STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355081	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLETTE COMMUNITY CARE CENTER	804 STATE STREET ROLETTE, ND 58366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 08/20/23 and concluded 08/23/23.	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		9/27/23

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

Electronically Signed | 09/21/2023

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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 in a manner that maintained or enhanced dignity for 1 of 2 sampled residents (Resident #12) and 1 supplemental resident (Resident #14) observed while being fed in the dining room. Failure to feed Resident #12 and #14 in a dignified manner does not promote their dignity or enhance their quality of life. Findings include: Review of the facility policy titled "Dignity" occurred on 08/23/23. The undated policy stated, ". . . Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. . . . Demeaning practices and standards of care that compromise dignity are prohibited . . ." - Review of Resident #12's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/20/23, identified severely impaired cognition and extensive assistance required for eating. Observation on 08/22/23 at 12:10 p.m. showed Resident #12 sat at an assisted table with a	F 550	1. Corrective Action: a. The facility will ensure that napkins/wet facial wipes will be available at all times while assisting residents at meal times. 2. Identification of Others: a. All residents have the potential to be affected by this deficient practice. Napkins/wipes will be placed at every table to ensure residents and staff have access to wiping products. The wipes will be used before and after eating for hand and facial cleansing. The napkin products will be utilized during the mealtime to wipe off excess food to preserve dignity. 3. System Changes: a. DON or Designee will provide all staff education regarding Resident's Right to Dignity by September 21, 2023 4. Monitoring a. DON or Designee will audit staff assisting residents during meal time to ensure that their dignity is being honored 1) daily x 2 wks; and then	

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F 550	Continued From page 2 certified nurse aide (CNA) (#11) seated next to her. The CNA (#11) used a spoon to scrape food residue from Resident #12's lips four times during the observation. The CNA (#11) mixed the residue on the spoon with the food on Resident #12's plate and continued feeding her. - Review of Resident #14's medical record occurred on August 21-23, 2023. The quarterly MDS, dated 06/11/23, identified severely impaired cognition and dependent on staff for eating. Observation on 08/21/23 at 8:35 a.m. showed Resident #14 sat at an assisted table with a medication assistant (MA) (#12) seated next to her. The MA (#12) used a spoon to scrape food residue from Resident #14's lips eight times and from her clothing protector three times during the observation. The MA (#12) mixed the residue on the spoon with the food on Resident #14's plate and continued feeding her. During an interview on 08/23/23 at 4:30 p.m., an administrative nurse (#4) confirmed she expected staff to use a napkin to remove food residue from a resident's face/clothing protector.	F 550	2) weekly x 10 wks; and then 3) monthly x 3 mths. b. The report will be brought to the QAPI Committee for review and recommendations. 5. Correction Date: September 27, 2023	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or	F 578		9/27/23

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F 578	Continued From page 3 medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the residents' rights to request, refuse, and/or discontinue treatment for 1 of 13 sampled residents (Resident #17) reviewed for advance	F 578	1. Corrective Action: a. The resident #17 code level was corrected, signed by appropriated personnel, scanned	

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F 578	Continued From page 4 directives. Failure of staff to ensure Resident #17's family/legal representative signed documentation regarding their wishes limited the facility's ability to communicate to direct care staff and emergency personnel the family/representative's wishes in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Directives" occurred on 08/23/23. This policy, revised October 2017, stated, ". . . The facility will . . . approach the . . . legal representative if the resident is determined not to have decision making capacities. . . . During the care planning process, the facility will review with the . . . legal representative whether they desire to make any changes related to the Advanced directives. . . ." - Review of Resident #17's medical record occurred on all days of survey and showed the resident signed a "Physician Orders for Life-Sustaining Treatment" (POLST) form on 12/16/21, indicating her wish for ". . . Cardiopulmonary Resuscitation (CPR) . . . Full Treatment . . . as indicated to support life. . . ." The current face sheet (identifying information) stated, ". . . Directive . . . Do Not Resuscitate (DNR) . . ." This conflicts with the POLST form stating CPR. The record lacked evidence the facility discussed the conflicting wishes with Resident #17 and the family/legal representative.	F 578	and filed in the appropriate places. Order for DNR placed in orders. 2. Identification of Others: a. All residents have the potential to be affected by the deficient practice of the facility not following the residents wishes for life choices. 3. System Changes: a. All new residents and re-admission with significant changes will be asked their wishes for POLST and code levels and signed. These will then be faxed to the medical director for his signature. The appropriate code order will be entered in the EMR. The unsigned POLST and code level copy will be scanned into the electronic chart until the signed copy can be scanned upon return from the medical director. The chart and the resident□s room will be labeled with the appropriate marker for their code level desired. Education completed to SSD and nursing on 9/21/2023 4. Monitoring: a. Social Service Designee or her designee will do audits on all new admissions and re-admits with significant changes in status POLST/code levels: 1) a weekly basis for 12 wks; 2) then monthly for 3 mths. b. Report will be submitted to the QAPI meeting for further recommendations. 5. Correction Date: September 27, 2023	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		9/27/23

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F 623	Continued From page 5 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 6 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 7 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide a written notice of transfer that included all required content, to the resident and/or their representative for 1 of 2 closed records (Resident #23) reviewed. Failure of the facility to provide a written notice with all required content to the resident/representative limited their ability to make informed decisions. Findings include: Review of the facility policy titled, "Transfer or Discharge, Emergency," occurred on 08/23/23. This undated policy stated, "Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures . . . d. Prepare a transfer form to send with the resident; e. Notify the	F 623	1. Corrective Action: a. The Transfer for Hospitalization for resident #23 was pulled and completed properly. It was then signed, refaxed to the State Ombudsman, the resident and scanned to the EMR. 2. Identifying of Others: a. This deficient practice has the potential to affect all of the residents that are transferred from our facility to hospital for further care. 3. System Changes: a. All Notices of Transfers for Hospitalization will be read carefully to make sure that they are fill out completely and signed before	

