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F 000	INITIAL COMMENTS A Standard Recertification Survey was conducted in conjunction with an Abbreviated Survey investigating Complaint KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 beginning on 06/15/2021 and concluded on 06/19/2021. Complaint KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 were determined to be substantiated with deficient practice identified. Deficient practice was identified with the highest Scope and Severity identified at an "F" level. Census: 109. After supervisory review, the Standard Recertification Survey and Abbreviated Surveys investigating KY00033911, KY00033745, KY00034030, KY00034031, and KY00034032 were reopened on 07/27/2021, in conjunction with complaints KY00034173, KY00034237, KY00034238, KY00034299, KY00034400, and KY00034404. KY00034299 and KY00034404 were unsubstantiated. KY00033911, KY00033745, KY00034030, KY00034031, KY00034032, KY00034173, KY00034237, KY00034238, KY00034400 were substantiated and Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist, 05/18/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), 42 CFR 483.25 Quality of Care (F684), and 42 CFR 483.80 Infection Control (F880). The facility was notified of the Immediate Jeopardy on 08/11/2021. The Immediate Jeopardy is ongoing. The facility failed to protect Resident #64,	F 000		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Resident #86 and Resident #322 from abuse of Resident #82. Resident #82 displayed behaviors of exposing himself/herself numerous times to other residents, wandered in/out of other resident's rooms, and was verbally/physically abusive to other residents. The facility failed to implement effective interventions to prevent Resident #82 from abusing other residents. Resident #82's behaviors resulted in the following resident-to-resident abuse: On 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear; On 06/04/2021, Resident #82 grabbed Resident #64's wrist and would not let go; On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave; On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm; and, On 07/31/2021, Resident #82 hit Resident #64 on the left wrist. Interviews with residents and staff revealed Residents #64, #86 and #322 were afraid of Resident #82. Interview with Resident #86 on 07/27/2021 revealed the resident was afraid to sleep because Resident #82 still came in his/her room and the facility had taken no action to protect the resident.

The facility failed to develop a baseline care plan for Resident #321 and Resident #323 and failed to ensure the residents received treatment and care in accordance with professional standards of practice. On the morning of 07/18/2021, at approximately 7:30 AM, staff obtained Resident #321's blood glucose level, which was sixty-seven 67) mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). Although the nurse held the resident's insulin injection, she administered the resident an oral hypoglycemic medication. The nurse stated after breakfast she re-checked

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the resident's blood glucose level, which was then one hundred thirty-nine (139) mg/dL. However, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until sometime later that afternoon. Sometime after 3:00 PM, staff found Resident #1 unresponsive with a blood glucose level of forty (40) mg/dL. Interviews with staff revealed they administered Resident #321 both, injectable and oral glucose, and the resident regained consciousness. However, there was no documented evidence staff continued to monitor the resident's blood glucose level, until approximately 12:30 AM on 07/19/2021, when Resident #321 was found unresponsive and clammy. Interviews and record review revealed the resident's blood glucose was thirty-two (32) mg/dL. Staff again administered the resident injectable glucagon and oral glucose. Resident #321 remained unresponsive and developed difficulty breathing. The facility transferred Resident #321 to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit (ICU).

In addition, the facility admitted Resident #323, on 07/06/2021, after being on a ventilator at the hospital. At approximately 7:30 AM on 07/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. Although interview with a nurse revealed she administered the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Upon Resident #323's arrival to the

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hospital, the resident required high flow oxygen, and was diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus atelectasis (lung collapse).

Further, the facility failed to establish and maintain an infection prevention and control program to properly prevent and contain the spread of COVID-19 to Resident #314, Resident #311, Resident #327, Resident #82, Resident #325, Resident #328 and Resident #329.

On 07/24/2021, two staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, there was no attempt by the facility to determine which residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus. In addition, the facility failed to immediately test residents for COVID-19 per the facility's policy. Residents were not tested until 07/28/2021, four (4) days after the staff members were positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for COVID-19. However, the facility did not quarantine the residents to prevent the spread of infection to others until 08/05/2021, eight (8) days after the residents tested positive, when a plastic zip barrier was placed over the resident's doorway.

Further, the facility documented staff were routinely tested for COVID-19 on 07/30/2021. However, SRNA #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she

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reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. Again, there was no documented evidence the facility attempted to determine which residents SRNA #13 cared for during her shift.

From 07/28/2021 through 08/05/2021, an additional three (3) residents tested positive for COVID-19, Resident # 329, Resident #82, and Resident # 328. Resident #82 and Resident #329 were also hospitalized due to COVID-19.

Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask. On 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on 08/12/2021, and on 08/19/2021, Resident #325 developed respiratory distress again, and was sent back to the hospital where he/she expired on 08/26/2021.

One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021, was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital.

Immediate Jeopardy (IJ) was also identified, on 08/20/2021, and was determined to exist, on 03/23/2021, at 483.25 Quality of Care (F692). The facility was notified of the Immediate Jeopardy on 08/20/2021.

