| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE MEADOWS ON UNIVERSITY | 1315 S UNIVERSITY DR FARGO, ND 58103 |

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey and complaint investigations started on 04/18/22 and concluded on 04/21/22. | F 000 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the | F 582 | | 5/24/22 |

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

Electronically Signed | 05/19/2022

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| F 582 | Continued From page 1<br>facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Medicare Part A letters/notices and staff interview, the facility failed to ensure the resident/their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) for 1 of 2 supplemental residents (Resident #35) discharged from Medicare Part A who remained in the facility. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights in regard to Medicare Part A services.<br><br>Findings include:<br><br>Review of Medicare Part A beneficiary notices identified Resident #35 discharged from Medicare Part A on 01/21/22. The SNFABN, | F 582 | F582 Medicare/Medicaid Coverage<br><br>Corrective Action: Resident #35 has been discharged.<br><br>Identification of Others: The Business Office Manager will conduct a review of completed NOMNC/SNF ABNs in the last 30 days to validate that they were completed with accuracy and to ensure that the resident/their representative completed the SNF ABN for residents discharged from Medicare Part A who remain in the facility. | |

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| F 582 | Continued From page 2<br>signed by the resident's legal representative, failed to identify if they chose to continue or discontinue skilled services or request a demand bill.<br><br>During an interview on the morning of 04/20/22, a social services staff member (#5) confirmed the resident's representative failed to choose an option on the SNFABN and stated staff should have ensured they completed the form. | F 582 | Systemic Changes: The Administrator will educate both Social services and Business Office Manager in the correct process of completion and issuance of NOMNC/SNF ABN to ensure that the resident/their representative completed the SNF ABN for residents discharged from Medicare Part A who remain in the facility.<br>The Business Office Manager will immediately start reviewing all NOMNC/SNF ABNs that are issued. Social services will continue to issue any NOMNC/SNF ABN notices to the patient/responsible party as expected. Once it is issued/signed by the patient, then the Business Office Manager will review it to ensure accuracy before it is scanned into Point Click Care, faxed to insurance company, or sent to KEPRO for any potential appeals. If the Business Office Manager is not in the building it will be reviewed by the Administrator or 2nd Social Service employee.<br><br>Monitoring: The Business Office Manager will conduct monitoring/auditing 3 times a week x 1 month then weekly x 2 months and then quarterly to ensure all NOMNCs/SNF ABNs are being completed with accuracy. Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Correction Date: 05/24/2022 | |

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| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and | F 584 | | 5/26/22 |

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| F 584 | Continued From page 4<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, information from the complainant, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 4 of 21 sampled residents (#22, #41, #46, and #71) and 8 supplemental residents (#4, #7, #8, #16, #33, #38, #39, and #61). Failure to clean personal fans, maintain and clean environmental surfaces (walls, doors, outlets, hand-rails, toilet seats) does not provide a comfortable/homelike environment and has the potential to place resident's at risk for injury or illness.<br><br>Findings include:<br><br>Information received by the department from an anonymous complainant identified concerns with cleanliness and upkeep of the environment of the facility.<br><br>Review of the facility policy titled "Cleaning and Disinfection of Environmental Surfaces" occurred on 04/21/22. This policy, dated June 2021, stated, "Policy Statement: Environmental surfaces will be cleaned and disinfected . . . Policy Interpretation and Implementation . . . 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. . . . " | F 584 | F584 Plan of Correction-Education<br><br>Corrective Action¿<br><br>Resident #16 had her fan taken apart and the fan bed cleaned. In addition, the larger fan on the floor of the room was also cleaned. Since 04/21/2022, the housekeepers have a daily task sheet to check each resident fan to ensure cleanliness and to document each time the fan gets cleaned.<br><br>Repairs will be made to noted rooms and walls.<br><br>Resident #16 had his electrical outlet cover replaced on 05/11/2022.<br><br>For stains on the floor, and dirty flooring, housekeepers have been given a daily task sheet which includes wiping down the doors, walls, handles and handrails daily. The carpeted floor will also be shampooed monthly.<br><br>The facility will systematically start repairs to fix the broken handrails and will work to replace the built-in dressers with sharp edges and missing pieces | |

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| F 584 | Continued From page 5<br><br>Observation on 04/18/21 at 5:30 p.m. showed Resident #16 sitting up in bed and wearing oxygen per nasal cannula. The resident stated she was in the hospital for pneumonia and just returned to the facility that afternoon. Observation showed a small fan (with visible dust on the outside grate covering the fan blade) on the window ledge by the resident's bed, blowing air directly toward the resident. Observation also showed a larger fan on the floor in the room with visible dust on the grate.<br><br>Observation on 04/19/21 at 8:00 a.m. showed the same small fan, not in use, on Resident #16's window ledge next to the bed with a thick accumulation of dust on the fan blade and on the grate covering the fan. The thick dust hung in clumps on some areas of the blade.<br><br>Review of Resident #16's medical record occurred on the morning of 04/19/21. Diagnoses included pneumonia and shortness of breath. Resident #16's current care plan stated, "Potential for altered respiratory function r/t [related to] diagnosis of Pneumonia. . . . O2 [oxygen] as ordered. . . . Potential for impaired gas exchange r/t CHF [congestive heart failure], COPD [chronic obstructive pulmonary disease] . . ."<br><br>General observations of the environment on all days of survey showed the following:<br>Resident #8's room - Wallpaper torn at left side of bed near the head of the bed.<br>Resident #38's room - Walls scuffed/scraped.<br>Resident #16's room - Electrical outlet cover broken by the air conditioner. | F 584 | Identification of Others¿<br><br>The Maintenance Director and/or Laundry Supervisor will conduct a sweep of all resident rooms to ensure the fans are cleaned. The Maintenance Director and/or Laundry Supervisor will also conduct a sweep of all rooms to check for peeling wallpaper or stains on the floor. The Maintenance Director and/or Laundry Supervisor will also do an audit of all resident rooms to check for any furniture that may be broken missing parts. The Maintenance Director and/or Laundry Supervisor will also be checking all resident rooms to ensure that there are no holes in electrical covers and that all toilet covers are in proper working order.<br><br>Systemic Changes¿<br><br>The Maintenance Director and/or Laundry Supervisor will provide training to all maintenance and housekeeping staff to look for rooms that have broken furniture, holes in electrical covers, dirty fans, peeling wallpaper, or stains on the floor. They will also be trained to report any of the above-mentioned items to the Maintenance Director and/or Laundry Supervisor and will be added to the maintenance log, which will then be brought up to the interdisciplinary team for discussion and documentation.¿¿ | |

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| F 584 | Continued From page 6<br>Missing end caps on the handrails on both sides of the hall outside of rooms 87 and 88.<br>Resident #7's room - Wallpaper torn and scuffed; hallway wall just outside of room with dried liquid spill.<br>Resident #33's room - Large area of torn wallpaper above the head of the bed.<br>Resident #22's room - Liquid spill stains on the outside of bathroom door. Side of bedside table with a dried-on red/orange colored stain; floor dark in color around the edges and with visible dirt/debris.<br>Resident #61's room - Wallpaper scuffed, hole in electrical outlet cover for air conditioner.<br>Resident #46's room - Toilet seat removed from toilet revealing two sharp edges where the toilet seat used to be. Floor shows visible dirt around the edges and dark dirt-like stains on the floor.<br>Locked door in hallway across from room 94 - large area of black scuff marks.<br>Resident #39's room - Wallpaper scraped away from wall in multiple areas to the right of the bathroom, air conditioner facing broken.<br>Resident #71's room - Wallpaper peeling from wall above left side of window and around air conditioner. Wallpaper scraped away from wall in multiple areas to the left of sink area. Built in dresser drawers with multiple broken areas with sharp edges and large areas of cork visible.<br>Resident #4's room - Wallpaper peeling from wall under the air conditioner.<br>Resident #41's room - Fan blade and grates with accumulation of dust.<br><br>During an interview on 04/21/22 at 12:20 p.m., two administrative staff members (#1 and #3) confirmed peeling wallpaper on some walls. | F 584 | Monitoring¿<br><br>The Maintenance Director and/or Laundry Supervisor will conduct audits through observation on the fans in random rooms throughout the facility to make sure they are cleaned. The Maintenance Director and/or Laundry Supervisor will also check the rooms for broken furniture, peeling wallpaper, and stained flooring. Audits will be completed 3x/week for 1 month, weekly for 3 months, and quarterly.¿<br><br>The Maintenance Director and/or Laundry Supervisor will report any identified trends to the Administrator, and they will report this to the Quality Assurance Committee monthly and as needed until a lessor frequency is deemed appropriate.¿<br><br>Date of Compliance¿<br><br>5/26/2022 | |

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| F 584 | Continued From page 7<br>During an interview on 04/21/22 at 12:25 p.m., a maintenance staff member (#4) stated staff periodically check fans for cleaning as needed, but confirmed it was not on a scheduled basis. | F 584 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility policy, review of the facility's investigation report, and staff and resident interviews, the facility failed to provide an environment free of verbal abuse for 1 of 1 resident (Resident #11) with an allegation of mistreatment by staff. Failure to ensure residents are free from verbal abuse, which includes disparaging and derogatory terms, and the disregard for resident personal possessions and privacy resulted in psychosocial harm.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse | F 600 | F-600- Free from Abuse and Neglect<br><br>Corrective Action:<br>- On 4/9/2022, CNA #15 entered Resident # 11 room and attempted to intervene by asking the nurse to exit the room. CNA #15 stayed in the room with Resident #11 until Nurse #14 left the room and apologized to Resident #11.<br>- On 4/11/2022, immediately upon notification of the incident, administrative nurse #1 began the investigation into the incident. Administrative nurse #1 then informed Administrator and made the | 5/24/22 |

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| F 600 | Continued From page 8<br>Prevention Program" occurred on 04/21/22. This undated policy stated, "Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse . . ."<br><br>During an interview on 04/18/22 at 2:45 p.m., when asked about abuse and neglect, Resident #11 reported an incident that occurred with a registered nurse (RN) (#14) a week ago Saturday. Resident #11 stated the nurse brought his medications into his room along with several other medication cups containing pills and an insulin pen. The resident asked the nurse who the other medication and insulin were for, and the nurse said they were for other residents and then left the resident's room. Resident #11 stated after about ten minutes the nurse returned to his room, looked on top and inside the drawer of the resident's nightstand, and then left the room. After another 5-10 minutes the nurse returned to the resident's room and accused the resident of hiding the other resident's medications and insulin pen. Resident #11 stated the nurse opened his nightstand drawer and started going through the resident's wallet. The resident stated he told the nurse he did not have permission to be going through his personal belongings. The resident said the nurse stated, "You're an [expletive] idiot and I'm on a drug seize and no one can tell me to get out of this room." The resident stated the nurse continued searching his room, looking in the resident's closet and other drawers. The resident told the nurse to leave and stop looking through his personal belongings and | F 600 | initial report to North Dakota Department of Health, and terminated nurse #14.<br>- Administrative Nurse #1 began education with floor nurses and cnas on mandatory reporting of abuse and the incident from 4/11/22-4/15/2022<br>- The Administrator met with resident #11 and apologized and reviewed facility abuse and neglect policy and investigation progress on 4/12/2022 and again on 4/21/2022 to provide resident #11 /representative with the investigation outcome. Resident #11 has had no further issues with any staff or resident at the facility and advises a feeling of safety and satisfaction with outcome.<br>- All facility staff have been educated by the Director of Nursing on Abuse and Neglect including all types, identification, policies and procedures for mandatory reporting process. This education will be completed between 5/2/22 and 5/24/22.<br><br>Identification of others:<br>- All residents or representatives have been interviewed regarding abuse and neglect by an assigned member of the IDT Team (Administrator, Director of Nursing, Social Worker, RN/LPN Unit Managers) as part of the facility advocate program. No other residents have been identified as being affected by the deficient practice.<br><br>Systemic Changes:<br>- Both licensed and unlicensed staff have been provided Abuse and Neglect training by the Director of Nursing. This | |

