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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys from 12/5/22 through 12/8/22. Also reviewed in the course of the survey were complaint intake(s) WY000003481, WY000003500, and WY000003507.<br><br>The following common abbreviations are used throughout the document:<br><br>ADL - Activities for Daily Living<br>BIMS - Brief Interview for Mental Status<br>CNA - Certified Nurse Aide<br>DON - Director of Nursing<br>ED- Executive Director<br>HA - Hospitality Aide<br>MAR - Medication Administration Record<br>MDS - Minimun Data Set<br>mg - milligrams<br>PPE - Personal Protective Equipment | F 000 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to | F 585 | | 1/6/23 |

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

Electronically Signed | 01/04/2023

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resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those

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grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:

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| F 585 | Continued From page 3<br>Based on medical record review, resident and staff interview, review of facility grievances, and policy and procedure review, the facility failed to ensure grievances were resolved for 1 of 2 sample residents (#56) reviewed for grievances. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 11/1/22 showed resident #56 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Further review showed the resident had diagnoses which included unspecified head injury and torticollis. Review of the activity care plan last revised on 11/3/22 showed the resident had little or no activity involvement due to disinterest, physical limitations, and desire to not participate. Interventions included "...prefers the following radio stations: Country and Western...preferred activities are:...music." The following concerns were identified:<br>a. Interview with the resident on 12/6/22 at 1:40 PM revealed the resident recently went to the hospital and upon his/her return, s/he identified some compact discs which had been broken. Further interview revealed the resident reported the broken compact discs to facility staff.<br>b. Review of the progress notes showed the resident went to the hospital on 11/14/22 and returned to the facility on 11/16/22. Further review showed no documentation related to the damaged compact discs.<br>c. Review of a grievance form dated 11/21/22 showed the resident reported 2 broken compact discs, and a missing black headset and headlamp. Further review showed the headset was found and the compact discs were placed in a holder; however, there was no evidence the facility followed up on the missing headlamp or | F 585 | Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual.<br><br>F585 Corrective Action<br>Resident #56 missing items were found, but resident passed away prior to being able to replace the broken items.<br>Identification of Others<br>Initial audit completed by AIT/ Designee of grievances over the last ninety days to ensure no others were affected by deficient practice.<br>Systemic Changes<br>Education provided by the AIT to current staff related to the grievance policy.<br>Ongoing audits completed by the AIT/Designee two times per week for three months to assess grievances for timely and appropriate follow up.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations.<br>01/06/23 | |

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| F 585 | Continued From page 4<br>addressed the broken compact discs.<br>d. Interview with the social services director on 12/8/22 at 9:10 AM revealed the headlamp and headset went missing and the compact discs were damaged while the resident was at the hospital. Prior to hospitalizations, the social services director received reports the resident was damaging his/her own compact discs; however, there was no documentation of the events. Further interview revealed the facility was still attempting to determine if the resident had a headlamp and stated the inventory was not usually updated if belongings were brought in after admission. The social services director confirmed the resident's belongings were moved to a different room while the resident was in the hospital and the missing and damaged items were identified upon his/her return to the facility.<br>e. Interview with the ED on 12/8/22 at 9:37 AM confirmed the facility did not follow up on the damaged compact discs or headlamp.<br><br>2. Review of the policy titled "Grievance Procedure Policy" last revised September 2017 showed "...7. When immediate resolution is not possible, the grievance is routed to the Grievance Official and/or Social Services/designee within 24 hours. The individual receiving the grievance fills out a Grievance form...9. Social Services or designee routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within two business days, and returns the Grievance Form to Social Services or designee. 10. The person with the grievance has the right to a written decision regard his/her grievance..." | F 585 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3) | F 656 | | 1/6/23 |

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| F 656 | Continued From page 5<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care | F 656 | | |

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| F 656 | Continued From page 6<br>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure a comprehensive care plan was developed for 3 of 15 sample residents (#15, #28, #49). The findings were:<br><br>1. Review of the quarterly MDS assessment dated 9/7/22 showed resident #15 had a BIMS score of 4 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. Further review showed the resident had a depression score of 0 and no behaviors were exhibited. Review of the physician's orders showed the resident received trazodone (antidepressant) 100 mg by mouth one time per day related to insomnia and duloxetine (antidepressant) 20 mg by mouth twice per day for anxiety. The following concerns were identified:<br>a. Review of the MAR for December 2022 showed the resident had 2 orders for target symptoms monitoring; however, there was no indication which symptoms were being monitored for which psychotropic medication.<br>b. Review of the antidepressant care plan last revised on 3/23/22 showed the resident used antidepressant medication (trazodone, duloxetine) related to anxiety and insomnia. Interventions included administer medications per | F 656 | F656 Corrective Action<br>Residents #15, #28, and #49 care plans have been addressed and updated to meet the standard of practice related to appropriate monitoring of target symptoms as related to specific psychotropic medications for Residents #15 and #49 and the wound care plan has been updated for Resident# 28.<br>Identification of Others<br>Initial audit completed by DNS/Designee to review care plans to confirm appropriate development of comprehensive care plans and assess for others who may have been affected and ones that are affected are corrected.<br>Systemic Changes<br>Education provided to IDT by DNS/Designee related to timely and accurate development of care plans.<br>Ongoing audits will be completed by DNS/Designee weekly times three months to assess for the timely and accurate development of care plans.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.<br>01/06/23 | |

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physician orders and monitor the resident for side effects and effectiveness. Further review showed no evidence the facility included target symptoms identified for each medication or non-pharmacological interventions.