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F 623	Continued From page 8 representative (sponsor) or other family member . . ." Review of Resident #23's medical record occurred on 08/23/23 and identified a hospital transfer on 07/12/23. A form titled, "Notice of Transfer for Hospitalization," dated 07/12/23, identified the facility notified the resident's representative verbally of the transfer. The form lacked a signature to identify the facility staff member who completed the form and the resident's name. The medical record lacked evidence the transfer notice was given to the resident/representative in writing. During an interview on 08/23/23 at 2:57 p.m., an administrative staff member (#3) confirmed the notice was incomplete and staff failed to notify the resident/representative in writing.	F 623	they are processed. If not complete, they will be returned to the nurse to be completed before processing. Education will be provided to the nursing staff about this practice. Education completed by 9/21/2023. 4. Monitoring: a. Social Service Designee or Designee will complete audits of all transfers for hospitalizations: 1) weekly atimes 12 wks; and then 2) monthly for 3 mths. b. Results will be submitted to QAPI Committee for their review and recommendations. 5. Corrective Date: September 27, 2023	
F 641 SS=D	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 record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and resident and staff interviews, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 13 sampled residents (Resident #16) and 1 supplemental resident (Resident #14). Failure to accurately complete the MDS does not allow each resident's	F 641	1. Corrective Action: a. The MDS for Resident #14 was corrected to reflect the proper coding for her eating assistance to only one assisting staff member. b. The MDS for Resident #16 was corrected to reflect the proper coding for the lack of documentation for range of	9/27/23

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F 641	Continued From page 9 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 G - The Long-Term Care Facility RAI User's Manual, revised October 2019, pages G-9 and 11 stated, ". . . Code totally dependent in eating: only if resident was assisted in eating all food items and liquids at all meals and snacks . . . and did not participate in any aspect of eating (e.g., did not pick up finger foods . . . or assist with swallow or eating procedure). . . . Code 3, two+ person physical assist: if the resident was assisted by two or more staff persons. . . ." Review of Resident #14's medical record occurred on August 21-23, 2023. The quarterly MDS, dated 06/11/23, identified severely impaired cognition and dependent on two or more staff for eating. Observation on 08/21/23 at 8:35 a.m. showed Resident #14 sat at an assisted table with a medication assistant (MA) (#12) seated next to her. The MA (#12) fed Resident #14 breakfast. Observation showed Resident #14 required meal assistance from one staff member. Section O - The Long-Term Care Facility RAI User's Manual, revised October 2019, page O-43 states, ". . . Restorative Nursing Programs . . . For the	F 641	motion exercises. 2. Identification of Others: a. All residents who participate in restorative aide will have proper documentation in POC and/or nursing progress notes. All MDS will also reflect proper coding for restorative and assistance for ADLs from documentation in POC and/or nursing progress notes. 3. System Changes: a. MDS Coordinator and SSD/RHIT will proof read all MDS prior to submitting. The policy has been updated for the same. They work closely together on other resident projects and the electronic record. Education to nursing staff as well as MDS and SSD has been completed by 9/21/2023. 4. Monitoring a. MDS Coordinator or designee will audit each MDS done: 1) weekly for 12 wks; then 2) monthly for 3 mths. b. QAPI for review and recommendations. 5. Corrective Date: September 27, 2023	

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F 641	Continued From page 10 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period . . ." Review of Resident #16's medical record occurred on all days of survey. The admission MDS, dated 08/06/23, identified the resident received seven days of active range of motion exercises. The medical record lacked evidence to show the resident received these services. During an interview on 08/20/23 at 1:42 p.m., Resident #16 stated, "I came here for therapy and to get stronger, but nobody has come to do exercises with me since I got here." During an interview on 08/22/23 at 2:35 p.m., an administrative staff member (#1) confirmed staff failed to provide exercises to Resident #16 and coded the MDS incorrectly.	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.	F 644		9/27/23

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F 644	Continued From page 11 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or 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 for 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 2 of 2 sampled residents (Resident #3 and Resident #16) with a newly diagnosed mental illness and/or change in treatment. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual, revised 12/29/20, page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Maximus 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. . . ."	F 644	1. Corrective Action: a. Resident #16 that the PASRR was indicated to be incorrect as resident had behavioral health diagnoses. Behavioral Health records were requested from his home clinic which did not verify the mental health diagnoses. When they did not confirmed a behavioral health diagnosis, and the provider who had stated the behavioral diagnoses was contacted in regards to the diagnosis and after his review, he amended his dictation to remove the diagnosis. A new PASRR Level will be completed for resident #16 due to new medication orders. b. On Resident #3, the diagnosis of Depression was not identified on the PASRR Level I that had been done prior to admission to the facility. This was completed to reflect the complete list of diagnoses for the resident. 2. Identify Other Residents: a. All resident have the potential to be affected by this deficient practice of not resubmitting PASRR Level screenings for new psychotropic medications. 3. System Changes:	

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	355081	A. BUILDING _____ B. WING _____	08/23/2023