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| F 600 | Continued From page 9<br>that he did not have the medications or insulin pen. Resident #11 said the nurse (#14) stated, "Where did you put them? You are an [expletive] loser." The resident stated a certified nurse aide (CNA) (#15) entered the resident's room and attempted to get the nurse out of his room and the nurse kept saying, "I'm on a drug seize and I'm not leaving this room." The resident reported after a short time the nurse and CNA left his room. The resident stated later he put his call light on to ask when he would get his lunch tray and the nurse (#14) answered his call light. When the resident asked the nurse his question the nurse stated, "By the looks of you, you don't need any [expletive] food." The resident stated he spoke with the head nurse and the administrator on the following Monday regarding the situation.<br><br>Information from the facility's investigative report, dated 04/15/22, identified the following:<br>* During the administrative nurse's phone interview on 04/12/22 with the RN (#14) "Employee was very aggressive with communication, raised voiced . . . continued to be aggressive with communication . . ." During the interview the nurse (#14) acknowledged he did pre-dish 4 resident medications and carried them into other residents rooms and misplaced these. The nurse acknowledged he made an error yet continued to place the entire blame on the resident.<br><br>During an interview on 04/20/22 at 10:38 a.m., an administrative nurse (#1) stated she was first notified of the situation on Monday 04/11/22 when Resident #11 requested to speak with her and the administrator. The administrative nurse | F 600 | included the policy and procedure for identifying the types of abuse and neglect as well as the mandatory reporting requirement. This education will be completed on 5/12/2022.<br>- The Administrator/Designee will conduct abuse and neglect training and education as part of all new hire orientation. Also, for unlicensed and licensed staff on a quarterly basis for a period of one year beginning 5/9/2022 and then biannually thereafter.<br>- Grievance Officer/Designee has been identified and this information shared with all residents and staff as well as contact information of said person as of 5/12/22.<br>- 24/hr -on call phone number to report concerns of abuse and neglect to be posted in facility locations.<br>- The Administrator/Designee will be notified immediately of all potential abuse and neglect reports beginning 5/2/2022 to ensure policy and procedure is followed. Any deficiency will be corrected immediately thru re-education and other remedies as needed.<br>- The Facility Advocate Program will continue, and all residents will have a visit by their advocate weekly, any concerns of abuse or neglect will be reported immediately to the grievance officer and administrator.<br>- The Resident Council will discuss a resident rights and review abuse and neglect policy as part of monthly resident council. Any concerns noted will be reported to the grievance officer and administrator immediately. This will begin | |

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| F 600 | Continued From page 10<br>stated she immediately started an investigation and notified the North Dakota Department of Health (NDDOH). The administrative nurse confirmed the incident happened on Saturday 04/09/22 and the RN (#14) worked in the facility the next day 04/10/22. The administrative nurse confirmed she terminated the RN's (#14) employment on 4/12/22 when she conducted a phone interview with the RN.<br><br>During an interview on 04/20/22 at 11:00 a.m., the administrative nurse (#1) verified she had not educated all staff on abuse prevention stating, "Starting 04/11/22, I just grabbed whoever I could and spoke to them about abuse."<br><br>Review of a facility in-service attendance form showed the administrative nurse (#1) had provided education titled "Mandatory Reporting/Handling Concerning Situation to eight staff members on 04/11/22 - 04/15/22."<br><br>During an interview on 04/20/22 at 6:32 p.m., a CNA (#15) stated she became aware of the incident described above when she answered the phone at the facility on 04/09/22 and the caller, Resident (#11) demanding to get the administrator's phone number. The CNA stated she went to the resident's room and heard the nurse (#14) "screaming and yelling at the resident that he was not leaving his room and was on a drug seize. I attempted to get him to leave the resident's room and apologized to the resident, other residents and visitors in the facility that had witnessed or overheard the incident." The CNA stated, "(RN's name) was out of his mind accusing the resident of hiding the other medications." | F 600 | 5/2022.<br><br>Monitoring:<br>- The Human Resources Director/Designee will verify all abuse and neglect training has been completed by new hires as part of orientation process prior to the end of orientation. A signed Abuse and Neglect Policy will be reviewed and signed by the employee and kept in the employee file.<br>- The Administrator/Designee along with Human Resources will ensure unlicensed and licensed staff have completed quarterly abuse and neglect training for a period of 1 year and then biannually thereafter and keep record of this as part of staff education/competency beginning 5/12/2022.<br>- The Administrator and Director of Nursing will conduct random abuse and neglect Q&A with 3 staff weekly x 12 weeks and then quarterly. Any deficiency will be corrected immediately through re-education.<br>- Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate. The QA/QAPI committee has reviewed and approved this plan of correction on 5/17/2022.<br><br>Date of Compliance: 05/24/2022 | |

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| F 600 | Continued From page 11<br>The CNA stated she had heard the nurse (#14) on the phone reporting the incident to the on call manager, so she felt the incident was already reported. When asked who the CNA would report potential abuse to she stated, "The admission's lady is who we are to report it to." The CNA verified she had received abuse training but could not recall when the date of the last training.<br><br>During an interview on 04/21/22 at 8:13 a.m., an administrative nurse (#1) stated the missing medications and insulin were found in another resident's room.<br><br>During an interview on 04/21/22 at 8:33 a.m., an administrative nurse (#1) verified the nurse (#14) had received abuse education upon hire 02/17/21 and had not received any further education on abuse.<br><br>During an interview on 04/22/22 at 10:38 a.m., an administrative nurse (#1) stated it is inappropriate and unacceptable for staff to use disparaging and derogatory terms to the residents.<br><br>The facility failed to protect the resident from abuse and the staff failed to immediately report the abuse to the administrative staff. | F 600 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's | F 656 | | 5/24/22 |

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| F 656 | Continued From page 12<br>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the facility policy, and resident and staff interview, the facility failed to develop a comprehensive care plan for 1 | F 656 | F656 Develop/Implement Comprehensive Care Plan | |

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| F 656 | Continued From page 13<br>of 21 sampled residents (Resident #34) with care plans. Failure to develop a comprehensive care plan that includes the services to be provided to the resident may negatively impact the resident's quality of care.<br><br>Findings Include:<br><br>Review of the facility policy titled "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" occurred on 04/21/22. This policy, dated Qtr (quarter) 3, 2021, stated, ". . . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications . . ."<br><br>Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated 02/24/22, identified severe weight loss. The care plan failed to address weight loss management.<br><br>The record identified the following weights obtained from admission on 11/24/21 through 03/09/22:<br>* 11/24/21 116 lbs. (pounds)<br>* 11/29/21 116 lbs.<br>* 12/06/21 116 lbs.<br>* 12/09/21 114 lbs.<br>* 01/10/22 110 lbs.<br>* 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss) | F 656 | Corrective Actions:<br>Resident # 34 was affected during the survey process. Her care plan was revised to include risk for nutrition/weight loss on 4/18/22.<br><br>Identifications of Others:<br>The DON/designee will review all residents, including residents at risk for weight loss, to validate that the care plan has been updated and include nutritional risks and plan to reach resident goals for nutritional risks.<br><br>Systemic Changes:<br><br>The DON/designee will provide education to staff on how and where to find information related to required care needs for each resident, including review of new physician orders, daily report and for significant changes to assure interventions are in place and updated in plan of care, and who is responsible for providing and updating plan of care.<br><br>Monitoring and QAPI<br><br>The DON/designee will conduct resident review of 3 random residents and newly admitted residents 3 times a week for 4 weeks, then weekly for 2 months and then quarterly, to validate that residents care plan is up to date with nutritional risks and needs addressed in plan of care. | |

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| F 656 | Continued From page 14<br>* 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss)<br>* 03/01/22 94 lbs.<br>* 03/02/22 93.6 lbs.<br>* 03/04/22 93 lbs.<br>* 03/07/22 91.2 lbs.<br>* 03/09/22 91.4 lbs.<br><br>During an interview on 04/20/22 at 2:30 p.m., a supervisory nurse (#8) stated, "The dietician determines recommendations and works with nursing for care plan interventions and goals."<br><br>During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed staff failed to care plan goals and interventions for Resident #34's weight loss management. | F 656 | The Administrator/designee will report any identified trends to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of compliance<br>5/24/2022 | |
| F 658 SS=D | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>1. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to administer medications according to professional standards of practice for 1 of 1 sampled resident (Resident #63) who received a medication without a current order and 1 supplemental resident (Resident #52). Failure to follow physician's orders when administering medications may lead to adverse reactions. | F 658 | F-tag 658 Services Provided Meet Professional Standards<br><br>Corrective Actions:<br><br>The DON/designee re-assessed resident #52 for any negative outcomes. The physician/ provider was updated on resident wishes and order clarified with | 6/14/22 |

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| F 658 | Continued From page 15<br>Findings include:<br><br>Review of the facility policy titled "Administering Medications" occurred on 04/20/22. This undated policy stated, ". . . 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. . . 3. Medications must be administered in accordance with the orders, including any required time frame. . . ."<br><br>Review of the facility policy titled "Medication and Treatment Orders" occurred on 04/20/22. This undated policy stated, ". . . Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. . . . All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. . . . Verbal orders must be recorded immediately in the resident's chart by the person receiving the order . . ."<br><br>Review of the facility policy titled "Administering Topical Medications" occurred on 04/21/22. This undated policy stated, ". . . 1. Verify that there is a physician's medication order for this procedure. . . ."<br><br>- During an interview on the afternoon of 04/19/22, Resident #52 expressed concern that he did not always get his medications as prescribed.<br><br>Review of Resident #52's medical record occurred on April 19-20, 2022. The medication administration records (MARs) identified:<br>*"Calcium Acetate Capsule 667 MG [milligrams] | F 658 | provider for holding Labetalol and the care plan updated on 4/26/22.<br><br>The DON/Designee reassessed resident # 63 for any negative outcomes. Medication was removed from the room on 4/21/22 per physician order to discontinue.<br><br>The DON/Designee reassessed resident # 71 for any negative outcomes. Physician/provider updated on range for holding insulin and notified of any out of range in last 30 days on 5/12/22.<br><br>Physician and Responsible Parties were notified of any changes in condition and any new physician orders were noted, and care plan updated as applicable.<br><br>Identification of Others:<br><br>The DON/designee will review residents who currently have physician orders for insulin and parameters for MD notification to validate those notifications have been updated to physician/provider in last 14 days when order indicates MD notification. Any identified concerns will be corrected, physician and responsible party notified, physician orders noted, and care plan updated as applicable<br><br>The DON/designee conducted a sweep of all resident MARS/TARS to validate accuracy, timeliness, of orders. | |