2. Review of the 11/10/22 significant change MDS assessment showed resident #28 was readmitted to the facility on 11/4/22 with diagnoses which included dysphasia, hemiplegia and hemiparesis following a cerebral infarction, and human immunodeficiency virus disease. The resident required the extensive assistance of 2 staff members for bed mobility and transfers. In addition, the resident was admitted to the facility with four stage 2 pressure ulcers. Review of the care area assessment showed the resident triggered for pressure ulcers and the triggered care area would be care planned. Review of a skin/wound note dated 11/24/22 showed "pressure wound is unstageable at this time due to slough and cap covering slough. Wound measuring 4.4 x 4.3 cm. Purulent drainage observed; odor observed..." Review of a 12/7/22 progress note showed "...Air mattress in place. Lower extremities floated/supported on pillows...Resident requires complete assist for all of [his/her] care, repositioning, transfer and mobility needs..." The following concerns were identified:

a. Review of the care plan, last revised on 6/4/19, showed the resident had a potential for pressure ulcer development with interventions which included: following the "facility policies/protocols for the prevention/treatment of skin breakdown" and weekly treatment documentation. Further review, showed the care plan did not include person-centered interventions related to the resident's pressure

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| F 656 | Continued From page 8 | F 656 | | |

ulcers.

b. Interview with the DON on 12/8/22 at 10:35 AM revealed the resident was admitted from the hospital with four stage 2 pressure ulcers. Three of the pressure ulcers had resolved; however, the pressure ulcer on the right heel had deteriorated to unstageable. Further, the DON confirmed a pressure ulcer care plan had not been developed.

3. Review of the quarterly MDS assessment, dated 9/7/22, showed resident #49 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact. Further review showed the resident had diagnoses which included dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbances. Review of the physician orders showed the resident was prescribed 75 mg of Seroquel (antipsychotic) daily and 25 mg daily of Zoloft (antidepressant) The following concerns were identified:

a. Review of the MAR for December 2022 showed the resident had 2 orders for target symptom monitoring; however, there was no indication which symptoms were being monitored for which psychotropic medication.

b. Review of the antidepressant care plan last revised on 10/20/22 showed a generic list of antidepressant and antipsychotic side effects and areas of concern to monitor daily. No differentiation was made between the two medications; no target symptoms/side effects or individualized interventions per each medication were identified to respond to the resident's needs.

4. Interview with the DON on 12/8/22 at 2:58 PM revealed she was told the drug name could not be on the behavior monitoring. In addition the DON confirmed that the monitoring and target

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| F 656 | Continued From page 9<br>symptoms should be identified for each of the medications on the care plan. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to revise the care plan to reflect the resident's needs after a comprehensive assessment for 1 of 15 (#34) | F 657 | F657 Corrective Action<br>Resident #34 care plan has been revised to reflect resident's needs.<br>Identification of Others | 1/15/23 |

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| F 657 | Continued From page 10<br>sample residents reviewed. The findings were:<br><br>1. Review of the 10/21/22 significant change MDS assessment showed resident #34 had a BIMS score of 3 out of 15 (cognitively impaired) and required the extensive assistance of one staff member for eating. Review of a 10/16/22 nurse's note showed the resident had returned from the hospital with a diagnosis of "inoperable left hip fracture". The following concerns were identified:<br>a. Observation on 12/5/22 at 6:08 PM showed the resident was in bed and CNA #1 was assisting him/her with the evening meal. Interview with CNA #1 at that time revealed the resident required the assistance of staff with eating.<br>b. Interview on 12/8/22 at 8:57 AM with CNA #2 revealed staff had assisted the resident with eating either in his/her room or at the table since the resident broke his/her hip.<br>c. Review of the resident's ADL care plan, last revised on 3/18/21, showed the resident was able to eat independently with supervision.<br>d. Interview with the ED on 12/8/22 at 9:01 AM confirmed the care plan had not been updated. | F 657 | Initial audit completed by DNS/ Designee to review and assess care plans of other residents for appropriate care plan revisions to meet resident's needs.<br>Systemic Changes<br>Education provided to current staff related to timely care plan revisions. Ongoing audits completed by<br>E.D./Designee two times per week times three months to assess for appropriate and timely care plan revisions.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure baths or showers were provided routinely for 3 of 4 sample residents (#7, | F 677 | F677 Corrective Action<br>Residents #7, #42, and #56 are receiving their showers as requested.<br>Identification of Others | 1/15/23 |

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| F 677 | Continued From page 11<br>#42, #56) who required assistance with bathing. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 11/18/22 showed resident #7 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included seizure disorder or epilepsy, depression, arthritis, unsteadiness on feet, and other lack of coordination. Further review showed the resident required total physical assistance of 1 person for bathing. Review of the ADL care plan last revised on 10/28/22 showed "...BATHING/SHOWERING: The resident requires limited-extensive assist by 1 staff with showering or bathing 2-3X [two to three times] weekly and as necessary..." The following concerns were identified:<br>a. Interview with the resident on 12/8/22 at 11:35 AM revealed s/he had received a shower on that day and it was the first time since before Thanksgiving. Further interview revealed s/he felt it was unacceptable to not receive showers routinely.<br>b. Review of the bathing record from 9/1/22 through 12/8/22 showed the resident went more than 4 days between showers/baths 9 times during the period, which included 9 days between 10/11/22 and 10/20/22, 14 days between 10/24/22 and 11/8/22, and 23 days between 11/15/22 and 12/8/22. Further review showed no evidence the resident refused showers/baths during the period.<br><br>2. Review of the quarterly MDS assessment dated 10/15/22 showed resident #42 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included diabetes mellitus and depression. Further review showed the resident required | F 677 | Initial audit completed to confirm and update resident preferences regarding the number of showers they preferred each week. This list will be compared to the last thirty days of showers given to assess for others who may be affected.<br>Systemic Changes<br>Education provided to current staff r elated to resident shower preference<br>Ongoing audits will be completed twice weekly times three months by DNS/0esignee to assess for compliance.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations. | |

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| F 677 | Continued From page 12 | F 677 | | |

supervision/oversight of 1 person for bathing. Review of the ADL care plan last revised on 7/27/22 showed "...BATHING/SHOWERING: The resident requires limited-extensive assist by 1 staff with showering or bathing 2-3X [two to three times] weekly and as necessary..." The following concerns were identified:

a. Review of the bathing record from 9/1/22 through 12/7/22 showed the resident went more than 4 days between showers/baths 8 times during the period, which included 13 days between 9/14/22 and 9/27/22, 13 days between 9/27/22 and 10/10/22, and 10 days between 11/11/22 and 11/21/22. Further review showed there was no documented shower/bath after 11/29/22 and no evidence the resident refused showers/baths during the period.

b. Interview with the resident on 12/6/22 at 4 PM revealed the resident felt there was not enough staff to provide assistance with care.

