STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	C 11/30/2022

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GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 11/28/22 and concluded 11/30/22.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		1/4/23

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

Electronically Signed | 12/22/2022

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide care for 1 of 2 sampled residents (Resident #4) with an indwelling catheter in a manner and environment that maintained, enhanced, and respected the resident's dignity. Failure to cover the resident's catheter drainage bag does not preserve the resident's personal dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Catheter Care" occurred on 11/30/22. This policy, revised 11/28/22, stated, "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. . . . Privacy bags will be available and catheter drainage bags will be covered at all times while in use. . . ." Observations of Resident #4 showed the following: * 11/28/22 at 12:30 p.m., The catheter drainage bag (containing urine), hanging below the wheelchair arm rest and not covered. * 11/28/22 at 3:58 p.m., The catheter drainage	F 550	F550- 1. Corrective Action a. 11/30/22 Nurse Manager contacted both Environmental Services Manager and Central Supply worker to provide privacy bags to cover Resident #4□s catheter drainage bag. b. 11/30/22 Nurse Manager went to place privacy bag on Resident #4's catheter and CNA had already placed an appropriate cover on the bag. 2 Extra catheter covers placed in Resident #4 room. c. 11/30/22 Nurse Manager verbally educated nursing staff working on 11/30/22 on the facility□s policy titled Catheter Care which states that privacy bags will be available and catheter drainage bags will be covered at all times while in use. The Nurse Manager then verbally repeated this education during the shift change report twice daily on AM and PM shift until 12/1/22. 2. Identification of Others a. 11/30/22 A review of resident charts was completed by the Nurse Manager to identify residents who have an elimination bag of any kind.	

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F 550	Continued From page 2 bag hanging below the wheelchair arm rest and not covered. * 11/29/22 at 7:54 a.m., The catheter drainage bag hanging by wheelchair footrests and only partially covered with a pillow case. Review of Resident #4's medical record occurred on all days of survey. The care plan stated, ". . . Store collection bag [of catheter] inside a protective dignity pouch . . ." During an interview on 11/30/22 at 8:34 a.m., a nurse manager (#1) confirmed she expected urine drainage bags be covered.	F 550	b. Functional Abilities Assessments are completed for each resident upon admittance to the SNF, quarterly, and with any significant change. This assessment helps identify a resident's elimination status. Care plans will be updated with appropriate interventions to ensure privacy and dignity. 3. System Changes a. Review and sign off on policy Catheter Care by all SNF nursing staff by January 3, 2023. Review of policy will occur a minimum of once a year. 4. Monitoring - a. Nursing Manager/designee will complete a Quality Assurance (QA) audit to ensure resident dignity and privacy regarding elimination status is respected. Once a week for 6 weeks an audit will be completed ensuring drainage bag cover usage complies with the Catheter Care policy. b. If the weekly audit is not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5. Correction Date: 1/4/2023	
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- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		1/4/23

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F 658	Continued From page 3 Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to follow professional standards of practice regarding skin assessments for 3 of 5 sampled residents (Resident #3, #16, and #19) observed with skin issues. Failure to identify and treat skin concerns, document skin assessments, notify/obtain a physician's order or write an appropriate standing order may result in worsening of the skin issues and/or infections. Findings include: Review of the facility policy titled "Risk Assessment and Skin Care Policy" occurred on 11/29/22. This policy, dated November 2020, stated, ". . . Ongoing assessment of skin can be done at time of physical assessment, bathing, changing dressings, exercise routines, or other patient care activities . . . Document all wounds found during assessment . . ." - Observation on 11/28/22 at 11:48 a.m. showed a staff nurse (#2) entered Resident #3's room and identified a reddened area on Resident #3's inner crease of the right elbow. The resident complained of the area itching to the staff nurse. Review of Resident #3's medical record occurred on all days of survey. The medical record lacked a progress note or physician's order for treatment of the identified reddened skin area. During an interview on 11/29/22 at 4:50 p.m., an administrative nurse (#1) confirmed staff failed to write a progress note regarding the assessment and provide treatment to the reddened area.	F 658	F658- 1.Corrective Action a.11/30/22 Nurse Manager reviewed chart of Resident #3, noted documentation by LPN on 11/28/22, 11/29/22. Secondary review on 12/20/22 showed resolution by RN on 12/4/22. b. 11/30/22 Nurse Manager reviewed chart of Resident #16, noted documentation by LPN on 11/29/2022 regarding the condition of Resident's skin. Secondary review on 12/20/22 showed continued monitoring of skin by RN on 12/4/22. Review on 12/28/22 showed further nurse documentation and treatment with PRN anti-itch lotion on 12/5/22. Resident #16 was seen on Provider rounds on 12/7/22 and Resident's increased itching was addressed, prn anti-itch cream ordered. c. 11/30/22 Nurse Manager reviewed chart of Resident #19 showed no further skin charting documentation at that time. 12/05/22 review of documentation showed weekly skin charting on R shin completed. 12/20/22 review of documentation showed no further skin charting for the week of 12/9/22 or 12/15/22. The Nurse Manager gave informal coaching to the nurse working those shifts on 12/20/22. 12/28/22 review of documentation showed informal coaching was effective as RN documented the complete healing of ankle and shin wounds on 12/21/22.	

