STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355103	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 10/27/24 and concluded 10/30/24. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		12/12/24

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

Electronically Signed | 11/29/2024

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment in multiple areas of the facility (supply room, laundry room, oxygen storage room, and resident rooms) observed during survey. Failure to maintain a safe, clean, comfortable, and sanitary environment and keep resident care equipment clean and properly stored does not provide a homelike area for residents or promote quality of life. Findings include: Review of the facility policy titled "Oxygen Concentrator" occurred on 10/30/24. This policy, dated 10/23/24, stated, ". . . An 'oxygen concentrator' is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen. . . Keep concentrators covered when not in use. . . Care of the Concentrator . . . Nurse responsibilities . . . The main body cabinet should be dusted when needed . . ." Observations during survey showed the	F 584	F584 1. Immediate corrective actions taken for the resident(s) found to have been affected include: a) On 10/30/2024 the Maintenance Supervisor replaced the overbed table in the room of Resident #8 and put the old one into the garbage. b) The Oxygen concentrator in Resident #8's room that was covered in dust was cleaned on 10/30/2024 per facility policy. c) The equipment found in the Clean Supply Room that was dirty was cleaned by nursing staff per facility policy and disposable tubing/masks disposed of in the garbage on 10/30/2024. d) The Oxygen concentrators were covered after being cleaned per facility policy while being stored in the Clean Supply Room on 10/30/2024. e) The Laundry Room fan grate and blades were cleaned of dust and debris on 10/30/2024 by the laundry staff. f) The Oxygen Storage Room ceiling vents were cleaned of the thick layer of dust and the floor was swept and mopped	

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F 584	Continued From page 2 following: - Clean Supply Room: * An oxygen concentrator with a layer of dust on the outside and filter. * Oxygen tubing and a mask attached to the concentrator laid on the floor beside the machine. A portable liquid oxygen tank and a nebulizer machine sat on the floor next to the concentrator. - Laundry room: * Visible dust/debris on a fan grate and blades blowing into the clean laundry area. - Oxygen storage room: * Two ceiling vents had a thick layer of dust accumulation. * Floor tiles cracked/broken and a visible layer of fine dirt along the perimeter of the floor. * Ceiling tiles with water leak marks. - Resident rooms: * Rooms on Unit A with scuff marks, chipped paint, and gouges/paint scratched off walls. * An overbed table in room B8 with an approximate two-inch strip of missing laminate along the entire front length of the table with wood exposed, and a large area of loose laminate on the right top side of the table. * The top of the oxygen concentrator in room B8 covered in dust. During an interview the afternoon of 10/29/24, a maintenance staff member (#10) confirmed the facility failed to have a process for identifying areas within the facility and/or resident rooms in need of cleaning or repairs. He/she reported being unaware of any resident room concerns.	F 584	up by the Maintenance Supervisor in the afternoon of 10/30/2024. The floor tiles will be removed and replaced by 12/6/2024. g) All resident rooms were assessed on 11/1/2024, forms were prioritized based on needed repairs, repairs to walls will be completed by 12/11/2024. Corrective Actions 2. All residents have the potential to be affected as failure to maintain a safe, clean, comfortable, and sanitary environment and keeping resident care equipment clean and properly stored does not provide a homelike area for residents or promote quality of life. 3. The current policies and procedures were reviewed by the Interdisciplinary Team: Oxygen Concentrator. A new policy: Environmental Services ~ Maintenance Process for Repairs was put in place on 10/30/2024 with the maintenance repairs forms that are hanging at the Nurses' Station for all staff to utilize. 4. A cleaning schedule will be posted in the Oxygen Storage Room to be cleaned weekly, signed off by designated staff when cleaned. 5. Monthly and PRN forms were developed for the Maintenance Supervisor to check and clean all ceiling vents, wall and floor heat registers in the facility. 6. A Repair Required Report was developed for the Maintenance Supervisor to track issues identified in resident rooms, priority of issue, and the	

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F 584	Continued From page 3 During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) stated he/she expected staff to clean/sanitize oxygen and nebulizer equipment removed from a resident's room prior to storage and dispose of items such as oxygen tubing and oxygen masks in the resident's room.	F 584	date it was completed. 7. A QA was developed by the DON to check that oxygen concentrators, filters, liquid oxygen concentrators, and nebulizer machines are cleaned weekly by nursing. The cleaning task is added to the resident's treatment record when placed on oxygen or getting nebulizer treatments, and the storage of each piece of equipment per facility policy. 8. A monthly cleaning form was developed for the laundry room for when the equipment is being cleaned that can accumulate dust/debris (fans/ tables/ chairs/etc.). These forms will be completed by laundry staff and be kept in a file until the quarterly QA meetings. 9. A weekly QA Committee Meeting form was developed to review immediate concerns that need to be addressed. All staff involved will bring their findings for their section on that designated day to go over during the morning meeting. 10. All QA forms will be reviewed at the Quarterly QA Meeting by the designated staff. 11. An All-Staff Meeting will be held on December 11, 2024, to offer staff education on the State Survey Plan of Correction that includes any current, updated, and new policies, QA audits that will be completed, and new forms put into use.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		12/12/24

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F 625	Continued From page 4 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or the resident's representative a written bed hold notice at the time of the transfer or if an emergency, within 24 hours for 1 of 2 sampled residents (Resident #23) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice in a timely manner does not allow the resident and/or their representative to make an informed decision	F 625	F625 Notice of Bed Hold 1. The bed hold notice was provided for resident #23 and his family on July 8, 2024. Resident #23 was made aware that the notice was given later than the 24 hours' notice required to make an informed decision, resident #23 chose to still sign the bed hold. 2. The facility has determined that all residents who are transferred to the	