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| F 658 | Continued From page 16<br>Give 2 capsule by mouth with meals for Hyperphosphatemia [high phosphorus levels in the blood], ESRD [end stage renal dialysis], HTN [hypertension] **OK TO HOLD if pt [patient] does not eat a meal or if pt is out of the facility** -Start Date- 09/29/2021 . . ."<br>*"Labetalol HCl [high blood pressure medication] Tablet, Give 150 mg by mouth in the morning every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for Hypertension, -Start Date- 08/07/2021 . . . -D/C [discontinue] Date- 01/19/2022 . . ."<br>*On 01/20/22, a nurse added the following entry to the MAR without obtaining a physician's order: "Labetalol HCl Tablet, Give 150 mg by mouth in the morning every Tue, Thu, Sat for Hypertension **GIVE ONLY IF REFUSES DIALYSIS. HE DOES NOT WANT BEFORE DIALYSIS -Start Date- 01/20/2022 . . ."<br><br>Resident #52's medical record lacked evidence of a physician's order dated 01/20/22 to hold labetalol on dialysis days and only give if Resident #52 refused dialysis.<br><br>Resident #52's meal intake records and MAR for December 18, 2021 through April 18, 2022 identified 10 occasions when Resident #52 ate a meal, but staff did not administer (i.e., held) the calcium acetate.<br><br>During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated staff should not hold medications if Resident #52 has eaten and identified that staff updated the physician's order for labetalol without getting a verbal order from the provider. | F 658 | The DON/Designee will validate that medication that has been discontinued is removed from medication/treatment carts and nursing unit.<br><br>Systemic Changes:<br><br>The DON/designee will provide education to licensed nurses on proper notification to physician for change in orders or order clarifications.<br><br>The DON/Designee will provide education to licensed nurses on notification to physician when parameters indicate medication hold and notify MD.<br><br>The DON/Designee will provide education to licensed nurses on removal of medication when discontinued, including proper storage and application by licensed personnel .<br><br>Monitoring/QAPI:<br><br>The DON/designee will audit medication cart 3 times a week x 4 weeks, weekly x 2 months, and then quarterly to validate medications that have been discontinued are removed.<br><br>The DON/Designee will review orders for insulin 3 times a week x 4 weeks, then a | |

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| F 658 | Continued From page 17<br>Observation on 04/19/22 at 11:38 a.m. showed a certified nurse aide (CNA) (#13) removed a tube of flucinonide cream from a drawer in the Resident #63's room and applied the flucinonide cream to the resident's left abdomen/groin area. The drawer also contained a tube of hydrocortisone cream with a prescription label.<br><br>- Review of Resident #63's medical record occurred on all days of survey. Review of medication orders showed the flucinonide cream prescribed on 04/04/22 and discontinued on 04/14/22, and hydrocortisone cream prescribed on 04/04/22 and discontinued on 04/06/22.<br><br>During an interview on 04/21/22 at 10:09 a.m., a nurse manager (#1) verified the doctor discontinued the ointments, staff should not keep them in the resident's room, and agreed the CNA should not apply the ointment.<br><br>2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 5 sampled residents (Resident #71) selected for unnecessary medication review. Failure to notify the physician of abnormal blood glucose levels may result in untreated hypoglycemia (low blood glucose level) or hyperglycemia (high blood glucose level).<br><br>Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on 04/21/22. This policy, dated Qtr [quarter] 3, 2018, stated, ". . . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): specific instruction to notify the physician of changes in the residence | F 658 | minimum of weekly x 2 months then quarterly, in clinical meetings for accuracy and provider notification<br><br>The DON/Designee will review all new orders in clinical meeting for accuracy and provider notification, 3 times a week x 4 weeks, then a minimum of weekly x 2 months , then quarterly.<br><br>The DON/designee and Administrator/designee will report any identified trends to the QAPI (Quality Assurance and Performance Improvement) committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of compliance<br><br>5/24/2022 | |

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| F 658 | Continued From page 18<br>condition . . ."<br><br>Review of Resident #71's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The quarterly Minimum Data Set (MDS), dated 03/28/22, identified the resident required insulin injections for all seven days of the assessment period. The care plan stated, "Observe for high blood sugar symptoms . . . Observe for low blood sugar symptoms . . . Report abnormal results per Physician parameters/guideline . . ." The physician's orders identified, ". . . Accuchecks [blood glucose checks] QID [four times a day] - Call PCP [primary care provider] if < [less than] 100 [milligram per deciliter (mg/dl)] or > [greater than] 400 [mg/dl] . . . before meals and at bedtime for blood sugars . . ."<br><br>Review of Resident #71's blood glucose levels for February and March 2022, showed facility staff failed to notify the physician of blood glucose results less than 100 mg/dl or greater than 400 mg/dl on 12 occasions.<br><br>During an interview on 04/21/22 at 9:45 a.m., the nurse (#16) stated, "The nurses document physician notification in the nurses progress notes" and verified the documentation lacked provider notification required for Resident #71's blood glucose results.<br><br>During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed their expectation is to notify the physician of blood glucose results per physician's order. | F 658 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25 | F 684 | | 5/24/22 |

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| F 684 | Continued From page 19<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility policy, record review, and staff interview, the facility failed to ensure appropriate care and services for 1 of 2 sampled residents (Resident #63) with a foley catheter. Failure to ensure timely and consistent emptying of a foley catheter may result in back flow of urine causing unnecessary pain and complications for the resident.<br><br>Findings include:<br><br>Review of the facility's policy titled "Emptying a Urinary Drainage Bag" occurred on 04/21/22. This undated policy stated, " . . . The purpose of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder . . ."<br><br>Review of Resident #63's medical record occurred on all days of survey. Current physician orders included, "Catheter care per facility protocol: Empty the bag when 2/3 full or when impeded flow. Two times a day. . ."<br><br>Observations on 04/19/22 showed the following:<br>* 8:53 a.m., Resident #63 in his room in the bed | F 684 | F- 684 Quality of Care<br><br>Corrective Actions:<br><br>The DON/designee reassessed Resident # 63 to validate that resident's immediate catheter care needs were being met, including emptying and maintenance of catheter. Any unsolved concern was immediately addressed.<br><br>Identification of Others:<br><br>The DON/designee will review/interview/observe all residents with urinary catheters to validate they are receiving proper care and maintenance of catheters and are emptied as per physician orders. | |

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| F 684 | Continued From page 20<br>with his call light on.<br>* 8:55 a.m., an unidentified staff member looked into the resident's room asking him what she could help him with. Resident #63 stated, "Can you get a nurse in here right away I think my catheter is kinked again."<br>* 8:56 a.m., the unidentified staff member informed a nurse (#11) who was at the nurse's station. The nurse stated she would tell the resident's nurse.<br>* 8:57 a.m., Resident #63 yelling out for a nurse stating, "Having problems with catheter backing up again, someone hurry up."<br>* 9:14 a.m., a nurse (#2) was in the hallway and noticed Resident #63's call light was on and entered the resident's room and asked how he could help the resident. The resident stated, "I think my catheter was kinked. I had a few really sharp pains."<br>* 9:16 a.m., the nurse (#2) ensured the resident's foley catheter wasn't kinked and emptied the resident's bag, stating, "This is really full. Apparently it has not been emptied for a while. There was 1400 ml's [milliliters] in it [bag]."<br><br>During an interview on 04/21/21 at 10:18 a.m., a nurse manager (#1) verified she expected the facility staff to follow physician orders and facility policy regarding emptying the residents foley catheter. | F 684 | Systemic Changes:<br><br>DON/designee will provide education to the nursing staff on proper catheter care, maintenance, and appropriate emptying of catheters and following physician orders on catheter care to be completed by 5/24/2022.<br><br>Monitoring/QAPI<br><br>The DON/designee will audit through observation/interview 3 residents with urinary catheter to validate cares are completed as ordered and per policy.<br><br>3 x a week x 4 weeks, weekly x 2 months, and then quarterly. The DON/designee will report any identified trends to the QAPI (Quality Assurance and Performance Improvement) committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of compliance<br><br>5/24/22 | |
| F 686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | F 686 | | 5/24/22 |

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| F 686 SS=D | Continued From page 21<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of professional reference, and staff and resident interviews, the facility failed to provide the necessary treatment/services to prevent the occurrence and promote the healing of pressure ulcers for 1 of 4 sampled residents (Resident #63) identified with pressure ulcers. Failure to consistently use interventions and follow physician orders to prevent and heal the resident's pressure ulcers may result in deterioration of the ulcers and result in further skin breakdown and/or ulcers.<br><br>Findings include:<br><br>Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 64, stated, ". . . It is the nurse's responsibility to seek clarification of | F 686 | F-686- Treatment/Svcs to Prevent/Heal Pressure Ulcers<br><br>CORRECTIVE ACTION:<br><br>The Director of Nursing (DON) or designee will review and validate that resident #63 physician orders accurate and followed to prevent and promote heal of the resident's pressure ulcers (including positioning and pressure relief). Staff will be educated on physician orders as well as interventions to prevent skin breakdown and promote healing (including repositioning and pressure relief. | |

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| F 686 | Continued From page 22<br>ambiguous or seemingly erroneous orders from the prescriber . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ."<br><br>During an interview on 04/19/22 at 9:33 a.m., Resident #63 stated, "Yesterday I was up in my wheelchair for four hours and I'm only supposed to be in the chair for two hours because of the sores on my butt."<br><br>Review of Resident #63's medical record occurred on all days of survey and included the following pressure ulcers:<br>* Left heel- stage II<br>* Left ankle- stage II<br>* Right buttock- stage II<br>* Left buttock- stage II<br><br>A current physician order, dated 04/14/22, stated, ". . . May be up in chair for 60 minutes at a time, then rest for 2 hours in supine (lying horizontally with the face and torso facing up), then may get back up in chair. two times a day. . . ."<br><br>Observation on 04/20/22 at 11:48 a.m., showed Resident #63 in his wheelchair.<br>At 3:05 p.m., observation showed a certified nurse aide (CNA) (#6) covered Resident #63 up in the bed.<br><br>During an interview on 04/20/22 at 3:05 p.m., the CNA (#6) stated Resident #63 had been in the wheelchair since 11:00 a.m. Observation showed the CNA (#6) had just transferred the resident to bed at 3:05 p.m., (four hours later).<br><br>During an interview on 04/20/22 at 3:09 p.m., | F 686 | IDENTIFICATION OF OTHERS:<br><br>The DON/designee will conduct a review of all residents with moderate or higher risk for skin breakdown have appropriate interventions ordered to promote wound healing and prevent new pressure ulcers and applicable care plan interventions are in place.<br><br>SYSTEMIC CHANGES<br><br>The DON/designee will provide education to the licensed nurses on requirements of obtaining orders for interventions and care planning interventions for residents identified at risk for skin breakdown with Braden assessment with completion date of 05/24/2022.<br><br>The DON/designee will provide education to the wound nurse on implementing appropriate orders for prevention and healing of pressure ulcers on residents identified at risk or being treated for pressure injuries with completion of 05/24/2022. | |

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| F 686 | Continued From page 23<br>Resident #63 stated he had put his call light on for the staff to assist him back into the bed.<br><br>During an interview on 04/21/22 at 10:26 a.m., an administrative nurse (#1) confirmed the facility failed to consistently follow interventions that would prevent worsening of Resident #63's pressure ulcers. | F 686 | The DON/designee will provide education to the certified aides on following interventions ordered to promote wound healing and prevent new pressure ulcers as well as ensuring nurse is updated on concerns with completion of 05/24/2022.<br><br>MONITORING:<br><br>The DON/designee will conduct monitoring 3 times a week x 12 weeks, and then quarterly through chart review, observation, and interviews on all newly identified at risk residents to validate those interventions related to prevention of skin breakdown and promoting wound healing are appropriately implemented and care planned as applicable. The DON/designee will report any identified trends to the QAPI (Quality Assurance and Performance Improvement) committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of Compliance<br><br>05/24/2022 | |