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F 658	Continued From page 4 - During an interview on 11/28/22 at 11:23 a.m., Resident #16 reported a "slit" on his right side "where the butt and top of my leg meet [gluteal fold]" and "It hurts. It seems to open and close when I move." Observation on 11/28/22 at 2:24 p.m., while staff performed personal cares, showed an adhesive dressing to Resident #16's mid pubic region. During an interview on 11/28/22 at 3:05 p.m., when asked if Resident #16 had any dressings in place and/or scheduled to be changed, a nurse (#2) stated "No." Observation on 11/29/22 at 5:19 p.m., showed a nurse (#8) completed a skin assessment on Resident #16. The nurse confirmed an intact dressing to the resident's mid pubic region and identified it as a protective dressing. The nurse stated she could not determine who placed the dressing or how long the dressing had been in place because the protective dressing lacked a date and initials. As the nurse (#8) removed the resident's brief, the brief adhered to the resident's buttocks, and showed small, scattered blood spots on the brief. Also present were three parallel approximate one to two inch linear open areas (slits) to the right gluteal fold and an approximate one-inch linear slit present to the resident's left gluteal fold. Review of Resident #16's medical record occurred on all days of survey. The record lacked documentation in the progress notes, the medication administration record (MAR), and/or physician's orders related to the open skin areas	F 658	2.Identification of Others a.In order to identify other residents at risk for skin breakdown a baseline Braden Scale will be completed for every resident in the SNF by 12/31/22. Braden Scales will then be completed quarterly and with condition changes. b.Resident Care Plan, EMAR, and EHR will be updated within one week of the January baseline Braden Score Assessment and will include individualized pressure ulcer prevention interventions based on the most recent Braden Score, patient preference, and multidisciplinary collaboration. c.For six weeks all residents will be assessed weekly on skin rounds, after that time they will be completed based on individual Braden Score and skin condition. Residents with Braden Scores <12 or with current skin breakdown will be monitored by the Nurse Manager/designee weekly until the condition is resolved or the Provider orders otherwise. Residents with a Braden Score of 13> will be included in the formal skin rounds every quarter and upon a change in condition. 3.System Changes a.Review and sign off on policies Skin Risk Assessment, Skin Assessment by CNA, and Braden Scale Risk Predictors	

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F 658	Continued From page 5 and the protective dressing. During interviews on 11/29/22 at 4:22 p.m. and on 11/30/22 at 8:02 a.m., an administrative nurse (#1) agreed staff failed to follow the facility's skin protocol and stated she expects the nurses to do the following: * Assess skin areas of concern when identified/reported and document a progress note and/or a wound assessment. * Notify the provider or the on-call provider the same day and/or when at the facility for rounds when a skin issue occurs and/or they apply a dressing. * Date all dressings, including protective dressings, document on the MAR for follow-up, and change the dressings every three days or if they become soiled, unless otherwise directed by a provider. - Observation on 11/28/22 at 4:02 p.m. showed the certified nursing assistant (CNA) (#5) provided cares for Resident #19 and reported the resident had a skin tear on her left shoulder, right shin and back of calf. Review of Resident #19's medical record occurred on all days of survey. Review of the progress notes identified the following: * 11/14/22 1:10 p.m., "Resident returned from acute/swing bed . . . Resident has 3 wounds noted upon readmit to facility. Wounds noted to have happened after admit date to acute care. Wound (1) 11/8/22 skin tear to left lateral elbow, wound (2) 11/11/22 skin tear to right pretibial [shin] and wound (3) 11/11/22 skin tear to right medial ankle. Allevyn dressings [dressings used for wounds] intact to areas. . . ."	F 658	For Skin Breakdown by all SNF nursing staff by January 3, 2023. Review of policies will occur a minimum of once a year. b.Braden scale to be completed upon admission, quarterly, and with condition changes. c.Care plans to be updated with interventions that decrease the risk of skin breakdown based on the residents most recent Braden Score, personal preference, and multidisciplinary collaboration. d.Weekly skin rounds by the Nurse Manager/designee will occur based on the resident□s Braden scale number and current skin condition. e.Routine skin monitoring will occur during bathtime. All residents will be monitored at least once a week, any skin breakdown will be brought to the attention of the nurse on duty who will assess the resident, document the findings and alert the provider. 4.Monitoring a.Nursing Manager/designee will complete a Quality Assurance (QA) audit to ensure staff are following professional standards of practice regarding skin assessments, documentation, provider notification, and obtaining treatment orders. For six weeks an audit will be	