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F 000	Continued From page 5 The facility failed to ensure Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, Resident #81 and Resident #40 maintained acceptable parameters of nutritional status and/or body weight and failed to ensure their physicians were notified of weight loss. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss due to the facility's failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure residents were served adequate portions to prevent weight loss. In addition, Immediate Jeopardy was identified on 08/27/2021 and determined to exist on 05/02/2021 at 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F656) and 42 CFR 483.25 Quality of Care (F686). The facility was notified of the Immediate Jeopardy on 08/27/2021. The facility failed to develop a comprehensive care plan to address Resident #65's pressure ulcer risk, failed to ensure Resident #65 received care to prevent pressure ulcers, and failed to ensure care and treatment was provided to promote healing, prevent infection and/or prevent	F 000		

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F 000	Continued From page 6 new pressure ulcers from developing. Resident #65 was admitted to the facility on 03/23/2021 without pressure ulcers. The facility failed to turn and reposition the resident as required. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements, appearance, drainage, odor, etc.) as required. Subsequently, the facility also failed to identify the pressure ulcer had worsened until 05/28/2021, when the resident was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer. Resident #65 was admitted to the hospital for worsening sacral wound and was, "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent surgical debridement on 05/30/2021, when all necrotic tissue was removed and "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65 and failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure ulcers, a Stage I (one) to the left heel on 06/23/2021, a DTI to the right heel on 06/26/2021, an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021, and two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021. Further, a wound care specialist assessed Resident #65's sacral pressure ulcer, on 08/26/2021, at 9:00 AM, and documented the wound had worsened. An acceptable allegation of compliance was	F 000		

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received on 09/02/2021 and the facility alleged removal of the Immediate Jeopardy effective 09/02/2021. A partial extended survey was initiated on 08/25/2021 and completed on 09/10/2021, and determined that the Immediate Jeopardy was not removed prior to exit on 09/10/2021. Immediate Jeopardy was also identified on 09/10/2021 at 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835 and F837) and 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The Immediate Jeopardy is ongoing.

Based on the findings of the partial extended survey, concluded on 09/10/2021, it was determined the facility failed to utilize their resources to effectively manage the facility in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Facility Administration and the Governing Body failed to ensure Quality Assurance/Performance Improvement activity was implemented and failed to provide oversight to ensure systems were in place to ensure the health and safety of residents in the facility. The facility's AOC stated the facility would complete "wound assessments" on 08/26/2021 and weekly wound assessments would be audited daily to ensure they had been completed. Review of Resident #14 and Resident #45's medical record revealed no documented evidence the facility assessed their pressure ulcers on 08/26/2021, as required by the AOC. Further, there was no documented evidence the facility was conducting weekly wound/pressure ulcer assessments for residents with pressure ulcers as stated in the AOC. Subsequently, there were no wound assessments available for the facility to audit.

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F 000	Continued From page 8 Further review of the facility's AOC revealed residents would be weighed monthly. However, as of 09/10/2021, ten (10) residents had not been weighed since 08/03/2021, and seven (7) residents who had not been weighed since 08/06/2021. Additional deficient practice was identified at F585, F609, F623, F641, F689, F695, and F842 at "D" level; F584, F804, F809 and F925 at an "E" level; F557, F802, F803, F806, and F812 at "F" level; and F657 and F697 at "G" level. After supervisory review, on 09/22/2021, Immediate Jeopardy was identified, on 09/22/2021, and determined to exist on 03/26/2021 at 42 CFR 483.75 Pharmacy Services (F755). The facility was notified of the Immediate Jeopardy on 09/22/2021. The facility failed to provide pharmaceutical services to meet the needs of Resident #321, Resident #326, Resident #351, Resident #9, and Resident #321. The facility failed to acquire and administer prescribed medications to meet the needs of Resident #326, Resident #351, Resident #9 and Resident #324. In addition, the facility admitted Resident #321 on 07/16/2021 with the diagnoses of Urosepsis and Invasive Bladder Cancer with Physician's Orders to receive an antibiotic to treat the Urosepsis. The pharmacy required the facility to "cost over-ride" the medication before it could be dispensed. However, the facility failed to address the cost over-ride and Resident #321 did not receive the physician ordered antibiotic.	F 000		
F 557 SS=F	Respect, Dignity/Right to have Prsnl Property	F 557		

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F 557	Continued From page 9 CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to protect residents' dignity for one hundred eight (108) out of one hundred nine (109) residents in the facility. Observation of the noon meal on 06/15/2021, revealed residents' meal trays were observed to have plastic silverware, styrofoam cups, and styrofoam bowls. In addition, observation of the breakfast trays on 06/16/2021, revealed residents were being served food in styrofoam bowls and styrofoam cups on their meal trays. The findings include: Review of the facility's policy titled," Resident Rights", dated June 2020, revealed each resident would be treated with consideration, respect, and full recognition of their dignity and individuality in care for their needs. The policy also stated the resident had a right to a dignified existence. Observation of the lunch meal service on 06/15/2021 at 1:14 PM, revealed residents' meals	F 557		

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were being served with plastic silverware, styrofoam cups, and styrofoam bowls.

Observation of the breakfast meal on 06/16/2021 at 8:30 AM, revealed residents' meal trays had styrofoam cups and styrofoam bowls on them.

Group interview conducted with six (6) residents (Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch and supper trays had plastic silverware which made it hard to cut anything, especially meats. The residents also stated they had been receiving styrofoam cups and bowls which they did not like. Continued interview revealed they had received the plastic silverware, styrofoam cups and bowls for a few weeks.

Interview with Dietary Aide (DA) #1 on 06/16/2021 at 2:00 PM, revealed they had been using plastic silverware, styrofoam cups, and styrofoam bowls for a few weeks. The DA stated they had been out of bowls, cups, and silverware and had used styrofoam bowls and cups and plastic silverware.

