| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 355024 | A. BUILDING _____ B. WING _____ | C 08/30/2022 |

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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>An unannounced onsite complaint investigation survey was completed on 08/17/22. Based on the findings, an extended survey was conducted on August 29-30, 2022. | F 000 | | |
| F 558 SS=F | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>1. Based on information provided by the complainants, observation, review of Resident Council meeting minutes, and confidential resident and staff interviews, the facility failed to provide reasonable accommodation of needs regarding call lights for 22 of 26 sampled and confidential residents (Resident #4, #6, #7, A, B, C, D, E, F, G, H, I, K, L, M, N, P, Q, R, S, V, and W) with call light concerns. Failure to answer call lights in a timely manner may result in falls/injury, discomfort, incontinence, and/or skin breakdown.<br><br>Findings include:<br><br>Information provided by the complainants' indicated staff failed to answer call lights in a timely manner resulting in incontinence.<br><br>The facility failed to provide a copy of their call light policy when requested. | F 558 | Corrective Actions:<br><br>The Director of Nursing/designee assessed Resident #4 for any unmet immediate needs, any concerns were promptly addressed.<br>The Director of Nursing/designee assessed Resident # 6 for any unmet immediate needs, any concerns were promptly addressed.<br>The Director of Nursing/designee assessed Resident #7 for any unmet immediate needs, any concerns were promptly addressed.<br>The Director of Nursing/designee assessed Resident # 8 to validate appropriate device was in place to activate her call light, any concerns were promptly addressed. Resident # 8 received soft touch call light on 9/9/2022.<br>Identification of Others: | 9/28/22 |

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

Electronically Signed | 09/20/2022

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| F 558 | Continued From page 1<br>Review of the May-July 2022 Resident Council meeting minutes identified residents had concerns with the following:<br>* 06/29/22, ". . . Call light[s are] not being left within reach [of residents] . . . "<br>* 07/28/22, ". . . Call light times . . ."<br><br>During confidential interviews on 08/15/22, when asked questions regarding call light response times, residents responded as follows:<br>* 08/15/22 at 6:25 p.m., Resident I stated, "I don't like when they [staff] leave me on that toilet in [the bathroom]. They get busy, until they get the other people done."<br>* 08/15/22 at 6:35 p.m., Resident H stated, "Sometimes, if they [staff] are busy, you have to wait 30 or more minutes."<br>* 08/15/22 at 6:45 p.m., Resident K stated, "I try to call as soon as I can, in case I have to wait. Sometimes it takes a very long time. I have urinated and had BM [bowel movement] accidents and they [staff] have to clean me up."<br>* 08/15/22 at 7:00 p.m., Resident F stated, "We have to wait a lot. We have to wait for a long time. They [staff] are busy and can't always take me to the bathroom. I don't like peeing in my bed either. Then, I have to lay in it."<br>* 08/15/22 at 8:06 p.m., Resident G stated, "They [staff] are not good with [answering call lights]. For three days, they gave me medicine, so I could have a bowel movement. They didn't come when I called. I had to wait twenty some minutes. I hadn't gone for three days, so it was all over."<br>* 08/15/22 at 7:10 p.m., Resident N reported waiting up to an hour for staff assistance to the bathroom and stated, "I feel bad about myself when I have to wait so long and soil myself."<br>* 08/15/22 at 7:10 p.m., Resident Q reported | F 558 | All Residents have the potential to be affected.<br>The Director of Nursing/designee conducted resident observations and interviews to validate the facility residents had no unmet immediate needs and that call lights were in place and that residents were able to use call light device available. Any concerns were promptly addressed, resident/resident representative, and physician were notified, any new orders obtained were noted and care plans updated as applicable.<br><br>Systemic Changes:<br><br>The Administrator/designee provided education to all staff on 9/22/2022 on the requirement to answer call lights promptly and attend to immediate needs if within scope of job duties, non-direct care staff will be trained to respond to the call light, validate resident is safe and not in danger, stay with resident until staff responds and/or alert appropriate staff to attend to care needs.<br>The Director of Nursing/designee will provide education to nursing staff on 9/22/2022 regarding devices/equipment including soft touch call lights available for residents who have difficulty with upper extremity mobility and sensitivity.<br>The Administrator/designee will provide education to the individual recording Resident Council Meeting minutes on the requirement to submit any concerns reported/ or identified during the Resident | |

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| F 558 | Continued From page 2<br>waiting "longer during the night shift" for staff to assist him.<br>* 08/15/22 at 7:25 p.m., Resident R stated, "It takes longer [for staff to respond to my call light] during the night shift."<br>* 08/15/22 at 7:30 p.m., Resident B reported the average call light wait time is "30 minutes to an hour, depending on staffing." He said staff frequently tell him "I'll be back with help," but they don't come back. Resident B stated, "I'll be laying in my own urine and feces for some time, sometimes over an hour."<br>* 08/15/22 at 7:30 p.m., Resident P stated, "There is just not enough people working. It can take an hour [for staff to respond to my call light]." He reported he has been incontinent "a few times" while waiting for staff to assist him.<br>* 08/15/22 at 7:50 p.m., Resident C reported that it can take up to 30 minutes for someone to assist him to the bathroom. He said staff tell him "I'll be back," but they don't come back.<br>* 08/15/22 at 7:57 p.m., Resident V stated, "the biggest problem is they don't have enough help here. I don't need much help, but when I do, I wait 30-45 minutes for them [staff] to come."<br>* 08/15/22 at 8:15 p.m., Resident D reported waiting up to 30 minutes to an hour for staff to respond to his call light. He said staff tell him "We'll be right back," but they don't come back. He reported calling again, and he stated, "[by then] I have had an accident on the floor."<br>* 08/15/22 at 8:35 p.m., Resident A stated, "Call lights can go off for an hour and then, when answered, you're told, 'I'll be back,' but they [staff] don't come back."<br>* 08/16/22 at 8:38 a.m. Resident S stated, "The average time to wait is 30 minutes." He reported needing help with the urinal and indicated he has | F 558 | Council Meeting to the applicable Department Manager and complete a Grievance form if applicable on 9/21/2022.<br><br>Monitoring:<br><br>The Administrator/designee will conduct audits through interviews and observational rounds 5 times a week on various shifts for 8 weeks, then weekly x 3 months, to validate that call lights are within reach/appropriate device is utilized, and that call lights are answered/responded to within a reasonable period. Any concerns will be addressed, staff educated and corrected. The Administrator/designee will report any identified trends to the Quality Assurance and Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>The Administrator/designee will review Resident Council Meeting minutes with Activity Director/designee monthly following Resident Council Meeting to validate that concerns voiced by residents in the meeting have been addressed through notification of Department Head and resolution of concern has been determined including completion of a Grievance form as appropriate. The Administrator/designee will report any identified trends to the Quality Assurance and Improvement Committee monthly and as needed until a lessor frequency is | |

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| F 558 | Continued From page 3<br>had an accident while waiting for staff to assist him.<br>* 08/16/22 at 9:20 a.m., Resident E described staff as "slow to respond at times." He said he "will fall asleep, but they [staff] don't wake me" so he "[has] to put [his] call light on again."<br>* 08/16/22 at 11:30 a.m., Resident W stated she sometimes "waits an hour or more" during the night when she puts her call light on and "they don't have enough help at night." She stated she has urinated in her bed while waiting for staff to come help her.<br>* 08/16/22 at 2:49 p.m., Resident L reported waiting an average of 45 minutes for staff to respond to his call light. He stated, "If they [staff] would communicate more, this wouldn't happen, and we wouldn't wait so long."<br>* 08/16/22 at 3:38 p.m., Resident M stated, "Well, it could definitely be better. Usually, I wait half an hour or more."<br><br>Observations on 08/16/22 showed the following:<br>- Resident #4's call light alarmed from 9:25 a.m. to 9:51 a.m., 26 minutes.<br>- Resident #6's call light alarmed from 9:25 a.m. to 9:58 a.m., 33 minutes.<br>- Resident #7's call light alarmed from 11:05 a.m. to 11:28 a.m., 23 minutes.<br><br>During an interview on the afternoon of 08/17/22, an administrative nurse (#1) stated she expects staff to answer call lights in a timely manner. The administrative nurse (#1) failed to define "timely manner."<br><br>Failure of the facility to make reasonable accommodations and assist residents in maintaining their highest level of functioning | F 558 | deemed appropriate.<br><br>Date of Compliance: 9/28/2022 | |

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| F 558 | Continued From page 4 | F 558 | | |

negatively affected their feelings of well-being and resulted in some residents experiencing incontinence.

2. Based on observation, record review, and resident and staff interviews, the facility failed to provide reasonable accommodation of needs for 1 of 1 sampled resident (Resident #8) who was unable to activate her call light. Failure to ensure residents are able to activate their call lights may result in incontinence, falls/injury, and/or decreased quality of life.

Findings include:

The facility failed to provide a copy of their call light policy when requested.