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F 658	Continued From page 6 * 11/20/22 4:43 a.m., "Resident was found on bathroom floor. . . . has a skin tear on her left shoulder. . . ." * 11/22/22 4:00 a.m., ". . . Resident noted to have multiples wounds in different areas of her body. Resident has a skin tear to left shoulder and left forearm dressing intact. Resident also has skin tear to left lateral elbow, and skin tear to right medial ankle. Order in place to change these dressing every 3 days. Allevyn dressing intact at the time . . . Will monitor skin tears and update as needed." Review of physician's orders stated the following: * 11/17/22 Measure skin tear on right shin weekly and document in wound management site until healed. * 11/18/22 Protective dressing to right shin skin tear until healed. During an interview on 11/30/22 at 9:52 a.m., an administrative nurse (#1) failed to provide copies of the weekly skin assessments per request. She confirmed the medical record failed to show wound assessments for Resident #19. The facility failed to accurately and consistently document, assess, and monitor Resident #3, #16 and #19's skin issues.	F 658	performed on all residents monitoring: Braden Scores, Braden Score based interventions and action taken if they are not present or documented on,the presence of documentation for known skin breakdown and action taken if it is not present, the presence of a date on any dressings and action taken if it is not present, the presence of provider orders for known skin breakdown and action taken if it is not present, and the completion of documentation, including orders from the provider, for any new skin breakdown found during the weekly skin rounds. b.For six weeks and twice a month after, the Nursing Manager/designee will complete a weekly audit on: completion of the routine bath day skin monitoring,Nurse assessment and documentation of skin breakdown, provider notification and new orders placed, dates on dressings, and any action taken for failure to comply with Nursing Standards. c.If the weekly audits are not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5.Correction Date - 1/4/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		1/4/23

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F 684	Continued From page 7 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 3 of 5 sampled residents (Resident #1, #6, and #11) observed during meals received the care and services necessary to attain the highest degree of safety possible. Failure to ensure staff properly positioned residents and are cognizant of/respond to signs and symptoms of dysphagia during meals placed these residents at risk of aspiration. Findings include: Nancy B. Swigert's "The Source for Dysphagia; Third Edition," LinguiSystems, Inc., Illinois, 2007, page 125 and educational handouts identified, ". . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . This position must be maintained during and following the meal. Repositioning is frequently required during the meal. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . . Signs and symptoms of aspiration: Coughing . . . Throat clearing, Wet gurgling voice after swallowing . . ."	F 684	F684 1. Corrective action a. 11/30/22 Nurse Manager observed noon meal and identified four residents that were at high risk for improper positioning. At the time, Resident #1, Resident #6, and Resident #11 were properly positioned to attain the highest degree of safety possible and reduce the risk of aspiration. CNA's on duty were able to verbally state the signs and symptoms of dysphagia and actions to take if a resident should start coughing, choking, gagging, and drooling. b. 12/20/22 Nurse Manager observed morning meal, same four residents continued to be at risk for improper positioning. Resident #1, Resident #6, and Resident #11 were properly positioned to reduce aspiration risk. CNA□s on duty once again able to verbally state the signs and symptoms of dysphagia and the actions to take if a resident displayed those signs and symptoms.	