3. Review of the quarterly MDS assessment dated 11/1/22 showed resident #56 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact, and diagnoses which included right knee hemoarthrosis, unspecified head injury, arthritis, unsteadiness on feet, and other abnormalities of gait and mobility. Further review showed the resident required total physical assistance of 1 person for bathing. Review of the ADL care plan last revised on 10/18/22 showed "...BATHING/SHOWERING: The resident requires limited-extensive assist by 1 staff with showering or bathing 2x [two times] weekly and as necessary..." The following concerns were identified:

a. Review of the bathing record from 9/1/22 through 12/7/22 showed the resident went more than 4 days between showers/baths 6 times

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| F 677 | Continued From page 13<br>during the period, which included 9 days between 10/9/22 and 10/18/22, 16 days between 11/5/22 and 11/21/22, and 9 days between 11/27/22 and 12/5/22. Further review showed there was no documented shower/bath after 11/29/22 and no evidence the resident refused showers/baths during the period.<br>b. Interview with the resident on 12/6/22 at 1:41 PM revealed the resident felt the facility needed more staff to assist with his/her daily care.<br><br>4. Interview with the DON on 12/8/22 at 8:38 AM revealed showers should be provided to the residents as indicated on their care plans, staff on the floor were assigned 4 to 5 showers each day, and staffing difficulties had resulted in showers not being performed.<br><br>5. Review of the policy titled "Bath or Shower Assistance" last updated November 2016 showed " ...14. Document assistance refused on the resident's Service Notes (refer to the Refusal of Service section in this manual). 15. Report to the Community Director, Wellness Director, and/or designated staff changes noticed in the resident's bathing-related needs and/or preferences. Make appropriate documentation in the resident's Service Notes ...." | F 677 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range | F 688 | | 1/15/23 |

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| F 688 | Continued From page 14<br>of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, and resident representative and staff interview, the facility failed to ensure residents received services to maintain range of motion for 2 of 2 residents (#19, #37) reviewed for range of motion. The findings were:<br><br>1. Review of the 10/5/22 annual MDS assessment showed resident #19 had a BIMS score of 8 out of 15 (moderate cognitive impairment) and was admitted with diagnoses which included left artificial knee joint, generalized muscle weakness, pain in the right shoulder, joint disorder of the right knee, lack of physical exercise, osteoarthritis in the right hand, and dementia. Review of the care plan, revised on 3/17/22, showed the resident was to receive restorative nursing rehabilitation, which included stationary pedaling for the arms and legs, free weights, and tension band exercises. The following concerns were identified:<br>a. Review of the care conference notes dated 12/5/22 and timed 10:36 AM, showed the resident participated in restorative therapy exercises; however, review of the medical record failed to | F 688 | F688 Corrective Action<br>Residents #19, and #37 are receiving services to maintain range of motion.<br>Identification of Others<br>Initial audit completed by E.D. / Designee to assess residents who are at risk for a decrease in range of motion and have appropriate interventions in place.<br>Systemic Changes<br>Education provided by E.D. / Designee to current staff related to prevention of decreases in range of motion. Ongoing audits will be completed by E.D./Designee weekly times three months to assess those at risk for a decrease in range of motion have appropriate interventions in place.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations. | |

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show documentation of restorative therapy sessions.

b. Interview with the director of rehabilitation on 12/7/22 at 12:07 PM revealed the resident had not been receiving restorative therapy, or physical therapy. He further stated that the resident had a history of refusing therapy; however, the refusals were not documented.

2. Review of the 11/7/22 annual MDS assessment showed resident #37 required extensive physical assistance of 1 staff for bed mobility, transfers, toilet use, dressing, personal hygiene, and bathing. Further review showed the resident had diagnoses which included arthritis, spinal stenosis of the lumbar region with neurogenic claudication, and dementia. The resident had limited range of motion of the upper and lower extremities. Review of resident's care plan, last revised 3/10/22, showed the resident had impaired mobility related to decreased range of motion, decreased bed mobility, decreased transfer skills, and decreased ambulation skills. The care plan goal stated the resident would maintain present muscle strength and endurance, wheelchair positioning, strengthening, activities, self-feeding, and group activities with the use of the restorative program. The intervention was to use the nursing rehabilitation/restorative: active range of motion program. The following concerns were identified:

a. Interview with the resident's representative on 12/6/22 at 9:41 AM revealed the resident had not received restorative services for several months and she thought perhaps it was because of the lack of staff.

b. Review of the 11/7/22 annual MDS assessment showed the resident had not received passive or active restorative services