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F 625	Continued From page 5 regarding their rights. Findings include: Review of the facility policy titled "Bed Hold Notice Upon Transfer" occurred on 10/30/24. This policy, dated 12/12/23, stated, ". . . Before a resident is transferred to the hospital . . . the facility will provide to the resident and/or the resident representative written information that specifies . . . The duration of the state bed-hold policy . . . The reserved bed payment policy . . . The facility policies regarding bed-hold periods . . . Conditions upon which the resident would return to the facility . . . In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies . . ." Review of Resident #23's medical record occurred on all days of survey and identified a hospital transfer occurred on 06/30/24. The medical record identified the facility provided the resident and/or representative with a written bed hold notice on 07/08/24, eight days after the transfer. During an interview on 10/29/24 at 10:15 a.m., an administrative staff member (#3) confirmed staff provided the required bed hold notice to the resident and/or their representative eight days after the resident was transferred to the hospital.	F 625	hospital or go out on therapeutic leave have the potential to be affected. 3. The current policy and procedure titled Bed Hold Notice Upon Transfer and the Bed Hold Transfer form was reviewed by the SSD and the Interdisciplinary team for updates needed per State defined requirements. 4. Nurses will receive education on charting verbal bed holds in emergency situations in the residents' progress notes if resident is unable to sign or DPOA/Guardian is not present at the time of the transfer on 12/11/2024 at a Nurses Meeting. 5. The SSD will obtain bed hold forms from the resident or their DPOA/Guardian to be signed in one of three ways: leaving the forms at the nurse's station for the DPOA/Guardian, mailing the forms, or emailing out the bed hold paperwork for the residents DPOA/ Guardian to sign that they were given the information to make an informed decision on the bed hold. The SSD will chart the date that the DPOA/Guardian was phoned about the paperwork and when it was sent out for signature in the resident's chart, as well as the date received back. 6. A QA form was developed to audit the last 2 months (October & November) and all transfers and therapeutic leaves of all residents for bed hold signatures, notifications of rights within 24-hour time frame, and notification of Ombudsman going forward per facilities policy completed by the SSD. The SSD will bring these QA findings to the quarterly	

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F 625	Continued From page 6	F 625	QA meetings. 7. The SSD will develop a checklist to use for when a resident is going to be transferred to the ED, hospital, or goes on leave of absence for all paperwork that needs to be signed for all transfers going forward according to facility policy to ensure 100% compliance. 8. The SSD and DON will put together an in-service for nursing staff to review the Bed Hold Notice Upon Transfer Policy, discuss the forms to be used as new nursing staff have been hired, and why they are to be completed prior to transfers or leave. Our SSD has emailed the State LTC Ombudsman for our area to educate our nursing staff on Bed Holds, we are awaiting a reply from her. An all-staff In-service will be held on 12/11/2024 with education by SSD and DON with hopes of the Ombudsman being able to provide her input during the meetings that day also.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 8 of 12 sampled residents (Resident #3, #4, #6, #11, #15, #20, #23, and	F 641	F641 Accuracy of Assessment Immediate corrective action: 1. Resident #4 still had the presence of an indwelling catheter coded on the MDS that had been removed in July 2024. MDS fixed 10/30/2024. 2. Resident #11 did not have insulin	12/12/24

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F 641	Continued From page 7 #24). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION H - BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-2, stated, ". . . Check next to each appliance that was used at any time in the past 7 days. . . . H0100A, indwelling catheter . . ." - Review of Resident #4's medical record occurred on all days of survey. A nursing home recertification of care, dated 07/10/24, stated, "Resident does not currently have a foley catheter in place." Observation on 10/28/24 at 3:30 p.m. showed no indwelling catheter present. Review of the MDS, dated 07/25/24, Section H0100A, indicated the presence of an indwelling catheter. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page N-3, stated, ". . . N0350: Insulin . . . Coding Instructions . . . Enter in Item N0350A, the number of days during the 7-day look-back period . . . that insulin injections were received. . . ." - Review of Resident #11's medical record occurred on all days of survey. The physician's orders included Insulin Glargine (used to control	F 641	coded on the Significant change in status MDS, dated 8/19/24. MDS fixed 10/30/2024. 3. Resident #3, # 6, #15, #20, #23, and #24 aspirin were not coded on their quarterly/annual MDS as an Antiplatelet medication during the period of the survey. MDS coding's fixed 10/30/2024 . 4. All residents are determined to be affected by staff failing to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. 5. The MDS Coordinator will review all MDS's in the last month and going forward for accuracy of the new coding of Section N via a QA audit form developed to ensure medication coding is accurate. This QA audit will be reviewed at the quarterly QA Meetings by the MDS Coordinator. 6. A QA audit form will be developed to check medication coding with number of days a medication is received in the last 7-day look-back period (ie: insulin injections). The MDS Coordinator will bring her findings of the QA audits completed to the quarterly QA meetings. 7. The MDS Coordinator will review all MDS's in the last month and going forward for accuracy of coding of Section H via a QA audit form developed to ensure coding of devices is coded accurately. This QA audit will be reviewed at the quarterly QA Meetings by	

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F 641	Continued From page 8 high blood sugar) in the evening for diabetes mellitus 2. The facility failed to code insulin use on the significant change in status MDS, dated 08/19/24. The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-6 to N-8, stated, ". . . Code all high-risk drug class medications according to their pharmacological classification . . . N0415: High-Risk Drug Classes . . . Coding Instructions . . . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., [example] aspirin/extended release . . .) was taken by the resident at any time during the 7-day observation period. . . ." - Review of Resident #3's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 07/25/24. - Review of Resident #6's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 10/12/24. - Review of Resident #15's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the annual MDS, dated 07/20/24. - Review of Resident #20's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the annual MDS,	F 641	the MDS Coordinator. 8. The DON will educate nursing staff on notifying the MDS Coordinator of any changes that will affect Section H- coding of devices (indwelling catheters) immediately when something changes. This will be completed at the nurses meeting on 12/11/24. 9. The MDS Coordinator will have on file her continuing education on MDS/RAI information. An updated MDS/RAI Manual will be available for the MDS Coordinator either in virtual or paper format to be able to complete her job to the best of their ability by 12/12/2024.	

