an interview on the morning of 02/25/21, an administrative nurse (#7) stated staff should follow the policy when administering medications via G-tube and remove the needle caps prior to priming all insulin pens.	F 759	provide training to licenses nurses on medication administration via insulin pen. ¿ Monitoring The Director of Nursing/designee will conduct reviews through observation on medication administration for insulin pens and g-tube medications 3 times per week for 4 weeks, then weekly for 3 months. The Director of Nursing/designee will report any identified trends to the Quality Assurance and Performance Improvement Committee monthly and as need until a lessor frequency¿is¿deemed¿appropriate.¿	
F 761	Label/Store Drugs and Biologicals	F 761		3/31/21

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F 761 SS=E	Continued From page 27 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. §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: EXPIRED MEDICATIONS 1. Based on observation, review of facility policy, and staff interview, the facility failed to properly store medications in 1 of 3 medication carts (South #1 medication cart) reviewed. Failure to discard expired medications increases the risk of residents receiving outdated medications with reduced efficacy.	F 761	F761 Label/Store Drugs and Biologicals Corrective Action: DON/Designee validated that all expired	

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F 761	Continued From page 28 Findings include: Review of the facility policy titled "Facilities Medication Ordering/Refilling Policy and Procedure" occurred on 02/25/21. This policy, dated 09/11/20, stated, ". . . Nurses are responsible for checking expired medications monthly. . . ." Observation of the South #1 medication cart on 02/24/21 at 1:58 p.m., with a certified medication aide (CMA) (#10) and showed one bottle of Tums, expired December 2020. During an interview on 02/25/21 at 12:30 p.m., an administrative nurse (#7) stated she expected facility staff to check expiration dates on medications prior to administering them and dispose of any expired meds according to policy. MEDICATION LABELING 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications in 2 of 2 medication carts (South #1 medication cart and North #1 medication cart) observed during medication pass and medication storage review. Failure to correctly label medications may increase the risk of residents receiving an inaccurate dose of medication. Findings include: Review of the facility policy titled "Medication Ordering and Receiving from Pharmacy" occurred on 02/25/21. This policy, dated	F 761	medications were removed from medication carts. DON/Designee validated appropriate labels were affixed to all insulin pens and use as directed stickers were affixed to any medications with orders updated and available to all nurses. ID of Others: The Director of Nursing/designee will conduct a review of all medication carts to validate expired and discontinued medications have been removed and secured per regulations for either destruction or returned to pharmacy.¿ The Director of nursing/designee will verify all medications have full label affixed to outside container or prescription containers. The Director of Nursing/designee will validate Use as directed stickers are attached to all medications with dose or direction changes. Systemic Changes: The¿Director¿of Nursing/designee will provide training to license nurses on process of removal of¿routine¿expired and discontinued medications from	

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F 761	Continued From page 29 10/01/20, stated, "A. Labels are permanently affixed to the outside of the prescription container. . . . If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container . . . but the resident's name, at least, must be maintained directly on the actual product container. B. Each prescription medication label includes: 1. Resident's name 2. Specific directions for use . . . may be labeled "use as directed" and refer the person administering the medication to the medication administration record for instruction details. 3. Medication Name . . . 4. Strength of medication . . . 5. Prescriber's name 6. Date dispensed . . . 8. Expiration date of medication . . . " - Observation on 02/23/21 at 8:30 a.m. showed the staff nurse (#5) prepared to administer Novolog (short acting) and Lantus (long acting) insulins to Resident #30 from the South #1 medication cart. The Novolog insulin pen lacked a pharmacy label and only contained Resident #30's first name written on the pen cap. The label on the Lantus insulin pen stated, "use by 09/30/19 . . . administer 40 units daily." Review of Resident #30's medical record occurred all days of survey. A physician's order dated 02/18/21 stated "Lantus 42 units subcutaneously daily." - Observation on 02/23/21 at 8:50 a.m. showed the staff nurse (#5) prepared to administer Novolog (short acting) and Lantus (long acting) insulins to Resident #50 from the South #1 medication cart. The Novolog insulin pen lacked a pharmacy label and only contained Resident	F 761	medication carts, Process to assure that medications are labeled correctly with order or update with Use as directed stickers. The Director of nursing/designee will confer with pharmacy to change labeling of insulin pens so that each pen is held in outside container which is fully labeled. ¿ ¿ Monitoring: The Director of Nursing/designee will conduct reviews through observation and interviews 3 times a week for¿4 weeks and then weekly thereafter to¿validate¿that both routine and scheduled medications that have expired or have been¿discontinued¿have been removed promptly from medication cart. The Director of Nursing/Designee will conduct reviews through observation of alternating medication carts, 3 times a week for 4 weeks and then weekly thereafter to validate that all insulin pens in cart are properly labeled with full name, directions on either pen or outside container in which they are held.	