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| F 688 | Continued From page 16<br>during the 7-day look-back period.<br><br>3. Interview with the ED on 12/7/22 at 10:11 AM revealed residents were not receiving restorative services. She stated the restorative aide was a CNA who resigned 2 or 3 months ago and the facility did not have staff for the restorative program. | F 688 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure water did not reach hazardous temperatures for residents on 3 of 3 units (front unit, back unit, secure unit). The findings were:<br><br>1. Observation on 12/8/22 at 10:29 AM with the maintenance director showed the hot water temperature at the handwashing sink in room 10 was 130 degrees Fahrenheit. The maintenance director verified the temperature at that time.<br><br>2. Observation on 12/8/22 at 10:34 AM with the maintenance director showed the hot water temperature at the handwashing sink in room 20 was 124.5 degrees Fahrenheit. The maintenance director verified the temperature at that time. | F 689 | F689 Corrective Action<br>Water temperatures within access o' residents are being regulated at a safe temperature.<br>Identification of Others Maintenance Director has contacted plumbers to change the mixing valve and is waiting on a scheduled repair date.<br>Systemic Changes<br>Maintenance Director is checking mixing valve multiple times daily to regulate the water at a safe temperature. He is also verifying the safe water temperatures in resident access areas at least twice daily with no temperature spikes observed.<br>Monitoring for Compliance Temperature adjustments, temperature audits, and | 1/15/23 |

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| F 689 | Continued From page 17<br><br>3. Observation on 12/8/22 at 10:38 AM with the maintenance director showed the hot water temperature at the handwashing sink in room 35 was 136 degrees Fahrenheit. The maintenance director verified the temperature at that time.<br><br>4. Observation on 12/8/22 at 10:40 AM with the maintenance director showed the hot water temperature at the handwashing sink in room 42 was 132.8 degrees Fahrenheit. The maintenance director verified the temperature at that time.<br><br>5. Observation on 12/8/22 at 10:43 AM with the maintenance director showed the hot water temperature at the handwashing sink in room 30 was 133.5 degrees Fahrenheit. The maintenance director verified the temperature at that time.<br><br>6. Interview with the maintenance director on 12/8/22 between 10:29 AM and 10:43 AM revealed he did not verify water temperatures at the hand washing sinks because he had to maintain the boiler at more than 140 degrees Fahrenheit. | F 689 | mixing valve repair status will be monitored via the QAPI process monthly times at least three months for further recommendations. | |
| F 725 SS=F | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in | F 725 | | 1/6/23 |

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| F 725 | Continued From page 18<br>accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident, resident representative and staff interview, medical record review, and staffing log review, the facility failed to ensure adequate staff to meet the needs of the residents. The census was 59. The findings were:<br><br>1. Review of the staffing logs from 12/1/22 to 12/8/22 showed the facility required 1 nurse or medication aide per unit on each shift, which would result in 4 nurses and/or medication aides for each day. Further review showed the facility required 8 CNAS (3 CNAs on the front unit, 3 CNAs on the back unit, and 2 CNAs on the secure unit) from 6 AM to 2 PM (day shift), 6 CNAs (2 CNAs on the back unit, 2 CNAs on the front unit, and 2 CNAs on the secure unit) from 2 PM to 10 PM (evening shift), and 3 CNAs (1 CNA on the back unit, 1 CNA on the front unit, and 1 CNA on the secure unit) from 10 PM to 6 AM (night shift), and 1 restorative aide daily. Interview | F 725 | F725 Corrective Action<br>Adequate staffing is provided per Center's Facility Assessment. As stated during survey, the Center has seven new CNAs who were HAs during survey. Also, other new hires since survey include one agency nurse, one agency CNA, two additional CNAs, one restorative CNA, and one shower CNA.<br>Identification of Others<br>Initial audits completed by DNS/ Designee include restorative needs, shower preferences, and dining assist needs to estimate minimal staffing needs.<br>Systemic Changes<br>Education provided to current staff by DNS/Designee related to Facility Assessment staffing requirements. The facility assessment identifies the minimum staffing requirements to meet resident | |

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| F 725 | Continued From page 19<br>with the ED on 12/7/22 at 10:30 AM confirmed staffing identified on the staffing logs was the required staffing to ensure resident care was performed. The following concerns were identified:<br>a. Review of the staffing log for 12/1/22 showed the facility did not have 2 of the 2 required nurses for the day shift which resulted in the DON and ED performing the nurse duties. Further review showed the facility only had 4 out of 8 required CNAs for the day shift and 3 out 6 of required CNAs for the evening shift.<br>b. Review of the staffing log for 12/2/22 showed the facility did not have 1 of 2 required day shift nurses which resulted in the ED and DON splitting the day shift nursing duties. Further review showed the facility only had 5 of the 8 required CNAs for day shift and 4 of 6 required CNAs for evening shift.<br>c. Review of the staffing log for 12/3/22 showed the facility only had 3 of the 8 required CNAs for the day shift and 4 of 6 required CNAs for the evening shift.<br>d. Review of the staffing log for 12/4/22 showed the facility only had 3 of the 8 required CNAs for the day shift and 4 of 6 required CNAs for the evening shift.<br>e. Review of the staffing log for 12/5/22 showed the facility did not have 1 of 2 required day shift nurses which resulted in the ED and DON splitting the day shift nursing duties. Further review showed the facility only had 3 of the 8 required CNAs for the day shift and 4 of 6 required CNAs for the evening shift.<br>f. Review of the staffing log for 12/6/22 showed the facility did not have 2 of the 2 required nurses for the day shift which resulted in the DON and ED performing the nurse duties. Further review showed the facility only had 3 out | F 725 | needs_ Facility continues with recruiting for nurses. If there is a call-in, staff are called in and offered a bonus as needed.<br>Shower preferences have been obtained and showers will be monitored weekly then compared to the preference list.<br>Ongoing audits will be completed by DNS/Designee weekly times three months to assess for staffing patterns as related to meeting resident needs.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations.<br>01/06/23 | |

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of 8 required CNAs for the day shift and 3 out 6 of required CNAs for the evening shift.

g. Review of the staffing log for 12/7/22 showed the facility did not have 1 of the 2 required nurses for the day shift which resulted in the DON performing the nurse duties. Further review showed the facility only had 3 out of 8 required CNAs for the day shift and 4 out 6 of required CNAs for the evening shift.

h. Review of the staffing log for 12/8/22 showed the facility only had 3 of the 8 required CNAs for the day shift and 4 of 6 required CNAs for the evening shift.

i. Review of the staffing logs from 12/1/22 through 12/8/22 showed there was no evidence a restorative aide was scheduled or utilized during the time period.