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F 641	Continued From page 9 dated 09/18/24. - Review of Resident #23's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 10/05/24. - Review of Resident #24's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 08/30/24. During interviews the morning of 10/30/24, an administrative nurse (#2) confirmed staff failed to code the MDSs correctly for Residents #3, #4, #6, #11, #15, #20, #23 and #24.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or	F 644		12/12/24

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F 644	Continued From page 10 a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #8) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised December 2020, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC [mental illness, intellectual disability, and conditions related to intellectual disability referred to in regulatory language as related conditions or RC] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #8's medical record occurred on all days of survey and identified the following;	F 644	F644 Coordination of PASARR and Assessments The Facility failed to complete a change in status Level 1 screen for Resident #8 when the new diagnosis of delusions and hallucinations was added by the provider. 1. Resident #8 had a PASARR Level I completed on 10/31/2024 by the SSD, reviewed by ND Dept. of Human Services on 11/1/2024, with no level II required. 2. All residents who require a Level II PASARR have the potential to be affected by the deficient practice. The SSD will complete an audit of all current residents to check for the need to have a Level II PASARR level screening and review completed. This audit will be completed by 12/10/2024. 3. The SSD will review important Best Practice Tips & Reminders under the ND PASRR Program Announcement and complete the Certification training if not completed prior to 10/30/2024. Certifications will be included with the Plan of Care on the date completed to be in compliance. SSD will educate all nursing staff on diagnosis that would trigger the need for a new Level I or II screening at the next nurses meeting on December 11, 2024. 4. The SSD will complete a 100% audit of Level I and II PASARR upon admission, monthly, and as needed with	

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F 644	Continued From page 11 * PASARR completed on 08/13/21. * Progress note, dated 09/22/24, ". . . communication with physician . . . updated on resident's delusion's [sic] and hallucinations that he has been having over the last month or more. . . ." * Progress note, dated 09/24/24, ". . . communication with physician . . . Recommendations: New orders received and observed by fax from [name of physician] . . . increase Quetiapine [antipsychotic medication] to 37.5 mg [milligram] in PM [evening]. . . ." The record lacked evidence facility staff completed a PASARR related to the new diagnoses of delusions and hallucinations. During an interview on 10/29/24 at 1:32 p.m., a social services staff member (#3) confirmed the facility failed to complete a change in status Level 1 screen for Resident #8.	F 644	any new MD (Mental Disorders) or ID (Intellectual Disabilities) or related condition. The SSD will report on her findings at the weekly QA committee meetings for 2 months for compliance. SSD will continue regular and consistent QA audits of PASARR levels at least monthly thereafter. The SSD will bring the QA audits to the quarterly QA Meetings to report on them.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		12/12/24

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F 657	Continued From page 12 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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 3 of 12 sampled residents (Resident #4, #10, and #23). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 10/30/24. This policy, dated 10/29/24, stated, ". . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . ." - Review of Resident #4's medical record occurred on all days of survey. A nursing home recertification of care, dated 07/10/24, stated, "Resident does not currently have a foley	F 657	F657 Care Plan Timing and Revision Resident #4, #10, and #23's care plans will be updated to reflect their current individual needs, conditions, and medications by 12/5/2024, if not completed already by the MDS Coordinator. The facility has determined that all resident's who reside at Four Seasons Healthcare Center have the potential to be affected as it limits the staff's ability to communicate needs and ensure continuity of care. The Policy "Comprehensive Care Plans" will be reviewed by the Interdisciplinary members for any updates or changes that are needed to be considered for our facility will be completed by 12/3/2024. Resident changes will be discussed in the morning huddle meetings and care plans will be adjusted accordingly with the assistance of the interdisciplinary care	

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F 657	Continued From page 13 catheter in place." Observation on 10/28/24 at 3:30 p.m. failed to identify the presence of an indwelling catheter. The current care plan stated, ". . . I have an indwelling catheter . . ." During an interview on 10/30/24 at 11:56 a.m., an administrative nurse (#2) confirmed staff failed to revise Resident #4's care plan following the removal of the foley catheter. - Review of Resident #10's medical record occurred on all days of survey. A physician order, dated 07/29/24, included Eliquis (an anticoagulant medication) five milligrams (mg) two times a day. The current care plan stated, ". . . Staff will monitor me for any bleeding problems that may be due to Plavix (an antiplatelet medication) use. . . ." - Review of Resident #23's medical record occurred on all days of survey and identified warfarin [an anticoagulant medication] discontinued on 05/01/24. The care plan stated, ". . . Staff will do PT/INR (a blood test done for people on warfarin) checks as ordered, and change Coumadin [warfarin] dose as directed. . . ." The facility staff failed to review and revise Resident #10 and #23's care plans following medication changes.	F 657	plan team. In the Weekly QA Committee Meeting the care plans that are reviewed and updated will be discussed for further input from outside staff other than the interdisciplinary team. QA audits will be completed on 4 random resident care plans weekly until all current residents' care plans are accurate, individualized and will ensure the staff's continuity of care by the DON. These audits will continue to be completed by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set), with final review done by the DON for the audit. **This may be done before or during*** All findings will be brought to the quarterly QA meetings by the DON to report on. An in-service will be held on December 11, 2024, to educate staff on reporting changes that should be added to the care plan, new forms for assisting with care plan updates, etc.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		12/12/24

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F 658	Continued From page 14 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 resident (Resident #14) observed receiving a topical medication. Failure to administer topical medications according to physician orders may result in adverse outcomes for the resident. Findings include: Review of the facility policy titled "Medication Administration" occurred on 10/30/24. This policy, dated 05/15/24, stated ". . . Medications are administered . . . as ordered by the physician and in accordance with professional standards of practice . . . administer medication as ordered in accordance with manufacturer specifications . . ." Skidmore-Roth's "Mosby's 2023 NURSING DRUG REFERENCE," 36th Edition eTEXT, 2023, Elsevier Inc., pages 365-367, stated, ". . . diclofenac sodium [Voltaren] . . . Topical gel route . . . Use only for osteoarthritis, mild to moderate pain . . . use dosing card to measure . . ." Observations during medication pass on 10/28/24 at 10:00 a.m. showed a staff nurse (#4) removed a box of Voltaren gel from the medication cart and carried the box into Resident #14's room. The nurse (#4) dispensed an undetermined amount of the gel from the tube into his/her gloved hand and applied the gel up and down the resident's left arm and partial left shoulder. The nurse (#4) dispensed another	F 658	F658 Services Meet Professional Standards Resident #14 was observed receiving a topical medication that was not administered according to physician orders and in accordance with manufacturer specifications. Resident #14 had no adverse outcome from receiving the undetermined amount of gel from the tube and to areas not designated on orders. A Medication error was completed and provider notified on 10/30/2024 when notified of deficient act. It has been determined that all residents who receive the same topical gel medication have the potential to be affected by the failure to provide the correct dose if the measurement tool is not used to ensure the proper amount is applied as ordered by the provider or per manufacturer specifications. On November 25th & 27th , 2024 the Director of Nursing provided in-service education to all licensed nursing staff regarding the proper administration dosing of Voltaren topical gel, use of the measurement tool, and dosage per site. The DON started Skills check on each licensed nursing staff member on November 25th, 2024, on the proper application of Voltaren 1% Gel. These Skills checks will be done quarterly for a year and then will be done annually. A QA audit will be completed by the DON on proper application of Voltaren 1%	