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F 684	Continued From page 8 - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included transient ischemic attack (TIA) [stroke-like attack] and cerebral infarction [stroke] without residual deficits. The quarterly Minimum Data Set (MDS), dated 09/28/22, identified extensive assistance of one person required for eating. A swallowing evaluation, dated 05/11/21, stated, ". . . Resident is to be upright for all oral intake to remain upright for 20-30 min after oral intake." Observations of Resident #1 in the dining room showed the following: * 11/28/22 at 12:03 p.m., The resident sat reclined in the wheelchair. A certified nursing assistant (CNA) (#4) provided liquid to the resident. The resident coughed after drinking liquid. * 11/28/22 at 5:02 p.m., The resident sat reclined in the wheelchair. A staff nurse (#2) administered crushed medications to the resident. The resident coughed and used her tongue to move the medications around. The nurse failed to offer fluids to the resident. * 11/29/22 from 12:13 p.m. to 12:27 p.m., The resident sat reclined in the wheelchair and the resident's head and torso leaned to the right of the wheelchair while a CNA (#5) fed the resident. The resident frequently coughed and cleared her throat throughout the meal. During an interview on 11/30/22 12:02 p.m., an administrative nurse (#1) confirmed there is no policy specific to proper positioning of residents while eating. She stated, "It is common sense to adjust (the resident)."	F 684	c. 12/28/22 New chair repositioning systems ordered. Resident #6, Resident #11, and Resident #1 will be assessed for use of the system upon its arrival. d. 12/28/22 Nurse Manager confirmed Physical Therapist/ restorative care will assess the wheelchair and positioning of Resident #1, Resident #6, and Resident #11 in January. 2. Identification of Others a. Functional Abilities Assessments are completed for each resident upon admittance to the SNF, quarterly, and with any significant change. This assessment helps identify any difficulty a resident may have with eating and positioning. Care plans will be updated with appropriate interventions if residents are at an increased risk for aspiration. 3. System Changes a. Yearly education on proper resident positioning will be provided to all nursing staff by Physical Therapy. The education will include any relevant, updated Physical Therapy policies; a hands-on demonstration on proper positioning and repositioning in a variety of chairs, wheelchairs, and beds; and who to contact if they are having difficulty properly positioning a resident. Special focus will be on proper positioning while	

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F 684	Continued From page 9 The facility failed to position Resident #1 upright and as close to 90 degrees as possible prior to serving each meal. Failure to implement these interventions placed the resident at risk for aspiration. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included history of traumatic brain injury and dementia. The resident's care plan stated ". . . Is on a pureed diet as has history of pocketing [food]. . . . Has swallowing issues and coughing while eating. . . . Eating is total assistance . . ." Resident #6's progress notes stated the following: * 10/28/22 at 3:35 p.m., "RA [restorative aid] had PT [physical therapy] look at resident in Juditta chair [reclining wheelchair] to see if she had any suggestions to help him sit up straight. Resident at the time was sitting with buttocks to the (L) [left] and sitting more on his (R) [right] side. RA straightened resident up and PT said if he is sitting properly in Juditta chair he sits pretty good. . . ." * 11/04/22 at 4:01 p.m., "resident changed to nectar thicken [sic] liquids. When drinking fluids he has been displaying for several days of having difficulty swallowing thin liquids and coughing up liquid. At risk and has HX [history] of aspiration. . . ." Observation on 11/28/22 at 12:03 p.m. showed a CNA (#5) fed Resident #6 while he leaned forward and to the right. The resident coughed periodically throughout the noon meal.	F 684	eating to reduce the risk of aspiration. b. Nursing staff to review and sign off on "Dysphagia Diets: Thickened Liquids" by Jan 4, 2023. c. Competencies on "Aspiration Precautions" and "Feeding Assistance for Oral Nutrition" added to the Calendar Year of Monthly competencies for nursing staff in January. d. Physical therapy/restorative care will complete a seating assessment upon admission, at 6 months, and yearly. 4. Monitoring a. Nursing Manager/designee will complete a Quality Assurance (QA) audit confirming staff are following consistent professional standards of practice to ensure residents are properly positioned to reduce the risk of aspiration while eating and to be cognizant and respond to signs and symptoms of dysphagia during meals. For six weeks, the Nurse Manager/designee will perform and audit once a week monitoring: if Care Plan is updated to include aspiration risk interventions and action taken if documentation is not present, Patient positioning and action taken if patient is not properly positioned to reduce aspiration risk, if the resident showed signs/symptoms of aspiration, actions taken by the CNA if aspiration occurred,	