2. Interview with the ED on 12/7/22 at 10:33 AM revealed the ED, DON, and infection control nurse had to cover the open nurse shifts. The facility had 3 full time nurse vacancies and an open position for a MDS nurse, which resulted in the ED, DON, and infection prevention nurse not having enough time to fulfill all their duties. Further interview revealed the ED completed reports and evaluations from home; however, the facility had 6 HAs who had completed the CNA training and were scheduled to test on 12/10/22.

3. Observation on 12/5/22 at 5:20 PM showed 8 residents were in the secure unit common room and resident #34 was in his/her room waiting for the evening meal. The secure unit was staffed with CNA #1. The CNA served the 8 residents in the common room and set aside the meal for resident #34. Interview with the CNA at that time revealed resident #34 required assistance to eat; however, she could not leave the other residents

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to assist him/her. The CNA stated the facility was short of staff and were doing "their best during a bad situation."

4. Observation on 12/5/22 from 6:01 PM to 6:10 PM of the secure unit showed CNA #1 left 5 residents unsupervised in the common area and assisted resident #34 with his/her meal. During this time one resident was observed wandering and exploring objects at the nurse's desk and resident #37 was crying and calling for help.

5. Review of the care plan, revised on 3/17/22, showed resident #19 was to receive restorative nursing rehabilitation, which included stationary pedaling for the arms and legs, free weights, and tension band exercises. Review of the care conference notes dated 12/5/22 and timed 10:36 AM, showed the resident participated in restorative therapy exercises. The following concerns were identified:

a. Review of the medical record showed no evidence restorative therapy was performed for the resident.

6. Review of the care plan for resident #37, last revised 3/10/22, showed the resident had impaired mobility related to decreased range of motion, decreased bed mobility, decreased transfer skills, and decreased ambulation skills. The care plan goal stated the resident would maintain present muscle strength and endurance, wheelchair positioning, strengthening, activities, self-feeding, and group activities with the use of the restorative program. The intervention was to use the nursing rehabilitation/restorative: active range of motion program. The following concerns were identified:

a. Interview with the resident's representative

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on 12/6/22 at 9:41 AM revealed the resident had not received restorative services for several months and she thought perhaps it was because of the lack of staff.

7. Interview with the ED on 12/7/22 at 10:11 AM revealed residents did not receive restorative services as the facility did not have a restorative aide at that time. Further interview revealed the restorative aide was a CNA who resigned 2 or 3 months ago and the facility did not have staff for the restorative program.

8. Review of the quarterly MDS assessment dated 11/18/22 showed resident #7 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included seizure disorder or epilepsy, depression, arthritis, unsteadiness on feet, and other lack of coordination. Further review showed the resident required total physical assistance of 1 person for bathing. Review of the ADL care plan last revised on 10/28/22 showed "...BATHING/SHOWERING: The resident requires limited-extensive assistance by 1 staff with showering or bathing 2-3X [two to three times] weekly and as necessary...". The following concerns were identified:

a. Interview with the resident on 12/8/22 at 11:35 AM revealed s/he had received a shower on that day and it was the first time since before Thanksgiving. Further interview revealed s/he felt it was unacceptable to not receive showers routinely.

b. Review of the bathing record from 9/1/22 through 12/8/22 showed the resident went more than 4 days between showers/baths 9 times during the period, which included 9 days between 10/11/22 and 10/20/22, 14 days between

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10/24/22 and 11/8/22, and 23 days between 11/15/22 and 12/8/22. Further review showed there was no evidence the resident refused showers/baths during the period.

9. Review of the quarterly MDS assessment dated 10/15/22 showed resident #42 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included diabetes mellitus and depression. Further review showed the resident required supervision/oversight of 1 person for bathing. Review of the ADL care plan last revised on 7/27/22 showed"...BATHING/SHOWERING: The resident requires limited-extensive assist by 1 staff with showering or bathing 2-3X [two to three times] weekly and as necessary..." The following concerns were identified:

a. Review of the bathing record from 9/1/22 through 12/7/22 showed the resident went more than 4 days between showers/baths 8 times during the period, which included 13 days between 9/14/22 and 9/27/22, 13 days between 9/27/22 and 10/10/22, and 10 days between 11/11/22 and 11/21/22. Further review showed there was no document shower/bath after 11/29/22 and there was no evidence the resident refused showers/baths during the period.

b. Interview with the resident on 12/6/22 at 4 PM revealed the resident felt there was not enough staff to provide assistance with care.

10. Review of the quarterly MDS assessment dated 11/1/22 showed resident #56 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact, and diagnoses which included right knee hemoarthrosis, unspecified head injury, arthritis, unsteadiness on feet, and

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| F 725 | Continued From page 24<br>other abnormalities of gait and mobility. Further review showed the resident required total physical assistance of 1 person for bathing. Review of the ADL care plan last revised on 10/18/22 showed "...BATHING/SHOWERING: The resident requires limited-extensive assist by 1 staff with showering or bathing 2x [two times] weekly and as necessary..." The following concerns were identified:<br>a. Review of the bathing record from 9/1/22 through 12/7/22 showed the resident went more than 4 days between showers/baths 6 times during the period, which included 9 days between 10/9/22 and 10/18/22, 16 days between 11/5/22 and 11/21/22, and 9 days between 11/27/22 and 12/5/22. Further review showed there was no documented shower/bath after 11/29/22, and there was no evidence the resident refused showers/baths during the period.<br>b. Interview with the resident on 12/6/22 at 1:41 PM revealed the resident felt the facility needed more staff to assist with his/her daily care.<br><br>11. Interview with the DON on 12/8/22 at 8:38 AM revealed showers should be provided to the residents as indicated on their care plans, staff on the floor were assigned 4 to 5 showers each day, and staffing difficulties have resulted in showers not being performed. | F 725 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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 | F 758 | | 1/6/23 |