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F 761	Continued From page 30 #50's first name written on the pen cap. The label on the Lantus insulin pen stated, "use by 09/30/19 . . . administer 25 units daily." Review of Resident #50's medical record occurred all days of survey. A physician's order, dated 02/23/21, stated, "Lantus 30 units subcutaneously daily." During an interview on 02/23/21 at 9:30 a.m. a staff nurse (#5) stated the "use by 09/30/19" on the labels of the Lantus insulin pens for Residents #30 and #50 "has to be a typo. Neither were even admitted here in 2019." The staff nurse (#5) also verified facility staff write the resident first name and last initial on the pen cap of unlabeled insulin pens. - Observation on 02/24/21 at 2:15 p.m. showed the North #1 medication cart with one Novolog Flexpen (insulin pen) with no pharmacy label and a manufacturers expiration date of November 2022. Handwriting on the cap of the insulin pen stated, "[First name, initial] Open 2/22, Exp. 3/22." During an interview on 02/24/21 at 2:30 p.m., a staff nurse (#6) stated a nurse wrote on the Novolog Flexpen cap in the North #1 medication cart. The staff nurse (#6) stated the information indicated the resident the insulin pen belonged to, the opened date and discard date of the insulin pen. During an interview on 02/25/21 at 12:30 p.m., an administrative nurse (#7) stated she expected staff to verify incorrect information on any pharmacy label with the pharmacy prior to	F 761	The Director of Nursing/Designee will conduct reviews through observation of alternating medication carts 3 times a week for 4 weeks then weekly thereafter to validate that all medication which have had change in direction have a use as directed sticker affixed to container/label. The Director of Nursing/designee will report any identified trends to the Quality Assurance and Performance Improvement Committee monthly and as need until a lessor frequency¿is¿deemed¿appropriate.¿ Date of Compliance 3/31/21	

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F 761	Continued From page 31 administering the medication. She agreed the facility staff failed to ensure the insulin pens contained correct pharmacy labels prior to administration. The facilty staff failed to ensure insulin pens contained correct pharmacy labels upon receipt of the medication and prior to administration. Failure to ensure appropriate pharmacy labeling may lead to residents receiving the wrong medication or inaccurate doses of medications.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/31/21

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F 880	Continued From page 32 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 33 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/16/19 Based on observation, review of facility policy, the facility failed to ensure staff followed standard infection control practices for 2 of 4 days of survey (02/23/21 and 02/24/21). Failure to follow standard infection control practices related to hand hygiene and glove use may result in the spread of infections within the facility. Findings include: Review of the facility policy titled "Handwashing/Hand Hygiene" occurred on 02/25/21. This policy, dated 2018, stated, "This facility considers hand hygiene the primary means to prevent the spread of infections. . . . 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections . . . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . . . b. Before and after direct contact with residents; c. Before preparing or handling medications; . . . h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; . . . m. After removing gloves . . . . "	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The director of nursing (DON), in conjunction with the interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: 1. Ensuring staff perform hand hygiene when donning PPE, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. 2. Identification of Others The DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 03/31/2021 the facility shall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 34 Observations during medication pass on 02/23/21 at 8:19 a.m. showed a staff nurse (#6) touched the inside of the medication cups with bare fingers and failed to perform hand hygiene when administrating medication between two residents. - 02/23/21 at 8:32 a.m., a CNA (#3) entered Resident #27's room to assist him/her with repositioning. The CNA failed to perform hand hygiene upon entering and exiting the resident's room. - 02/23/21 at 8:39 a.m., a CNA (#4) entered Resident #27's room to assist him/her with repositioning. The CNA failed to perform hand hygiene upon entering and exiting the resident's room. - 02/23/21 at 10:17 a.m., a CNA (#1) performed perineum/bowel movement cares on Resident #27 who laid in bed. The CNA removed the soiled gloves and failed to perform hand hygiene before applying new gloves and continued to perform perineum cares on Resident #27. - 02/24/21 at 11:00 a.m., two CNAs (#1 and #2) entered Resident #35's room to assist with morning cares. The CNAs (#1 and #2) failed to perform hand hygiene before applying gloves or in between glove changes while performing perineum/bowel movement cares for the resident.	F 880	complete the following actions: 1. DON, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: Failure to complete handwashing or hand hygiene in accordance with CDC guidelines. 2. The DON, or suitable designee will ensure the following: All staff will receive education on hand hygiene, keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. 4. Monitoring Weekly for no less than 12 weeks, the DON, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: 1. Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in education for the involved staff. Such education will be documented on monitoring forms.	

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F 880	Continued From page 35	F 880	After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 03/31/2021	