During an interview on 08/15/22 at 7:00 p.m., when asked questions pertaining to call light response times, Resident #8 stated, "We have to wait a lot. We have to wait for a long time. Sometimes, I'm not sure if the light goes on, when I push the button. My fingers are bad." She also indicated she asks her roommate to activate her call light when she needs assistance. Observation showed a bandage on Resident #8's right hand and her left hand showed blackened fingertips.

Review of Resident #8's medical record occurred on all days of survey. The record identified diagnoses of muscle atrophy (wasting away), necrotic (dead) tissue to bilateral fingers/toes, surgical amputation, and need for assistance with personal cares. The comprehensive skills assessment, dated 08/08/22, identified, ". . . surgical wound care . . . resident c/o [complains

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| F 558 | Continued From page 5<br>of] pain to right hand not resolved . . . tips to all digit[s] to upper left hand and bilateral lower extremities blackened, shriveled, and hard . . ." The current care plan identified, " . . . Resident has physical functioning deficit related to: Eschar/necrotic [dead] tissue to bilateral fingers/toes . . . Call bell within reach . . ."<br><br>Observation on 08/16/22 at 3:10 p.m. showed Resident #8 holding the call light with her bandaged right hand and pushing the call button with her left hand. Resident #8 failed to activate the call light after multiple attempts.<br><br>During an interview on 08/16/22 at 5:03 p.m., when asked if she notified staff of her inability to activate her call light, Resident #8 stated, "Oh yeah. I've told a couple CNAs [certified nursing assistants]. Then, they try the call light and it works. Nothing happens after that."<br><br>During an interview on the afternoon of 08/17/22, an administrative nurse (#1) agreed staff should have reported Resident #8's concerns regarding her call light and suggested she may benefit from "a soft touch call light." | F 558 | | |
| F 565 SS=F | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at | F 565 | | 9/28/22 |

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| F 565 | Continued From page 6<br>the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information provided by the complainants, record review, review of facility policy, review of monthly Resident Council meeting minutes, and confidential resident interviews, the facility failed to act upon grievances expressed by 10 of 10 confidential residents (Resident G, H, I, J, T, V, W, X, Y, and Z), and 1 resident discharged from the facility (Resident #28). Failure to act upon the grievances regarding staffs' failure to serve meals and/or snacks in a timely manner resulted | F 565 | Corrective Action:<br><br>Resident #28 is discharged.<br>Administrator/designee completed review meeting minutes from most recent resident council meeting on 9/20/2022 to ensure any identified grievances were addressed<br><br>Identification of others: | |

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| F 565 | Continued From page 7<br>in the residents continued dissatisfaction.<br><br>Findings include:<br><br>Information provided by the complainants' indicated staff failed to provide residents with meals and/or snacks in a timely manner. The complainants' also reported staff failed to serve meals and/or evening snacks to some of the residents.<br><br>Review of the policy "Frequency of Meals" occurred on 08/16/22. This policy, dated Quarter 3, 2018, stated, ". . . Each resident shall receive at least three (3) meals daily . . . in accordance with resident needs, preferences, requests and the plan of care. . . . Meals will be served four (4) to six (6) hours apart to help assure that residents receive nutritional requirements. . . . Nourishing snacks will be available for residents who need or desire additional food between meals. . . . Evening snacks will be offered routinely to all residents. . . . "<br><br>Review of the policy "Snacks (Between Meal and Bedtime), Serving," occurred on 08/16/22. This policy, dated Quarter 3, 2018, stated, ". . . The purpose of this procedure is to provide the resident with adequate nutrition. . . . Place the snack on the overbed table or serving area. . . . Arrange the supplies so that they can be easily reached by the resident. . . . Place beverages within easy reach. . . . Assist the resident as necessary. However, encourage the resident to feed himself or herself as much as possible. . . . Place the call light within easy reach of the resident. . . . Once the resident has received adequate assistance, exit the room and allow the | F 565 | All residents have the potential to be affected. The IDT team will conduct full facility advocate rounds on or before 9/22/2022 and any identified concerns will be addressed with grievances and addressed as applicable.<br><br>Systemic Changes:<br><br>Administrator/designee will add a section to the morning meeting form to address all new grievances and ensure they are addressed per facility grievance policy and education with IDT team on completing grievances that are identified on advocate rounds or resident council meeting on or before 9/21/2022.<br><br>Monitoring:<br><br>Administrator/designee will assign any new grievances to the appropriate department to resolve the resident concern per facility grievance policy and will monitor the grievance process 3 x weekly x 3 months, 2x weekly x 3 months, 1x weekly x 3 months then during the morning meeting with facility IDT team, until a lessor frequency deemed appropriate.<br>Administrator/designee will review Resident Council meeting notes monthly to ensure compliance with any identified grievances.<br>Administrator/designee will report out the grievances in the monthly QAPI meeting going forward to include repeated | |

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| F 565 | Continued From page 8<br>resident to eat his or her snack. . . . Remove the snack tray when the resident has finished his or her snack. . . . The person performing this procedure should record the following information in the resident's medical record . . . The date and time the snack was served. . . . The name and title of the individual(s) who served the snack. . . . The amount of snack eaten by the resident (i.e., 50%, 75%, etc.) . . . . If the resident refused the snack, the reason(s) why and the intervention taken. . . . Notify the supervisor if the resident refuses the snack and why. . . ."<br><br>Review of the May-July 2022 Resident Council meeting minutes identified the following:<br>* 06/29/22, ". . . people gave snacks at 5:15 [p.m.] . . . switch ways [the snack carts] go so [residents on the last unit served] have a chance at good snacks . . . "<br>* 07/28/22, ". . . Snack carts aren't being rotated . . ." Residents also discussed concerns regarding food arriving cold.<br><br>During an interview on 08/15/22 at 6:15 p.m., a dietary staff member (#3) stated breakfast is served from 7:30 a.m. to 9:15 a.m., lunch from 11:00 a.m. to 1:00 p.m., and dinner from 5:00 p.m. to 7:00 p.m.<br><br>Confidential resident interviews identified the following:<br>* 08/15/22 at 6:25 p.m., Resident I stated, "Yeah, I demand [snacks]."<br>* 08/15/22 at 6:35 p.m., Resident H stated, "Sometimes we have to wait twenty minutes or more. The food is cold."<br>* 08/15/22 at 6:49 p.m., Resident W stated meal trays are brought to her room and "the food is | F 565 | grievances.<br><br>Date of Compliance: 9/28/2022 | |

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| F 565 | Continued From page 9<br>cold."<br>* 08/15/22 at 7:06 p.m., Resident G stated, "There is a little bit of a wait with trays. Hot foods are not hot, more like warm."<br>* 08/15/22 at 7:42 p.m., Resident X stated he eats in his room and the food is "sometimes cold."<br>* 08/15/22 at 7:50 p.m., Resident V stated, "Sometimes the snack cart comes, and sometimes it doesn't, one night it came at 8:30 [p.m.], that is too late." Resident V reported "some of the food is cold" when brought to her room and she was told there is no microwave to heat the food up.<br>* 08/16/22 at 8:10 p.m., Resident Y stated "sometimes I get a snack and sometimes not." Resident Y stated that one of the staff members told him "if the cart goes by and the resident's door is closed, they won't knock, as they will think you are sleeping."<br>* 08/15/22 at 8:23 p.m., Resident J stated, "Timely, no. One night they [staff] didn't come [with my meal] until 7:00 p.m. Sometimes it's [the food is] hot, sometimes it's cold. Another night, I didn't get any [snacks]."<br>* 08/15/22 at 8:34 p.m., Resident Z stated he eats in his room and the "food is not the best." The resident stated the food is not hot when it arrives to his room, it is "warm."<br>* 08/16/22 at 9:19 a.m., Resident T stated, "[I] very seldom [get snacks]."<br><br>- Review of Resident 28's medical record occurred on all days of survey. The record identified diagnoses of diabetes, end stage renal disease (ESRD), and severe malnutrition. The physician's orders identified, ". . . RENAL, DIABETIC diet . . ." | F 565 | | |

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

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| F 565 | Continued From page 10<br><br>The nutritional assessment, dated 07/08/22, identified, ". . . In need of increased nutrition related to HD [hemodialysis] . . . Will add Liquacel [supplement] daily 1 oz [ounce] for additional protein . . ."<br><br>The care plan identified, ". . . I am at risk for Alteration in Blood Glucose due to: Diabetes Mellitus Type 2 . . . Educate patient . . . related to Diabetes management, following nutritional recommendations . . . Alteration in Kidney Function r/t [related to] ESRD, on HD . . . Encourage patient to follow nutritional and hydration program interventions . . . Provide diet as ordered . . ."<br><br>The facility failed to provide a record of Resident 28's meal intake upon request. Resident 28's snack record, dated June 29-July 31 2022, identified staff failed to consistently offer/provide snacks. Documentation identified staff offered snacks as follows:<br>* No snacks: on 9 days<br>* Once a day: on 9 days<br>* Twice a day: on 10 days<br>* Three times a day: on 4 day<br>Staff indicated "resident not available" on fourteen occasions, "not applicable" on three occasions, and "resident refused" on eleven occasions. Staff failed to indicate whether attempts were made to offer snacks at a later time when "unavailable" earlier in the day. | F 565 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility | F 609 | | 9/28/22 |