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F 644	Continued From page 12 -Review of Resident #3's medical record occurred on all days of survey. The record showed an initial PASARR completed 05/26/23, prior to the resident's admission to the facility. The PASARR failed to identify the resident's diagnosis of chronic depressive disorder and Effexor (anti-depressant medication) as the current treatment. The record lacked evidence the facility completed a Level I screening/change in status assessment with the diagnosis of chronic depressive disorder. During an interview on 08/22/23 at 3:00 p.m., an administrative staff member (#3) confirmed the facility failed to contact Maximus to update the Level I screen with the diagnosis of chronic depressive disorder. -Review of Resident #16's medical record occurred on all days of survey. The record showed an initial PASARR completed 07/30/23, prior to the resident's admission to the facility. The PASARR identified a diagnosis of major depressive disorder with Sertraline and Wellbutrin (anti-depressant medications) as current treatments. The resident's current physician's orders identified the resident receives Buspar (anti-anxiety medication) as needed and aripiprazole (antipsychotic medication). The record lacked evidence the facility completed a Level I screening/change in status assessment with the addition of the two medications. During an interview on 08/22/23 at 3:00 p.m., an administrative staff member (#3) confirmed the	F 644	a. Social Service Designee or her designee provided education to the staff that if any behavioral health diagnosis given or new psychotropic medication is ordered on a resident to bring it to the social service designees attention. The SSD will then submit a new PASRR Level I/II screening if needed. Education was completed to nursing and SSD by 9/21/2023 4. Monitoring a. Social Service Designee or her designee will perform audits on all new and re-admitted residents for new behavioral health diagnoses or new psychotropic drugs for same: 1) weekly for the next 12 weeks; and then 2) monthly x3 mths. b. Report will be submitted to QAPI for review and recommendation. 5. Corrective Date: September 27, 2023	

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F 644	Continued From page 13 facility failed to contact Maximus to update the Level I screen with the addition of the new medications.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		9/27/23

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F 656	Continued From page 14 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 13 sampled residents (Resident #16). Failure to develop a comprehensive care plan related to psychotropic medication use may negatively impact the resident's quality of care. Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 08/23/23. This undated policy stated, ". . . Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas . . . Reflect treatment goals, timetables and objectives in measurable outcomes . . ." Review of Resident #16's medical record occurred on all days of survey. Diagnoses included major depressive disorder. Resident #16's current physician's orders identified the following psychotropic medications:	F 656	1. Corrective Action: a. The care plan for Resident #16 was updated to clearly state what psychotropic drug he is receiving and the side effects to watch for. 2. Identifying Other Residents: a. All residents have the potential to be affected by this practice of identifying diagnoses such as psychotropic medications and reviewing their comprehensive care plans as such. 3.System Changes: a. MDS Coordinator or Designee will review and complete comprehensive care plans for all admissions and re-admission for new psychotropic medications. A daily report of all psychotropic medications and a review of the care plans will be done to ensure that they are all accurate and complete. Education to MDS coordinator and nursing completed 9/21/2023.	

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F 656	Continued From page 15 *Aripiprazole (antipsychotic medication) 5 milligrams (mg) daily *Buproprion HCl (antidepressant medication) 150 mg daily *Buspirone (antianxiety medication) 10mg as needed *Doxepin (antidepressant medication) 25 mg daily *Sertraline (antidepressant medication) 100 mg daily The care plan failed to address Resident #16's psychotropic medications. During an interview on 08/23/23 at 4:30 p.m., administrative staff members (#1, #4, and #5) confirmed staff failed to care plan goals and interventions to reflect Resident #16's use of psychotropic medications.	F 656	4.Monitoring a. MDS Coordinator or Designee will complete an audit for all messages of new psychotropic medications: 1) weekly times 12 weeks; and then 2) monthly times 3 months. b. Report submitted to QAPI for review and recommendation. 5. Correction date: September 27, 2023	
F 657 SS=E	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 the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		9/27/23

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F 657	Continued From page 16 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: THIS IS A REPEAT DEFICIENCY FROM THE PREVIOUS STANDARD SURVEY CONDUCTED ON 06/09/22. Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the current status for 4 of 13 sampled residents (Resident #12, #17, #19, and #20) and 1 closed record reviewed (Resident #22). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plans - Comprehensive" occurred on 08/23/23. This undated policy stated, ". . . care plans are revised as information about the resident and the resident's condition change. . ." - Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . ADL [Activities of Daily Living]	F 657	1. Corrective Action: a. Comprehensive Care Plan was revised for Resident #12 to clarify which mechanical lift will be used for her safety. b. Comprehensive Care Plan was revised for #17 for clarification of consistency of liquids. c. Comprehensive Care Plan was revised for #19 to clarifying his visual impairment, activities for his visual impairments and his personal preferences. d. Comprehensive Care Plan was revised to clarify that resident #20 does not have any alarms. e. Comprehensive Care Plan was reviewed for #22 for clarification of comfort care orders. 2. Identify Other Residents: a. All residents have the potential to be	

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F 657	Continued From page 17 Functional Status: . . . Resident uses sit-to-stand [mechanical lift] unless Hoyer [mechanical full body] lift is appropriate for safety and 2 staff to transfer . . ." Observation on 08/20/23 at 4:55 p.m. showed two certified nurse aides (CNAs) (#9 and #13) utilized a Hoyer lift to transfer Resident #12 from the bed to the wheelchair. The care plan lacked clear direction regarding which type of mechanical lift staff are to utilize and failed to identify who makes that determination. - Review of Resident #17's medical record occurred on all days of survey. The current physician's order stated, ". . . honey thick liquids . . ." The current care plan stated, ". . . Dehydration/Fluid Maintenance: Resident is on honey thick liquids . . . Resident will be provided nectar thickened liquids throughout the day by nursing, dietary and activities. . . ." Observation on 08/21/23 at 12:15 p.m. showed Resident #17 seated in the dining room. An administrative nurse (#4) cued/encouraged Resident #17 to drink a honey-thickened supplement and glass of honey-thickened milk. The care plan lacked clear direction regarding the liquid consistency (honey-thick or nectar-thick) deemed safe for Resident #17 to consume. - Review of Resident #19's medical record	F 657	affected by this deficient practice. 3. System Changes: a. MDS Coordinator or Designee will review all resident messages for new orders; re-admissions; PT notes; to update the care plans. Education to all nursing staff was completed by 9/21/2023. 4. Monitor: a. Audits will be done on orders; PT notes; re-admissions; and updated care plans: 1) weekly for 12 weeks; and then 2) monthly for 3 months. b. The audit will be submitted to QAPI for review and recommendation. 5. Correction Date: September 27, 2023	

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occurred on all days of survey. Diagnoses included adult failure to thrive, bilateral degeneration of the retina (resulting in vision loss), and diabetic retinopathy (damage to the blood vessels at the back of the eye also resulting in vision loss).