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| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information received from the complainant, observation, facility policy, record review, and staff, resident, and family interview, the facility failed to provide the necessary assistance to prevent a fall for 1 of 1 sampled resident (Resident #71) who slid out of his powered wheelchair while transported in the facility van. Failure of the facility to ensure staff properly secured Resident #71 in his wheelchair, in the van, immediately called for assistance, and transferred resident using the van's restraint system, resulted in the resident experiencing a fall with possible injury.<br><br>Findings include:<br><br>The complainant alleged the facility failed to properly transport a resident in the facility van.<br><br>Review of the facility policy titled "Transportation Services" occurred on 04/21/22. This policy, dated December 2020, stated, ". . . Drivers shall be trained on safe transportation of residents routinely with periodic re-training and return demonstration. Drivers will have access to two-way communication at all times . . . Resident | F 689 | F-689 □ FREE OF ACCIDENTS AND HAZARDS<br><br>CORRECTIVE ACTION:<br>- Resident #71 had been evaluated by a physical and occupational therapist for positioning in electric wheelchair and use of safety belt. This resident in the past has refused to use the chair safety belt. The evaluation concluded that a stationary wheelchair would be the safest use for transportation in the wheelchair van. Resident #71 and representative are in agreement with this.<br>- All drivers employed by the facility have been provided education and return demonstration training on use of the wheelchair safety belt, two -way communication system while in van (cell-phone), and van restraint system. This education was completed by the administrator on 4/08/2022. Due to the education log not being dated, all drivers will be re-educated and trained with return demonstration completed on or before 5/19/2022. The training and education will | 5/24/22 |

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| F 689 | Continued From page 25<br>care needs will be considered when arranging transport so that needs will be appropriately met during travel to and from the facility . . ."<br><br>Observation on all days of survey showed Resident #71 with the safety belt secured while in his powered wheelchair.<br><br>Review of Resident #71's medical record occurred on all days of survey. Diagnoses included right above the knee amputation, pain in right hip, muscle weakness, and difficulty walking. The care plan stated, ". . . I like to wear my safety belt at times when in electric [powered] wheelchair . . ."<br><br>The progress notes identified the following:<br>* 03/16/22 at 4:26 p.m., ". . . On return slid down in W/C [wheelchair] in van and drive [sic] [#9] helped him back into or up in w/c. resident said that he is sore and tired. requested a pain pill and given."<br>* 03/17/22 at 5:25 p.m., ". . . fall-witnessed . . . Resident was sent Via [by] ambulance to ED [emergency department] to be evaluated per family request. . . . Resident was senti [sic] in to be evaluated by ED. Came back around 2100 [9:00 p.m.] . . . No new orders [sic] or treatments-no injuries identified in ED. . . ."<br><br>Review of Grievance/Concern form, dated 03/29/22, stated, ". . . Driver [#9] reported resident slid out of chair in van. Chair was restrained in as was shoulder restraint latched. [Resident #71] refuses to use chair seat belt. This has not happened before but he began to slide so driver stopped lowered him to floor positioned him and drove van two blocks to | F 689 | be conducted by the Maintenance Director and Director of Rehabilitation. This education will also be occurring bi-annually with all drivers or as part of orientation for new drivers and will be kept as a competency in the employee file. This education is beginning 5/19/2022.<br>- Several audits were completed by the Director of Nursing and Administrator to make certain the resident was being properly placed and secured in the van. A checklist has been created for this audit and will be filed. These audits occurred on 4/08/2022 and 4/15/2022.<br><br>IDENTIFICATION OF OTHERS:<br>- A full facility sweep will be conducted by the RN Unit Managers of any residents who currently use a wheelchair safety belt. A log will be created of these residents and will be given to the drivers weekly by the Administrator. This will be completed by 5/24/2022.<br><br>SYSTEMIC CHANGES:<br>- A log will be created of these residents who use a wheelchair safety belt and will be given to the drivers by the Administrator. This will be completed by 5/24/2022.The log will be reviewed weekly or more frequently as needed and updated as any new safety belt is placed on any wheelchair or removed so the resident log for the drivers is always updated. This will begin 5/19/2022.<br>- All drivers employed by the facility have been provided education and return | |

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| F 689 | Continued From page 26<br>facility for help. . . ."<br><br>The incident report, dated 03/24/22, stated, ". . . Root Cause - Resident avoids use of the chair seat belt . . . . Intervention: Driver retraining on restraint system and van use and properly restraining wheelchairs, notification of facility . . . "<br><br>The undated staff education form stated, "Communicating repositioning concerns during transports -Transport drivers have been educated to alert nursing/therapy to assess resident if noticing any problems with positioning. Transport drivers will always stop and contact the facility for additional support if there is a safety concern while transporting." The Driver (#9) completed the "Wheelchair Transportation Safety Checklist" on 04/08/22.<br><br>During an interview on 04/21/22 at 11:10 a.m., a driver (#9) described the transport from the clinic appointment and stated, "Resident #71 got himself onto the van in his [powered] wheelchair." The driver secured the four wheelchair restraints, the van lap restraint, and shoulder restraint. The driver said as she drove the van the resident told her he was sliding, she asked him to push his butt back in the chair, as she continued to drive, he answered, "I can't." The resident was unable to reposition in his chair and yelled "I'm slipping." As the driver approached a stop light, she looked in the rearview mirror and saw the resident sliding towards the bottom of the wheelchair with his arms up in the air and the shoulder restraint in his armpit area and the van lap belt up to his chest. The driver pulled the van over, lowered the resident to the floor, and positioned him against | F 689 | demonstration training on use of the wheelchair safety belt, two -way communication system while in van (cell-phone), and van restraint system. This education is provided by the Maintenance Director and the Director of Rehabilitation and will continue biannually for all drivers as well during orientation for any new drivers and be kept as a competency in employee file. This education will begin and be completed on 5/24/2022.<br><br>MONITORING:<br>- The Maintenance Director/Designee will conduct 2 audits per week for 1 month and then 2 per month and then quarterly of a resident transport to ensure the resident is being secured in wheelchair if ordered, secured using van restraint system properly, and using cell phone for two -way communication. This audit will be kept on a log and filed. Any deficiency identified will be immediately corrected to ensure resident safety and re- education and return demonstration training provided on the spot. These audits will be reported to the Administrator immediately. These audits will begin 5/19/2022 for one month and then continue monthly until efficacy is consistent.<br>- Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate. The QA/QAPI Committee has reviewed and approved this plan of correction on 5/24/2022. | |

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| F 689 | Continued From page 27<br>the inside wall of the van, unable to use restraint system. The driver called for assistance while driving the van the remainder of the way to the facility. After arriving at the facility, two additional staff boarded the van, and all three staff manually lifted the resident onto his wheelchair. The driver confirmed she failed to ensure the resident's wheelchair safety belt was secured because he usually refuses it.<br><br>During an interview on 04/18/22 at 2:32 p.m., Resident #71 denied that he refused his safety belt on the date of the incident and stated, "I usually wear it [safety belt]." A family member D, stated, "sometimes they [staff] don't even use it [safety belt]."<br><br>During an interview on 04/21/22 at 12:48 p.m., two administrative staff (#1 and #3) confirmed the van driver transported Resident #71 without his wheelchair safety belt and the van's restraint system secured, and staff failed to stop and call for assistance with a safety concern while transporting. | F 689 | Date of compliance: 05/24/2022 | |
| F 692 SS=G | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte | F 692 | | 5/24/22 |

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| F 692 | Continued From page 28<br>balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/25/21<br><br>Based on review of facility policy, record review, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #34) with severe weight loss. Failure to adequately monitor and evaluate weights, implement recommended dietician recommendations, assess the effectiveness of current interventions, re-evaluate the need for updated or additional interventions, and physician notification of weight loss resulted in continued, severe weight loss.<br><br>Findings include:<br><br>Review of the facility policy titled "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" occurred on 04/21/22. This policy, dated Qtr [quarter] 3, 2021, stated, ". . . The physician and staff will monitor nutritional status, an individual's response to interventions . . . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the | F 692 | F-692- NUTRITION/HYDRATION STATUS MAINTENANCE<br><br>CORRECTIVE ACTION:<br>- Resident #34□s entire facility medical record reviewed by Director of Nursing along with IDT Team on 4/28/2022 at this time resident #34□s weight is increasing in past 17 days. Resident #34 weight on 4/27/2022 is 99.8lbs. This is a 8.2lb increase in past 45 days. Resident intake of meals and Med Pass supplement has increased to 75%.<br>- Director of Nursing to request physician and RD review of Resident #34□s weights, intake record, medication list, and lab review to be completed by 5/19/2022 and any recommendations will be reviewed with Resident #34 and representative. Weights ae being conducted every Monday, Wednesday, and Friday and being audited by the Director of Nursing/designee on those days for completion and accuracy. This is beginning on 5/11/2022. | |

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| F 692 | Continued From page 29<br>physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications . . ."<br><br>Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated 02/24/22, identified severe weight loss.<br><br>Review of Resident #34's physician's orders identified, ". . . Regular diet . . . Med Plus 2.0 [nutritional supplement] two times a day . . . Weight 3x [times] / [per] week - Monday/Wednesday/Friday every day shift . . ."<br><br>The record identified the following weights obtained from admission on 11/24/21 to 03/09/22:<br>* 11/24/21 116 lbs. (pounds)<br>* 11/29/21 116 lbs.<br>* 12/06/21 116 lbs.<br>* 12/09/21 114 lbs.<br>* 01/10/22 110 lbs.<br>* 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss)<br>* 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss)<br>* 03/01/22 94 lbs.<br>* 03/02/22 93.6 lbs.<br>* 03/04/22 93 lbs.<br>* 03/07/22 91.2 lbs.<br>* 03/09/22 91.4 lbs.<br>The facility failed to weigh Resident #34 as ordered on six occasions 12/13/21, 12/20/21, 12/27/21, 12/31/21, 02/25/22, and 02/28/22. | F 692 | IDENTIFICATION OF OTHERS:<br>- A full sweep will be conducted by the Director of Nursing and RN Unit Managers of all residents weights, RD recommendations, and physician orders to ensure accuracy. Any deficiencies will be addressed in the same manner as noted above for Resident #34.<br><br>Systemic Changes:<br>- A weekly clinical skin/weight meeting will be conducted with the presence of the IDT Team that will include the Administrator, Director of Nursing/Designee, RN/LPN Unit Managers, Dietary Manager, RD, and Social Services. All weights during the prior 7 days will be reviewed by the IDT Team and RD. Any recommendations will be assigned to the RN/LPN unit managers to be followed up on with the resident/representative and resident physician within 48 hours unless an emergent situation and documentation will be added to resident record for the IDT to review at the end of the 48-hour period to ensure recommendation/intervention has been reviewed and implemented or not implemented per physician order and care plan will be updated. Implementation will begin 5/17/2022.<br>- Any resident at risk for nutritional deficiency will be placed on the clinical log by the Director of Nursing/Designee and be reviewed at the clinical skin/weight meeting to monitor nutritional status and intervention efficacy. Any change of | |

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| THE MEADOWS ON UNIVERSITY | 1315 S UNIVERSITY DR FARGO, ND 58103 |