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F 684	Continued From page 10 - Review of Resident # 11's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. The resident's care plan stated, ". . . Provide Total assistance for meals. . . ." A progress note, dated 11/04/22 at 3:58 p.m., stated, ". . . resident changed to nectar thicken [sic] liquids. When drinking fluids he has been displaying for several days of having difficulty swallowing thin liquids and making gurgling sounds. At risk for aspiration. . . ." Observation on 11/28/22 at 12:03 p.m. showed Resident #11 slouched in a reclining wheelchair with his head below the headrest and his bottom near the edge of the wheelchair seat while a CNA (#5) fed him. The CNA stated, "He keeps sliding down in his chair." The CNA continued to feed the resident his entire meal without repositioning. The resident coughed, cleared his throat, and made gurgling sounds frequently throughout the noon meal. During an interview on 11/29/22 at 9:39 a.m., a therapy staff member (#3) stated Resident #11 does not require any positioning devices, confirmed Resident #11 frequently slides down in his wheelchair, and stated, "They [nursing staff] just need to pull him back up." During an interview on 11/30/22 at 10:27 a.m., an administrative staff member (#1) stated the facility has no formal assessments completed by the therapy department for positioning while feeding and stated staff should have assured proper positioning for Residents #6 and #11 throughout their meals prior to feeding.	F 684	actions taken by the Nurse if aspiration occurred, documentation of the aspiration event, and action taken if the event is not documented. b. If the weekly audit is not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5. Correction Date - 1/4/2023	
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		1/4/23

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F 686 SS=D	Continued From page 11 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to promote the healing and prevent the worsening of pressure ulcers for 1 of 2 sampled residents (Resident #18) with pressure ulcers. Failure to consistently monitor, measure, and identify changes may lead to the worsening of Resident #18's pressure ulcers. Findings include: Review of the facility policy titled "Risk Assessment and Skin Care Policy" occurred on 11/29/22. This policy, dated November 2020, stated, ". . . Ongoing assessment of skin can be done at time of physical assessment, bathing, changing dressings, exercise routines, or other patient care activities . . . Document all wounds found during assessment . . ."	F 686	1. Corrective action a. 11/29/22 Nurse Manager assessed and documented the skin changes on Resident #18, resident was then placed on the list for the provider to see that week. 11/30/22 Provider assessed resident and started antibiotics for cellulitis. 12/20/22 Nurse Manager review of chart shows continued monitoring of skin condition including effectiveness of antibiotics and increased body itching from antibiotics. b. Developed a Pressure Ulcer Prevention Protocol policy regarding turning and positioning, and prevention of skin breakdown. Policy education will be given by 12/4/22 to all CNAs and RNs by the Nurse Manager.	

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F 686	Continued From page 12 Observation on 11/28/22 at 3:40 p.m. showed Resident #18 lying on the bed with a dressing on her left and right buttocks. Two CNAs (#5 and #6) performed incontinence cares. Both confirmed the resident had two pressure ulcers. Review of Resident #18's medical record occurred on all days of survey. The progress note, dated 11/14/22 at 3:07 p.m., stated "Resident returned to Nrsg [nursing] Facility . . . Note two new stage 2 shearing wounds to right and left buttock area (Left butt cheek site measures 2 X 2cm [centimeter] and Right butt cheek site measures 2 X 2cm also). Both shearing sites have a pink wound base with No slough [dead skin tissue]. Protective dressings applied. . . ." Resident #18's current care plan stated, ". . . Pressure Ulcer . . . Returned from Acute Care 11/14/22 with 2 areas on buttocks stage 2 . . . Protective dressing to 2 shearing wounds to right and left buttock area until healed . . . Measure right and left buttock skin tear wounds weekly and document under wound management. . . ." The care plan lacked interventions for turning and repositioning the resident every two hours. Review of Resident #18's physician's orders identified the following: * 11/17/22 "Measure right and left buttock skin tear wounds weekly and document under wound management." * 11/18/22 "Protective dressing to 2 shearing wounds to right and left buttock area until healed . . ."	F 686	C. On January 5, a Wound Care Nurse is scheduled to educate SNF nurses on skin breakdown identification and preventative actions as well as the role documentation plays in preventing and treating skin breakdown. 2.Identification of Others a. In order to identify other residents at risk for skin breakdown a baseline Braden Scale will be completed for every resident in the SNF by 12/31/22. Braden Scales will then be completed quarterly and with condition changes. b. Resident Care Plan, EMAR, and EHR will be updated within one week of the January baseline Braden Score Assessment and will include individualized pressure ulcer prevention interventions based on the most recent Braden Score, patient preference, and multidisciplinary collaboration. c. For six weeks all residents will be assessed weekly on skin rounds, after that time they will be completed based on individual Braden Score and skin condition. Residents with Braden Scores <12 or with current skin breakdown will be monitored by the Nurse Manager/designee weekly until the condition is resolved or the Provider orders otherwise. Residents with a Braden Score of 13> will be included in the formal skin rounds every quarter and	