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| F 609 | Continued From page 11<br>must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>1. Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure all alleged violations involving possible abuse were reported immediately to the administrator of the facility and to other officials (including the State Survey Agency) for 1 of 1 sampled resident (Resident #19) who sustained a skin tear to her arm during cares. Failure to immediately report alleged violations to the State agency per the facility's | F 609 | Corrective Action:<br><br>Resident #27 the 5-day investigation was completed<br>Resident #28 the 5-day investigation was completed<br>Resident #19 was evaluated for signs and symptoms of infection of skin tear for proper healing and treatment order.<br>Investigation was conducted on | |

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| F 609 | Continued From page 12<br>policy, placed Resident #19 and other residents at risk for at risk for possible abuse and/or further injury.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Investigation and Reporting" occurred on 08/17/22. This policy, dated 2018, stated, ". . . All reports of resident abuse . . . mistreatment . . . shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. . . . All alleged violation of abuse . . . mistreatment . . . will be reported immediately, but not later than . . . Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. . . ."<br><br>- Observations showed the following:<br>* 08/15/22 at 6:50 p.m., A protective sleeve over a bandage on Resident #19's right lower forearm. When asked about the bandage, Resident #19 stated it happened a couple of weeks ago, when a certified nurse assistant (CNA) "yanked on [her]" while assisting her to turn in bed. Resident #19 reported staff are not careful when turning her, they sometimes "yank" the drawsheet, and she has asked them not to do that as she gets sores on her bottom from it. She also told one of the night nurses she wanted to talk to someone about her care, but thinks the nurse did not tell anyone.<br>* 08/16/22 at 11:30 a.m., Resident #19 asked a staff nurse (#4) to cut the protective sleeve over the bandage on her right lower forearm to a smaller size. Observation showed a gauze | F 609 | 9/20/2022 and abuse was unsubstantiated.<br><br>Identification of Others:<br><br>Director of Nursing/Designee completed review of facility residents to determine if any have had any skin issues or any outstanding investigations that have not been reported.<br><br>Systemic Changes:<br><br>Administrator/Designee competed education with facility staff on types of abuse, who to report to, and timeframe in which reporting needs to occur. Education will be provided on or before 9/22/2022 as well as for future staff members. Corporate Clinical Consultant completed education with Administrator on reporting abuse on 9/20/2022.<br><br>Monitoring:<br><br>Administrator/designee will review 5x per week for compliance with facility reportable events through record review, risk management, 24-hour report, telephone orders, and advocate rounds. Will continue until a lessor frequency is deemed appropriate. Administrator/designee will report identified trends to QAPI committee monthly and as needed until a lessor frequency is deemed necessary. | |

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| F 609 | Continued From page 13<br>dressing over the wound with dried drainage. The nurse moistened the gauze with saline, removed the soiled gauze, and placed a new gauze bandage over the v-shaped skin tear. The nurse then cut the protective sleeve to a smaller size and placed it over the gauze bandage. Resident #19 stated she also got a skin tear on her bottom this morning from the bed pan. Observation showed a small bandage on the resident's right buttock.<br><br>On 08/16/22 at 12:45 p.m., when asked about Resident #19's skin tear, an administrative nurse (#1) stated she was not aware of any skin issues and said she would talk to the resident and assess her skin.<br><br>Review of the Nurses Notes, dated 08/16/22 at 2:28 p.m., identified, ". . . resident reported to nurse that they had a skin tear to right forearm and right buttock. The forearm skin tear, they state was caused when 'they were turning me a couple weeks ago.' On assessment, this skin tear is covered with gauze and a small tubigrip [a tubular protective bandage]. The wound appears to be no older than a day or too. Skin flap is flush, and edges clean. Slight sangiouneous [bloody] drainage from distal end. Cleansed and covered with gauze and tubigrip, as resident does not want tape to skin due to skin tearing. Resident states skin tear to right buttocks caused by bed pan. on assessment, author finds a skin tear 1.5 cm [centimeters] x 1 cm. Author cleansed, covered with small xeroform and mepilex [foam dressing] sbar [communication] left for provider."<br><br>During interview on 08/16/22 at 3:00 p.m., an administrative nurse (#1) confirmed staff should | F 609 | Date of Compliance: 9/28/2022 | |

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| F 609 | Continued From page 14<br>have reported the injury.<br><br>2. Based on record review and review of facility policy, the facility failed to ensure the results of 2 of 2 final investigations of alleged neglect (Resident #27 and #28) were reported to the State agency within five working days of each incident. Failure to report the results of each investigation to the State agency per the facility's policy placed all residents at risk for possible abuse and/or further injury.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Investigation and Reporting" occurred on 08/17/22. This policy, dated 2018, stated, ". . . All reports of resident . . . neglect . . . mistreatment . . . shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. . . . The Administrator, or his/her designee, will provide the appropriate agencies . . . with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. . . ."<br><br>Review of alleged violations showed the facility failed to report the results of each investigation to the State agency within five working days of each incident.<br>* Resident #27's representative reported staff failed to reposition him and he was found in same position, greatly soiled, possible neglect: initial report submitted 07/26/22.<br>* Resident # 28 reported staff failed to pass meal trays/snacks, possible neglect: initial report submitted 07/25/22. | F 609 | | |

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| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, policy and procedure review, and staff interview, the facility failed to thoroughly investigate falls with injury for 1 of 1 sampled resident (Resident #26) and 1 resident discharged from the facility (Resident #28). Failure to thoroughly investigate falls with injury does not allow the facility to determine causative factors of the injury and has the potential to place residents at risk for falls, mistreatment, neglect, or abuse.<br><br>Findings include:<br><br>Review of the facility policy titled "Abuse Investigation and Reporting" occurred on 08/17/22. This policy, dated 2018, stated, ". . . All | F 610 | Corrective Action:<br><br>Resident #26 has been discharged<br>Resident #28 has been discharged<br><br>Identification of Others:<br><br>All Residents have the potential to be affected.<br>Administrator/designee completed review of facility reportable incidents to determine if any outstanding investigations have not been completed on 9/21/2022 with all noted to be up to date. | 9/28/22 |

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| F 610 | Continued From page 16<br>reports of resident abuse, neglect . . . mistreatment . . . shall be . . . thoroughly investigated by facility management. . . . The individual conducting the investigation will, at a minimum . . . Review the completed documentation forms, Review the resident's medical record to determine events leading up to the incident . . . Interview any witnesses to the incident . . . Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident . . . Review all events leading up to the alleged incident. . . ."<br><br>- Review of Resident #26's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and history of falls. Resident #26's current care plan stated, ". . . I am at risk for falls . . . Activities of daily living and Level of Assistance: 2 Person Assist, Total Assist, Hoyer lift [full body mechanical lift] . . . Wheelchair for locomotion . . ."<br><br>Review of the fall incident report, dated 07/31/22, identified, ". . . Incident Description: Resident was found lying on the floor next to his wheelchair in the hallways when CNA [certified nursing assistant] called writer to come over quickly. When writer asked the CNA how the resident got on the floor, CNA told her, He tried to stand immediately after stopping wheelchair and felt [sic] to the floor. Resident was assessed . . . helped back to his wheelchair by 3 CNAs using the Hoyer lift. Resident has a little cut on the size [sic] of head. . . ."<br><br>During interviews on 08/16/22 at 3:54 p.m. and 4:12 p.m., an administrative nurse (#1) stated, "[Resident #26] can't propel himself. They push | F 610 | Systemic Changes:<br><br>Administrator/designee completed education to facility staff on types of abuse, who to report to, and timeframe in which reporting needs to occur. Education will be provided on or before 9/22/2022 as well as for future staff members. Corporate Clinical consultant completed education with Administrator and Nurse Management on regulations for timely reporting, including a thorough, complete investigation for all of abuse allegations on 9/22/22.<br><br>Monitoring:<br><br>Administrator/designee will review 5x per week for compliance with facility reportable events through record review, risk management, 24-hour report, telephone orders, and advocate rounds. Will continue until a lessor frequency is deemed appropriate. The administrator/designee will report identified trends to QAPI committee monthly and as needed until a lessor frequency is deemed necessary.<br><br>Date of Compliance: 9/28/2022 | |

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| F 610 | Continued From page 17 | F 610 | | |

him everywhere. He always has his feet on the foot pedals. He is transferred with a Hoyer lift." The administrative nurse (#1) acknowledged information documented under the incident description section of the report contradicted her personal knowledge/observations of Resident #26.

The facility failed to thoroughly investigate/determine the causative factors of Resident #26's fall. Failure to question/investigate how Resident #26 could "stand" when he requires total assistance from two staff members and a Hoyer lift to transfer, may result in future falls and has the potential to place Resident #26 and other residents at risk for neglect.