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| F 692 | Continued From page 30<br><br>Review of Resident #34's nursing progress note, dated 02/17/22, stated, "Orders placed for Med Pass [nutritional supplement] BID [twice a day]. Pt. [patient's] son, [name], notified of weight loss and supplement added. Will monitor weight closely at this time."<br><br>Review of Resident #34's dietician's notes showed the following:<br>* 02/17/21 "Nutritional review given underweight status and weight loss. PO [by mouth] intakes variable. Overall suboptimal intakes. Will add MedPass BID given high kcal [kilocalorie] content. . . ."<br>* 02/25/21 "Nutritional review given weight loss. Resident very underweight. Current BMI [body mass index] of 15.9 [percent]. Med Pass not accepted well. Does like Liquacel [protein supplement], would recommend 1 ounce daily. Would also trial Magic Cup [nutritional supplement] for more caloric supplement. Will continue to monitor. If intakes remain poor and weight not increasing would recommend enteral nutrition if appropriate." The facility failed to implement the dietician's recommendations of Liquacel, Magic Cup, or enteral nutrition.<br><br>Resident #34's physician progress note, dated 03/10/22, identified a weight of 91.2 lbs., but failed to evaluate the resident's response to interventions and failed to address the 24.8 pound severe weight loss.<br><br>During an interview on 04/20/22 at 2:30 p.m., a supervisory nurse (#8) confirmed the dietician and nursing staff failed to obtain an order for, and implement recommended nutritional | F 692 | condition will be reported to the physician. This will begin on 5/17/2022.<br>- RD will conduct a nutritional assessment on each resident at least quarterly and more frequently as needed.<br>- All licensed staff to be educated by the Director of Nursing on following physician orders and obtaining accurate weights on residents. Any significant change will be reported by the licensed staff member to the Director of Nursing/designee as well as the resident/representative. This education will be completed by 5/24/2022. This education will be repeated biannually by the Director of Nursing/Designee.<br><br>MONITORING:<br>- DON/Designee will conduct audit with a random sample of 3 residents per unit for physician orders for obtaining weights are being followed. Any deficiency will be investigated and corrected immediately. This will continue for a period of 1 month and then continue quarterly or more frequently if need is identified until the systemic change has proven effective. These audits will begin the week of 5/16/2022 and be kept on a log.<br>- DON/Designee will monitor weekly x 12 weeks and then quarterly for appropriate follow up on recommendations/interventions within 48 hours from weekly skin/weight meeting, including physician notification, interventions, and care planned.<br>- | |

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| F 692 | Continued From page 31<br>supplements, failed to monitor Resident #34's severe weight loss, complete weights as ordered, and were unable to locate a physician's note that addressed the weight loss.<br><br>During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed the physician and staff failed to adequately monitor Resident #34's nutritional status and severe weight loss.<br><br>Failure to consistently obtain weights as ordered, monitor and notify physician and dietician of weight loss identified, ensure implementation of nutritional recommendations, evaluate interventions for effectiveness, and promptly communicate weight changes to the physician and nursing staff resulted in Resident #34's continued, severe weight loss. | F 692 | - Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate. The QA/QAPI Committee has reviewed and approved this plan of correction effective 5/24/2022.<br><br>Date of compliance: 05/24/2022 | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 02/25/21 and 03/25/21.<br><br>Based on observation, record review, information | F 695 | F 695 Respiratory/Tracheostomy Care and Suctioning<br><br>Corrective Actions: | 6/14/22 |

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| F 695 | Continued From page 32<br>from the complainant, review of facility policy and procedure, family and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 3 of 10 sampled residents (Residents #10, #55, and #63) receiving respiratory care. Failure to administer nebulizer medications and clean nebulizer equipment according to policy and professional standards (Residents #10 and #55), failure to replace broken respiratory equipment promptly (Resident #55), and failure to obtain a physician's order for oxygen administration (Resident #63) may result in complications and compromise of residents' respiratory status.<br>Findings include:<br><br>NEBULIZER TREATMENTS<br><br>Information received by the department from an anonymous complainant identified concerns with nebulizer treatments not being administered properly.<br><br>Review of the facility policy, "Administering Medications through a Small Volume (Handheld) Nebulizer" occurred on 04/20/22. This policy, dated 2021, stated, "Purpose: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. . . Steps in the Procedure: . . . 6. Obtain baseline pulse, respiratory rate and lung sounds. 7. Wash and dry hands. 8. Draw up the medication to be nebulized. 9. Dispense medication into nebulizer cup. . . . 13. Turn on the nebulizer and check the outflow port for visible mist. 14. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask). 15. Instruct the resident | F 695 | Resident # 10 was assessed by Director of Nursing (DON)/designee to validate no change in condition occurred from omitted baseline and post assessments of lung sounds, pulse rate and proper cleaning of nebulizer equipment and delay in reapplying 02 cannula and resuming 02 administration. Any concerns that were identified were promptly corrected, resident, resident representative, and physician notified, any orders obtained noted and care plan updated as applicable.<br><br>Resident #55 was assessed by DON/designee to validate no change in condition occurred from omitted baseline and post assessments of lung sounds, pulse rate and proper cleaning of nebulizer equipment, in addition resident #55 CPAP mask has been replaced, with validation of a secure mask seal. Any concerns that were identified were promptly corrected, resident, resident representative, and physician notified, any orders obtained noted and care plan updated as applicable.<br><br>Resident # 63 was assessed by DON/designee to validate no change in condition occurred from omitted O2 order and documentation of the residents respiratory 02 status. Any concerns that were identified were promptly corrected, resident, resident representative, and physician notified, any orders obtained noted and care plan updated as | |

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| F 695 | Continued From page 33<br>to take a deep breath, pause briefly and then exhale normally. 16. Encourage the resident to repeat the above breathing pattern until the medication is completely nebulized or until the designated time of treatment has been reached. 17. Remain with the resident for the treatment. 18. Approximately five minutes after treatment begins (or sooner if clinical judgement indicated) obtain the resident's pulse. 19. Monitor for medication side effects, including rapid pulse, restlessness and nervousness throughout the treatment. 20. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. 21. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 22. Encourage the resident to cough and expectorate as needed. 23. Administer therapy until medication is gone. 24. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 25. Wash and dry hands. 26. Obtain post-treatment pulse, respiratory rate and lung sounds. 27. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water: b. Rinse with hot water: c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. Rinse all pieces with sterile water (NOT tap, bottle or distilled); and e. Allow to air dry on a paper towel. 28. Wash and dry hands. 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. . . . "<br><br>- Review of Resident #10's medical record occurred on all days of survey. Diagnoses included shortness of breath and chronic | F 695 | applicable.<br><br>Identification of Others:<br><br>The Director of Nursing/designee will complete record review and observational rounds to validate that residents receiving respiratory services including O2 administration, nebulizer and and C-pap treatments have orders for administration including required baseline and post assessments, any equipment used is clean per recommendations and in good working order. Any identified concerns will be promptly corrected, resident/representative and physician notified, any new physician orders noted, and care plans updated as applicable.<br><br>Systemic Changes<br><br>The Director of Nursing/designee will provide training to license nurses on requirements to have physician orders respiratory services including O2 administration and, nebulizer and C-PAP administration with instructions for baseline and post assessments, cleaning of equipment and validation that any equipment used is in good working order including C-PAP mask. Any concerns identified will be promptly corrected. | |

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| F 695 | Continued From page 34<br>obstructive pulmonary disease (COPD).<br><br>Observation on 04/19/22 at 8:50 a.m. showed a licensed nurse (#10) administered Resident #10's nebulizer medication. The nurse failed to assess lung sounds and obtain a baseline pulse and respiratory rate prior to starting the treatment, failed to check pulse rate during the treatment, and failed to obtain pulse, respiratory rate and assess lungs post treatment. The nurse failed to clean the nebulizer equipment, and re-apply Resident #10's nasal cannula and resume oxygen.<br><br>During an interview on 04/21/22 at 12:48 p.m., two administrative staff (#1 and #3) confirmed staff failed to follow the facility's policy when administering nebulizer treatments.<br><br>- Review of Resident #55's medical record occurred on all days of survey. Diagnoses included COPD, respiratory disorders, and sleep related hypoventilation (reduced amount of oxygen entering the lungs).<br><br>Observation on 04/19/22 at 4:11 p.m. showed a licensed nurse (#12) administered two separate nebulizer treatments to Resident #55. The nurse failed to assess lung sounds and obtain a baseline pulse and respiratory rate prior to each treatment, failed to check pulse rate during the treatments, and failed to obtain pulse, respiratory rate and assess lungs post treatments. After treatments, the nurse rinsed the mask and the nebulizer cup with tap water, cleaned the mask and cup with soap, rinsed the mask and cup with tap water and placed the pieces on a paper towel to dry. The nurse failed to soak all pieces in a | F 695 | Monitoring<br>The Director of Nursing/designee will conduct reviews of respiratory services through record review and observational rounds 3 times a week for 1 month and then weekly for 2 months and then quarterly to validate those residents receiving 02 have orders for administration and, nebulizer and C-PAP administration have baseline and post assessments performed, proper cleaning of equipment is completed, and any equipment used is in good working order.<br><br>The Director of Nursing/designee will report any identified trends will be reported to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of Compliance<br>5/24/22 | |

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| F 695 | Continued From page 35 | F 695 | | |

bowl with isopropyl alcohol for five minutes and rinse with sterile water.

During an interview on 04/21/22 at 12:20 p.m., two administrative staff (#1 and #3) confirmed staff failed to follow the facility's policy regarding nebulizer treatments.

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY

Review of the facility policy, "CPAP/BiPAP [Bilevel Positive Airway Pressure] Support" occurred on 04/20/22. This policy, dated 2021, stated, "Purpose: 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation . . . in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. 3. To promote resident comfort and safety . . . Steps in the Procedure: . . . 10. Holding the mask to the resident's face, turn on the machine and allow him/her to become acclimated to the pressure. 11. Once the resident is acclimated, secure mask to his/her face. a. The mask should fit firmly but does not need to be airtight . . ."

During an interview with family member (E) and a social service staff member (#5) on 04/19/22 at 4:30 p.m., the family member stated a nurse informed her of the resident's cracked CPAP eight days ago. At 5:02 p.m., an administrative nurse (#1) entered the room to check the CPAP mask. Observation showed a crack in the seal of the mask. The family member (E) stated she has never seen staff cleaning the CPAP and has at

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| F 695 | Continued From page 36 | F 695 | | |

times seen parts of it on the floor. The administrative nurse (#1) stated he/she would make sure the mask is replaced.

Review of Resident #55's nursing progress note, dated 04/15/22, stated "CPAP on as ordered but noted to have a tear on the mask, leaks at times . . . morning nurse to call [health care accessories business] for possible replacement."

Observation on 04/20/22 at 2:25 p.m. showed a nurse (#16) came into Resident #55's room to apply the CPAP. The nurse (#16) placed the mask on the resident and stated the "air is leaking out" and it "does not have a good seal" and left the room to check on getting a new mask.

Review of Resident #55's treatment administration records showed staff utilized the mask with the cracked seal for CPAP therapy each night from 04/15/22 until 04/20/22.

During an interview on 04/20/22 at 4:00 p.m., an administrative nurse (#1) stated the CPAP masks have been ordered and will arrive later that day.

OXYGEN

Review of the facility policy titled "Oxygen Administration" occurred on 04/21/22. This undated policy stated, ". . . Verify that there is a physician's order for this procedure . . ."

Observation on all days of survey showed Resident #63 had oxygen on at 2 liters per nasal cannula (L/NC).