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F 658	Continued From page 15 undetermined amount of the gel into the same gloved hand and applied the gel starting at the resident's right upper arm, down to the right wrist, and then onto the right back shoulder area. Review of Resident #14's medical record occurred on all days of survey. Physician's orders, dated 03/24/22, identified ". . . Voltaren Gel . . . Apply to shoulder and knees topically two times a day for OA [osteoarthritis] 2 grams for shoulders and 4 grams for knees . . ." and ". . . Voltaren Gel . . . Apply to affected areas topically every 24 hours as needed for pain 2 grams for shoulders and 4 grams for knees . . ." The nurse (#4) failed to measure the correct dose of Voltaren gel and apply as ordered. During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) agreed the nurse (#4) failed to follow the provider orders for accurately measuring and applying the medication.	F 658	topical gel according to resident orders by licensed nursing staff once per week for three months, then twice per month for three months, then once per month going forward. These audits will be reviewed at the quarterly QA meetings with findings reported by the DON.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy,	F 684	F684 Quality of Care	12/12/24

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F 684	Continued From page 16 and staff interview, the facility failed to provide necessary care and services for 1 of 1 closed record resident (Resident #28) reviewed. Failure to assess, monitor and implement interventions in response to Resident #28's decline in condition may have contributed to the resident's death. Findings include: Review of the facility policy titled "Vital Signs" occurred on 10/30/24. This policy, dated 12/12/23, stated, ". . . 'Vital signs' are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. . . . Vital signs shall be obtained at least in the following circumstances: . . . When the resident's general condition changes. . . . When a resident reports nonspecific symptoms of physical distress (e.g., [example] feeling 'funny' or 'different'). . . . Acceptable ranges for adults: . . . Oxygen saturation: > [greater than] 90% [percent]. . ." Review of Resident #28's medical record occurred on 10/30/24. Diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (damaged lung tissue), and congestive heart failure (CHF). The baseline care plan identified the resident as independent with bed mobility, transfers, walking, toileting and eating, assistance of one with locomotion grooming/hygiene and bathing and oxygen use at two liters per minute. The care plan also stated the resident, "Wants to do as much as possible for himself but feels weak so at least offer assist and supervise."	F 684	1. Resident #28 was a closed record review. 2. All Residents who have a change in condition or abnormal vital signs have the potential to be affected by the deficient practice. 3. The Policy “Vital Signs” was reviewed by the DON on 11/5/2024. 4. Licensed nursing staff will be educated on the guidelines for charting in the resident’s progress notes or under the resident assessments in Point Click Care per facility policies on Medicare A, change in condition, abnormal vital signs, falls, infections, appointments, etc. This education will include the frequency of charting and what should be included in the charting for the residents. 5. A Nursing In-service will be held with all nursing staff to review Policy/Procedures on Change of Conditions, Vital Signs, Assessment charting, Use of SBARs, Notifying Providers (who, when, how) on December 11, 2024. 6. Charting audits on licensed nurses progress notes and assessments will be completed on all resident who are new admits, on residents who fall, residents with a change in condition, residents with new skin concerns, or residents with abnormal vital signs will be performed by the DON daily for 1 month, then weekly for 3 months, the bi-weekly for 3 months, with all audits being done accordingly when a new occurrence happens and staff will be re-educated immediately on charting that is required. Auditing will	

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F 684	Continued From page 17 The medical record identified Resident #28 admission date of 08/30/24. The record lacked documentation in the nurse progress notes for August 30, 31, and September 1, 2024. The nurse progress notes dated 09/02/24 stated the following: * At 4:06 p.m. "Note Text: Vitals completed. O2 [oxygen] sat [saturation] 81% at 3 liters. Resident has normal respirations at 20 per minute and non labored. and denies shortness of breath." * At 6:22 p.m. "Note Text: Resident states he is not feeling well. Vitals are stable and has no fever. O2 sat 89%. It is warm in his room so fan is moved to blow on him per his request." The nurse progress notes dated 09/03/24 stated the following: * At 3:20 a.m. "Note Text: Resident told this nurse he is dying and can't eat because it's too hard to breathe. This nurse mentioned Hospice and resident stated, 'That is a great idea because I am definitely dying.' This nurse will pass message on to the day nurse." * At 6:50 a.m. "Note Text: Called [family member's name], the president's [sic] son and informed him of his dad's condition. Resident is having SOB [short of breath]. Poor appetite. He said he did not eat or drink for four days. [Resident #28] asked for the nurse's opinion. Informed will consult with the provider and get back to him. Called [Resident #28's son] again but went to his voice. Left message that his dad is on his way to the emergency. Left phone number to call back." * At 7:30 a.m. "Note Text: Called the [name of clinic] and spoke with [name of physician] nurse, [name of nurse] Informed her that the resident is having SOB and had not been eating or drinking.	F 684	begin on 12/2/2024. All QA audit findings will be brought to the quarterly QA meeting by the DON. 7. QA audits of review of weights and vital signs monthly will continue as completed from previous survey by DON. 8. Staff will be re-educated on an ongoing basis based on the audits by the DON or designee. The monitoring results will be reported quarterly at the QA Meeting with the Medical Director being able to give recommendations for education, staff charting, etc by DON.	

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F 684	Continued From page 18	F 684		

[name of nurse] said she will check with [name of physician] and call back. [Name of physician] called and ordered ER [emergency room] transfer for evaluation. Resident sent to the ER via ambulance 0820 [8:20 a.m.]."
* At 8:00 a.m. "COMMUNICATION - with Physician* Situation: SOB. Accessory muscle for breathing. Background: Poor appetite. SOB. Oxygen 2L [liters] NC [nasal cannula]. Assessment (RN) [registered nurse]/Appearance (LPN) [licensed practical nurse]: BP [blood pressure] 98/62, P [pulse]-96, r[respirations]- 28, Oxygen 82, T[temperature]-97.3. Recommendations [sic]: Send to ER via Ambulance to [name of town]."
* At 8:20 a.m. "Transfer to Hospital Summary* Note Text: Resident had been experiencing SOB and poor appetite. Complained of pain as well but said 'pain is a lesser evil. I can't breathe' [name of physician] ordered ER transfer for evaluation."
* At 8:21 a.m. "Note Text: Report given to the ER nurse. Resident on his way in Ambulance to the ER."
* At 9:25 a.m. "Note Text: [name of person], Nurse from the [name of town] Hospital called and reported that the patient passed away today at 0908 [9:08 a.m.]. Family notified per the nurse."