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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 §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

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| F 758 | Continued From page 26<br>renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, medical record and policy and procedure review, the facility failed to ensure PRN (as needed) orders for anti-psychotic medications were limited to 14 days for 1 of 5 sample residents (#34). In addition the facility failed to ensure the physician provided a rationale for contraindication to a dose reduction for 1 of 5 sample residents (#43) reviewed for psychotropic medications. The findings were:<br><br>1. Review of the physician orders for resident #34 showed s/he was prescribed 25 mg of Seroquel (antipsychotic) every 12 hours as needed for agitation with a start date of 3/25/22. The following concerns were identified:<br>a. Review of the "Consultant Pharmacist Recommendation to Physician", dated 4/29/22, showed the pharmacist recommended the discontinuation of the PRN Seroquel on or before 5/9/22 and noted the resident had used 2 doses during the month of April. The physician responded on 6/17/22 to "Renew order for PRN antipsychotic Seroquel prescribed for agitation for 14 days, as the benefit outweighs the risk." There was no evidence the physician evaluated the resident prior to renewing the PRN order.<br>b. Review of the "Consultant Pharmacist Recommendation to Physician", dated 7/25/22 showed the pharmacist recommended the discontinuation of the PRN Seroquel and noted the resident had used 12 doses in the last 90 days. The physician responded on 8/10/22 to "Renew order for PRN antipsychotic Seroquel prescribed for agitation for 14 days, as the benefit | F 758 | F758 Correction Action<br>Resident #34 PRN Seroquel has been discontinued. Resident #43 Physician has addressed the contraindication to a dose reduction.<br>Identification of Others<br>Initial audit completed by DNS/ Designee to assess for other residents on psychotropic medications who may be at risk for deficient practice. Residents affected are corrected.<br>Systemic Changes<br>Education provided by DNS/Designee to current staff related to the GDR process as well as the PRN psych med regulation.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations<br>01/06/23 | |

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outweighs the risk." There was no evidence the physician evaluated the resident prior to renewing the PRN order.

c. Review of the "Consultant Pharmacist Recommendation to Physician", dated 8/26/22 showed the pharmacist recommended the discontinuation of the PRN Seroquel and noted the resident had not used any of the medication in the last 30 days and the previous order had expired on 8/20/22. The physician responded on 9/14/22 to "Renew order for PRN antipsychotic Seroquel prescribed for agitation for 14 days, as the benefit outweighs the risk." There was no evidence the physician evaluated the resident prior to renewing the PRN order.

d. Review of the "Consultant Pharmacist Recommendation to Physician", dated 10/19/22 showed the pharmacist recommended the discontinuation of the PRN Seroquel, noted the resident had last used a dose on 9/6/22, and the previous order had expired on 9/28/22. The physician responded on 11/14/22 to "Renew order for PRN antipsychotic Seroquel prescribed for agitation for 14 days, as the benefit outweighs the risk." There was no evidence the physician evaluated the resident prior to renewing the PRN order.

e. Review of the April through December 2022 MARs showed an order for 25 mg of Seroquel to be giving by mouth every 12 hours as needed for agitation with a start date of 3/25/22 and no end date.

f. Review of the 12/1/22 "Psychotropic Drug and Behavior Monthly & PRN" report showed under "Current Medication" #6. Seroquel Tablet 25 mg by mouth every 12 hours as needed had a start date of 3/25/22 and the last change date was 3/25/22. Further review under "PRN Psychotropic or Antipsychotic medication" the

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resident was marked no for being prescribed a PRN medication.

g. Interview with the DON on 12/8/22 at 2:58 PM confirmed the start date on the MAR for resident #34 was inaccurate. Further, the DON confirmed the physician had not evaluated the resident prior to renewing the PRN Seroquel.

2. Review of the physician orders for resident #43 showed s/he was prescribed 25 mg of Sertraline HCl (antidepressant) by mouth one time a day for depression. The following concerns were identified:

a. Review of the "Consultant Pharmacist Recommendation to Physician", dated 4/29/22, showed "This resident has been using Sertraline 25 mg since March 2021. If this therapy is required to prevent future depressive episodes, please document to that effect in your progress notes." The physician responded on 5/25/22 with "Continue THIS antidepressant therapy; dose reduction contraindicated." There was no evidence the physician had provided a clinical rationale for the continuation of the antidepressant medication.

b. Interview with the ED on 12/7/22 at 10:31 AM confirmed the physician had not provided a clinical rationale for the continuation of the antidepressant for resident #43.

3. Review of the "Psychotropic Drugs" policy, last updated 10/2022, showed "7. Gradual Dose Reduction (GDR) Guidelines...e. A resident need not undergo a gradual dose reduction if: i. The resident has a "specific condition" and has a history of recurrence of psychotic symptoms (delusions, hallucination, etc.) which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant

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| F 758 | Continued From page 29<br>side effects. ii. The resident's physician provides a justification why the continued use of the drug and dose are clinically appropriate. This justification should include: Diagnosis, but not simply a diagnostic label or code, but the description of symptoms. A discussion of differential psychiatric and medical diagnosis (e.g. why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition of a psychosocial or environmental stressor). A description of the justification for the choice of a particular treatment, or treatments. A discussion of why the present dose is necessary to manage the resident's symptoms. This information does not necessarily need to be in the physician's progress notes but is a part of the resident's medical record...12. PRN Psychotropic Drugs are limited to 14 days EXCEPT if the prescribing physician or practitioner believes that it is appropriate for the PRN orders to be extended beyond 14 days. a. The practitioner documents their rationale in the medical record. 13. PRN Antipsychotic drugs are limited to 14 days and CANNOT be renewed unless the prescribing physician/practitioner evaluates the resident for appropriateness of that medication. A. The evaluation is not simply a replacement order but an onsite evaluation of the resident's condition to determine continued use." | F 758 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources | F 812 | | 1/6/23 |