Interview with DA #2 on 06/16/2021 at 2:15 PM, revealed they had been using plastic silverware, styrofoam cups, and styrofoam bowls since he had worked there, two (2) weeks ago. The DA stated they had been out of bowls, cups, and silverware.

Interview with the Dietary Manager (DM) on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated the facility was out of silverware, cups, and bowls. The DM stated she was aware this was a dignity issue with using disposable dishes and silverware. Further interview with the DM revealed she would order

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F 557	Continued From page 11 the needed supplies from the supply company but never got the supplies. The DM stated it was a budget issue. Interview conducted with the Registered Dietician (RD) on 06/18/2021 at 4:18 PM, revealed she was aware the facility was using plastic silverware, styrofoam cups and bowls. Continued interview with the RD revealed she was told there was enough silverware that they were just not using it. Per interview, she had informed the DM they must use regular silverware as it was a dignity issue. The RD stated the DM had told her the company would not provide the cups and bowls that were needed. Interview with the Administrator on 06/19/2021 at 1:30 PM, revealed she had only been at the facility for two (2) weeks. She stated she had talked with the DM and the RD and they had not told her about using styrofoam cups and bowls and plastic silverware. The Administrator stated there was no problem with ordering replacement cups and bowls.	F 557		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		

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F 580	Continued From page 12 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policy, it was determined the facility failed to notify the physician for nine (9) of fifty-seven (57) sampled residents when the resident experienced a significant change in status and a need to alter treatment (Resident #321, Resident #323, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81).

On the morning of 07/18/2021, before breakfast, staff obtained Resident #321's blood glucose level, which was 67 mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). However, there was no evidence the staff notified the resident's physician of the resident's low glucose levels. Later that afternoon, sometime after 3:00 PM, staff found Resident #1 unresponsive with a blood glucose level of 40 mg/dL. Interviews with staff revealed they administered Resident #321 both injectable and oral glucose, and the resident regained consciousness. However, there was no documentation made in the resident's medical record regarding the resident's second episode of hypoglycemia, or that staff notified the resident's physician. On 07/19/2021, at approximately 12:30

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AM staff found Resident #321 unresponsive and clammy. Interviews and record review revealed the resident's blood glucose was 32 mg/dL. Staff again administered the resident injectable glucagon and oral glucose. The facility transferred Resident #321 to the hospital, where the resident was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. The hospital admitted Resident #321 to the Intensive Care Unit (ICU).

Further, the facility admitted Resident #323 on 07/06/2021 after being on a ventilator at the hospital. At approximately 7:30 AM on 7/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. However, there was no evidence that staff notified the resident's physician of the resident's status, until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Resident #323 was admitted to the hospital and diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus Atelectasis (lung collapse).

In addition, the facility failed to ensure Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's physicians were notified when the residents sustained significant weight loss.

The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident

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Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686), (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Review of the facility's policy titled, "Acute Condition Changes-Clinical Protocol", dated March 2018, revealed prior to contacting the physician about an acute change in condition, the nursing staff would collect pertinent details to report to the physician, such as the history of present illness and previous and recent test results for comparison. Further review, revealed the nurse would assess, document, and report baseline information including; vital signs, neurological status, current pain level, level of consciousness, cognitive and emotional status, onset, duration and severity of illness, recent labs, history of psychiatric disturbances, mental

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illness or depression, all active diagnoses, and all current medications. The nurse would then contact the physician based on urgency of the situation, and for emergencies, they would call or page the physician and request a prompt response.

Review of the facility's policy titled, "Management of Hypoglycemia", dated November 2020, revealed staff may need to make urgent notification to the physician if a diabetic resident had not eaten well or consumed sufficient fluids for two (2) or more days and had a fever, Hypotension, lethargy or confusion. For a resident who was lethargic, but not comatose, treatment might include oral glucose paste rubbed into buccal mucosa, intramuscular glucagon, or the administration of intravenous dextrose and immediate notification to the physician.

1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021 with diagnoses that included Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer.

Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13). The facility assessed the resident to be cognitively intact.

Review of Resident #321's Baseline Care Plan dated 07/16/2021, revealed the care plan did not include the resident's diagnosis of Diabetes Mellitus.

Review of Resident #321's Physician Orders

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Summary Report, revealed Physician's Orders dated 07/17/2021, which stated staff were to monitor for signs/symptoms of hypoglycemia/hyperglycemia (low/high blood sugar) every shift, obtain blood glucose levels as needed and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL.

Review of Resident #321's Medication Administration Record (MAR) for June 2021, revealed the MAR had an entry stating diabetic monitoring every shift for hypoglycemia/hyperglycemia, may complete finger sticks as needed, and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL.

Review of Nursing Notes dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM on 07/18/2021, Licensed Practical Nurse (LPN) #6 obtained a blood glucose reading for Resident #321, which was 67 mg/dL. The Note stated that after breakfast, LPN #6 obtained a follow-up blood glucose level, which she documented as 139 mg/dL. However, there was no indication or documentation that LPN #6 notified the resident's physician when the resident's blood glucose dropped below 70 mg/dL. In addition, there was no evidence the LPN continued to monitor the resident for signs/symptoms of hypoglycemia/hyperglycemia or re-checked the resident's blood glucose level.