During an interview the morning of 10/30/24, an administrative nurse (#2) confirmed the medical record lacked nurse progress notes for August 30, 31, and September 1, 2024.

The medical record lacked documentation or evidence of the following;
* An assessment, treatment interventions, and/or

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F 684	Continued From page 19 symptom management interventions, and/or physician notification on 09/02/24 at 4:06 p.m., when the resident was on three liters of oxygen with an oxygen saturation of 81% and again at 6:22 p.m. (almost two and a half hours later), when the resident's oxygen saturation was 89%. * Vital signs or assessment of resident condition from 09/02/24 at 6:22 p.m. until 09/03/24 at 3:20 a.m. (almost nine hours later) when the resident reported to nurse "he is dying and can't eat because it's too hard to breathe." * Physician notification of a change in resident condition when Resident #28 first reported difficulty breathing and statements of dying on 09/03/24 at 3:20 a.m. until four hours later at 7:30 a.m. when the facility first contacted the physician's clinic. The facility failed to promptly identify and intervene for an acute change in a resident's condition resulting in an actual decline in health status, delayed treatment, and a negative outcome.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, and review of facility policy, the facility failed to	F 689	F689 Free of Accident Hazards/ Supervision/Devices	12/12/24

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F 689	Continued From page 20 properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 3 sampled residents (Resident #11) observed during a gait belt transfer. Failure to utilize a gait belt during transfers placed the resident at risk for falls and/or injury. Findings include: Review of the policy titled "Use of Gait Belt" occurred on 10/30/24. This policy, dated 04/04/24, stated, ". . . It is the policy . . . to use gait belts with residents that cannot independently ambulate or transfer for the purpose of resident and staff safety. . . ." Observation on 10/28/24 at 10:44 a.m. showed a licensed nurse (#4) assisted Resident #11 to stand up from a sitting position by placing her arm under the resident's arm. The nurse failed to utilize a gait belt during the transfer. Review of Resident #11's medical record occurred on all days of survey and identified repeated falls. The care plan, dated 07/20/23, stated, ". . . Staff will assist me with transfer and locomotion . . ." 2. Based on observation, record review, review of a facility incident report, and staff interview, the facility failed to ensure the safety of 1 of 1 resident (Resident #20) who ingested non-toxic craft paint. Failure to ensure craft paint is secured in a locked cabinet placed Resident #20's safety and health at risk. Findings include:	F 689	Gait Belt Use 1. Staff failed to utilize a gait belt during a transfer of Resident #11 placing them at risk for falls and/or injury. 2. All residents who cannot independently walk or transfer on their own are potentially at risk for falls and/or injury due to this possible deficient practice. 3. DON reviewed the Policy “Use of Gait Belts” on 11/27/24 with all nursing staff to review and sign off that they reviewed the policy and procedure of use by 12/4/24. 4. Skills checks of all nursing staff will be conducted on the use of gait belts by the DON or designee. This will be done on hire and annually for all nursing staff. 5. Random QA audits on the use of gait belts by nursing staff will be conducted 3 times a week for 4 weeks, then 2 times a week for 6 months, then 4 times a month for 6 months thereafter with all QA audits being brought to the quarterly QA meetings for discussion and review by the DON. Failure to ensure liquids are secured in a locked cabinet 1. Staff failed to ensure craft paint is secured in a locked cabinet placing Resident #20’s with an altered mental status putting his safety and health at risk. Immediate action: The cabinet that was found to be unlocked on 10/29/2024 was moved by nursing staff to a storage room with a door that residents were not able to access. 2. All residents with altered mental status are potentially at risk of obtaining	

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F 689	Continued From page 21 Review of the policy titled "Supplies & Equipment" occurred on 10/30/24. This policy, dated 07/10/19, stated ". . . When not in use, supplies and equipment are stored in designated activity storage. . . ." Review of Resident #20's medical record occurred on all days of survey and included diagnoses of dementia, restlessness, agitation, and wandering. A progress note dated 08/03/24, stated, ". . . Resident was found with a battle [sic] of craft paint on his arms, mouth, and pant [sic]. The nurse was not sure of how much the resident might have consumed. resident [sic] tongue and teeth were all blue from the paint. Nurse called the on-call provider who gave an order to send resident to the ER for evaluation. . . ." Review of the facility's incident report, dated 08/03/24, stated, ". . . Storage of Paint: . . . The cabinet door does have a key to unlock it hanging beside it and staff are aware that it needs to be always locked. . . . Keeping any liquids that could potentially be drank by a resident with altered mental status out of reach and in a locked cabinet, cupboard, or room. . . ." Observation on 10/29/24 at 1:11 p.m., with an administrative nurse (#1) showed the activities supply cabinet unlocked. The administrative nurse (#1) confirmed the cabinet should be locked.	F 689	liquids that could potentially be drunk in an unlocked cabinet, cupboard, or room due to this deficient practice. 3. The supply cabinet was moved from the storage room by the nurses' station into the Activities Office where the door automatically locks when shut on 11/4/2024. 4. The Policy titled "Supplies & Equipment" will be reviewed by the QA Committee at the weekly meeting on 12/5/2024 for any updates or revisions that are needed. 5. The current and incoming Activities Coordinator was educated on 10/29/2024 about locking all cabinets, cupboards, or rooms that can be potentially drank by a resident with altered mental status out of reach. 6. All Volunteers will be educated on the Policy Supplies & Equipment with a signature being obtained that they have read and understand it prior to volunteering with the activities department. 7. A random QA audit by the Administrative Assistance will be conducted to check that the activities door is closed when not occupied by designated staff twice a week for 3 months, then once a week for 3 months, then twice a month for 3 months, then once a month for 3 months, the findings will be brought to the quarterly QA meeting with findings reported at that time.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		12/12/24