- Review of Resident #28's medical record occurred on all days of survey. Diagnoses included absence of right upper limb below elbow, difficulty walking, muscle wasting/atrophy, muscle weakness. Resident #28's care plan stated, ". . . I have physical functioning deficit . . . Bed mobility assistance of (1) . . . Transfer assistance of (1) . . . [Resident #28] is at risk for falls . . . Bed in low position . . . Call light and personal items available and in easy reach . . ."

Review of the fall incident report, dated 07/31/22, identified, ". . . Incident Description: At 3:55 pm heard a loud frantic scream for help x [times] 2 from down the hall. Arrived at pt [patient] room and found her lying on her rt [right] side with blood all around her, in her hair, on floor mixed in with spilled milk, on sheet and blanket that was on floor with her. Immediately assessed where blood was from and noted approx [approximately]

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| F 610 | Continued From page 18<br>2-3 cm [centimeter] laceration in chin. Pressure applied and pt head assessed for further areas of injury. Pt crying and moaning, asked her what happened, stated that she slid off the bed onto the floor, that it was slippery. Said she was sitting at side of bed and tried to push herself back on bed and fell, and the only thing that hurt was her chin. Noted bed was in higher position like pt usually has it. Told her we would be sending her to ER [emergency room] for eval [evaluation] and probable sutures to her chin. O2 [oxygen] on per nasal cannula. Blood noted in nose and mouth. Called for help and had someone call 911 . . . Predisposing Environmental Factors: . . . wet floor . . . bed position . . ."<br><br>During an interview on 08/17/22 at 2:05 p.m., an administrative nurse (#1) acknowledged information documented under the incident description section of the report failed to address the location of the call light, the position of the bed, the resident's footwear and/or cleanliness of the floor.<br><br>The facility failed to thoroughly investigate/determine the causative factors of Resident #28's fall. Failure to question/investigate the location of the call light, the position of the bed, the resident's footwear and/or cleanliness of the floor, has the potential to place residents at risk for falls and/or neglect. | F 610 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of | F 657 | | 9/28/22 |

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| F 657 | Continued From page 19<br>the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to review and revise comprehensive care plans to reflect the current status for 5 of 26 sampled residents (Resident #8, #11, #13, #14, and #21) and 1 resident discharged from the facility (Resident #27). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care.<br><br>Findings include: | F 657 | Corrective Action<br><br>Residents #8, 11, 13, 14, 21 care plans were reviewed and updated along with Kardex to reflect current status and interventions as appropriate.<br>Resident #27 is discharged from facility<br><br>Identification of Others<br><br>Director of Nursing/Designee will review through chart review and observational rounds, residents care plans to ensure | |

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| F 657 | Continued From page 20<br>Review of the facility policy titled "Care Plans, Comprehensive Person-Centered" occurred on 08/17/22. This policy, dated 2018, stated, "The comprehensive, person-centered care plan will. . . . Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . . . Incorporate identified problem areas. . . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change . . ."<br><br>- Review of Resident #8's medical record occurred on all days of survey. The current care plan identified, ". . . Personal Hygiene assistance of (IND) [independent] . . . Toileting assistance of (one) . . ." The current care card [summary of care plan provided to staff] contradicted the care plan, identifying, ". . . Toileting assistance of (2) . . ."<br><br>Observation on 08/16/22 at 3:05 p.m. showed a partially full urinal hanging from Resident #11's bed rail.<br><br>During an interview on the afternoon of 08/17/22, an administrative nurse (#1) agreed Resident #11's urinal should be part of the care plan.<br><br>- Review of Resident #11's medical record occurred on all days of survey. The current care plan failed to address the resident's bathing/shower needs and use of a urinal.<br><br>Observation on 08/15/22 at 6:40 p.m. showed a partially full urinal hanging from Resident #13's garbage can. | F 657 | appropriate and current interventions are reflected in resident care plan and kardex by 9/23/2022. Any identified concerns were promptly corrected, and care plans updated as applicable.<br><br>Systemic Change<br><br>The Director of Nursing/designee will provide training to IDT team on having a comprehensive assessment with a person-centered care plan with interventions in place and updated with residents change in condition on 9/21/2022.<br><br>Monitoring<br><br>The Director of Nursing/Designee will conduct monitoring 3 times a week for 1 month, weekly for 2 months, until a lessor frequency deemed appropriate, through chart review, to validate that Care Plans are initiated/updated/revised in a timely manner/per policy and with change in condition and that care plan accurately reflects residents' current condition and care needs.<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>9/28/22 | |

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| F 657 | Continued From page 21<br><br>- Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, "Toileting assistance of 1. . . Toilet riser in place. . ." The current care plan failed to address Resident #13's use of a urinal.<br><br>- On 08/16/22 at 2:18 p.m., observations showed Resident #14 wearing a yellow "Fall Risk" bracelet on his wrist.<br><br>Review of Resident #14's medical record occurred on all days of survey. A "Fall Assessment-Post Incident", dated 03/03/22, identified the resident as a moderate risk for falls. The current care plan failed to identify Resident #14 as a fall risk.<br><br>During an interview on 08/17/22 at 2:05 p.m., an administrative nurse (#1) confirmed staff failed to revise Resident #13 and Resident #14's care plans to reflect their current care needs.<br><br>- During an interview on 08/15/22 at 8:00 p.m., Resident #21 stated he/she has an insulin pump (computerized medical device that delivers insulin through a thin tube that goes under the skin). The resident stated he/she manages the pump and administers insulin through the pump according to the amount of carbohydrates eaten.<br><br>Review of Resident #21's medical record occurred on all days of survey. The current care plan failed to address the insulin pump, the fact she manages the pump independently, and administers insulin via the pump based on carbohydrate intake. | F 657 | | |

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| F 657 | Continued From page 22<br>During an interview on the afternoon of 08/16/22, an administrative nurse (#1) agreed Resident #21's insulin pump should be part of the care plan.<br><br>- Review of Resident #27's medical record occurred on all days of survey. The care plan identified, ". . . I am at risk for pressure injury . . . Turning and repositioning schedule per assessment . . ." The care plan failed to delineate the repositioning schedule.<br><br>- During an interview on 08/15/22 at 7:47 p.m., Resident #? (Bette H) state | F 657 | | |
| F 677 SS=F | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on information provided by the complainants, record review, review of facility policy, and confidential resident/family and staff interviews, the facility failed to assist with activities of daily living (ADLs) for 13 of 26 sampled and confidential residents (Resident #8, #10, #11, #12, #14, #20, F, G, H, I, J, P, and V) who required staff assistance for bathing and expressed concerns regarding showers/bathing. Failure to provide assistance to residents who cannot perform the bathing task independently may result in poor personal-hygiene and decreased self-esteem.<br><br>Findings include: | F 677 | Corrective Actions:<br><br>The Director of Nursing/designee validated that Resident #8 was offered and accepted a bath per preference and that task was documented accurately in the resident record<br>The Director of Nursing/designee validated that Resident #10 was offered and accepted a bath per preference and that task was documented accurately in the resident record<br>The Director of Nursing/designee validated that Resident #11 was offered and accepted a bath per preference, task | 9/28/22 |

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| F 677 | Continued From page 23<br><br>Information provided by the complainants' indicated staff failed to bathe residents as scheduled.<br><br>Review of the facility policy titled "Supporting Activities of Daily Living (ADLs)" occurred on 08/17/22. This policy, dated 2021, stated, ". . . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently . . . in accordance with the plan of care, including appropriate support and assistance with . . . Hygiene (bathing, dressing, grooming, and oral care) . . . "<br><br>Confidential resident and family interviews identified the following:<br>* 08/15/22 at 6:25 p.m., Resident I stated, "I give myself a bath."<br>* 08/15/22 at 6:35 p.m., Resident H stated, "[Baths/Showers] are very sporadic. There doesn't seem to be any schedule."<br>* 08/15/22 at 7:00 p.m., Resident F stated, "They [staff] are busy and can't always take me to the bathroom. I don't like peeing in my bed either. Then, I have to lay in it. I'm supposed to have a bath two days a week, but maybe it needs to be more often." Resident F's family member (sitting in the room at the time of the interview) stated, "When I came, [Resident F's] bedding was soaked, and her brief was ripped. She was in a soaking wet bed. I'm not sure if she would have gotten a shower, if I hadn't been here.<br>* 08/15/22 at 7:06 p.m., Resident G stated, "I got a shower last Wednesday. Other than that, I got a pan with soapy water, and I washed myself."<br>* 08/15/22 at 7:30 p.m., Resident P stated, "I have maybe had one bath since I have been | F 677 | was documented accurately in the resident record and the care plan was updated to reflect current assistance required and refusals.<br>The Director of Nursing/designee validated that Resident #12 was offered and accepted a bath per preference, task was documented accurately in the resident record and the care plan was updated to reflect current assistance required and refusals.<br>The Director of Nursing/designee validated that Resident #14 was offered and accepted a bath per preference, task was documented accurately in the resident record and the care plan was updated to reflect current assistance required and refusals.<br>The Director of Nursing/designee validated that Resident #20 was offered and accepted a bath per preference, task was documented accurately in the resident record and the care plan was updated to reflect current assistance required and refusals.<br><br>Identification of Others:<br><br>The Director of Nursing/designee conducted a review of current residents through interview and record review to validate that showers/baths were given per preference timely, and that task were documented accurately in the resident record and care plans current with resident bathing needs. If concerns with bathing/showers were voiced/identified corrective actions were implemented | |