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F 686	Continued From page 13 During an interview on 11/30/22 at 10:12 a.m., an administrative nurse (#1) verified no weekly skin assessments were documented under wound management since the initial progress note on 11/14/22. The nurse agreed the care plan lacked turning and repositioning interventions, and the record lacked documentation of any repositioning.	F 686	upon a change in condition. 3.System Changes a. Review and sign off on policies Skin Risk Assessment, Skin Assessment by CNA, and Braden Scale Risk Predictors For Skin Breakdown by all SNF nursing staff by January 3, 2023. Review of policies will occur a minimum of once a year.Pressure ulcer prevention and Skin Risk Assessment will be added to the yearly list of competencies and focused education each member of the nursing staff will be required to complete. b. Braden scale to be completed upon admission, quarterly, and with condition changes. c. Care plans to be updated with interventions that decrease the risk of skin breakdown based on the residents most recent Braden Score, personal preference, and multidisciplinary collaboration. d.Weekly skin rounds by the Nurse Manager/designee will occur based on the resident□s Braden scale number and current skin condition. e. Routine skin monitoring will occur during bathtime. All residents will be monitored at least once a week, any skin breakdown will be brought to the attention of the nurse on duty who will assess the resident, document the findings and alert	

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F 686	Continued From page 14	F 686	the provider. 4.Monitoring a. Nursing Manager/designee will complete a Quality Assurance (QA) audit to ensure staff are following professional standards of practice regarding skin assessments, documentation, provider notification, and obtaining treatment orders. For six weeks an audit will be performed on all residents monitoring: Braden Scores, Braden Score based interventions and action taken if they are not present or documented on,the presence of documentation for known skin breakdown and action taken if it is not present, the presence of a date on any dressings and action taken if it is not present, the presence of provider orders for known skin breakdown and action taken if it is not present, and the completion of documentation, including orders from the provider, for any new skin breakdown found during the weekly skin rounds. b. For six weeks and twice a month after, the Nursing Manager/designee will complete a weekly audit on: completion of the routine bath day skin monitoring, nurse assessment and documentation of skin breakdown, provider notification and new orders placed, dates on dressings, and any action taken for failure to comply with Nursing Standards. c.If the weekly audits are not 100%	

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F 686	Continued From page 15	F 686	compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5.Correction Date - 1/4/2023	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 1 of 2 sampled residents (Resident #12) observed during ambulation. Failure to use a gait belt during ambulation placed the resident at risk of an accident and/or injury. Findings include: Review of the facility policy titled "Gait Belt Usage" occurred on 11/30/22. This policy, revised September 2022, stated, "In order to ensure safe patient transfers, gait belts should be used when transferring or ambulating patients to assist in the prevention of falls . . . Gait belts must be used with all residents/patients needing assistance . . ."	F 689	F689 1. Corrective Action a. 11/30/22 Nurse Manager reviewed chart of Resident #12. Care plan stated "recent fall with no fractures, staff to assist her with ambulation using a gait belt." Discussed lack of gait belt usage with Restorative, it was found the care plan needed to be updated to indicate gait belt use was not necessary as Resident #12 was seen on 12/1/22 by Physical Therapy for her semi-annual evaluation and gait belt use was discontinued. Restorative Care quarterly progress note states "Resident ambulates independently throughout the facility with no assistive device."	1/4/23