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F 725	Continued From page 22 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on confidential resident interviews, the facility failed to ensure the availability of sufficient nursing staff to respond to residents' needs for 3 of 3 confidential residents (Residents A, B, and C). Failure to provide sufficient staffing for resident needs/assistance may negatively affect the residents' physical, mental, and psychosocial well-being.	F 725	F725 Sufficient Nursing Staff 1. Immediate actions: All nursing staff educated that call lights are to be answered in a timely manner and use of their walkies to notify staff of assistance was discussed at afternoon huddle on 11/29/2024. 2. All residents have the potential to be	

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F 725	Continued From page 23 Findings include: During confidential interviews the morning of 10/30/24, Resident's A, B, and C (identified as interviewable by the resident's most recent Brief Interview for Mental Status (BIMS) score) stated the following: * Resident A - "Not enough staff at night." The resident reported a wait time of 20-30 minutes "about every night" for toileting clean up assistance "ever since I've been here [several weeks]." * Resident B - The facility is "shorthanded." "I need two people and they can't help me. So, I have to wait [until a second person is available]." "My pad will be wet. I have to sit in it. I get sore." The resident stated this occurs after he/she receives evening cares and throughout the night. * Resident C - "I wait 1-2 hours for my pain cream for my knees." The resident indicated the wait time for the pain cream occurs on all shifts The facility failed to provide sufficient staffing to meet the needs and assistance required by residents during the overnight shift.	F 725	affected by this area of concern who reside in the facility. 3. Current interviewable residents will be interviewed during the first week, and 6 residents will be interviewed weekly for 2 weeks, and then 6 residents will be interviewed monthly for compliance concerns. 4. QA audits on Call lights being answered in a timely manner will be conducted randomly on all shifts by designated staff to ensure they are answered in a timely manner. The audits will be completed on every shift twice a week until 100% in compliance with no complaints from residents surveyed. 5. A QA audit for when staff call for a Transfer/ Lift assist will be initiated and conducted randomly throughout all shifts by designated staff to ensure residents/staff are assisted in a timely manner. The audits will be completed on every shift twice a week until 100% in compliance with no complaints from residents surveyed. 6. A QA audit will be initiated on residents wait time for scheduled and prn analgesic cream on all shift by designated staff. The audits will be completed on every shift twice a week until 100% in compliance with no complaints from residents surveyed. All these QA results will be compiled by the DON with findings/solutions discussed at the quarterly QA Meeting. 7. All staff will be educated about answering resident call lights even if not a CNA, answering call lights in a timely	

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F 725	Continued From page 24	F 725	manner, using walkies and answering co-workers back right away, calling for assistance and going to help or to complete treatments in a timely manner will be discussed at the next All Staff Meeting on 12/11/24 8. Recruitment efforts continue to include: a. Advertising on Job Websites b. Advertising on our Local City Scoop (email newsletter) c. Advertising on our Facility Website d. Advertising on our Facebook page e. Utilizing multiple outside staffing agencies to fulfill staffing needs f. Interviews being conducted with any walk-in 9. The DON or designee will audit all upcoming shifts to ensure all daily facility staffing needs are met. This includes all shifts for a rolling 7 days. The DON or designee will audit all staffing daily x 5 for all shifts, weekly x4 for all shifts, and monthly x3 for all sifts to maintain ongoing staffing compliance. Results of the audits will be reviewed weekly at the QA Committee meeting until substantial compliance is met. The QA audits will then be reviewed at the quarterly QA meeting by the DON or designee.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		12/12/24

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F 732	Continued From page 25 (ii) The current date. (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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (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. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §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. §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. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 3 of 4 days of survey (October 27-29, 2024). Failure to post accurate staffing	F 732	F732 Posted Nurse Staffing Information 1. The facility failed to ensure the posting of accurate and complete staffing information on 3 of 4 days, which does not allow residents and visitors to be	

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F 732	Continued From page 26 data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Review of the facility policy titled "Daily Nurse Staffing Form" occurred on 10/30/24. This undated policy stated, ". . . requires skilled nursing facilities and nursing facilities to post daily for each shift the number of licensed and unlicensed staff directly responsible for resident care in the facility. . . ." Observations of a clipboard located by the nurse's station containing the facility daily staffing reports showed the facility failed to update the number of licensed and unlicensed staff working each shift from October 27 - 29, 2024. During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) stated she expected the charge nurse to complete and post a daily census/staffing report.	F 732	aware of the number of licensed and unlicensed staff on duty each shift. 2. All residents and visitors have the potential to be affected by the deficient practice. 3. Information on the dates not posted October 27-29, 2024, was obtained and nursing completed the forms for the facility's records accuracy on 10/30/2024. 4. Facility policy "Daily Nurse Staffing Form" was reviewed with nursing staff on the morning of 10/31/2024. (Nights, Days, PM's) 5. All nursing staff will be educated on how to fill out the Daily Nurse Staffing Form to follow State posting requirements. All staff who oversee posting will sign off that they have read the policy, been educated on how to fill the form out, with the form being placed into education/in-service file in the DON office. This will be part of all the New Nursing Staff Orientation Files. 6. A QA audit of Daily Nurse Staffing Form posting was initiated on 11/4/2024 to be monitored daily for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 3 months, then 1x every 2 weeks for 6 months by the DON with results being reported on at the quarterly QA meetings.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		12/12/24

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F 761	Continued From page 27 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure medications were properly dated, expired medications are discarded, and medications were securely stored in 2 of 3 storage areas (treatment cart and medication room). Failure to store all medications securely may result in unauthorized access to medications (treatment cart) and failure to dispose of expired medications and date an opened multi-dose vial (medication room) may result in reduced efficacy of the medications. Findings include: Review of the facility policy titled "Medication	F 761	F761 Label/ Storage of Drugs and Biologicals 1. The facility failed to ensure medications were properly dated, expired medications were discarded, and medications were securely stored in 2 of 3 storage areas (treatment cart and medication room). No residents were affected by these deficient practices at the time the survey was conducted, but the risk was evident. 2. All residents are at risk to have been affected by the deficient practices. 3. The expired acetaminophen suppositories and the undated, open multi-vial Tubersol (tuberculosis testing	