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| F 695 | Continued From page 37<br>Review of Resident #63's medical record occurred on all days of survey. Diagnoses included acute respiratory failure with hypoxia. A physician's history and physical (H&P), dated 04/11/22, included the following admitting diagnoses: community acquired pneumonia, large left side pleural effusion, congestive heart failure, and history of paroxysmal atrial fibrillation. The medical record lacked an order to administer oxygen and monitoring of the resident's respiratory/oxygen status.<br><br>During an interview on 04/19/22 at 9:47 a.m., Resident #63 stated he used oxygen at all times since returning from the hospital last week.<br><br>During an interview on 04/20/22 at 2:00 p.m., a licensed nurse (#2) stated, "He [Resident #63] uses oxygen continuously."<br><br>During an interview on 04/21/22 at 10:21 a.m., an administrative nurse (#1) verified staff did not have an order for administering oxygen for Resident #63 and failed to document the resident's respiratory/oxygen status. The administrative nurse (#1) agreed failure to have a physician's order for oxygen and monitor the resident's respiratory status while on oxygen may complicate the resident's respiratory status. | F 695 | | |
| F 710 SS=D | Resident's Care Supervised by a Physician<br>CFR(s): 483.30(a)(1)(2)<br><br>§483.30 Physician Services<br>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse | F 710 | | 5/24/22 |

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| F 710 | Continued From page 38<br>specialist must provide orders for the resident's immediate care and needs.<br><br>§483.30(a) Physician Supervision.<br>The facility must ensure that-<br><br>§483.30(a)(1) The medical care of each resident is supervised by a physician;<br><br>§483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy, record review, and staff interview, the facility failed to ensure a physician response to changes in resident's weight/condition for 1 of 1 sampled resident (Resident #34) with severe weight loss. Failure to ensure the physician responded in a timely manner may result in a delay of treatment and resulted in further weight loss for Resident #34.<br><br>Findings include:<br><br>Review of the facility policy titled "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" occurred on 04/21/22. This policy, dated Qtr (quarter) 3, 2021, stated, ". . . The physician and staff will monitor nutritional status, an individual's response to interventions . . . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and | F 710 | F710- Resident care supervised by a physician<br><br>CORRECTIVE ACTION:<br>- Director of Nursing requested physician and RD review of Resident #34□s weights, intake record, medication list, and lab review to be completed by 5/19/2022 and any recommendations will be reviewed with Resident #34 and representative.<br>IDENTIFICATION OF OTHERS:<br>- A full sweep will be conducted by the Director of Nursing and RN Unit Managers of all residents' weights, to assure any noted significant changes have physician notification documented, as well as recommendations in place. Any deficiencies will be addressed immediately with notification and initiation of any physician orders and care plan updated as needed.<br>Systemic Changes:<br>- A weekly clinical skin/weight meeting | |

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| F 710 | Continued From page 39<br>complications . . ."<br><br>Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated 02/24/22, identified severe weight loss. The care plan failed to address weight loss.<br><br>The record identified the following weights completed from admission on 11/24/21 to 03/09/22:<br>* 11/24/21 116 lbs. (pounds)<br>* 11/29/21 116 lbs.<br>* 12/06/21 116 lbs.<br>* 12/09/21 114 lbs.<br>* 01/10/22 110 lbs.<br>* 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss)<br>* 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss)<br>* 03/01/22 94 lbs.<br>* 03/02/22 93.6 lbs.<br>* 03/04/22 93 lbs.<br>* 03/07/22 91.2 lbs.<br>* 03/09/22 91.4 lbs.<br><br>Resident #34's physician progress note, dated 03/10/22, identified a weight of 91.2 lbs., but failed to evaluate the resident's response to the MedPass (liquid supplement) recommended by the dietician on 02/17/22 or address the 24.6 pound severe weight loss.<br><br>During an interview on 04/20/22 at 2:30 p.m., a licensed nurse (#8) confirmed Resident #34's physician note failed to address the severe | F 710 | will be conducted with the presence of the IDT Team that will include the Administrator, Director of Nursing/Designee, RN/LPN Unit Managers, Dietary Manager, RD, and Social Services. All weights during the prior 7 days will be reviewed by the IDT Team and RD. Any recommendations will be assigned to the RN/LPN unit managers to be followed up on with the resident/representative and resident physician within 48 hours unless an emergent situation and documentation will be added to resident record for the IDT to review at the end of the 48-hour period to ensure recommendation/intervention has been reviewed and implemented or not implemented per physician order and care plan will be updated. Implementation will begin 5/17/2022.<br>- All licensed staff to be educated by the Director of Nursing/designee on notification to physician of significant weight change, including any new orders documented and care planned. This education will be completed by 5/24/2022. This education will be repeated biannually by the Director of Nursing/Designee.<br><br>MONITORING:<br>- DON/Designee will monitor weekly x 12 weeks and then quarterly for appropriate physician notification, interventions and care plan updated of any residents with significant weight change.<br>- Any identified trends will be reported | |

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| F 710 | Continued From page 40<br>weight loss.<br><br>During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) agreed the physician failed to address Resident #34's severe weight loss. | F 710 | to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate. The QA/QAPI Committee has reviewed and approved this plan of correction effective 5/24/2022.<br><br>Date of compliance: 05/24/2022 | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>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).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and | F 726 | | 5/24/22 |

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| F 726 | Continued From page 41<br>techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of employee files, facility policy, and staff interview, the facility failed to ensure nursing staff with appropriate competencies and skill sets to care for the needs of residents for 1 of 1 nursing staff observed using the suction machine (Staff A) and 1 of 3 certified nursing assistant (CNA) personnel files reviewed (Staff B). Failure to ensure nursing staff are knowledgeable regarding the use of suction machines and CNAs complete annual competencies may result in inadequately trained staff and poor resident care.<br><br>Findings include:<br><br>Review of the facility policy titled "Job Descriptions and Performance Evaluations" occurred on 04/20/22. This policy, revised August 2021, stated, ". . . The primary purpose of our facility's job descriptions and performance evaluations is to provide uniform guidelines for the implementation of our job requirements and the evaluation of the standards of job performance. . . ."<br><br>- CNA (Staff B's) personnel file identified a hire date of 07/09/19. The facility completed the most recent performance evaluation on 06/01/20 (22 months prior).<br><br>During an interview on the morning of 04/20/22, a supervisory nurse (#1) stated the facility should complete CNA performance evaluations annually. | F 726 | F 726<br>Competent Nursing staff<br><br>Corrective Action<br>The facility completed a performance evaluation on CNA Staff B on 05/13/2022. The nurse unit manager educated Staff A on 05/11/2022 on the proper technique and usage of a suction machine and had Staff A demonstrate competence with using the machine.<br><br>Identification of Others<br>DON/Designee will review all nursing personnel files to ensure all performance evaluations were completed within the last 12 months including use and set up of suction machine.<br><br>Systemic Changes<br>DON/Designee will validate that all nursing staff have annual performance evaluations to ensure that nurses and CNAs are able to demonstrate competency in skills and techniques necessary to care for residents□ needs, as identified through resident assessments, and described in the plan of care. Through the performance evaluations done annually, the facility will | |

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| F 726 | Continued From page 42<br><br>- Observation of the suction machine on 04/20/22 at 2:09 p.m. showed a staff nurse (Staff A) attempted to demonstrate the use of the suction machine. The staff member located tubing in the drawer of the cart, and stated she needed an adaptor to be able to connect the tubing. When asked where she would find an adaptor, the staff nurse stated she was unsure and would find out. At 2:45 p.m., the staff nurse returned and identified the adaptor as part of the tubing. The nurse then demonstrated the use of the suction machine.<br><br>During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated nursing staff should know how to use the suction machine in case of emergencies. | F 726 | also ensure nursing staff are able to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Use of a suction machine will also be a part of new employee orientation so that the facility can guarantee all staff are trained and are able to competently use the device.<br><br>Monitoring<br>DON/designee validate through record review/interview that all new hires have completed competencies timely 3x/week x 4 weeks then monthly x 2 months. DON/designee will conduct audits on nursing staff through observation, and interview, on use of suction machine including set up of machine 3x/week for 1 month and then weekly for 2 months and then quarterly. The DON/designee will report any identified trends to the QAPI committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of Compliance<br>05/24/2022 | |
| F 755 SS=D | Pharmacy<br>Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain | F 755 | | 5/24/22 |

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| F 755 | Continued From page 43<br>them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/25/21<br><br>Based on observation, record review, review of facility policy, and staff and resident interviews, the facility failed to obtain routine, regularly scheduled medication for 1 of 21 sampled residents (Resident #63). Failure to ensure each | F 755 | F755<br>1. Corrective Action<br><br>The facility will immediately implement an appropriate routine and emergency drugs and biologicals, or obtain them under an agreement described in §483.70(g) and consistent with the requirements of | |

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| F 755 | Continued From page 44<br>resident receives routine, regularly scheduled pain medications has the potential for unnecessary pain and other adverse effects.<br><br>Findings include:<br><br>Review of the facility policy titled "Administering Medications" occurred on 04/21/22. This undated policy stated, ". . . Medications shall be administered in a safe and timely manner, and as prescribed. . . ."<br><br>During observation of morning cares on 04/19/22 at 11:38 a.m., Resident #63 requested the staff apply the pressure relieving boot to his left foot due to increased pain from the ulcer to his left heel.<br><br>During an interview on 04/20/22 at 2:00 p.m., Resident #63 stated, "I didn't get much sleep last night because my left heel was hurting so bad, and they said they were out of my Tramadol."<br><br>Review of Resident #63's medical record occurred on all days of survey and included diagnoses of pressure ulcers to right and left buttocks, left heel and left ankle, neuropathy (bone pain), and osteomyelitis (bone infection).<br><br>Resident #63's current physician orders included: Tramadol 50 milligrams [mg]. Give one tablet by mouth three times a day for pain.<br><br>Resident #63's current care plan stated, ". . . I need pain management and monitoring related to: pressure wounds . . . Pain medication scheduled routinely. . . ." | F 755 | §483.45 for the affected resident(s)/neighborhood(s) identified in the deficiency. The facility will immediately implement appropriate pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) consistent with the requirements of §483.45(a) to meet the needs of each resident. The facility will immediately employ or obtain the services of a licensed pharmacist who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility. 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled to be consistent with the requirements of §483.45(b)<br><br>The Director of Nursing (DON) or other designee will verify and monitor that medication is readily available with no additional concerns identified.<br><br>2. Identification of Others<br><br>The DON/designee will validate medications are readily available to all residents and that any concerns are promptly corrected.<br><br>3. System Changes | |

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| F 755 | Continued From page 45<br>The electronic medication administration record (EMAR) for Resident #63 identified the following:<br>* 04/19/22 at 8:00 a.m., Tramadol not administered. ". . . scheduled Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Hold per MD [medical doctor] orders."<br>* 04/19/22 at 12:00 p.m., Tramadol not administered. ". . . scheduled Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Resident out of facility." (Resident #63 was out of facility at emergency room at this time).<br>* 04/19/22 at 8:00 p.m., Tramadol not administered. ". . . Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Hold per MD orders."<br><br>Nursing progress notes included the following:<br>* 4/20/22 at 9:20 p.m., ". . . [Dr. name] oncall (sic) attending was unable to give one time order for Tramadol tonight. One time hold order Tramadol tonight obtained by [Dr. name]. Resident is made aware."<br><br>Resident #63's controlled substance record showed no Tramadol 50 mg tablets available on 04/18/22 at 8:15 p.m. The controlled substance record on 04/20/22 showed twelve Tramadol 50 mg tablets available.<br><br>During an interview on 04/20/22 at 2:25 p.m., a nurse (#12) verified he had received twelve Tramadol from the pharmacy this morning for Resident #63. When asked the process when a scheduled medication is not available the nurse stated, "We have the nexys system [automated medication dispensing system] but I don't believe I have access to that system and even if I did the | F 755 | The DON met with pharmacy representatives on 05/23/2022 to verify appropriate stocking of medications in Nexsys and to ensure all licensed nursing personnel are able to access the Nexsys.<br><br>The DON/designee will maintain ongoing communication with the Pharmacy and representatives to assure routine stocking of Nexsys is maintained.<br><br>The DON/designee completed education with nursing staff on 05/23/2022 on appropriate measures to follow when medication is needing to be reordered or is not available at time of dispensing.<br><br>4. Monitoring Weekly<br><br>For no less than 12 weeks, the DON/ designee will conduct audits 3 times a week x 4 weeks then weekly on medication carts through observation, chart review, and interview to verify availability of all medications for residents.<br><br>The DON/designee will report any identified trends to the Quality Assurance and Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.<br><br>Date of Compliance<br><br>05/24/2022 | |