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F 689	Continued From page 16 Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . Recent fall with no fractures . . . Staff to assist her with ambulation using gait belt . . ." Observation on 11/28/22 before lunch and dinner showed a staff member (#3) ambulated Resident #3 to the dining room without using a gait belt. During an interview on 11/30/22 at 11:24 a.m., an administrative staff member (#1) stated, "The standard for everyone that needs assistance is that the gait belt is to be used with ambulation."	F 689	b. Resident #3 as referenced on the Statement of Deficiencies and Plan of Correction does not ambulate, showing there was a possible typo. 2. Identification of Others a. 11/30/22 A review of resident charts was completed by the Nurse Manager to identify residents' ambulation plans of care. b. Functional Abilities Assessments are completed for each resident upon admittance to the SNF, quarterly, and with any significant change. This assessment helps identify how a resident ambulates. Care plans will be updated with appropriate interventions to decrease resident risk of fall. 3. System Changes a. Review and sign off on policy “Gait Belt Usage” by all SNF nursing staff by January 3, 2023. Review will occur a minimum of once a year. b. Gait belts must be used with all residents needing assistance, unless the resident is care planned not to need a gait belt when ambulating with assistance. 4. Monitoring a. To ensure the facility provides assistive devices necessary to prevent accidents, for six weeks the Nurse	

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F 689	Continued From page 17	F 689	Manager/designee will complete a weekly Quality Assurance(QA) audit monitoring gait belt compliance on all residents that require assistance and are care planned for gait belt use. b. If the weekly audit is not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5. Correction Date - 1/4/2023	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(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. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		1/4/23

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F 726	Continued From page 18 to resident's needs. §483.35(c) Proficiency of nurse aides. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete competency skills evaluations for 1 of 3 certified nurse assistants (CNAs) (Staff A). Failure to monitor the skills/techniques of the CNA may result in physical or psychological harm to the residents through improper care. Findings include: Review of the CNA (Staff A's) individual employee records identified the following: * Hire date: 05/01/15 * Competencies currently remain incomplete since hire date (seven years of employment) for modified bed bath, recording urine output, modified passive range of motion, catheter care for female resident, foot care on one foot, and perineal care for female resident. During an interview on 11/30/22 at 1:51 p.m., an administrative nurse (#1) verified Staff A's competencies are incomplete.	F 726	F726 1. Corrective Action a. 11/30/22 Nurse Manager located additional information on CNA competencies but identified they were more than a year old. 12/12/22 CNA out of State off and on throughout the month, Nurse Manager unable to schedule a competency evaluation. 12/21/22 CNA and Nurse Manager arranged competency evaluation for January 9, 2023. This will occur prior to CNA working any further shifts with residents. 2. Identification of Others a. 12/1/22 Nurse Manager reviewed available files for current SNF nursing staff. Because of the New Year, the Nurse Manager identified the need for yearly competency evaluations to be completed for all staff, regardless of how recently they had been deemed competent. 3. System Changes	

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F 726	Continued From page 19	F 726	a. A Calendar Year of Monthly competencies and focused education will be designed based on the CMS requirements. Each staff member will be required to complete their education and have their competencies evaluated by the Nurse Manager/designee or Unit Nurse by the 23rd of each month. After the 23rd of the month, the Nurse Manager/designee will evaluate each staff member's completion and make arrangements for individuals to complete or improve competencies and education. Staff will be disciplined per the “Corrective/Disciplinary Action” Human Resource policy. 4. Monitoring a. Nursing Manager/designee will complete a Quality Assurance (QA) audit monthly for one year in order to ensure the SNF has sufficient nursing staff with appropriate competencies and skill sets to care for the residents’ needs safely and effectively. Audit will include: completion of monthly competency/competencies, completion of monthly education, document action taken for failure to comply with CMS required nursing staff education and skill set competency. b. If the monthly audit is not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit.	

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F 726	Continued From page 20	F 726	5. Correction Date - 1/4/2023	
F 732 SS=D	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. (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	F 732		1/4/23

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F 732	Continued From page 21 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on facility staffing documents and staff interview, the facility failed to post complete and accurate daily staff information for 12 of 23 days (November 6, 8-13, 15, 19, 21, 23, and 26, 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. Findings include: An administrative nurse (#1) provided staffing data on 11/29/22 at 11:55 a.m. The staffing data dated November 6-28, 2022 showed staff failed to consistently post complete and accurate staffing information. During an interview on 11/30/22 at 1:51 p.m., an administrative nurse (#1) verified the facility staff failed to routinely update the staffing data.	F 732	F732 1. Corrective Action a. 11/30/22 Nurse Manager verbally educated Nurses on the importance of correctly documenting the number and type of staff working each shift, each day. The Nurse Manager gave verbal education for two changes of shift. b. 12/5/22 Nurse Manager reviewed the occurrence of documentation on the current form. Audit was not 100% so staff that did not complete the form were verbally re-educated on the importance of providing public access to nurse staffing data. 2. Identification of Others a. On 12/6/22 a new form was developed which included all CMS required Nurse Staffing Information. The new form was implemented, verbal education was provided to staff on 12/6/22, 12/7/22, and 12/8/22. b. Reviewed form effectiveness on 12/21/22, revised form to increase documentation clarity. c. Will review effectiveness of new form on 12/27/22 and revise again as necessary.	