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| F 812 | Continued From page 30<br>approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure food was properly stored in 1 of 1 kitchen. The findings were:<br><br>1. Observation on 12/5/22 at 2:27 PM of the walk-in refrigerator showed one opened carton of thickened cranberry juice with a received date of 11/16/22; four open cartons of lemon-flavored thickened water with received dates of 9/14/22, 10/26/22, and 11/23/22; and one open carton of thickened apple juice with a received date of 11/23/22. None of the cartons were marked with an open or use-by date. Review of the Sysco Imperial Thickened liquid cartons showed "After opening can be kept for 7 days."<br><br>2. Observation on 12/5/22 at 2:27 PM of the walk-in refrigerator showed two cases containing 75 four fluid ounce cartons of Sysco Imperial strawberry-flavored and vanilla-flavored shakes. In addition to the boxes of shakes multiple loose cartons of the shakes were stored in plastic tubs. | F 812 | F812 Corrective Action<br>Cartons of fluids not appropriately dated for consumption have been discarded.<br>Indentification of Others<br>Initial audit completed by E.D/ Designee of refrigerators in the center to assess for other areas of non-compliance. Items found to be non-compliant are discarded.<br>Systemic Changes<br>Education provided to current staff on the container dating process for fluids to be consumed. Ongoing audits of refrigerators will be completed by ED/ Designee weekly times three months to assess for compliance.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least times three months for further recommendations.<br>01/06/23 | |

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| F 812 | Continued From page 31<br>None of the cartons were marked with a date they were removed from the freezer and made available for resident consumption. Review of the Sysco Imperial shakes cartons showed "Store frozen. Thaw under refrigeration. After thawing keep refrigerated and use within 14 days after thawing."<br><br>3. Interview with cook #1 on 12/7/22 at 9:05 AM confirmed the thickened liquids and nutritional shakes should be marked with an open date and use-by date. | F 812 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; | F 880 | | 1/15/23 |

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| F 880 | Continued From page 32<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F 880 | | |

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| F 880 | Continued From page 33<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility reportable incidents, staff interview, review of the facility's COVID surveillance documentation, Centers for Disease Control (CDC) guidelines and policy and procedure review, the facility failed to ensure infectious disease outbreaks were reported as required, and failed to ensure infection control practices were implemented for 5 random observations. The census was 59. The findings were:<br><br>Regarding reporting of the infectious disease outbreaks:<br><br>1. Review of the "COVID-19 OUTBREAK STRATEGY ACTION PLAN" dated 11/10/22, provided by the facility at the time of entrance, showed one staff member tested positive for COVID-19 on 11/10/22 and a second staff member was sent home on 11/13/22. Review of the resident testing records showed 14 residents tested positive on 11/28/22; 2 residents tested positive on 11/30/22; and 5 residents tested positive on 12/2/22.<br><br>2. Review of the facility reportable incidents from 10/1/22 through 12/1/22 showed no evidence the facility had reported the infectious disease outbreak to the state survey agency or state epidemiology unit.<br><br>3. Interview with the ED on 12/8/22 at 3:21 PM revealed she was unaware of the requirement.<br><br>Regarding the implementation of infection control | F 880 | F880 The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of 483.80 for the affected unit identified in the deficiency. In addition, the facility will implement an infectious disease outbreak identification and reporting procedure, including but not limited to, all single cases and/o additional cases of Covid-19 among residents and staff.<br>The infection preventionist (IP) and director of nursing (DON), in conjunction with the medical director, shall complete the following:<br>1) Identify and implement hand hygiene procedures, for staff and resident, consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br>2) Identify and implement use of personal protective equipment (PPE) procedures consistent with current nursing facility guidelines from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS).<br>3) The facility will implement an infectious disease outbreak identification and reporting procedure including but not limited to, all single cases and/or additional cases of Covid-19 among residents and staff.<br>4) Infectious disease outbreaks are | |

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| **WIND RIVER REHABILITATION AND WELLNESS** | **1002 FOREST DRIVE RIVERTON, WY 82501** |

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| F 880 | Continued From page 34<br>practices:<br><br>1. Observation of the secure unit on 12/5/22 at 5:09 PM showed 8 residents and CNA #1 were in the common area. The evening meal arrived at 5:12 PM and the CNA proceeded to serve the residents; however, no hand hygiene was provided to the residents prior to the meal service.<br><br>2. Observation of the secure unit on 12/8/22 at 11:26 AM showed 9 residents and CNA #3 were in the common area. The noon meal arrived at 12:23 PM and the CNA proceeded to serve the residents; however, no hand hygiene was provided to the residents prior to the meal service. Interview with the CNA at 12:37 PM revealed it was her usual practice to use a cleansing wipe on the resident's hands prior to the meal service and confirmed she had not completed the task.<br><br>3. Interview with the ED and infection preventionist on 12/8/22 at 3:21 PM revealed it was the facility's expectation hand hygiene be performed before meals.<br><br>4. Observation on 12/6/22 at 9:29 AM showed HA #1 exited a room on transmission based precautions and doffed personal protective equipment. Prior to doffing her dirty face mask, the HA donned a clean face mask over top of the dirty face mask and allowed it to rest on top of the dirty mask. At that time, the inside of the clean face mask was in contact with the external portion of the dirty face mask. The HA then repositioned her hand and placed the face mask around her neck and removed the dirty face mask. After the dirty mask was removed, the HA | F 880 | reported as required. CNA #1, CNA #3, HA #1, AIT, are using appropriate infection control practices.<br>Identification of Others<br>The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current Covid-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance.<br>Systemic Changes<br>On or before 1/6/2023, the facility shall complete the following actions:<br>1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to:<br>a) Failure to ensure hand hygiene was performed by residents after toileting and before meals.<br>b) Failure to ensure PPE was appropriately donned and doffed after resident care.<br>c) Failure to identify and report infectious disease outbreaks.<br>2) The DON and IP will ensure education is provided for the following:<br>a) All staff are educated on proper hand hygiene procedure in accordance with the current CDC and CMS guidelines.<br>b) All staff are educated on the proper use of PPE in accordance with the current CDC and CMS guidelines.<br>c) All Staff are educated on identification and reporting of identification and reporting of infectious disease outbreaks. | |