The care plan stated, ". . . Psychosocial Well-Being: Resident lacks sense of initiative/involvement as he is a new resident . . . Provide verbal reminders of upcoming activities. Encourage self-initiated activities. . . ."

Observations throughout the survey showed Resident #19 sitting/dozing in the recliner in his room with the tv on in the background and not participating in any room or group activities.

The care plan failed to address Resident #19's visual impairment, reflect his preferences, and identify self-initiated activites.

- Review of Resident #20's medical record occurred on all days of survey. The current care plan stated, "Category: Falls . . . Chair and Bed alarm put to use to avoid falls risk . . ." A quarterly Minimum Data Set (MDS), dated 08/01/23, identified no alarms in use.

Observation on 08/20/23 at 8:39 a.m. showed Resident #20 without bed or chair alarms in place.

During an interview on 08/22/23 at 2:36 p.m., an administrative staff member (#1) confirmed Resident #20 had no bed or chair alarms in place and staff failed to revise the resident's care plan.

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F 657	Continued From page 19 - Review of Resident #22's medical record occurred on all days of survey. A physician's order, dated 07/06/23, stated, ". . . Continue fluids, nutrition and medications as able. Overall plan of care is comfort cares. . . ." Resident #22's care plan failed to address the problem, goals, or interventions for comfort care. During an interview on 08/22/23 at 2:36 p.m., an administrative staff member (#1) confirmed Resident #22's care plan failed to reflect individual needs.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		9/27/23

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F 676	Continued From page 20 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff and resident interviews, the facility failed to provide services to maintain or improve abilities in activities of daily living (ADLs) for 3 of 9 sampled residents (Resident #12, #16, and #17) with recommendations for restorative therapy (RT). Failure to provide the residents with RT may result in decreased mobility and safety. Findings include: Review of the facility policy titled "Restorative Nursing" occurred on 08/23/23. This undated policy, stated, ". . . Nursing personnel are trained . . . maintenance, restorative nursing care . . . The training may include . . . assisting with any exercises according to the plan of care. . . . Assisting residents with range of motion exercises, performing passive range of motion for residents unable to actively participate . . . Residents . . . will receive services from restorative aides when they are assessed to	F 676	1. Corrective Action: a. Resident #16's RA program was put into the care plan with documentation being done in the progress notes and/or POC. b. Resident #12's RA program was put into the care plan with documentation being done in progress notes and/or POC. c. Resident #17's RA program was put into her care plan with documentation being done in the EMR progress notes and/or POC. 2. Identifying Others: a. This deficient practice does have the potential to affect other residents who need RA services. 3. System Changes: a. All residents with recommendations for RA will be care planned for same. RA will be notified of	

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F 676	Continued From page 21 have a need for such services . . . These services may include: . . . Passive or active range of motion. . . . Restorative aides will implement the plan for a designated period of time, performing the activities, and documenting on the Restorative Aide Activity Worksheet. . . ." - During an interview on 08/20/23 at 1:42 p.m., Resident #16 stated, "I came here for therapy and to get stronger, but nobody has come to do exercises with me since I got here." Review of Resident #16's medical record occurred on all days of survey. Diagnoses included osteoarthritis of the hip/knee and spondylosis (degeneration of the vertebral column). The current care plan stated, ". . . RESTORATIVE . . . Recommend RA [restorative aide] exercise up to 6 days a week or as tolerates to be completed by RA and nursing staff. . . ." The facility failed to provide restorative therapy documentation upon request. During an interview on 08/22/23 at 2:35 p.m., an administrative nurse (#1) confirmed staff failed to provide RT services as care-planned for Resident #16. - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, osteoarthritis, rheumatoid arthritis, and femur fracture. The current care plan stated, ". . .	F 676	this recommendation so this can be carried out. Documentation will be done. DON or her designee will be following this process. Education to nursing/MDS Coordinator including PT/restorative for this will be completed by 9/21/2023. 4. Monitoring: a. MDS Coordinator or Designee will audit the care plans and documentation for 5 random RA residents: 1) weekly times 12 weeks; and then 2) monthly times 3 months. b. Reports submitted to QAPI for review and recommendation. 5. Corrective Date: September 27, 2023	

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F 676	Continued From page 22 RESTORATIVE: Maintain current status . . . Recommend RA [Restorative Aide] program up to 6 days a week or as tolerates for PROM [passive range of motion]/AAROM [active range of motion] exercise for UE [upper extremity] and LE [lower extremity] assisted by nursing or RA staff. Recommend gentle hamstring stretching bilaterally. . . . Edited: 05/09/2023 . . ." A progress note, dated 08/16/23 at 1:07 p.m., identified, ". . . Quarterly PT [Physical Therapy] Assessment . . . Recommend RA program up to 6 days a week or as tolerates for PROM/AAROM exercise for UE and LE assisted by nursing or RA staff. Recommend gentle hamstring and heel cord stretching bilaterally. Goals: 1. The resident to maintain UE and LE PROM to prevent contractures. 2. Resident to maintain UE and LE strength to participate with ADLs and transfers. . . ." The facility failed to provide restorative therapy documentation (reflecting the number of sessions Resident #12 attended and specific goals addressed) upon request. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, cerebrovascular disease with hemiplegia, back pain, and obesity. The current care plan stated, ". . . Needs to improve or maintain functional abilities RESTORATIVE PROGRAM . . . Daily gentle elbow extension stretch, hamstring and heel cord stretch to be completed by nursing and/or RA staff. Continue with RA exercise for Right UE and LE AROM/AAROM; Left UE/LE AAROM/PROM	F 676		