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| F 677 | Continued From page 24<br>here, otherwise they just bring in a tub of water or clean me up in the bathroom."<br>* 08/15/22 at 7:50 p.m., Resident V stated "sometimes they don't come in to take me to the shower until late, one time they gave me a shower at 10:00 at night." Resident V stated the other day they came in at 8:30 p.m. to shower her, but she refused because she already had her pajamas on and ready for bed.<br>* 08/15/22 at 8:23 p.m., Resident J stated, "I'm supposed to have a shower on Tuesdays and Fridays. They haven't asked me for a while now."<br><br>- Review of Resident #8's medical record occurred on all days of survey. The record identified a diagnosis of muscle atrophy (wasting away). The current care plan identified, ". . . Personal Hygiene assistance of (IND) [independent] . . ." The current care card identified, ". . . Bathing/Shower - Monday/Thursday PM [afternoon/evening] . . ."<br><br>Resident #8's bathing/shower record (indicating the type of bath provided), dated August 01-15, 2022, identified staff failed to bathe (in a bathtub)/shower her for 15 days. Staff documented "bed/towel bath" on two occasions, "resident not available" on two occasions, and "not applicable" on one occasion.<br><br>- Review of Resident #10's medical record occurred on all days of survey. The record identified a diagnosis of muscle weakness. The current care plan identified, ". . . Personal Hygiene assistance of (1) . . ." The current care card identified, ". . . Bathing/Shower - Tuesday/Friday NOC [night] . . ." | F 677 | including offering/providing a bath/shower per preference. Care plans updated as applicable.<br><br>Systemic Changes:<br><br>The Director of Nursing/designee will provide education to nursing staff on requirements to provide baths/showers to residents per their schedule and preferences, including steps to take if a resident refuses on 9/27/2022. Further education will include the requirement to accurately document tasks in the resident record.<br>The Director of Nursing/designee will provide education to the Inter-disciplinary team on the requirements to update resident care plans with bathing needs and steps to take if resident refuses on 9/21/2022.<br><br>Monitoring:<br><br>The Director of Nursing/designee will conduct monitoring through record review and interviews 3 times a week for 3 months, then monthly x quarterly to validate that residents are receiving timely baths/showers per preference and if refused the resident is given opportunities to reschedule if applicable, review will also include validation that bathing, and shower tasks are documented accurately in the resident record. Any concerns will be promptly corrected.<br>The Director of Nursing/designee will | |

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| F 677 | Continued From page 25<br>Resident #10's bathing/shower record, dated July 19-August 15, 2022, identified staff provided a bath/shower on three occasions. Staff documented "bed/towel bath" on one occasion, "not applicable" on one occasion, and "resident refused" on one occasion. Staff failed to make an entry on two occasions, and failed to indicate whether attempts were made to reschedule missed baths/showers.<br><br>- Review of Resident #11's medical record occurred on all days of survey. The record identified diagnoses of compression fractures, muscle weakness, and myasthenia gravis [disorder causing rapid muscle fatigue and weakness]. The current care plan failed to address bathing/shower needs. The current care card identified, ". . . Bathing/Shower - Mon/Thurs [Monday/Thursday] PM . . ."<br><br>Resident #11's bathing/shower record, dated July 26-August 15, 2022, identified staff failed to bathe (in a bathtub)/shower him for 21 days. Staff documented "bed/towel bath" on two occasions, "not applicable" on three occasions, and "resident refused" on one occasion. Staff failed to indicate whether attempts were made to reschedule missed baths/showers.<br><br>- Review of Resident #12's medical record occurred on all days of survey. The record identified diagnoses of arthritis, muscle weakness, and pain. The current care plan identified, ". . . Bathing extensive assist of 2 . . ." The current care card identified, ". . . Bathing/Shower - Monday/Thursday AM . . ."<br><br>Resident #12's bathing/shower record, dated July | F 677 | report any identified trends to the Quality Assurance Performance Improvement Committee monthly and as needed until a lessor frequency is deemed appropriate.<br><br>Date of Compliance: 9/28/2022 | |

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| F 677 | Continued From page 26 | F 677 | | |

19-August 15, 2022, identified staff provided a bath/shower on one occasion. Staff failed to bathe (in a bathtub)/shower him for 25 days. Staff documented "bed/towel bath" on two occasions, "not applicable" on two occasions, and "resident refused" on four occasions. Staff failed to indicate whether attempts were made to reschedule missed baths/showers.

- Review of Resident #14's medical record occurred on all days of survey. The record identified diagnoses of generalized weakness and polyneuropathy. The current care plan failed to address bathing/shower needs. The current care card identified, ". . . Bathing/Shower - Tuesday/Friday NOC [night] . . ."

Resident #14's bathing/shower record, dated July 26-August 12, 2022, identified staff provided a bath/shower on one occasion. Staff documented "not applicable" on two occasions and "resident refused" on two occasions. Staff failed to indicate whether attempts were made to reschedule missed baths/showers.

- Review of Resident #20's medical record occurred on all days of survey. The record identified diagnoses of difficulty walking and generalized muscle weakness. The current care plan failed to address bathing/shower needs. The current care card identified, ". . . Bathing/Shower - Tuesday/Friday AM . . ."

Review of Resident #20's bathing/shower record, dated July 22 - August 12, 2022, identified staff provided a shower on two occasions and a bed/towel bath on one occasion. Staff documented "not applicable" on two occasions

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| F 677 | Continued From page 27<br>and "Resident Not Available" on two occasions. Staff failed to indicate whether attempts were made to reschedule missed baths/showers.<br><br>During an interview on 08/16/22 at 2:36 p.m., when asked questions pertaining to the bathing/shower records, an administrative nurse (#1) was unable to explain the "not applicable" notations in the records. The administrative nurse (#1) also stated, "There is no way [some residents incontinent of bowel] would get clean without a bath." | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<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>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/21/22.<br><br>Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to provide services to prevent skin breakdown and | F 686 | CORRECTIVE ACTION:<br><br>The Director of Nursing (DON) or designee will review and validate that resident #2 physician orders are accurate and followed to prevent and promote healing of the resident's pressure ulcers | 9/28/22 |

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| F 686 | Continued From page 28<br>minimize the potential for the development of pressure ulcers for 1 of 2 sampled residents (Resident #2) and 1 resident discharged from the facility (Resident #27). Failure to consistently reposition residents for pressure relief may result in delayed healing of current pressure ulcers and/or the development of new pressure ulcers.<br><br>Findings include:<br><br>Information provided by the complainants' identified the facility failed to reposition residents in a timely manner. The complainants' reported observing residents in the same position throughout the day and/or sitting in heavily soiled clothing and/or bedding.<br><br>Review of the facility policy titled "Supporting Activities of Daily Living (ADLs)" occurred on 08/17/22. This policy, dated 2021, stated, ". . . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently . . . in accordance with the plan of care, including appropriate support and assistance with . . . Mobility . . . "<br><br>- Review of Resident #2 medical record occurred on all days of survey. The record identified diagnoses of obesity and pressure ulcers. The current care plan, dated 08/16/22, stated, ". . . [Resident] is at risk for increased presence of pressure ulcers d/t [due to] the current presence of wounds and pressure ulcers r/t [related to] immobility and obesity . . ."<br><br>Resident #2's repositioning record, dated July 20-August 15, 2022, identified staff failed to consistently reposition the resident. | F 686 | (including positioning and pressure relief).<br><br>Resident #27 has been discharged<br><br>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 nursing staff on requirements of obtaining orders for interventions, implementing preventative measures to prevent and heal pressure injuries, and care planning interventions for residents with pressure injury or identified at risk for skin breakdown with Braden assessment with completion date of 9/27/22<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, as well as monitoring interventions are implemented, with completion of 9/21/22<br><br>MONITORING: | |

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| F 686 | Continued From page 29<br>Documentation identified the time span between repositioning attempts varied from approximately three hours to fifteen hours.<br><br>- Review of Resident #27's medical record occurred on all days of survey. The record identified diagnoses of cerebral infarction with hemiplegia/hemiparesis [partial paralysis on one side of the body], muscle atrophy [wasting], and sacral pressure ulcer. The care plan identified, ". . . I am at risk for pressure injury due to: incontinence, cognitive loss, weakness and debility, med [medication] side effects, hx [history] PU [pressure ulcer] to sacrum at hospital . . . Turning and repositioning schedule per assessment . . ." Resident #27's care plan and care card failed to address the need for repositioning assistance or delineate the recommended repositioning schedule.<br><br>Resident #27's bed mobility record, dated June 23-July 26, 2022, identified staff failed to consistently reposition the resident. Documentation identified staff repositioned Resident #27 as follows:<br>* Not repositioned: on one day<br>* Once a day: on eight days<br>* Twice a day: on seventeen days<br>* Three times a day: on five days<br>* Four times a day: on three days<br>Documentation further identified the time span between repositioning attempts varied from approximately one hour to 22 hours and 45 minutes.<br><br>During an interview on the afternoon of 08/17/22, an administrative nurse (#1) stated she expects staff to reposition residents within an appropriate | F 686 | The DON/designee will conduct monitoring 3 times a week for 1 month, weekly for 2 months, 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.<br>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><br>9/28/22 | |