Interview with Resident #321's Daughter on 08/02/2021 at 5:30 PM, revealed she visited the resident on 07/18/2021 and arrived to the facility at 10:45 AM for a scheduled visit. She stated Resident #321 told her his/her blood sugar had

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dropped to 67 mg/dL that morning. However, the daughter stated no staff re-checked the resident's blood glucose level or assessed the resident for signs/symptoms of hypoglycemia/hyperglycemia while she was at the facility from 10:45 AM until approximately 3:00 PM.

Interview with Resident #321's Spouse on 07/28/2021 at 2:19 PM, revealed he/she talked with Resident #321 on the phone numerous times on 07/18/2021, and the resident reported feeling like his/her blood glucose was low. However, the resident told the spouse at 4:00 PM, that staff had not re-checked his/her blood sugar since early that morning when his/her blood glucose was low.

Interview with LPN #6 on 07/27/2021 at 4:10 PM, revealed on the morning of 07/18/2021, she obtained a blood glucose of 67 mg/dL for Resident #321. She stated she re-checked the resident's glucose after the breakfast meal and it was back up to 139 mg/dL. LPN #6 stated she could not recall if she notified the physician that the resident's blood glucose had dropped below 70 mg/dL. However, the LPN stated that since the resident's blood glucose came up to 139 mg/dL, she probably thought the resident was doing well, and she did not need to notify the physician that the resident's blood glucose had dropped below 70 mg/dL.

Interview with SRNA #1 on 07/27/2021 at 4:40 PM, revealed she was working on 07/18/2021 during day shift from 6:00 AM to 6:00 PM. She stated she did recall Resident #321 having a blood sugar of 67 mg/dL that morning. Additional interview with SRNA #1 on 08/03/2021 at 3:19 PM, revealed later that same day, she entered Resident #321's room late in the afternoon, exact

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time unknown, and found the resident non-responsive and immediately alerted LPN #6. She stated LPN #6 got RN #1 from the other end of the unit to help her, and both nurses were working with the resident.

Interview with LPN #6 on 07/30/2021 at 11:30 AM revealed that Resident #321 had a hypoglycemic episode during the late afternoon on 07/18/2021, but could not recall the exact time, however, stated it was after lunch. She stated when she entered the room the resident was not responsive and she obtained a blood sugar of around 40 mg/dL. She stated she got RN #1 from the other end of the unit to assist her and administered an injection of Glucagon to the resident as well as oral glucose and the resident began to respond. LPN #6 stated following the episode she thought the resident's blood glucose had come up to "around 139 mg/dL", but she was unsure. LPN #6 stated she notified the resident's physician of the hypoglycemic event. However, review of Resident #321's medical record revealed no documentation of the incident, no documentation of the resident's blood glucose levels, and no documentation that LPN #6 notified the physician of the event.

Interview with Registered Nurse (RN) #1 on 07/30/2021 at 10:54 AM revealed she was working on 07/18/2021 on day shift from 7:00 AM to 7:00 PM, and recalled late in the afternoon LPN #6 came to her requesting assistance with Resident #321, who had a blood glucose level of 40 mg/dL. RN #1 stated when she arrived to the room the resident was non-responsive. RN #1 stated they administered the resident a Glucagon injection, and the resident began to regain consciousness. However, according to RN #1,

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the resident's blood sugar remained low, and LPN #6 administered the resident oral glucose. RN #1 stated after administering the oral glucose, Resident #321's blood glucose came up to 111 mg/dL. RN #1 stated she then returned to her end of the unit, and did not know if LPN #6 contacted the physician regarding the hypoglycemic event and the resident's low blood glucose level.

Review of Resident #321's Nursing Notes revealed an entry dated 07/19/2021 at 12:23 AM, stating staff had found the resident unresponsive with a blood glucose of 32 mg/dL. The note stated staff administered the resident two Glucagon injections and oral glucose. However, Resident #321 remained un-responsive and experienced labored breathing. Staff notified the resident's physician and received orders to send the resident to the hospital. Continued review of the nursing notes revealed Emergency Medical Services arrived to the facility at 1:00 AM and transferred the resident to the hospital Emergency Department (ED).

Review of hospital records for Resident #321 dated 07/19/2021 and interview with the ED Physician on 08/03/2021 at 8:22 PM, revealed when Resident #321 arrived to the ED on 07/19/2021, the resident was unresponsive and required intubation. Continued review of the record and interview with the physician revealed Resident #321 was in acute respiratory failure and was hypoxic due to prolonged hypoglycemia.

Interview with Physician #1, Resident #321's physician, on 08/04/2021 at 1:05 PM revealed he did not recall staff notifying him of Resident #321's hypoxic event on 07/18/2021 before breakfast or the hypoxic event that afternoon,

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F 580	Continued From page 21 when staff found the resident unresponsive. Physician #1 stated if staff had notified him on the morning of 07/18/2021, when Resident #321 had a blood glucose of 67 mg/dL, he would have sent the resident to the hospital for evaluation. Physician #1 also stated the only time he remembered staff notifying him about Resident #321 was during the early morning hours of 07/19/2021, when staff found Resident #321 nonresponsive. Interview with the Director of Nursing (DON) on 08/11/2021 at 12:05 PM revealed that she expected nursing staff to notify the physician if a resident had a change in condition and complete a nursing assessment on the resident. The DON stated she was not aware that Resident #321 had two hypoglycemic episodes without physician notification occurring prior to the resident going to the hospital on 07/19/2021. Continued interview with the DON revealed she did not conduct routine monitoring or have any system in place to ensure physician notification was occurring timely and as warranted. Interview with the Administrator on 08/10/2021 at 1:50 PM, revealed she expected nursing staff to conduct a nursing assessment anytime a resident had a change in condition and notify the physician and the family. The Administrator stated she was unaware Resident #321 had two previous episodes of hypoglycemia.. However, she stated staff should have called the physician. 2). Review of Resident #323's medical record revealed the facility admitted the resident on 07/06/2021, with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia.	F 580		

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Review of Resident #323's Minimum Data Set (MDS) Admission assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition.