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| F 880 | Continued From page 35<br>placed the contaminated area of the clean face mask over her mouth and nose.<br><br>5. Observation on 12/6/22 at 9:35 AM showed HA #1 exited a room on transmission based precautions and doffed personal protective equipment. Prior to doffing her dirty face mask, the HA donned a clean face mask over top of the dirty face mask and allowed it to rest on top of the dirty mask. At that time, the inside of the clean face mask was in contact with the external portion of the dirty face mask. The HA then repositioned her hand and placed the face mask around her neck and removed the dirty face mask. After the dirty mask was removed, the HA placed the contaminated area of the clean face mask over her mouth and nose.<br><br>6. Interview with the DON on 12/8/22 at 3:18 PM revealed a clean mask should not be placed on top of a dirty mask and then placed over the staff member's mouth as the clean mask would be contaminated.<br><br>7. Observation on 12/5/22 at 5 PM showed the ED exited room 31 which was designated an isolation room for droplet precautions. The ED doffed her gown, and gloves and kept her N95 mask on. Further observation showed she wore glasses and no face shield. Continued observation showed the ED left her N95 mask on and walked through the dining room to her office and back out. Interview with the ED at that time confirmed the resident room she came out of was an isolation room for COVID-19 and the resident was on droplet precautions. She further confirmed she did not change her mask and should have prior to walking down the hall. | F 880 | 3) The facility leadership will contact the Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection and prevention and control within the facility.<br>4) Initial audit completed by AIT 'Designee to assess for up to date infectious disease reporting. Initial M,alking audits completed by DNS/Designee related to appropriate infection control practices to assess for others who may be affected by the deficient practice.<br>Monitoring for Compliance Monitoring of approaches to ensure he infection control and prevention are effective will include:<br>1. Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for:<br>a) Compliance of staff assisting residents with hand hygiene after toileting and before meals.<br>b) Compliance of staff with appropriate PPE use during resident care.<br>c) Compliance of staff with identification and reporting of infectious disease outbreaks.<br>2. Results of initial and ongoing audits will be monitored via the QAPI process monthly for at least three months for further recommendations. | |

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| F 880 | Continued From page 36<br>8. Review of the facility policy "Limiting the Spread of COVID-19 in SKilled Nursing Facilities," with a revision date 10/13/22, showed "...Covid-19 Isolation and Outbreak Status:...8. PPE use upon entry to isolation rooms: ...c. PPE should be removed and discarded as appropriate upon leaving an isolation room...l. If goggles or safety glasses are used instead of face shields, then masks or respirators should be removed when leaving the isolation room...."<br><br>9. Review of the Centers for Disease Control and Prevention (CDC) "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated on 9/23/22, showed a NIOSH-approved particulate respirator with N95 filters or higher should be used during the care of a patient with SARS-CoV-2 infection. The facemask "should be removed and discarded after the patient care encounter and a new one should be donned." | F 880 | | |
| F 883 SS=E | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; | F 883 | | 1/6/23 |

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| F 883 | Continued From page 37<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical | F 883 | | |

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| F 883 | Continued From page 38<br>contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the facility's resident immunization documentation, medical record review, and staff interview, the facility failed to ensure documentation related to the education, administration, refusal, or medical contraindication of immunizations was included in the medical record for 3 of 5 residents (#18, #34, #40) reviewed for immunizations. The findings were:<br><br>1. Review of the medical record for resident #18 showed s/he had declined the influenza vaccine on 10/5/22. Review of the facility's immunization documentation showed the resident had declined the SARS-CoV-2 vaccine. There was no evidence of documentation, signed by the resident or the resident's representative, of the education provided and the refusal of the vaccine in the resident's medical record.<br><br>2. Review of the medical record for resident #34 showed s/he had received the first dose of the SARS-CoV-2 primary series, however had refused the second dose. There was no evidence of documentation, signed by the resident or the resident's representative, of the education provided and the refusal of the vaccine in the resident's medical record.<br><br>3. Review of the medical record for resident #40 showed s/he had received the first dose of the SARS-CoV-2 vaccine on 5/7/21 and was not eligible for the second dose. Further review of the medical record show no documentation of the medical contraindication of the vaccine. | F 883 | F883 Corrective Action<br>Resident #18 has appropriate educational documentation as well ai appropriate vaccine declination documentation. Resident #34 has appropriate vaccine educational documentation as well as appropriate vaccine declination documentation. Resident #40 has appropriate documentation related to vaccine contraindication.<br>Identification of Others<br>Initial audit completed by DNS/ Designee to assess for others who may have been affected by deficient practice. Residents affected are corrected.<br>Systemic Changes<br>Education provided by DNS/ Designee to current staff related to appropriate vaccine declinations and vaccine contraindication documentation. Ongoing audits will be completed by DNS/Designee to assess for appropriate vaccine declination documentation as well as vaccine contraindication documentation weekly times three months.<br>Monitoring for Compliance<br>Results of initial and ongoing audits will be monitored via the QAPI process monthly times at least three months for further recommendations<br>01/06/23 | |

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| F 883 | Continued From page 39<br>4. Interview with the infection preventionist on 12/8/22 at 3:21 PM confirmed the required documentation was not in the residents' medical record. | F 883 | | |