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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 676	Continued From page 23 and gentle left elbow extension stretching, hamstring and heel-cord stretch bilaterally as resident tolerates. . . ." The facility failed to provide restorative therapy documentation (reflecting the number of sessions Resident #17 attended and specific goals addressed) upon request. During an interview on 08/23/23 at 10:07 a.m., a physical therapy staff member (#2) indicated the facility has failed to provide ongoing RT services.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and physical, mental, and psychosocial well-being for 1 of 13 sampled residents (Resident #19) dependent on staff for activities. Failure to provide meaningful activities for residents with visual impairments limited Resident #19's ability to reach his highest	F 679	1. Corrective Action a.Resident #19 had visitations to find what he liked to do, wanted to do, wished to do. He is invited to attend all activities of the facility. Other activities will be formatted for his activity plan. This will be re-evaluated as needed. 2. Identification of Others: a. All residents have the potential to be	9/27/23

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F 679	Continued From page 24 practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "Activities" occurred on 08/23/23. This undated policy, stated, ". . . 'Activities' refer to any endeavor . . . that is intended to enhance . . . his sense of well-being and to promote or enhance physical, cognitive, and emotional health. . . . Each resident's interests and needs will be assessed on a routine basis. . . . Activities will . . . Reflect resident's interests . . . Special considerations will be made for developing meaningful activities for resident with . . . special needs. . . ." Review of Resident #19's medical record occurred on all days of survey. Diagnoses included bilateral degeneration of the retina (resulting in vision loss) and diabetic retinopathy (damage to the blood vessels at the back of the eye also resulting in vision loss). The care plan stated, ". . . Psychosocial Well-Being: Resident lacks sense of initiative/involvement as he is a new resident . . . Provide verbal reminders of upcoming activities. Encourage self-initiated activities. . . ." The activity care plan failed to reflect Resident #19's interests/preferences, accommodate his visual impairments, and/or identify self-initiated activites. Observations throughout the survey showed Resident #19 sitting/dozing in the recliner in his room with the tv on in the background and not participating in any in-room or group activities.	F 679	affected by this deficient practice. 3. System Changes: a. All residents that do not attend activities will be visited to find their likes and dislikes, wishes and invited to attend all activities of the facility. b. Education about residents who do not attend activities or do not come out of their rooms for any reason (even eating) need extra visits during the day to see how they are doing. Documentation on these visits also need to be done. This education was given to the activity staff as well as to nursing by 9/21/2023. 4. Monitoring a. Activities Director or Designee will audit the documentation on residents who do not attend activities: 1) weekly times 12 weeks; and then 2) monthly times 3 months. b. The audits will be submitted to QAPI for review and recommendations. 5. Correction Date: September 27, 2023	

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F 679	Continued From page 25 The activity log, date July 1-August 17, 2023, showed staff invited Resident #19 to participate in several group activities, which the resident refused. During an interview on 08/22/23 at 2:00 p.m., an activities staff member (#3) described Resident #19 as "blind" and "an introvert," and indicated he preferred in-room activities. She reported Resident #19 participated in five one-on-one activities and no group activities. During an interview on 08/23/23 at 4:30 p.m., two administrative nurses (#1 and #4) agreed the majority of the activities offered were inappropriate for someone with a significant visual impairments. The facility failed to develop and implement an individualized activity program consistent with the resident's interests/preferences (such as in-room activities appropriate for the visually impaired).	F 679		
F 684 SS=D	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 observation, record review, review of	F 684	1. Corrective Action:	9/27/23

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F 684	Continued From page 26 professional literature, and staff interview, the facility failed to ensure 1 of 3 sampled residents (Resident #12) received the services necessary to attain the highest degree of safety possible while being fed in the dining room. Failure to ensure staff provided proper positioning and cueing when giving foods and liquids placed Resident #12 at risk for aspiration. Findings include: The facility failed to provide a policy addressing feeding assistance and/or positioning as requested. Swigert's "The Source for Dysphagia," 4th Edition, 2019, Pro-Ed, Inc., Texas, pages 19 and 130 stated, ". . . Signs of Dysphagia . . . DROOLING/INCREASED SECRETIONS . . . WEIGHT LOSS . . . COUGHING OR CHOKING . . . POCKETING . . . for the patient seated in a chair, the 90 [degrees] angle is necessary before and during feeding. . . . Being at 90 [degrees] allows the patient to control material in the oral cavity with a minimal impact of gravity. The position must be maintained during and following the meal. Repositioning is frequently required during the meal. . . ." - Review of Resident #12's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, blindness, dementia, dysphagia, and significant weight loss. The quarterly Minimum Data Set (MDS), dated 05/20/23, identified Resident #12 received a mechanically altered diet, demonstrated a loss of liquids/solids from mouth when eating/drinking, held food in cheek/mouth after meals, coughed	F 684	a. Resident #12 had a Physical Therapy Consult regarding her positioning in her chair. Positioning pillows were suggested by PT for proper body alignment. 2. Identifying Others: a. All other residents who are wheelchair bound have the potential to be affected by this deficient practice. 3. System Changes: a. All residents in wheelchairs will be monitored for proper positioning during meal times. Education all nursing staff completed by 9/21/2023. 4. Monitoring: a. DON or Designee will audit the positioning of residents in the wheelchairs during meal times: 1) daily times 2 wks, alternating meal times; 2) weekly times 10 wks; and then 3) monthly times 3 mths. b. Audit reports will be submitted to QAPI for review and recommendations. 5. Corrective Date: September 27, 2023.	