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F 761	Continued From page 28 Storage" occurred on 10/30/24. This policy, reviewed 05/15/24, stated, ". . . All drugs and biologicals will be stored in locked compartments (i.e., medications carts, cabinets, drawers . . .) . . . During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. . . ." Review of the facility policy titled "Multi-Dose Vials" occurred on 10/30/24. This policy, dated 11/10/23, stated, ". . . Multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured . . ." - Observation on 10/28/24 at 9:10 a.m. showed a staff nurse (#4) obtained medication from a treatment cart and entered a Resident's room. Observation showed the treatment cart remained unlocked and unattended for approximately 20 minutes. During this time residents and staff walked past the unlocked cart and one resident stood next to the cart without the nurse present. - Observation on 10/28/24 at 10:50 a.m. of the treatment cart contents with the nurse (#4) showed multiple topical medications and nebulizer medications. - Observation on 10/29/24 at 3:14 p.m. of the medication room with a staff nurse (#5) present showed a locked refrigerator contained: * Three acetaminophen suppositories expired 12/31/23. * An opened, undated multi-dose vial of tubersol (tuberculosis testing solution). During an interview on 10/30/24 at 7:44 a.m., an	F 761	solution) were disposed of immediately after being found to be on 10/29/2024. 4. The Policy “Multi-Dose Vials” policy and compliance guidelines were reviewed by the DON on 10/30/2024. Education on the policy and compliance will be given to all nurses by December 11, 2024. 5. A New Medication Inventory Control Log that includes the following on it: Item Name, Item Description/Location, Quantity in Stock, Expiration Date, Reorder: Y/N, Reorder Date, and Additional Notes. This was filled out with all the medications in the locked refrigerator in the Med Room on 10/29/2024 on the glass door to monitor expiration dates and when prn/stock medications need to be replaced. 6. The Med Aide and Nurses were educated on how to fill out the form and who receives medications that go into that refrigerator will be required to put the new medications information onto the list when received (insulin, suppositories, Tubersol, etc). 7. The night nurse oversees checking medications for expiration dates weekly per their task list. 8. The Pharmacy Consultant has also voiced that she is willing to aid in auditing/ monitoring expiration dates while here doing drug destruction or medication drop off. 9. All Nurses were educated and were shown that the Treatment cart does have a key that locks/unlocks it by the DON on 10/30/2024. The nurses will continue to be educated on this will all nurses being	

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F 761	Continued From page 29 administrative staff member (#1) stated she expected staff to lock the treatment cart unattended or out of sight.	F 761	shown with completion of education by December 11, 2024. 10. The Policy " Medication Storage" was reviewed by the QA Committee and all nurses will sign be required to read and sign off they have received education on the policy and compliance guidelines by December 5, 2024. 11. A medication cart QA audit to ensure that it is locked when out of the nurse's site or not in use was developed and started on 11/18/2024. These audits will be completed 4 times a week for 4 weeks, then 3 times a week for 6 weeks, then 2 times a week for 6 weeks, then 1 time a week until in compliance. All QA audits will be completed by Nursing Staff or designee with reports given to the DON for reporting during the quarterly QA Meetings.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the	F 812		12/12/24

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F 812	Continued From page 30 facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to prepare and store food in a sanitary manner in 1 of 1 kitchen and 1 of 2 resident refrigerators (main lobby). Failure to ensure proper concentration of sanitizer solution, apply an identifying label and an open date on food items brought into the facility, and ensure cleanliness in a resident refrigerator has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled "Food Storage" occurred on 10/30/24. This undated policy stated, ". . . Food will be stored in an area that is clean . . . and free from contaminates. . . . Scoops must be provided for bulk foods (such as sugar, flour, spices). Scoops are not to be stored in food . . . but are kept covered in a protected area near the containers. . . ." Review of the facility policy titled "Resource: Food Safety for Your Loved One" occurred on 10/30/24. This undated policy stated, "If you plan to bring food into the facility . . . please be sure that the food is handled safely. Food or beverages should be labeled and dated to monitor for food safety . . . Foods in unmarked or	F 812	F812 The scoop was removed from the flour bin on 10/27/2024, The staff person's food was removed from the kitchen refrigerator was removed from the kitchen on 10/27/2024. The expired sanitizer test strips were disposed of on 10/28/2024. The refrigerator in the main lobby area was cleaned on 10/31/2024. All residents have the potential to be affected should the facility fail to store food properly, label food properly, ensure that shelves are clean that food may be stored on, or to ensure that sanitizer strips are accurate and current. The facility policies for "food storage" and "food safety for your loved ones" were reviewed on 11/14/2024. All dietary staff were in-serviced on said policies on 11/26/2024. Cleaning of the main lobby refrigerator was added to the activities weekly cleaning checklist. An audit checking for scoops in bins, (flour, sugar, breadcrumbs), and refrigerator checks for both the kitchen and main lobby were developed. Audits will be conducted by the dietary manager or designee 3 times per week for the next 6 weeks, and audit checking of expired test strips 1 time a week if 100%	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 31 unlabeled containers should be marked with the current date the food item was stored . . ." - Observations on 10/27/24 during the kitchen tour showed the following: * A metal scoop in the flour bin. * An unlabeled, undated shaker containing a liquid located inside a reach-in cooler in the kitchen. A dietary staff member (#6) identified the container contained milk and oatmeal and belonged to a staff person. * An unidentified dietary staff member tested the sanitizer concentration in a bucket used to wipe down resident dining room tables. The results showed out-of-range (high). The test strips showed an expiration date of September 2024. - Observation on the morning of 10/30/24 showed dried liquid substances on two shelves inside a refrigerator located in the main lobby used to store foods brought in by family. During an interview on 10/30/24 at 10:38 a.m., the dietary manager (#8) stated she expected scoops for bulk foods be placed outside the storage bins in protective containers, all staff foods brought into the facility be labeled, dated, and stored away from resident foods, and verified the sanitizer test strips expired and may have altered the test results of the sanitizer bucket water.	F 812	compliance is achieved the audits will be conducted 3 times per month for the next year. Results of audits will be reported by the dietary manager to the QA committee on a quarterly basis.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and	F 865		12/12/24

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F 865	Continued From page 32 maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:	F 865		

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F 865	Continued From page 33 §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and	F 865		