Interviews on 07/28/2021, at 11:43 AM, with State Registered Nurse Aide (SRNA) #14, and at 2:35 PM with SRNA #15, revealed on the morning of 07/20/2021 at approximately 7:15 AM, they observed Resident #323 to be sweaty, clammy, red faced, and having difficulty breathing, which they stated was not normal for the resident. SRNA #14 stated she notified RN #6 of the resident's change in condition, and the nurse administered the resident a breathing treatment, but the resident continued to have difficulty breathing. SRNA #14 stated the resident was "breathing pretty hard". SRNA #15 stated RN #6 administered the resident another breathing treatment "a couple hours later". However, the SRNAs stated Resident #323 continued to have difficulty breathing. Continued interview revealed the resident's family arrived at the facility at approximately 11:15 AM and insisted the facility send the resident to the ED.

Interview with RN #6 on 07/28/2021 at 3:45 PM, revealed on 07/20/2021 at approximately 7:15 AM, staff notified her that Resident #323 was "congested". She stated she was not the assigned nurse to Resident #323. However, she went to the room to check on the resident. She stated when she entered the resident's room, the resident had audible wheezing and was using accessory muscles to aide in breathing. RN #6 stated she had last seen Resident #323 at approximately 6:15 AM, and the resident was not having difficulty breathing at that time, and the

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respiratory distress was new for the resident. However, RN #6 stated that she did not notify the resident's physician to report the resident's change in condition, because LPN #3 was the resident's assigned nurse. RN #6 stated it was LPN#3's responsibility to call the physician.

Continued interview with RN #6 on 07/28/2021 at 3:45 PM, and review of Resident #6's Treatment Administration Record (TAR) revealed she administered a breathing treatment to Resident #323 at 7:43 AM, which provided the resident with some improvement in breathing. However, according to RN #6, the improvement did not last long and the resident's status declined. RN #6 stated she administered the resident another breathing treatment at 11:34 AM, and assumed that LPN #3 would notify the physician of the resident's condition.

Interview with LPN #3 revealed she was the nurse assigned to Resident #323 on 07/20/2021. She stated that at approximately 6:30 AM on 07/20/2021, Resident #323 "seemed ok". However, at approximately 7:30 AM she realized "something was going on" with the resident. She stated she assessed the resident to be breathing fast and using accessory muscles to aide in breathing. LPN #3 stated she notified Physician #1 around 8:15 AM and received a new order for a chest x-ray. However, there was no documented evidence in the resident's medical record to indicate that LPN #3 notified the physician. She stated that following the breathing treatments administered by RN #6, Resident #323 condition "stayed about the same". Continued interview with LPN #3 revealed that the resident's family came in around 11:00 AM, and immediately requested the resident go to the

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F 580	Continued From page 24 ED. LPN #3 stated she called Physician #1, and received an order to transfer the resident to the hospital. Interview with Resident #323 family member on 08/02/2021 at 8:50 AM revealed she arrived to the facility on 07/20/2021 at approximately 11:00 AM. She revealed that upon arriving to the unit, he/she could hear the resident breathing from the hallway. The family member stated that she requested the resident go to the hospital for evaluation. Further review of the medical record for 07/20/2021, revealed no documented evidence the facility staff notified the resident's physician until after the resident's family member arrived to the facility. Review of the record revealed a change of condition form completed at 12:12 PM, which stated the resident was having shortness of air, abnormal lung sounds, labor or rapid breathing and cough. Continued review revealed documentation that the facility notified Physician #1 at 11:45 AM, and obtained an order to send Resident #323 to the ED for evaluation. Interview with Physician #1 on 08/04/2021 at 1:00 PM revealed he did not recall the facility notifying him of a change in Resident #323 on 07/20/2021. Physician #1 stated if the facility had called him, a chest x-ray would not have been standard of care for a resident exhibiting stridor (high pitched sound from breathing indicating a restriction) and difficulty breathing. The physician stated he would have initiated increased monitoring of vital signs and instructed the staff to monitor for signs/symptoms of decompensation of respiratory status, or more likely sent the resident to the ED for evaluation, especially if the resident was	F 580		

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exhibiting stridor. Continued interview with Physician #1 revealed he expected staff to notify him with changes of condition.

Review of Resident #323's ED record revealed the ED staff assessed the resident to have audible stridor, increased respiratory effort, was using accessory muscles to breathe and had mild wheezing to bilateral lungs. Continued review of Resident #323's hospital record revealed the resident was admitted to the ICU (Intensive Care Unit) at 10:54 PM. The hospital admitted Resident #323 with diagnoses of Acute Hypoxic Respiratory Insufficiency, Left Lower Lobe Pneumonia versus Atelectasis (collapsed lung), and an elevated Lactate level (results from low flow of oxygen level).