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| F 755 | Continued From page 46<br>pharmacist needs to do something in it so I could get the medication out, but I'm not sure how that all works."<br><br>During an interview on 04/20/22 at 2:35 p.m., a unit manager (#8) stated, "I don't think I have access to the nexys system, and I'm not even sure how it works. I think staff use their fingerprint to get into it."<br><br>During an interview on 04/20/22 at 2:40 p.m., a unit manager (#17) stated, "I did receive a call from the nurse (#19) last evening telling me there was no Tramadol for [Resident #63's name], and I asked her if there was any Tramadol in the nexys system and the nurse (#19) stated there was no Tramadol in the nexys system. So I told the nurse (#19)to call the physician and get a one time hold order for the resident's Tramadol. For whatever reason the day nurse didn't order a refill." During the interview both unit managers (#8 and #17) verified the nexys system contained Tramadol 50 mg during this time period.<br><br>During an interview on 04/22/22 at 10:15 a.m., an administrative nurse (#1) verified facility nursing staff failed to refill Resident #63's Tramadol and incorrectly obtained a hold order instead of refilling Resident #63's Tramadol. | F 755 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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 | F 761 | | 5/24/22 |

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| F 761 | Continued From page 47<br>applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility policy review, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 1 medication cart (North Hall). Failure to lock the medication cart at all times when unattended may result in unauthorized access to medications.<br><br>Findings include:<br><br>Review of the facility policy titled "Storage of Medications" occurred on 04/20/22. This policy, revised April 2021, stated, ". . . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such | F 761 | F761 Label/Store Drugs and Biologicals<br>Corrective Actions:<br>The Director of Nursing/designee validated that North Hall Medication Cart was locked and drugs and biologicals were stored safely and secured.<br>Identification of Others<br>The Director of Nursing/designee conducted facility observational rounds to validate that medication and treatment carts were locked and drugs and biologicals were stored safely and secured. Any concerns were promptly corrected.<br>Systemic Corrections:<br>The Director of Nursing/designee provided education to license nurses on | |

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| F 761 | Continued From page 48<br>items shall not be left unattended if open or otherwise potentially available to others. . . ."<br><br>Observation on 04/20/22 from 11:12 a.m. until 11:22 a.m. showed an unlocked medication cart located in the North Hall. Multiple staff members and residents walked by unlocked and unattended medication cart.<br><br>During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated staff should lock the medication cart when it is unattended. | F 761 | the requirement to keep drugs and biologicals stored safely and secure by locking medication carts when not attended.<br>Monitoring:<br>The Director of Nursing/designee will conduct observational rounds on various shift 3 times a week for 1 month and then weekly for 2 months and then quarterly to validate that drugs and biologicals are stored safely and secured including locking of medication carts; any concerns identified will be promptly corrected.<br>The Director of Nursing/designee will report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.<br>Date of Compliance:<br>5/24/22 | |
| F 803 SS=F | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident | F 803 | | 5/24/22 |

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| F 803 | Continued From page 49<br>groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of facility menus, facility policy review, and staff interview, the facility failed to ensure the nutritional adequacy of menus on 4 of 4 days of survey (April 18-21, 2022). Failure to ensure the dietician reviews menus, include portion sizes, and include menus for altered or therapeutic diets may result in residents experiencing nutritional deficiencies and weight loss.<br><br>Findings include:<br><br>Review of the facility policy titled "Menus" occurred on 04/20/22. The policy, revised October 2021, stated, ". . . The Dietician reviews and approves all menus . . . Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal . . ."<br><br>The facility provided a copy of the daily menu for the week of survey. The menu lacked portion sizes, menus for therapeutic and altered diets, and review by a dietician.<br><br>During an interview on the afternoon of 04/19/22, | F 803 | F 803- Menus Meet Resident Nds/Prep in Adv/Followed<br>CORRECTIVE ACTION:<br>- No specific residents were identified. All residents potentially affected.<br>- The Dietary Manager/designee will meet with each resident/representative to update resident food preferences. These updated preferences will then be uploaded into the tray card system. This will occur on or before 5/24/2022.<br><br>IDENTIFICATION OF OTHERS:<br>- All residents could be potentially affected.<br><br>SYSTEMIC CHANGES:<br>- The Administrator and RD have chosen to begin a new menu system. The menu system is called BluePrint Menus of US Foods.The new menu system will be implemented on 5/15/2022. The dietary manager, lead cook, and RD will be provided training the week of 5/15/2022 by a US Food Representative. | |

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| F 803 | Continued From page 50<br>a dietary cook (#18) identified she developed the menus and confirmed they lacked review by a dietician. | F 803 | - The new BluePrint Menu system meets our current policy. The menu system includes the recipes to meet all required nutritional adequacies according to national guidelines, include portion sizes, can meet religious and cultural preferences, and include specific menus to meet therapeutic diets.<br>- The RD will meet with the DM weekly beginning 5/15/2022 to review and approve the menu. Any changes made to the menu will only be completed by the dietary manager with approval from the RD.<br>- The new menu system will be reviewed and discussed at resident council by 5/24/2022. Any comments, concerns, or suggestions will be brought to the attention of the dietary manager, RD , and Administrator to address.<br>- The menus will be discussed at monthly resident council meetings for resident feedback. The feedback will be reviewed by the IDT team and reasonable changes will be made to accommodate resident choices.<br>- Resident food preferences will be reviewed and updated upon admission as well as quarterly or per resident request. Upon admission, this will be conducted by the dietary manager within the first 48 hours. Quarterly, this will be conducted as a part of the IDT advocate program. The updated preferences will be given to the dietary manager and any changes will be uploaded to the tray card system within 72 hours. This will begin on 5/24/2022.<br>- All residents who are on a therapeutic | |

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| F 803 | Continued From page 51 | F 803 | diet have been identified by the IDT team and a log has been created and shared with the DM to be updated as any changes occur. This information will be uploaded into the tray card system on or before 5/24/2022.<br>- All dietary staff have been provided training and education on the BluePrint Menu system by the dietary manager and RD. This training includes religious and cultural preferences, standard portion sizes, nutritional adequacies, and therapeutic diets. This education has been completed on or before 5/24/2022. This will continue as a biannual education for all dietary staff.<br>- Any new dietary staff will be provided training by the dietary manager/designee during orientation on religious and cultural preferences, standard portion sizes, nutritional adequacies, and therapeutic diets.<br><br>MONITORING:<br>- The menu for the following week will be brought to the weekly skin/weight meeting to be reviewed and approved by the RD after ensuring the portion sizes, nutritional values, and therapeutic diets are met based on national standards as well as to ensure all cultural and religious requests are met. This will begin the week of 5/15/2022.<br>- The dietary manager will provide the administrator with a copy of the weekly menu after the RD has reviewed and approved the menu. This will begin the week of 5/15/2022. | |

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| F 803 | Continued From page 52 | F 803 | - Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate. The QA/QAPI committee has reviewed and approved this plan of correction on 5/24/2022.<br><br>Date of Compliance<br>05/24/22 | |
| F 806 SS=D | Resident Allergies, Preferences, Substitutes<br>CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to accommodate resident/resident representative's preferences for food during 2 of 3 meals observed (evening meal on 04/18/22 and noon meal on 04/19/22). Failure to follow the resident/resident representative's preferences for less carbohydrates and less high calorie foods has the potential to result in weight gain.<br><br>Findings include: | F 806 | F806 Plan of Correction-Resident Allergies, Preferences, Substitutes<br><br>Corrective Action<br><br>Resident #55 has had dietary tray card updated to reflect resident/resident representative□s preferences for food. The tray card has been updated for less carbohydrates and less high calorie foods to help eliminate inadvertent weight gain. | 5/24/22 |

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| F 806 | Continued From page 53<br><br>During interviews on 04/19/22 at 3:45 p.m. and on 04/20/22 at 2:30 p.m., family member (E) expressed concern the resident's weight has slowly increased and she has talked with staff/dietary/administration many times about the resident's diet. The family member stated the resident gets "too many carbohydrates and sweets" and wants the resident to have lower calorie food items for dessert and less carbohydrates. The family member (E) stated she has discussed this with staff, but they continue to give high calorie desserts.<br><br>Observation of the evening meal on 04/18/22 showed the resident ate 100% of the following meal: broccoli cheese soup, egg salad (without bread), mashed potatoes with gravy, and vanilla pudding with chocolate sauce.<br><br>Observation of the lunch meal on 04/19/22 showed the resident ate 100% of the following meal: mashed potatoes, pasta, mixed vegetables (carrots, green beans, zucchini), and a pureed cake dessert (menu: peanut butter cake and chocolate frosting).<br><br>Review of Resident #55's medical record occurred on all days of survey. The record identified the resident's family member as her decision maker. Resident #55's quarterly Minimum Data Set, dated 03/17/22, identified the resident with mild cognitive impairment. The resident currently receives a regular diet (minced and moist in texture). Review of the resident's tray card from the kitchen identified the following preferences: Double vegetable, Half Carb [carbohydrates], Regular Protein. | F 806 | The tray card will reflect more plant-based diet options and a reduction in complex starches like rice, pasta, breads, etc. Resident #55 is being offered more fruit and vegetables. The tray card will also reflect the recommendation that resident should not have cake or cookies.<br><br>Identification of Others<br><br>The dietary manager or designee will conduct an audit of all resident tray cards and compare them to resident/resident representative□s preferences and/or physician ordered therapeutic diet recommendations to ensure that the tray cards are accurate, and thus, the meals being served to the resident, and reflective of preferences and physician recommendations.<br><br>Systemic Changes<br><br>The kitchen will restructure their menus to accommodate resident/resident representative□s preferences and physician recommendations to ensure that there is not an inadvertent weight gain or weight loss. In addition, the dietary manager will review all resident□s kitchen tray cards to ensure they reflect physician recommendations and resident/resident representatives wishes regarding food preferences.<br><br>Monitoring<br><br>The Dietary Manager and/or designee will | |