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F 865	Continued From page 34 other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the State Agency (SA) facility files, review of the facility Quality Assurance and Performance Improvement (QAPI) program, review of facility policy, survey findings, and staff interview, the facility failed to develop a QAPI process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements. Findings include: Review of the facility policy titled "QAPI Change Process" occurred on 10/30/24. This policy, dated 10/02/24, stated, ". . . The QAA [Quality	F 865	F865 QAPI Program/Plan, Disclosure/Good Faith Attempt 1. The following identified F-tags that have QA audits that coordinate with them from prior State and Federal Surveys will continue to be completed until all deficient processes are compliant with their Guidelines. The audit reports will be brought to the weekly QA meetings to determine performance improvement priorities to start working on prior to our next quarterly QA meeting. The F-tags area are as follows: *F865 QAPI Program/Plan, Disclosure/Good Faith Attempt *F625 Notice of Bed Hold Policy	

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F 865	Continued From page 35 Assessment and Assurance] Committee utilizes a systematic approach to performance improvement, including analysis of data, corrective action, and performance tracking. . . . As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes. . . . Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. . . . Performance on the measures are discussed in QAA Committee meetings. Data is analyzed, and the process continues as appropriate. . . ." Review of the state agency files indicated the facility failed to maintain compliance at F625, F657, F684, F689, F812, and F880 as indicated by deficiencies cited during the last standard survey on 11/08/2023 and the comparative and extended Federal Monitoring Survey (FMS) on 12/04/23. Refer to F625, F657, F684, F689, F812, and F880 for specific findings. During an interview the morning of 10/30/24, administrative staff members (#1) and (#8) stated management staff monitor areas identified as needing improvement based on the previous survey results. Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following: * F625 Notice Of Bed Hold Policy Before/upon Transfer * F657 Care Plan Timing And Revision * F684 Quality Of Care	F 865	Before/upon Transfer *F657 Care Plan Timing and Revision *F684 Quality of Care *F689 Free of Accident Hazards/supervision/devices *F812 Food Procurement, store/prepare/serve-Sanitary *F880 Infection Prevention and Control 2. All residents have the potential to be affected by the concerns mentioned in the above F-tags and any new areas of concern identified during the survey process or by the QAPI committee. 3. The facility policy titled “QAPI Change Process will be reviewed on 12/5/2024 at the Weekly QA Committee meeting. 4. To ensure systemic changes are made there will be an in-service to update all staff on the Basics of the QAPI Principles and Process, QAPI and the Requirements of Participation, the QAPI Committee roles and responsibilities, and data management on December 11, 2024. This education will continue to be done when new staff are hired and annually. 5. A Weekly QA Committee Meeting has been started with all Department Heads and any other staff designated to assist with QA audits bringing information on all areas that the facility was deficient in during the survey process. Progress of QA audits, paperwork, (staff, resident, family) interviews, prior areas of concern that should continue to be monitored by the QA committee are included in the forms to start the process of compliance. 6. A new focus list will be compiled of areas that need improvement in our	

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F 865	Continued From page 36 * F689 Free Of Accident Hazards/supervision/devices * F812 Food Procurement, store/prepare/serve-Sanitary * F880 Infection Prevention and Control	F 865	facility with the focus being on quality of life, quality of clinical care and services, safety and resident autonomy and choice. The QA committee will maintain the list to when implementation will start of the next PIP. Staff, resident, and family (interviews-residents/families) input will be gotten for the list at the in-service on December 11, 2024. 7. The Weekly QA committee Audits will be compiled into a monthly audit by the DON for the Administrator and Board of Directors to review at the Facility Board Meeting that is every 3rd Wednesday of each month unless rescheduled due to holidays or special circumstances where a quorum will not be present. The date of the first meeting will be presented will be January 15, 2025. Any Recommendations will be documented in the minutes of the meeting and on a QA signature sheet will be signed by all present. DON will collect this information for the QA Committee quarterly meeting.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/12/24

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F 880	Continued From page 37 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 38 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to follow standards of infection control and prevention for 1 of 1 sampled resident (Resident #11) observed during wound cares. Failure to practice infection control standards related to enhanced barrier precautions, has the potential to spread infection throughout the facility. Findings include: Review of the facility's policy titled "Enhanced Barrier Precautions" occurred on 10/30/24. This policy, dated 09/18/24, stated, ". . . 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . . . An order for enhanced barrier precautions will be	F 880	F880 Infection Prevention & Control The facility did not meet this requirement based on failure to practice infection control standards related to enhanced barrier precautions, which has the potential to spread infection throughout the facility. The facility staff failed to obtain an order and follow EBP according to the facility's policy for Resident #11. This was immediately remedied by obtaining the order from Resident #11's provider, signage was posted, and supplies placed in resident's room. All residents who have wounds or infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. The QA Committee will review the Enhance Barrier Precautions Policy and	

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F 880	Continued From page 39 obtained for residents with . . . Wounds . . . High-contact resident care activities include . . . Wound care: any skin opening requiring a dressing . . ." - Review of Resident #11's medical record occurred on all days of survey. A physician's order dated 10/14/24, stated, "Daily dressing changes to abdominal wound and prn [as needed]." The care plan stated, ". . . I have a wound on my right abdomen. Staff applies dressing as ordered by hospice. . . ." Observation on 10/28/24 at 10:44 a.m. showed Resident #11's room lacked EBP signage. A staff nurse (#4) entered the room, applied gloves and changed ther resident's abdominal wound dressing. The nurse failed to apply a gown for the dressing change. The facility staff failed to obtain an order and follow EBP according to the facility's policy.	F 880	Compliance Guidelines at their next weekly meeting December 5, 2024. All staff will receive education on the Enhanced Barrier Precautions Policy and Compliance Guidelines at the All Staff Meeting on December 11, 2024. Enhance Barrier Precautions Compliance training form for new employees and annual training was implemented. A EBP validation checklist was implemented for auditing nursing staff who are working with residents on EBP. A QA audit will be implemented to check for compliance with the use of enhanced barrier precautions of staff at random times/shifts by the DON or designated staff. This will be conducted three times a week for 4 weeks, then twice a week for 4 weeks, then once a week for 4 weeks, with re-evaluation at the end of each of the 4 weeks for need to continue at that rate of evaluation before moving to a decreased amount. The DON will report on the findings at the quarterly QA meetings. A QA chart and room audit for nursing will be implemented in the process of obtaining enhanced barrier precautions order, placing signage, setting up station with PPE, extra trash can in room, having alcohol-based rub in room by the DON. The DON will report on the findings at the quarterly QA meetings.	