Interview with the Administrator on 08/10/2021 at 1:48 PM and the Interim Director of Nursing on 08/11/2021 at 12:05 PM, revealed they expected staff to notify the resident's physician immediately when a change of condition such as difficulty breathing occurred. In addition, the Interim Director of Nursing and Administrator stated the facility had no system in place to monitor residents' records to ensure staff notified the physician when a resident's condition warranted or that notification was being made timely and appropriately.

3. Review of Resident #90's medical record revealed the facility admitted the resident on 10/07/2016 with diagnoses that included Dementia, Unspecified Protein-Calorie Malnutrition and Dysphagia.

Review of Resident #90's Minimum Data Set (MDS) assessment dated 02/19/2021, revealed the facility assessed the resident to have a Brief

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F 580	Continued From page 26 Interview for Mental Status (BIMS) score of eight (8) which indicated the resident had moderate cognitive impairment. The assessment stated the resident weighed 97 pounds. Review of Resident #90's comprehensive care plan in place on 02/19/2021, revealed the facility identified the resident had a potential for weight concerns and was at risk for malnutrition due to dependence on staff for eating, diagnosis of Dysphagia and Vitamin B12 deficiency. Review of Resident #90's weight record revealed on 03/06/2021, the resident weighed 86.8 pounds. This weight reflected a loss of 10.5% in fifteen days. However, there was no evidence the physician was notified of the resident's weight loss. Review of the Registered Dietitian's (RD) documentation dated 04/09/2021, revealed the RD noted Resident #90 had sustained a 8.8% weight loss in 30 days, and 10.5 % in 180 days. Continued review of Resident #90's weight record revealed on 06/08/2021, the resident's weight was 84.7 pounds, and on 06/15/2021, the resident's weight was 82.5 pounds. Review of the RD's documentation on 06/16/2021, revealed the RD noted an 11.9 % weight loss in 30 days, a 12.9 % weight loss in 90 days, and an 11.5 % weight loss in 180 days. Further review of Resident #90's weight record revealed on 06/29/2021, the resident weighed 82.3 pounds. Review of RD documentation dated 07/07/2021, revealed the RD documented the resident had lost 13.1 % in 90 days and 11.7% loss in 180 days.	F 580		

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F 580	Continued From page 27 Further review of Resident #90's weight record revealed on 07/08/2021, the resident's weight was 80.2 pounds. Observation of staff weighing Resident #90 on 08/05/2021, revealed the resident weighed 81.1 pounds. However, review of Resident #90's medical record from 02/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of Resident #90's 17% weight loss in approximately 167 days. 4. Review of Resident #327's medical record revealed the facility admitted the resident on 03/15/2021 with diagnoses that included Dementia, Anemia, and Hyperlipidemia. Review of Resident #327's MDS admission assessment dated 03/22/2021 revealed the facility assessed the resident to be severely cognitively impaired. The assessment also stated the resident complained of difficulty or pain with swallowing. The facility assessed the resident to be independent with meals requiring set up help only, and weighed 205 pounds. Review of Resident #327's baseline care plan did not contain information concerning Resident #327's nutritional status. Review of a RD evaluation dated 03/26/2021, revealed Resident #327 weighed 194.2 pounds, and the RD documented the resident had sustained a 5% weight loss in one week. Review of the RD's documentation dated	F 580		

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F 580	Continued From page 28 04/09/2021, revealed on 04/06/2021, Resident #327 weighed 184.2 pounds, a significant weight loss of 10% in 30 days. Further review of the report revealed the RD recommended referring the resident to the physician for a medication review due to the facility's documentation that the resident's intake was "fair", but continued to experience weight loss. However, there was no evidence the facility contacted the resident's physician. Review of the RD's documentation dated 05/07/2021, revealed she evaluated Resident #327 on 05/07/2021, because the resident weighed 182.5 pounds on 04/27/2021. The RD documented the resident had lost 6% of his/her body weight in the past 30 days and 10.8 % of body weight in the past 90 days. Review of the RD's documentation revealed on 06/06/2021, the RD evaluated Resident #327 because the resident weighed 178.5 pounds on 06/01/2021, a significant weight loss of 11.4% in 90 days. Continued review of Resident #327's record revealed the resident weighed 170 pounds on 08/03/2021, which was a 5.5 percent weight loss in 30 days. Observation of staff weighing Resident #327 on 08/05/2021, revealed the resident weighed 170.3 pounds. However, review of Resident #327's medical record from 03/22/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of Resident #327's 17% weight loss in approximately 136 days.	F 580		

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5. Review of Resident #82's medical record revealed the facility admitted the resident on 05/12/2021 with diagnoses including Parkinson's Disease, Alzheimer's Disease, Insomnia and Vitamin D Deficiency.

Further review of Resident #82's admission data revealed the resident's weight was 153.6 pounds on 05/12/2021.

Review of Resident #82's MDS admission assessment dated 05/18/2021, revealed the resident was severely cognitively impaired, but was independent with eating, requiring set up only. The assessment also stated the resident's weight was 148 pounds, a 5.6 pound weight loss in one week.

Review of Resident #82's weight record revealed on 06/01/2021, the resident weighed 145.1 pounds, a 5.5 % weight loss in less than 30 days. Review of the RD assessment dated 06/05/2021, identified Resident #82 had sustained a 5.5 % weight loss in 30 days, and a 13.4 % loss in 90 days.