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F 732	Continued From page 22	F 732	3. System Changes a. Daily at the beginning of each shift, one form will be filled out and posted in a prominent place readily accessible to residents and visitors. This form will include: the facility name, the current date, the Resident census, the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses/licensed vocational nurses, and certified nurse aides, Employee names will be included by their corresponding license type. b. This form will be maintained for 18 months or as long as required by State law, and will be available to the public upon oral or written request at a cost not to exceed the community standard. 4. Monitoring a. Nursing Manager/designee will complete a daily Quality Assurance (QA)audit for the month of January, then at least once a week until the audit shows 100% compliance. b. If the audits are not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit.	

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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 732	Continued From page 23	F 732	5. Correction Date - 1/4/2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		1/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	C 11/30/2022

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F 758	Continued From page 24 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 1 sampled resident (Resident #6) reviewed for as needed (PRN) lorazepam (anti-anxiety medication). Failure to limit PRN psychotropic drug orders to 14 days (or provide a rationale to extend the order beyond 14 days) may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, schizophrenia, major depressive disorder, and anxiety disorder. A physician's order, dated 10/05/22, stated, ". . . lorazepam . . . 0.5 mg [milligrams]; amt [amount]: every 6 hours PRN; oral Special Instructions: . . . Put on Doctor rounds to be renewed. As Needed	F 758	F758 1. Corrective Action a. 11/30/22 Nurse Manager reviewed chart of Resident #6 confirming the provider failed to provide a rationale for extending the PRN lorazepam order beyond 14 days. PRN lorazepam order had not been reviewed for 56 days. Nurse Manager notified the ordering provider and educated him that PRN orders for psychotropic drugs are limited to 14 days, unless the attending provider believes it is appropriate for the PRN order to be extended beyond 14 days and documents the rationale in the resident's medical record and indicates the duration for the PRN order. b. Provider reviewed the resident chart and discontinued prn lorazepam as it had not been given since 10/20/22.	

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F 758	Continued From page 25 . . ." A progress note, dated 10/05/22 at 1:58 p.m., stated, "[Provider's name] here . . . Reviewed medications . . . and renewed the Ativan [lorazepam] PRN. . . ." Review of the physician's progress notes and/or orders showed the provider failed to document a rationale to extend the order beyond 14 days. The physician had not renewed the PRN lorazepam order since 10/05/22 (56 days). During an interview the afternoon of 11/30/22, an administrative staff member (#1) confirmed the provider failed to review the PRN lorazepam every 14 days or provide a rationale to extend the order beyond 14 days.	F 758	2. Identification of Others a. 11/30/22 A review of resident charts was completed by the Nurse Manager to identify residents with PRN psychotropic medication orders. One other resident identified. Chart of that resident reviewed after re-order of PRN lorazepam on 12/7/22, found the rationale for extending the PRN medication was incomplete. Provider notified, he discontinued extended PRN lorazepam order and ordered it for 14 days. Provider will re-evaluate effectiveness in 14 days and document any rationale for extension. b. Review of psychotropic medications occurs upon admittance to the SNF, quarterly, and as new medications are ordered. 3. System Changes a. Education given at least yearly and upon hire to all providers and SNF nurses regarding proper use, documentation, and rationale for PRN psychotropic medication orders. 4. Monitoring a. For six weeks the Nurse Manager/designee will complete a weekly Quality Assurance(QA) audit to ensure all PRN psychotropic medication orders are reviewed every 14 days by the provider, or the provider has documented a rationale for extending the order beyond	

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F 758	Continued From page 26	F 758	14 days. After six weeks, the audit will be completed at least twice a month for three months. b. If the weekly audit is not 100% compliant the actions taken will be documented and the effectiveness of those actions will be reassessed within three days of the original audit. 5. Correction Date - 1/4/2023	
F9999	FINAL OBSERVATIONS The complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		