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F 684	Continued From page 27 during meals, and experienced weight loss. The current care plan identified, ". . . Nutritional Status . . . Have patience assisting to feed [Resident #12] . . . [Resident #12] wears a clothing protector after and between meals, due to drooling. . . . Staff will monitor . . . swallowing ability. Staff will assist resident in dining room at meal times. . . . Resident sits at an assisted table due to getting confused due to eyesight. . . . Resident will be provide [sic] pureed diet as ordered. . . ." A physician's rounds note, dated 03/09/23, identified, ". . . She [Resident #12] had a bedside swallow eval [evaluation] on 01/20/23 and had extensive coughing with food intake . . . and as of late, she is on a pureed diet with honey thickened liquids, primarily getting her nutrition from liquids. . . ." A progress note, dated 08/16/23 at 1:07 p.m., identified, "Quarterly PT [Physical Therapy] Assessment . . . There is a bilateral lateral trunk support in the w/c [wheelchair] to assist with sitting position as she tends to lean to the right . . ." Observations showed the following: * 08/21/23 at 12:15 p.m., Resident #12 sat in her wheelchair next to an assisted table in the dining room, leaning towards her right side with her head over her shoulder/the arm rest. An administrative nurse (#4) fed her the noon meal. Resident #12 drooled from the right side of her mouth and coughed twice during the meal. When asked if Resident #12 was capable of sitting upright, the administrative nurse (#12)	F 684		

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F 684	Continued From page 28 repositioned her with staff assistance. * 08/22/23 at 12:10 p.m., Resident #12 sat in her wheelchair next to an assisted table in the dining room, leaning towards her right side with her head over her right shoulder/the arm rest and chin to chest. Staff had placed a stuffed animal behind Resident #12 (with one leg of the stuffed animal visible on either side of her head) in an effort to position her closer to 90 degrees. A certified nurse aide (CNA) (#11) fed her the noon meal. Resident #12 drooled from the right side of her mouth throughout the meal. On 08/22/23 at 1:30 p.m., an administrative nurse (#4) confirmed staff failed to position/reposition Resident #12 in a manner appropriate for meal intake. She agreed this position contributed to Resident #12's drooling.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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 record review, review of facility policy,	F 686	1. Corrective Action:	9/27/23

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F 686	Continued From page 29 and staff interview, the facility failed to provide the necessary treatment/services to promote the healing of pressure ulcers for 1 of 1 sampled resident (Resident #16) identified with a pressure ulcer. Failure to routinely assess, monitor, and measure pressure ulcers may result in delayed interventions to aid in the healing of the pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcers/Skin Breakdown - Clinical Protocol" occurred on 08/23/23. This policy, revised April 2018, stated, ". . . the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; . . . staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. . ." Review of Resident #16's medical record occurred on all days of survey. Diagnoses included a non-pressure chronic ulcer of the right heel and type 2 diabetes mellitus. A physician's order, dated 07/31/23, stated, "Weekly Skin Assessment Once A Day on Sat [Saturday] . . ." The medical record showed the following skin assessment documentation: *07/31/23 "Assessment completed . . . Open areas existing on left buttock with overall area of 3 cm [centimeter] long x [by] 4.5 cm wide - stage 2 ulcer. Mepilex [dressing] applied for protection. The heel of the right foot has an ulcer. . . Overall wound encompasses a 7 cm long x 9 cm wide	F 686	a. Wound nurse has provided detailed documentation for Resident #16 including staging, measurements and healing process. 2. Identification of Others: a. All residents that need assistance in bed mobility or wheelchair bound can be affected by this deficient practice. residents. 3. System Change: a. Skin assessments will be moved from Saturday tasks to week days. b. Skin assessment policy will be updated to reflect that only the wound nurse will provide detailed measurements. Education was completed by 9/21/2023 to nursing staff. 4. Monitoring: a. Wound Nurse or Designee will audit all skin assessments and wound documentation: 1) weekly times 12 wks; and then 2) monthly times 3 mths. b. Reports submitted to QAPI for review and recommendations. 5. Corrective Action: September 27, 2023	

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F 686	Continued From page 30 area. . ." *08/05/23 "Skin assessment: Right heel wound: eschar [dry scab] with surrounding skin peeling. Left buttock has scattered stage 2 ulcers and right buttock has one area of stage 2 ulceration. Wound beds on buttocks are moist and pink. . . Mepilex placed over buttock wounds . . ." The medical record lacked evidence staff measured the ulcers on 08/05/23 and completed the skin assessments 08/12/23 and 08/19/23 as ordered. During an interview on 08/23/23 at 12:44 p.m., an administrative staff member (#1) confirmed facility staff failed to thoroughly assess and monitor Resident #16's pressure ulcers.	F 686		
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 the facility's policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 2 sampled residents (Resident #19) observed during stand-lift transfers. Failure to ensure proper use of a mechanical sit-to-stand lift placed Resident #19 and other residents at risk for	F 689	1. Corrective Action: a. Resident #19 has had a physical therapy consultation done for safety for transfers with recommendation of full hoyer lift if resident is too weak to participate in use of the	9/27/23

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F 689	Continued From page 31 possible accidents with/without injury. Findings include: Review of the facility policy titled "Safe Lifting and Movement of Residents" occurred on 08/23/23. This undated policy, stated, ". . . Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include the following: . . . Resident's mobility (degree of dependency) . . . Weight-bearing ability. . . ." - Review of Resident #19's medical record occurred on all days of survey. Diagnoses included adult failure to thrive, bilateral degeneration of the retina (resulting in vision loss) and diabetic retinopathy (damage to the blood vessels at the back of the eye also resulting in vision loss). The current care plan stated, ". . . Recommend the resident to transfer using the mechanical sit to stand lift with assist of 2. . . ." Observation on 08/20/23 at 3:50 p.m., 08/21/23 at 3:01 p.m., and the afternoon of 08/22/23, showed multiple certified nurse aides (CNAs) (#9, #11, #14, #15, and #16) transferred Resident #19 on/off the toilet utilizing a mechanical sit-to-stand lift. Resident #19 failed to bear weight and remained in a semi-seated position while they provided pericares and throughout the transfers to/from the bathroom. The harness straps pulled upward into Resident #19's armpits, raising his shoulders to ear level. The CNAs	F 689	mechanical sit to stand. 2. Identification of Others: a. This deficient practice has the potential to affect all other residents who need assistance with transfers. 3. System Changes: a. Reporting to charge nurse and physical therapy for any change in mobility and weakness of residents so assessment can be made for determentating of proper mechanical lift. Education completed to nursing by 9/21/2023. Demonstration done by Physical Therapy on 9/13/2023. 4. Monitoring: a. DON or Designee with audit the use of mechanical sit to stand/hoyer lifts to assure residents ability to participate with the proper mechanical lift: 1) daily times 2 wk; 2) weekly times 10 wks; and then 3) monthly times 3 mths. b. Submit reports to QAPI for review and recommendation. 5. Corrective Date: September 27, 2023	