Continued review of Resident #82's weight record revealed on 06/08/2021, the resident weighed 143.2 pounds.

Further review of Resident #82's record revealed the resident weighed 139.1 pounds on 07/20/2021, 137.3 pounds on 07/27/2021 and 132.9 pounds on 08/03/3021, a significant weight loss of 13.4% in the last 90 days.

However, review of Resident #82's medical record from 05/12/2021 thru 08/05/2021, revealed

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no evidence the facility notified the physician of Resident #82's 13.4 % weight loss in approximately 85 days.

6. Review of Resident #330's medical record revealed the facility admitted the resident on 03/11/2020 with diagnoses that included Cerebral Infarction, Diabetes Mellitus, Hemiplegia and Aphasia.

Review of Resident #330's MDS dated 05/12/2021, revealed the facility assessed the resident to have a BIMS score of four (4), indicating the resident was cognitively impaired. Further review revealed the facility assessed the resident to have swallowing difficulties and held residual food in his/her mouth. Further review of the assessment revealed the facility assessed the resident to require the limited assistance of one (1) staff member at meals. The assessment stated the resident's weight was 239 pounds.

Review of Resident #330's care plan in place on 05/12/2021, revealed the resident was at risk for potential weight concerns/malnutrition because of the resident's diagnosis of Dysphagia. However, the facility identified the resident was above ideal body weight and was obese. Interventions initiated on the care plan included notifying the physician of significant weight loss.

Review of Resident #330's weight record revealed on 06/08/2021, the resident's weight was 213.6 pounds. Review of a RD assessment dated 06/28/2021, revealed the RD documented the resident had lost 10.6% of his/her body weight in 180 days.

Review of Resident #330's weight on 08/03/2021,

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revealed the resident weighed 210 pounds. Observation of Resident #330's weight on 08/05/2021, revealed the resident weighed 210 pounds.

However, review of Resident #330's medical record from 05/12/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of the resident's 12% weight loss in approximately 85 days.

7. Review of Resident #39's medical record revealed the facility re-admitted the resident on 04/03/2018 with diagnoses that included Diabetes Mellitus, GERD, and Chronic Diastolic Heart Failure.

Review of Resident #39's MDS assessment dated 03/01/2021 revealed the facility assessed the resident to have a BIMS' score of 15, indicating the resident was cognitively intact. The assessment also revealed the resident was independent with eating and weighed 296 pounds.

Review of Resident #39's weight record revealed the resident weighed 290 pounds on 04/04/2021 and 253.3 pounds on 06/22/2021.

However, review of Resident #39's medical record from 03/01/2021 thru 06/22/2021, revealed no evidence the facility notified the physician of the resident's 14.4% weight loss in approximately 113 days.

8. Review of Resident #332's medical record revealed the facility admitted the resident on 03/12/2021 with diagnoses that included Diabetes, Chronic Kidney Disease,

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F 580	Continued From page 32 Gastro-Esophageal Reflux Disease, Hypertension, Atrial Fibrillation, and Femoral Neck Fracture. Review of Resident #332's Dietary-Nutrition Data Collection assessment completed on 03/16/2021 at 5:39 PM, revealed the resident's weight was 199.9 pounds and the resident's intake was inadequate to meet the resident's needs. Review of Resident #332's MDS assessment dated 03/19/2021, revealed the facility assessed the resident to have a BIMS' score of 14 indicating intact cognition. Further review of the assessment revealed the resident was independent with eating, and weighed 200 pounds. Review of Resident #332's weight record revealed the resident weighed 182.6 pounds on 04/05/2021. Review of the Nutrition Progress Note by the RD, dated 04/11/2021, revealed Resident #332 had sustained a 9% weight loss in thirty days. Review of Resident #332's weight record revealed the resident weighed 184.9 pounds on 05/04/2021. Review of a Nutrition Progress Note for Resident #332 dated 05/27/2021, revealed the resident had a 7.6% weight loss in 90 days. Further review of Resident #332's weight record revealed the resident weighed 183.6 pounds on 06/07/2021, 182.9 pounds on 07/05/2021 and 179.9 pounds on 08/03/2021. However, review of Resident #39's medical record from 03/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of	F 580		

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the resident's 10% weight loss in approximately 140 days.

9. Review of Resident #81's medical record revealed the facility re-admitted the resident on 09/30/2019 with Dementia, Anemia, Anxiety and Major Depressive Disorder.

Review of Resident #81's MDS assessment dated 05/18/2021, revealed the resident weighed 117 pounds.

Review of Resident #81's weight record revealed on 06/01/2021, the resident weighed 109.2 pounds. Review of a RD assessment for Resident #81, completed on 06/05/2021 revealed the resident sustained a 6.5% weight loss in 30 days and 8.9% weight loss in 90 days.

Review of the RD's documentation for Resident #81 dated 07/07/2021, revealed on 07/06/2021, the resident's weight was 108.7 pounds, representing a 9.4% weight loss in 90 days.

Review of Resident #81's weight on 08/03/2021, revealed the resident weighed 107.1 pounds.

However, review of Resident #81's medical record from 03/19/2021 thru 08/05/2021, revealed no evidence the facility notified the physician of the resident's 8.4 % weight loss in approximately 80 days.