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| F 806 | Continued From page 54<br><br>Review of Resident #55's current care plan identified the following: "I am at moderate nutrition risk r/t [related to] . . . dysphagia, high BMI [body mass index] for age, weight fluctuations . . . nutrition/weights/diet order as needed. . . . Honor food preferences as requested . . . Adjusted nutritional estimates per BMI > 30 . . . Offer snacks throughout the day and encourage low calorie snacks . . . I have cognitive loss as evidenced by memory deficits related to Dementia dx [diagnoses] secondary to MS [multiple sclerosis], dx of cognitive dysfunction. . . . Provide reminders to support memory. . ."<br><br>Review of dietary notes identified the following: 3/25/2022 "Nutrition/Weight . . . [name of Resident #55's family member] spoke to me about . . . menu. . . . explained that if she would like [Resident #55] to be on a specific diet, she would have to have a conversation with her primary doctor. I stated that we do offer choice when we can to upkeep quality of life. . . . I again told her to follow up with her doctor and that we will follow his/her direction."<br>6/23/2021 "Nutrition/Weight . . . Met with [Resident #55's family member] about diet recommendations from the doctor. More plant based-diet . . . (no complex starches like rice, pasta, breads, etc.) More vegetables at least two at lunch and dinner and fresh fruit, (no cake or cookies) Updated tray card. [Resident #55's family member] . . . wanted [resident] to have more fresh fruit and vegetables and I explained that we recommend she doesn't because of the mechanical soft diet recommended by therapy and that she could aspirate on the foods. . . . | F 806 | randomly audit 5 tray cards per week for accuracy (regarding preferences and recommendations) for one month. After that, the audit will be turn into 5 tray cards and audit of meals monthly for 2 months and then quarterly. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months and then quarterly. The QAPI committee can modify this plan to ensure the facility remains in compliance.<br><br>Date of Compliance: 05/24/2022 | |

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| F 806 | Continued From page 55<br>Recommended some other fruits, some cooked and some fresh along with cooked vegetables."<br><br>The dietary notes from 06/23/21 identified recommendations for no cake or cookies, however the kitchen tray card did not reflect this recommendation. Observation of the meal served to Resident #55 on 04/19/22 showed two servings of carbohydrates (potatoes and pasta) and a dessert. The facility failed to follow the resident/resident representative's wishes regarding food preferences. | F 806 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to maintain a Quality Assessment and Assurance (QAA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. These failures have the potential to result in adverse outcomes for all the residents.<br><br>Findings include:<br><br>Review of the North Dakota Department of | F 867 | F 867<br>QAPI/QAA Improvement Activities<br><br>Corrective Action<br><br>The Quality Assurance Performance Improvement (QAPI) committee will meet monthly to develop and implement appropriate plans of action to correct identified quality deficiencies that affect resident care in a manner that would enable each resident to attain or maintain his or her highest practicable physical, mental ad psychosocial well-being. | 5/24/22 |

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| F 867 | Continued From page 56<br>Health, Division of Health Facilities provider files identified the facility failed to maintain compliance in the following areas cited during the 04/21/22 standard recertification survey. The facility had repeat deficiencies cited from the recertfication survey on 02/25/21 and the federal survey on 03/25/21.<br>F692 Nutrition/Hydration Status Maintenance (cited 02/25/21)<br>F695 Respiratory/Tracheostomy Care (cited 02/25/21 and 03/25/21)<br>F755 Pharmacy Services/Procedures (cited 02/25/21 and 03/25/21)<br>F880 Infection Prevention & Control (cited 02/25/21 and 03/25/21)<br><br>The facility failed to develop and implement appropriate plans of action to correct the repeat deficient practices listed above.<br><br>Failure of the facility to effectively utilize QAA resulted in continued noncompliance at F692, F695, F755, and F880. | F 867 | Identification of Others<br><br>All residents have the potential to be affected by this practice.<br><br>Systemic Changes<br><br>The Administrator/designee educated the members of QAPI on 05/17/2022 on recognizing, developing, and implementing appropriate plans of action to correct identified deficient quality issues; specifically, related to F692 (nutrition/hydration status maintenance cited on 02/25/2021), F695 (respiratory/tracheostomy care cited on 02/25/2021 and 03/25/2021), and F755 (pharmacy services/procedures cited on 02/25/2021 and 03/25/2021).<br><br>Monitoring<br><br>The QAPI committee will continue to meet monthly with special additional focus on the areas listed above. We will monitor the progress and auditing of the above tags to make sure progress is made and maintained. The IDT will bring up these and other concerns that need to be addressed in the QAPI process going forward.<br><br>Date of Compliance<br>5/24/2022 | |
| F 880 | Infection Prevention & Control | F 880 | | 5/24/22 |

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| F 880 SS=D | Continued From page 57<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of | F 880 | | |

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| F 880 | Continued From page 58<br>infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 02/25/21 and 03/25/21.<br><br>Based on observation, review of facility policy, record review and staff interview, the facility failed to ensure staff followed appropriate | F 880 | 1. Corrective Action<br>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. | |

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| F 880 | Continued From page 59<br>infection control practices for 1 of 4 sampled resident (Resident #63) observed with pressure ulcers. Failure to follow appropriate infection control practices for pressure ulcer care may result in an infection or worsening of the affected area and cause delay in healing.<br><br>Finding include:<br><br>Review of the facility policy titled "Wound Care" occurred on 04/21/22. This undated policy, stated, "Steps in the Procedure 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's overbed table. Place all items to be used during procedure on the clean field. . . . 14. Be certain all clean items are on the clean field. . . ."<br><br>Review of Resident #63's medical record occurred on all days of survey and included the following pressure ulcers:<br>* Left heel- stage II<br>* Left ankle- stage II<br>* Right buttock- stage II<br>* Left buttock- stage II<br><br>Observation on 04/19/22 at 11:53 a.m., showed Resident #63 lying in bed on his left side. A licensed nurse (#2) gathered supplies to complete dressing changes to the resident's pressure ulcers on his buttocks and placed the supplies on the resident's bed sheets. The nurse donned gloves, poured sterile water on the old dressings, removed the old dressings and doffed his gloves. The nurse donned new gloves and applied more sterile water cleansing the resident's buttocks ulcers. The nurse opened the bottle of prescribed wound cleanser, poured the | F 880 | The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for:<br>(1) Ensuring staff provide wound cares consistent with facility policy and in accordance with CDC guidelines.<br><br>The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will:<br>(1) Educate clinical staff on correctly completing wound cares using a clean field.<br>(2) Educate clinical staff on correctly completing hand hygiene before, during and after wound care/dressing application or changes.<br><br>2. Identification of Others<br>The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for hand hygiene, wound and catheter care from CDC and CMS. The IP, 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.<br><br>3. System Changes<br>On or before 05/24/2022 the facility shall complete the following actions: | |

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| F 880 | Continued From page 60<br>wound cleanser into the cap of the bottle, which he had placed on the resident's bed sheet, handed the scissors and gauze to the certified nurse aide (CNA) (#13) who cut the gauze for the nurse and placed the scissors and remaining roll of gauze back on the bed sheets. The nurse soaked the gauze in the cap of the wound cleanser, opened a package of sterile q-tips removed one, placed the open package of q-tips back on the resident's bed sheets and packed the wound. The nurse picked up the rolled gauze and scissors from the bed sheets and handed them to the CNA (#13) who cut the gauze for the nurse.<br>The nurse failed to provide a clean field while completing the resident's wound care, and failed to sanitize or wash his hands in between doffing and donning gloves.<br><br>During an interview on 04/21/22 at 10:15 a.m., an administrative nurse (#1) stated she expected staff to use a clean field for dressing changes and to sanitize hands in between doffing and donning gloves. | F 880 | (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br>a. Failure to complete handwashing or hand hygiene in accordance with CDC guidelines.<br>Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf<br>(2) The DON, SDC, IP, or suitable designee will ensure the following:<br>a. All staff will receive education 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.<br>(3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods.<br><br>4. Monitoring<br>Weekly for no less than 12 weeks, the DON, IP, 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 | |

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| F 880 | Continued From page 61 | F 880 | monitoring will include:<br>(1) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when indicated, in the course of their routine duties.<br>(2) Observations of staff types to ensure performance of proper wound care, in the course of their duties.<br>(3) Observations of staff types to ensure performance of proper wound care, in the course of their duties.<br><br>Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms.<br><br>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 and then quarterly. 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.<br><br>5. Correction Date<br>05/24/2022 | |

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| | 355024 | A. BUILDING _____ B. WING _____ | C 04/21/2022 |

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| THE MEADOWS ON UNIVERSITY | 1315 S UNIVERSITY DR FARGO, ND 58103 |

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| F 888 SS=D | COVID-19 Vaccination of Facility Staff<br>CFR(s): 483.80(i)(1)-(3)(i)-(x)<br><br>§483.80(i)<br>COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.<br><br>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:<br>(i) Facility employees;<br>(ii) Licensed practitioners;<br>(iii) Students, trainees, and volunteers; and<br>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.<br><br>§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:<br>(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and<br>(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in | F 888 | | 6/14/22 |

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| F 888 | Continued From page 63<br>paragraph (i)(1) of this section.<br><br>§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:<br>(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;<br>(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;<br>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;<br>(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;<br>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;<br>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff | F 888 | | |

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| F 888 | Continued From page 64<br>COVID-19 vaccination requirements;<br>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:<br>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and<br>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;<br>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section | F 888 | | |

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| F 888 | Continued From page 65<br>are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, facility policy review, and staff interview, the facility failed to ensure an appropriate exemption from COVID-19 vaccination for 1 of 2 unvaccinated staff members (Staff C). Failure to ensure an appropriate exemption allowed staff to work while unvaccinated which placed residents and staff at risk for COVID-19 infection.<br><br>Findings include:<br><br>Review of the facility policy titled "Federal Vaccination Mandate Policy for Healthcare Facilities" occurred on 04/20/22. This undated policy stated, ". . . Medical Exemption: To be eligible for a Qualified Medical Reasons exemption the Eligible Person must provide to their employer a written statement that meets the following requirements: A letter or form signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the | F 888 | F-888- Vaccination of Facility Staff<br><br>CORRECTIVE ACTION:<br>The facility will immediately implement an appropriate policy and procedure plan consistent with the requirements of ¿483.80(i). The Director of Nursing (DON), Human Resource Manager (HR) or other designee, shall identify and implement a consistent system for ensuring a system for: 1. Ensuring staff are fully vaccinated for COVID-19 or have appropriate exemptions in place in accordance with facility policy and CDC guidelines. The DON, HR, or other designee will: 1. Review all staff records, including travel agency staff, for proof of COVID-19 vaccination and/or qualifying exemption. 2. Reach out contracted travel agencies to inquiry on COVID-19 vaccination mandate or exemption process for travel agency staff. 3. Educate and obtain facility staff and travel agency staff records for proof of COVID-19 vaccination and/or qualifying exemption. 4. Will cease utilization of all travel agency staff where there is no proof of COVID-19 vaccination and/or qualifying exemption. | |

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| F 888 | Continued From page 66<br>contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccine requirements for staff based on the recognized clinical contraindications. . . ."<br><br>Review of Staff C's COVID-19 vaccination exemption occurred on 04/20/22. The exemption lacked a statement from a licensed practitioner, specific contraindicated vaccines, and recognized clinical reasons for a vaccine exemption.<br><br>During an interview on 04/20/22 at 12:02 p.m., an infection control nurse (#7) identified Staff C last worked on 04/12/22 and agreed the exemption the facility has on file is not acceptable. | F 888 | IDENTIFICATION OF OTHERS:<br>- A full sweep will be conducted by the DON, HR, or other designees of all staff records, including travel agency staff to ensure compliance with mandated requirements for COVID-19 vaccination or qualifying exemption.<br><br>SYSTEMIC CHANGES<br>- Policy and Procedures for mandated requirements for COVID-19 vaccination or qualifying exemption will be updated<br>- Prior to first day of work, facility or travel agency staff will provide proof of COVID-19 vaccination or qualifying exemption<br><br>MONITORING:<br>- DON and HR, or other designee will review all proof of vaccinations or qualifying exemptions to ensure compliance with all staff, including the travel agencies.<br>- DON and HR will monitor all staff COVID-19 vaccinations or exemptions with all new hires, including travel agency staff.<br><br>Date of Compliance:<br>05/24/2022 | |