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F 689	Continued From page 32 failed to ensure Resident #19 could bear weight while in the stand lift. During an interview on 08/23/23 at 10:07 a.m., a physical therapy staff member (#2) confirmed staff should ensure residents are able to bear weight when utilizing a mechanical sit-to-stand lift.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 1 of 1 sampled resident (Resident #16) receiving hemodialysis outside the facility. Failure to ensure physician's orders for hemodialysis and to assess/monitor hemodialysis vascular access site (arterial-venous fistula) on a regular basis can result in missed dialysis appointments and complications related to the fistula. Findings include: Review of the facility policy titled, "Dialysis Arrangement" occurred on 08/21/23. This undated policy, stated, ". . . Development and implementation of the resident's care plan: 1. The care plan for all residents receiving dialysis will	F 698	1. Corrective Action: a. Resident #16 has had his dialysis order placed in his EMR to assess the dialysis site twice a day and dialysis added to his care plan. 2. Identifies Others: a. All residents who are on dialysis have the potential to be affected by this deficient practice. 3. System Changes: a. Any resident on dialysis will receive care for proper management for end stage renal disease and dialysis. Education was completed to nursing by 9/21/2023. 4. Monitoring: a. DON or Designee will audit the	9/27/23

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F 698	Continued From page 33 be developed and implement4ed [sic] and updated by the interdisciplinary team at the [facility name] . . . the plan of care will include how to handle emergencies and medical complications, medication and adverse effects if indicated, shunt/fistula care, infection control and holistic care of a resident with ESRD. . ." Review of Resident #16's medical record occurred all days of survey. Diagnoses included end stage renal disease and dependence on renal dialysis. The admission Minimum Data Set (MDS), dated 08/06/23, indicated Resident #16 received dialysis services. Resident #16's medical record lacked physician's orders for dialysis. The care plan failed to address dialysis services and interventions associated with dialysis, such as monitoring the fistula/catheter site. During an interview on 08/23/23 at 4:30 p.m., three administrative staff members (#1, #4 and #5) agreed the facility failed to obtain a physician's order, develop a care plan, and monitor the fistula for Resident #16.	F 698	documentation of the dialysis site: 1) weekly times 12 wks; and then 2) monthly times 3 mth. b. Submit reports to QAPI for review and recommendations. 5. Corrective Date: September 27, 2023	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		9/27/23

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F 757	Continued From page 34 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) 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 ensure a regimen free of unnecessary medications for 1 of 2 sampled residents (Resident #12) with a history of urinary tract infections (UTIs). Failure obtain a culture and sensitivity (lab test to identify the bacteria and antibiotics susceptible to the bacteria) before starting an antibiotic may result in treatment for a non-existent UTI, administration of a wrong antibiotic, and the risk of experiencing side effects related to the antibiotic. Findings include: Review of the facility policy titled "Antibiotic Stewardship - Orders for Antibiotics" occurred on 08/23/23. This undated policy, stated, ". . . Prior to calling a physician . . . the nurse will . . . have the following information available . . . Clinical signs and symptoms of suspected infection . . . A history of the present illness . . . Appropriate indications for use of antibiotics include . . .	F 757	1. Corrective Action: a. We will be communicating with the Medical Director on urine dipsticks and urinalysis to ensure proper usage of antibiotics. 2. Identify Others: a. All residents who need follow up documentation have the potential to be affected by this deficient practice. 3. System Changes: a. Standard Treatment eMAR entry will be made for all follow-ups for antibiotics. Education to RN/LPN completed by 9/21/2023. 4. Monitoring: a. DON or Designee will audit all antibiotic therapies and follow-up documentation: 1) weekly times 12 wks; and then 2) monthly times 3 mths. b. Report submitted to QAPI for review and recommendation. 5. Corrective Date:	

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	355081	A. BUILDING _____ B. WING _____	08/23/2023

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F 757	Continued From page 35 criteria met for clinical definition of active infection . . . pathogen susceptibility, based on culture and sensitivity, to antimicrobial . . ." Review of the facility policy titled "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes" occurred on 08/23/23. This undated policy stated, ". . . all clinical infections treated with antibiotics will undergo review by the infection preventionist [IP] . . . Therapy may require further review and possible changes if . . . the organism is not susceptible to antibiotic chosen . . . therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. . . ." Review of Resident #12's medical record occurred on all days of survey. Diagnoses included neuromuscular dysfunction of the bladder and bowel/bladder incontinence. On 12/22/22, staff performed a routine urinalysis (UA) due to Resident #12 ' s increased behaviors. The UA identified positive leukocytes and nitrates (abnormal values). The record lacked evidence of a follow up urine culture and sensitivity; however, the physician ordered the antibiotic Ciprofloxacin to treat the potential UTI on 12/23/22. A physician's progress note, dated 01/17/23, identified, ". . . Clarify if treated for UTI in 12/22 and repeat UA if not treated and continued behavior changes. . . . Completed Rx [prescription] [Ciprofloxacin] for UTI few weeks ago. . . ."	F 757	September 27, 2023	