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| F 686 | Continued From page 30<br>time frame to prevent skin breakdown, "in general every two hours." | F 686 | | |
| F 690 SS=F | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as | F 690 | | 9/28/22 |

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| F 690 | Continued From page 31<br>possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information provided by the complainants, observation, record review, review of facility policy, and confidential resident/family and staff interviews, the facility failed to provide appropriate services and assistance to maintain bowel/bladder continence for 16 of 26 sampled and confidential residents (Resident #4, #7, #8, #11, #13, #15, #16, #19, #20, #25, F, G, I, K, P and W) and 1 resident discharged from the facility (Resident #27). Failure to provide toileting assistance may result in unnecessary incontinence and a loss of dignity.<br><br>Findings include:<br><br>Information provided by the complainants indicated staff failed to toilet residents and/or empty urinals in a timely manner. The complainants reported observing residents sitting in soiled clothing, chairs, and/or bedding.<br><br>Review of the facility policy titled "Supporting Activities of Daily Living (ADLs)" occurred on 08/17/22. This policy, dated 2021, stated, ". . . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . . . Elimination (toileting) . . . "<br><br>TOILET USE<br><br>Confidential resident and family interviews identified the following: | F 690 | Corrective Actions:<br><br>The Director of Nursing/designee validated that Resident # 8's assessment of toileting/elimination needs were accurately documented in the resident's medical record and immediate needs were met.<br>The Director of Nursing/designee validated Resident # 15's assessment of toileting/elimination needs were accurately documented in the resident's medical records and immediate needs were met.<br>The Director of Nursing/designee validated Resident # 19's assessment of toileting/elimination needs were accurately documented in the resident's medical records and immediate needs were met.<br>The Director of Nursing/designee validated Resident # 20's assessment of toileting/elimination needs were accurately documented in the resident's medical records and immediate needs were met.<br>The Director of Nursing/designee validated Resident # 27's assessment of toileting/elimination needs were accurately documented in the resident's medical records and immediate needs were met.<br>Resident #27 no longer resides at the facility.<br>The Director of Nursing/designee | |

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| F 690 | Continued From page 32<br>* 08/15/22 at 6:25 p.m., Resident I stated, "I don't like when they leave me on that toilet in there [bathroom]. They get busy, until they get the other people done."<br>* 08/15/22 at 6:45 p.m., Resident K stated, "I try to call as soon as I can, in case I have to wait. Sometimes it takes a very long time. I have urinated and had BM [bowel movement} accidents and they [staff] have to clean me up."<br>* 08/15/22 at 7:00 p.m., Resident F stated, "They [staff] are busy and can't always take me to the bathroom. I don't like peeing in my bed either. Then, I have to lay in it." Resident F's family member (in the room at the time of the interview) stated, "When I came, [Resident F's] bedding was soaked, and her brief was ripped. She was in a soaking wet bed. She has sores on her bottom. It's just my opinion, but it smelled like old pee. Like she was sitting in it for a while. I know they are short staffed, but I feel like they are training her to be incontinent."<br>* 08/15/22 at 7:06 p.m., Resident G stated, "For three days, they gave me medicine so I could have a bowel movement. They didn't come when I called. I had to wait 20 some minutes. I hadn't gone for three days, so it was all over."<br>* 08/15/22 at 7:30 p.m., Resident P stated, "There is just not enough people working. It can take an hour [for staff to respond to my call light]." He reported he has been incontinent "a few times" while waiting for staff to assist him.<br>* 08/16/22 at 11:30 a.m., Resident W stated she sometimes "waits an hour or more" during the night when she puts her call light on and "they don't have enough help at night." She stated she has urinated in her bed while waiting for staff to come help her. | F 690 | validated that Resident #11's urinal was emptied, clean, appropriately placed and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br>The Director of Nursing/designee validated that Resident #13's urinal was emptied, clean, appropriately placed and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br>The Director of Nursing/designee validated that Resident # 25's urinal was emptied, clean, appropriately placed and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br>The Director of Nursing/designee validated that Resident # 7's urinal was emptied, clean, appropriately placed and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br>The Director of Nursing/designee validated that Resident # 4's urinal was emptied, clean, appropriately placed, floor was clean and free of odor and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br>The Director of Nursing/designee validated that Resident # 16 urinal was emptied, clean, appropriately placed and that the use of a urinal was care planned as appropriate. Any concerns identified were promptly corrected.<br><br>Identification of Others: | |

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| F 690 | Continued From page 33<br>- Review of Resident #8's medical record occurred on all days of survey. The record identified diagnoses of difficulty walking and urinary incontinence. The current care plan stated, ". . . Toileting assistance of (one) . . . Transfer assistance of (one with FWW) . . . Pressure Ulcer . . . risk . . ." The current care card contradicted the care plan and stated, ". . . Toileting assistance of (2) . . ."<br><br>Resident #8's toilet use record (indicating when staff provided toileting cares), dated August 01-16, 2022, identified the following:<br>* Not toileted: on two days<br>* Once a day: on four days<br>* Twice a day: on four days<br>* Three times a day: on one day<br>* Four times a day: on four days<br>* Five times a day: on one day<br>Documentation further identified the time span between toileting attempts varied from three hours thirty minutes to eleven hours thirty minutes. Staff also indicated "resident not available" on five occasions and "not applicable" on four occasions.<br><br>- Review of Resident #15's medical record occurred on all days of survey. The record identified a diagnosis of prostatic hyperplasia [age-associated prostate gland enlargement that can cause urination difficulty]. The current care plan and care card stated, ". . . Check and change . . . Provide assistance to toilet . . . Monitor and report S&S [signs and symptoms] of UTI [urinary tract infection] . . ."<br><br>Resident #15's toilet use record, dated August 01-16, 2022, identified the following: | F 690 | The Director of Nursing/designee conducted observational rounds and record reviews to validate that residents requiring assistance with toileting needs or incontinent cares were met, residents using a urinal for toileting/elimination were emptied, clean and properly positioned and care planed as well as room floors being free from spills and odors. Any identified concerns were promptly corrected.<br><br>Systemic Changes:<br><br>The Director of Nursing/designee provided education to licensed nurses and certified nurses aides on 9/27/2022 on the requirements to assist residents with incontinent cares, including timely toileting and cares, emptying urinals after use, providing clean urinals and appropriate storage when not in use. Further education included the requirement to clean up any identified spills promptly to assist with prevention of odor, accidents.<br>The Director of Nursing/designee provided education to licensed nurses and certified nurses aides on 9/27/2022 on the requirement to update/revise care plans with resident toileting/eliminations needs including the use of a urinal as needed.<br><br>Monitoring:<br><br>The Director of Nursing/designee will | |

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| F 690 | Continued From page 34<br>* Once a day: on one day<br>* Twice a day: on four days<br>* Three times a day: on two days<br>* Five times a day: on one day<br>Documentation further identified the time span between toileting attempts varied from two to fifteen hours. Staff also indicated "not applicable" on one occasion.<br><br>- Review of Resident #19's medical record occurred on all days of survey. The current care plan stated, ". . . I have a potential for self-care deficit r/t . . . impaired mobility or transfer ability, pain . . . two person assist with bed mobility, toileting and transfers . . ."<br><br>Resident #19's toilet use record, dated August 01-16, 2022, identified the following:<br>* Twice a day: one day<br>* Three times a day: seven days<br>* Four times a day: five days<br>* Five times a day: none<br>* Six times a day: one day<br>Documentation further identified the time span between toileting attempts varied from two hours to sixteen hours. Staff also indicated "not applicable" on two occasions.<br><br>- Review of Resident #20's medical record occurred on all days of survey. The record identified diagnoses of difficulty in walking and generalized muscle weakness. The current care plan stated, ". . . I have Potential for complications r/t incontinence . . . Assist to toilet resident requests, reminded and as needed . . . I have a potential for self care deficit r/t [related to] energy deficit, s/p [status post] L [left] toe amp [amputation], pain . . . decreased mobility . . . | F 690 | conduct observational rounds and record reviews 3 times a week for 8 weeks, then weekly for 8 weeks, then monthly to validate that residents are receiving proper incontinent cares, toileting assist, urinals that are required for toileting/elimination needs are care planned, emptied after use, clean, and appropriately placed. Further review will include validation that spills are promptly cleaned up to prevent odor/accidents. Any concerns will be addressed.<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><br>Date of Compliance: 9/28/2022 | |