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F 757	Continued From page 36 During the interview on 08/22/23 at 11:25 a.m., the administrative nurse (#1) confirmed the physician did not order a culture in December and agreed, because the test had not been done, it is unclear whether the prescribed antibiotic was appropriate to treat Resident #12's infection. The nurse (#1) also acknowledged it is unclear whether Resident #12 actually had a UTI as the progress notes failed to reflect any increased behaviors and/or symptoms of a UTI.	F 757		
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 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 and staff interview, the facility failed to store and serve food in a safe and sanitary manner in 1 of 1 kitchen. Failure to	F 812	1.Corrective Action: a. The Environmental Services Director contacted Johnsons Plumbing from	9/27/23

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F 812	Continued From page 37 store and serve food in a safe and sanitary manner may result in contaminated food, poor food quality, and potential spread of illness amoung residents, staff, and visitors. Findings include: Observation on 08/21/23 at 3:26 p.m. showed a pool of pale-yellow liquid on the floor and leaking from the ceiling in the walk-in cooler. The liquid leaked onto a cart which contained drinks and pudding for the next meal service and onto and under a bag of thawing hamburger. Observation on 08/21/23 at 12:23 p.m. showed a dietary staff member (#7) touched their hair, face, itched their arms and neck, and drank from a personal soda bottle and failed to sanitize their hands before touching resident plates and serving resident meals. During an interview on 08/21/23 at 3:36 p.m., a dietary manager (#6) stated she was aware of the leak and instructed staff not to store anything by liquid was leaking. During an interview on 8/21/23 at 3:45 p.m., an environmental service director (#8) identified the liquid as ethylene glycol [coolant used to prevent freezing and overheating]. During an interview on 08/22/23 at 5:49 p.m., a dietary manager (#6) stated, "I expect staff to use proper hand hygiene practices prior to serving food". The facility failed to keep a clean, safe, and sanitary environment where food is stored and	F 812	Rugby after the Surveyor□s visit, they arrived at the facility the next day. Johnsons Plumbing came in and fixed the leak in the cooler. The cooler is now leak free. b.The Dietary Manager provided all staff with Proper Hand Washing instructions the next day. 2.Identification of Others: a.All residents have the potential to be affected by this deficient practice. 3.System Changes: a.The Dietary Manager or Designee will provide all staff with education regarding Hand Hygiene. Education was completed by 9/21/2023. 4.Monitoring: a.The Dietary Manager will audit leaks in all dietary areas: 1) Daily x 2 weeks; then 2) Weekly x 10 weeks; and then 3)Monthly x 3months. b. Report submitted to QAPI for review and recommendation. c. The Dietary Manager will audit Proper Hand Hygiene during mealtimes: 1) Daily x 2 weeks; then 2) Weekly x 10 weeks; and then 3) Monthly x 3 months. d.Report submitted to QAPI for review and recommendation. 5. Corrective Date: September 27, 2023	

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F 812	Continued From page 38 served.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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;	F 880		9/27/23

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F 880	Continued From page 39 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 3 of 13 sampled residents (Resident #1, #13, and #19) observed during personal cares. Failure to	F 880	1. Corrective Action: a. Nursing will wash their hands before and after cares. Assuring that hand hygiene is done on residents after toileting and	

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F 880	Continued From page 40 follow infection control practices related to hand hygiene/glove use has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Policies and Practices - Infection Control" occurred on 08/23/23. This undated policy stated, ". . . infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment to help prevent and manage transmission of diseases and infection. . ." Review of the facility policy titled "Handwashing/Hygiene" occurred on 08/23/23. This undated policy stated, ". . . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." - Observation on 08/21/23 at 11:31 a.m. showed two certified nurse aides (CNAs) (#9 and #10) performed perineal care for Resident #1 after an incontinent bowel movement. After perineal care, the CNAs (#9 and #10) removed their gloves, and without performing hand hygiene, dressed the resident before transferring him into his wheelchair. Without performing hand hygiene, CNA (#9) then combed Resident 1's hair, performed oral cares, and shaved him. - Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, ". . . Resident engages is [sic] sexual self stimulation at times needing privacy. . ."	F 880	before and after meals. Education was completed on 8/24/2023 to 8/31/2023. b. Education on hand hygiene before and after glove usage was completed 9/21/2023 to nursing staff. 2. Identification of Others: a. All residents have the potential to be affected by this deficient practice. 3. System Changes: a. Wipes have been placed on the tables in the resident's dining room for staff to assist the resident's use before and after meals. Education completed by 9/21/2023. 4. Monitoring: a. DON or Designee will audit handwashing of 5 staff and/or residents (alternating times): 1) daily times 2wks; 2) weekly times 10 wks; and then 3) monthly times 3 mths. b. Report submitted to QAPI for review and recommendation. 5. Corrective Action: September 27, 2023	

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F 880	Continued From page 41 Observation on 08/20/23 at 4:29 p.m. showed a CNA (#9) assisted Resident #13 with toileting. The CNA (#6) failed to offer/provide Resident #13 hand hygiene after toileting and prior to assisting her to the lounge area. - Observations of Resident #19 showed the following: * 08/21/23 at 3:01 p.m., Two CNAs (#11 and #14) assisted the resident onto the toilet utilizing a mechanical sit-to-stand lift. One of the CNAs (#11) gloved, cleansed Resident #19's buttocks, adjusted his clothing, removed her gloves, and sanitized her hands. * On the afternoon of 08/22/23, Two CNAs (#15 and #16) raised Resident #19 in the mechanical sit-to-stand lift. One of the CNAs (#15) gloved, cleansed Resident #19's buttocks, adjusted his clothing and removed her gloves. The CNA (#15) failed to perform hand hygiene prior to transferring the resident into his recliner, setting up his meal tray, and handing him a glass of water. The CNA (#15) then took the garbage and exited the room without sanitizing her hands. During an interview on 08/23/23 at 4:30 p.m., administrative staff members (#1, #3, #4 and #5) indicated they expect facility staff to follow proper hand hygiene practices during and after perineal cares.	F 880		