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| F 690 | Continued From page 35<br>Assist to transfer as needed . . . Call light near and answered . . ."<br><br>Resident #20's toilet use record, dated August 01-16, 2022, identified the following:<br>* Once a day: two days<br>* Twice a day: five days<br>* Three times a day: three days<br>* Five times a day: one day<br>Documentation further identified the time span between toileting attempts varied from two hours to sixteen hours. Staff also indicated "resident not available" on nine occasions and "not applicable" on four occasions.<br><br>- Review of Resident 27's medical record occurred on all days of survey. The record identified diagnoses of cerebral infarction with hemiplegia/hemiparesis [partial paralysis on one side of the body], muscle atrophy [wasting], and sacral pressure ulcer. The care plan stated, ". . . Assist with pericare . . . Assist of 2 with . . . toileting, transfers . . . Notify MD [medical director] if . . . s/sx infection/UTI . . . at risk for pressure injury due to: incontinence . . . hx [history] PU [pressure ulcer] to sacrum at hospital . . ."<br><br>Resident 27's toilet use record, dated July 19-26, 2022, identified the following:<br>* Once a day: on one day<br>* Twice a day: on two days<br>* Three times a day: on three days<br>* Four times a day: on one day<br>* Five times a day: on one day<br>Documentation further identified the time span between toileting attempts varied from two to twenty-three hours. Staff also indicated "not | F 690 | | |

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| F 690 | Continued From page 36 | F 690 | | |

applicable" on one occasion.

During an interview on 08/16/22 at 2:36 p.m., when asked questions pertaining to the toileting record, an administrative nurse (#1) stated, "I made a rounding sheet for everybody. [Staff] should have more eyes on [the residents], like every couple of hours to see if they need anything."

URINAL USE

- Review of Resident #11's medical record occurred on all days of survey. The record identified diagnoses of myastinia gravis [disorder causing rapid muscle fatigue and weakness] and UTI. The current care plan stated, ". . . Peri cares as needed . . ." The current care card failed to address Resident #11's use of a urinal.

Observation on 08/16/22 at 3:05 p.m. showed a partially full urinal hanging from the bed rail. Resident #11 stated, "They need to come in and empty this."

Resident #11's toilet use record for 08/16/22 identified staff provided cares at 2:54 p.m. Staff provided cares, but failed to empty the urinal while they were in his room.

- Review of Resident #13's medical record occurred on all days of survey. The record identified diagnoses of difficulty walking and generalized weakness. The current care plan stated, "Toileting assistance of 1 . . ." The care plan failed to address Resident #13's use of a urinal.

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| F 690 | Continued From page 37<br>Observation on 08/15/22 at 6:40 p.m. showed a partially full urinal hanging from the resident's garbage can. Resident #13 reported staff empty the urinal when they have time.<br><br>- Random observations showed the following:<br>* 08/15/22 at 6:29 p.m., a partially full urinal on Resident #25's bedside table.<br>* 08/15/22 at 6:33 p.m., a partially full urinal on Resident #7's bedside table, next to food containers and a water mug.<br>* 08/15/22 at 8:15 p.m., a partially full urinal hung on Resident #4's garbage can. He stated, "They need to empty that (pointing at the urinal) and clean up the urine on the floor. They never clean the floor, it smells like urine in here."<br>* 08/15/22 at 8:35 p.m., a dirty urinal on Resident #16's bedside table surrounded by papers.<br>* 08/16/22 at 2:10 p.m., a partially full urinal on Resident #7's bedside table, next to a water mug.<br>* 08/17/22 at 10:06 a.m. and 11:07 a.m., a partially full urinal on Resident #7's bedside table, next to a water mug. | F 690 | | |
| F 692 SS=D | 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 balance, unless the resident's clinical condition | F 692 | | 9/28/22 |

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| F 692 | Continued From page 38<br>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 SURVEYS COMPLETED ON 02/25/21 and 04/21/22.<br><br>Based on record review, resident interview, and staff interview, the facility failed to ensure residents maintain acceptable parameters of nutritional status related to carbohydrate intake and blood glucose levels for 1 of 1 (Resident #21) resident with an insulin pump. Failure to provide carbohydrate counting information to a resident who manages his/her insulin pump doses according to carbohydrate intake has the potential to result in adverse affects from high or low blood glucose levels.<br><br>Findings include:<br><br>During an interview on 08/15/22 at 7:50 p.m., Resident #21 stated she has diabetes and has an insulin pump. The resident stated she has asked the dietary staff to provide her with the carbohydrate counts of the food so that she can dose her insulin according to her intake (carbohydrate counting is counting the number of grams of carbohydrates in a meal and matching that to the dose of insulin). Resident #21 stated | F 692 | CORRECTIVE ACTION:<br>Resident #21 was discharged and has not returned to the facility.<br><br>IDENTIFICATION OF OTHERS:<br>Director of Nursing/Designee will review all residents with diabetes to validate if insulin pump is in place or carbohydrate count is needed by resident, that orders are in place and care plan updated as applicable. Any identified concerns were promptly corrected, and care plans updated as applicable.<br><br>SYSTEMIC CHANGES:<br>Director of nursing/designee will educate nursing staff and dietary personnel on use of self- monitored insulin pump and carbohydrate counting for insulin administration on or before 9/27/2022.<br><br>MONITORING:<br>Director of Nursing/Designee will monitor all new residents with diabetes for use of insulin pump, or need for carbohydrate counting to dose insulin, 5 times per week for 4 weeks, weekly for 4 weeks, then | |

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| F 692 | Continued From page 39<br>no one has given her any information about the carbohydrate counts for the food provided in the facility.<br><br>Review of Resident #21's medical record occurred on 08/17/22. The facility admitted the resident in June 2022 and medical diagnoses included Type 1 Diabetes mellitus with diabetic nephropathy. Physician's orders included the following:<br>06/01/22 - "Diabetic diet regular texture"<br>06/08/22 - "OK for pt [patient] to self manage insulin with input from endocrinology"<br>06/16/22 - "Accuchecks TID [three times a day] - call provider if <60 or >500 when meal comes pt [patient] does BS [blood sugar] and doses insulin after eating with meals"<br><br>Review of Resident #21's initial nutritional assessment identified the diagnoses of diabetes mellitus, but did not include any information regarding the resident's use of an insulin pump.<br><br>Resident #21's care plan failed to identify the use of an insulin pump and that the resident checks her own blood sugar and administers insulin via the insulin pump based on her blood sugar level.<br><br>Review of Resident #21's blood glucose level checks from August 01-16, 2022 identified blood glucose levels ranging from 61 to 288 milligrams per deciliter (normal range for fasting blood sugar [the amount of glucose in your blood six to eight hours after a meal] is between 70 and 100 milligrams per deciliter.)<br><br>An interview with a nutrition staff member (#5) occurred on the afternoon of 08/17/22. When | F 692 | monthly until a lessor frequency deemed appropriate.<br><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.<br><br>Date of compliance: 09/28/2022 | |

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| F 692 | Continued From page 40<br>asked about Resident #21's insulin pump and carbohydrate counting, the staff member stated she was not aware the resident had an insulin pump, dosed her own insulin, or that the resident had inquired about carbohydrate counting. | F 692 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>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, 03/25/21 and 04/21/22<br><br>Based on observation, record review, review of facility policy/procedure, and resident and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 3 of 3 sampled residents (Residents #19, #23, and #24) receiving oxygen by nasal cannula. Failure to administer oxygen according to the physician's order may result in complications and compromise of the residents' respiratory status.<br><br>Findings include:<br><br>Review of the facility policy titled "Oxygen Administration" occurred on 08/17/22. This | F 695 | Corrective Actions:<br><br>Resident # 19 was assessed by DON/designee to validate no change in condition occurred from O2 order not per physician order. 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 # 23 was assessed by DON/designee to validate no change in condition occurred from O2 order not per physician order. Any concerns that were identified were promptly corrected, resident, resident representative, and physician notified, any orders obtained | 9/28/22 |

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| F 695 | Continued From page 41<br>policy, dated Qtr (quarter) 3, 2018, stated, "Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. . . ."<br><br>- Observation on 08/15/22 at 6:49 p.m. and on 08/16/22 at 11:30 a.m. showed Resident #19 receiving oxygen per nasal cannula at four liters per minute (LPM).<br><br>Review of Resident #19's medical record on 08/16/22 identified a physician's order, dated 6/28/22, for oxygen at three LPM via nasal cannula.<br><br>- Observation on 08/15/22 at 7:10 p.m. and in the afternoon of 08/16/22 showed Resident #23 receiving oxygen per nasal cannula at two and one half LPM.<br><br>Review of Resident #23's medical record on 08/16/22 identified a physician's order, dated 03/15/22, for continuous oxygen at four LPM.<br><br>- Observation on 08/15/22 at 8:34 p.m. and on 08/16/22 at 4:17 p.m. showed Resident #24 receiving oxygen per nasal cannula at four LPM. During an interview on 08/16/22 at 4:20 p.m., Resident #24 stated, "They have the oxygen on at four liters. That is too high."<br><br>Review of Resident #24's medical record on 08/16/22 identified a physician's order, dated 06/07/22, for oxygen at three LPM per nasal cannula at night and as needed during the day. | F 695 | noted and care plan updated as applicable.<br><br>Resident # 24 was assessed by DON/designee to validate no change in condition occurred from O2 order not per physician order. 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>Identification of Others:<br><br>The Director of Nursing/designee will complete record review and observational rounds to validate those residents receiving supplemental oxygen administration have orders for administration and what is observed is per physician orders. Any identified concerns will be promptly corrected, resident/representative and physician notified, any new physician orders noted, and care plans updated as applicable by 9/27/2022<br><br>Systemic Changes:<br><br>The Director of Nursing/designee will provide training to license nurses on 9/27/2022 on requirements to have physician orders for oxygen administration in place and followed, which include route of delivery and rate of oxygen. Any concerns identified will be | |

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| F 695 | Continued From page 42<br><br>During an interview the afternoon of 08/16/22, an administrative staff member (#1) confirmed staff should administer oxygen at the amount the physician ordered. | F 695 | promptly corrected.<br><br>Monitoring:<br><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, weekly for 2 months, and then quarterly to validate those residents receiving 02 have orders for administration, including route and rate of administration.<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>9/28/22 | |
| F 726 SS=E | 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). | F 726 | | 9/28/22 |

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| F 726 | Continued From page 43<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 techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure competent staff for 5 of 5 contract personnel files reviewed (Staff #8, #9, #10, #11, and #12). Failure to provide facility orientation may result in a lack of knowledge related to facility procedures, competencies and skill sets needed to care for residents and increase the risk of physical or psychological harm to the residents through improper care.<br><br>Findings include:<br><br>On 08/29/22, the survey team requested information regarding orientation of travel/contract staff for one travel nurse, and four certified nursing assistants (CNAs). Review of the facility's orientation files for travel/contract staff identified the facility failed to provide orientation to the travel/contract Staff #8, #9, #10, | F 726 | Corrective Action:<br><br>Director of Nursing/designee Validated on 9/21/2022 that contract/travel staff received orientation per facility policy prior to working.<br><br>Identification of Others:<br><br>Director of Nursing/designee will review all contract/travel staff that worked last 7 days to ensure orientation was completed prior to shift on 9/27/2022. Any identified concerns were promptly corrected.<br><br>Systemic Changes:<br><br>Director of Nursing/designee will educate | |

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| F 726 | Continued From page 44<br>#11, and #12.<br><br>During an interview on 08/29/22 at 5:00 p.m., an administrative nurse (#6) confirmed the facility failed to complete orientation with Staff #8, #9, #10, #11, and #12.<br><br>Failure to provide orientation increased the potential for lack of appropriate care, services, and monitoring of residents consistent with their individualized plan of care. | F 726 | nursing management and nurse scheduler regarding the requirement that all contract/travel staff have completed orientation checklist/review prior to working with residents on 9/21/2022.<br><br>Monitoring:<br><br>Director of Nursing/designee will validate through record review that all contract/travel staff have completed orientation prior to working with residents, 3 times a week x 4 weeks then monthly x 2 months, and then quarterly.<br>Director of Nursing/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>9/28/2022 | |
| F 732 SS=D | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses. | F 732 | | 9/28/22 |

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| F 732 | Continued From page 45<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure posting of daily staffing information for 8 of 29 days (August 5 and 23-29, 2022) reviewed. Failure to post accurate staffing data does not allow residents and visitors knowledge of the number of licensed and unlicensed staff on duty each shift.<br><br>Findings include:<br><br>Observation on 08/29/22 showed staff failed to | F 732 | Corrective Action:<br><br>Administrator validated that staffing numbers were updated and posted on 9/20/2022.<br><br>Identification of Others:<br><br>Administrator/designee will review daily nursing staffing postings to ensure | |

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| F 732 | Continued From page 46<br>post staffing information.<br><br>During an interview on 08/29/22 at 5:03 p.m., an administrative nurse (#6) verified the facility failed to post the daily staffing report. | F 732 | completed and updated appropriately for past 7 days on 9/27/2022.<br><br>Systemic Changes:<br><br>Administrator/designee will educate facility receptionist(s) on how to complete daily nurse staffing postings on 9/20/2022.<br>Administrator/designee will educate nursing management on daily nurse staffing postings regulations on 9/20/2022.<br><br>Monitoring:<br><br>Administrator/designee to validate that nursing staffing has been posted according to federal regulations 5 times per week x 4 weeks, then weekly x 3 months until a lessor frequency deemed appropriate.<br>Administrator/designee will report identified trends to QAPI committee monthly and as needed until a lessor frequency is deemed necessary.<br><br>Date of compliance: 9/28/2022 | |
| F 843 SS=F | Transfer Agreement<br>CFR(s): 483.70(j)(1)(2)<br><br>§483.70(j) Transfer agreement.<br>§483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer | F 843 | | 9/28/22 |

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| F 843 | Continued From page 47<br>agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that-<br>(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and<br>(ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii).<br><br>§483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. Failure to ensure an agreement is in place may result in negative outcomes for residents who require admission to the hospital and/or the delay of information required for care and treatment when a transfer is necessary. | F 843 | Corrective Action:<br><br>Administrator initiated transfer agreement with a minimum of 2 local hospitals on 9/16/2022.<br><br>Identification of others:<br><br>Administrator/designee reviewed the contract binder to identify if a transfer | |

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| F 843 | Continued From page 48<br>Findings include:<br><br>During an interview on 08/30/22 at 9:05 a.m., an administrative staff member (#7) stated the facility staff failed to locate any transfer contracts/agreements with the local hospitals. The staff member (#8) stated the facility contacted the local hospitals and they did not have a transfer contract/agreement on file with the facility either. | F 843 | agreement was in place and contacted local hospitals to incorporate transfer agreements with facilities if one was not identified.<br><br>Systemic Changes:<br><br>Administrator received education regarding the federal regulation of having a transfer agreement in place from corporate leadership on 9/20/2022.<br><br>Monitoring:<br><br>Administrator/designee to validate that transfer agreement(s) are in place with local hospital(s) by reviewing the facilities contract binder monthly x 3 months then annually thereafter. The administrator will review transfer agreements annually in QAPI meeting.<br><br>Date of compliance: 9/28/2022 | |
| F 943 SS=E | Abuse, Neglect, and Exploitation Training<br>CFR(s): 483.95(c)(1)-(3)<br><br>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents | F 943 | | 9/28/22 |

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| F 943 | Continued From page 49<br>of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>§483.95(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility assessment, Nursing Orientation/Annual Skills/Competency Checklist form, personnel files, and staff interview, the facility failed to ensure all staff received training on abuse, neglect, exploitation, and misappropriation of resident property for 5 of 5 nurses (#22, #23, #24, #25, and #26) reviewed. Failure to ensure staff receive required training places residents at risk for abuse, neglect, exploitation, and misappropriation of resident property.<br><br>Findings include:<br><br>Review of the "2022 Facility Assessment The Meadows on University" occurred on 08/29/22 and stated, ". . . 3. C Staff training/education and competencies: Role: Licensed Nurses Training Requirements . . . Abuse . . . See Licensed Nurse Competency Checklist . . ."<br><br>Review of the "Nursing Orientation/Annual Skills/Competency Checklist" occurred on 08/29/22 and stated, ". . . 31. Abuse: Definition, types, residents at risk including residents with Dementia/Alzheimer's: Prevention, Identifying, investigation, Reporting, Abuse Coordinator . . .<br><br>Review of personnel files occurred on 08/29/22 and failed to include abuse, neglect, exploitation, and misappropriation of resident property training | F 943 | Corrective Action:<br><br>Education has been initiated to facility staff on 9/7/2022 related to Abuse, Neglect, and Exploitation and misappropriation of funds.<br><br>Identification of Others:<br><br>Administrator/designee will review facility/contract/travel staff education files to ensure education has been provided related to Abuse, Neglect, and Exploitation and misappropriation of funds by 9/27/2022.<br><br>Systemic Changes:<br><br>Administrator/designee will complete education with facility/contract/travel staff regarding Abuse, Neglect, and Exploitation and misappropriation of funds on or before 9/27/2022 and prior to any scheduled shift thereafter.<br><br>Monitoring:<br><br>Administrator/designee will validate through record review that all newly hired facility/contract/travel staff have completed education related to Abuse, | |

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| F 943 | Continued From page 50<br>for five staff nurses (#22, #23, #24, #25, and #26).<br><br>During an interview on 08/29/22, when asked about training records, an administrative staff member (#6) stated the facility lacked training records related to abuse, neglect, exploitation, and misappropriation of resident property for the nurses. | F 943 | Neglect, and Exploitation, 1 time a week x 4 weeks then monthly x 2 months, and then quarterly<br>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: 9/28/2022 | |