Interview with Physician #1 on 08/04/2021 at 1:00 PM and on 08/27/2021 at 1:18 PM revealed he could recall being notified by staff at times related to residents that had lost weight; however, he was unable to recall specific dates or residents. He stated he expected the facility to follow its policy

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F 580	Continued From page 34 to weigh residents monthly and notify him of weight loss. Physician #1 stated he usually initiated Periactin (a medication used as an appetite stimulant) when a resident was not eating and losing weight. He also stated he expected staff to follow their policies related to physician notification in the facility. Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year, and was placed in the IDON position a few weeks ago. The ADON/IDON stated she had never monitored residents' weights, and never monitored to ensure the physician was notified when residents lost weight in the facility. Interview with the Administrator, on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator stated the facility had no systems in place to monitor residents' weight loss or nutritional needs. She stated she was not monitoring to ensure the residents' physician was notified when residents experienced weight loss. She stated she was not aware the physician had not been notified of residents' weight loss, but stated he should have been.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		

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F 584	Continued From page 35 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584		

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F 584	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide a clean, comfortable, and homelike environment for nine (9) of fifty-seven (57) sampled residents (Resident #3, Resident #321, Resident #17, Resident #96, Resident #316, Resident #86, Resident #39, Resident #92 and Resident #332). The facility failed to ensure Resident #316 and Resident #86 had a clean and odor free bathroom; Resident #39 had clean linens; and Residents #39's and #3's floor was free from soiled linen. Additionally, the facility failed to ensure Resident #96, Resident #86, Resident #316 and Resident #15 had properly functioning shower/bath equipment when the showerhead in the unit shower room was broken and non-functioning for five (5) days before being repaired. The findings include: Review of the facility's policy titled, "Quality of Life-Homelike Environment", revised on 05/2017 revealed residents were provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible. Further review revealed staff and management shall maximize, to the extent possible, the characteristics of the facility that reflected a personalized, homelike setting. These characteristics included: a clean, sanitary and orderly environment, comfortable yet adequate lighting, inviting colors and décor, personalized furniture and room arrangements, clean bed and bath linens that were in good condition, pleasant	F 584		

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neutral scents, plants and flowers where appropriate, comfortable and safe temperatures (71- 81 degrees Fahrenheit), and comfortable noise levels. Further review revealed the facility's staff and management shall minimize, to the extent possible, the characteristics of the facility that reflected a depersonalized, institutional setting. These characteristics included: overhead paging, institutional odors, institutional signage, medication carts, and chair and bed.

1. Observation on 07/27/2021 at 10:45 AM revealed trash and soiled laundry and linens on the floor in residents' rooms #312 and #316. Further observation revealed the floors and bedside tables were soiled with sticky substances throughout the rooms on the third floor. Soiled linens were observed on the floor of Resident #39's room. Odors of feces and urine were noted in residents' rooms with full urinals sitting on the floor in Resident #332's room.

Observations and interview with Resident #332 on 07/27/2021 at 11:00 AM revealed he/she was setting on the side of his/her bed and the resident's urinal was full of urine. Continued observation revealed urine spilled onto the floor as the resident held the urinal. A strong odor of urine was noted in the resident's room, and on the resident's person. Resident #332 stated, "I am always spilling pee all over the place because I can't get anyone to empty this for me." referring to his/her urinal. Further observations revealed the floor in the residents room had a sticky substance and the State Survey Agency's Surveyor's shoes stuck to the floor while observations were conducted. Three (3) pieces of bread and soiled linen were also observed on the floor by the resident's bed.

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F 584	Continued From page 38 Observation of Resident #17 on 08/05/2021 at 11:02 AM revealed a fitted sheet with a large brown discoloration and two (2) pillows without pillow cases. Interview with Resident #17 revealed that he/she would like to have clean linens and pillow cases on his/her two (2) pillows on the bed. Review of Resident #17's medical record revealed the facility admitted him/her on 03/15/2021 with Diabetes, Hypertension and Cancer. Review of his/her Quarterly MDS assessment dated 06/16/2021 revealed the resident had intact cognition with a BIMS score of 15. Interview with Resident #39, on 07/27/2021 at 10:50 AM, revealed his/her sheets were not changed unless he/she requested them to be changed. Resident #39 stated that soiled washcloths and linens were placed on the floor of his/her room and stayed until housekeeping picked them up. Interview with Resident #3 on 07/27/2021 at 11:00 AM revealed the facility piled his/her soiled laundry on the floor until housekeeping picked it up. Interview with Family Member #1, on 07/28/2021 at 2:19 PM, revealed Resident #321 had dirty blankets and washcloths. She stated the blankets were stained when provided, and when the blankets were soiled with pus and blood they stuck to the resident. Further interview revealed the facility had no clean blankets or washcloths available to provide to him/her.	F 584		

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Interview with State Registered Nurse Aide (SRNA) #4, on 07/28/2021 at 7:35 PM, revealed resident rooms were dirty and the floors in the residents' rooms were not cleaned regularly. She stated some of the curtains in the rooms had feces on them and housekeeping never changed the curtains or mopped the floors in the resident rooms. She further stated they used to check the rooms for cleanliness, but no one seemed to care now. SRNA #4 stated the residents' rooms were "nasty", and it had never been like that before.

Interview with the Housekeeping Supervisor, on 07/27/2021 at 4:08 PM, revealed if stains were present on blankets, linens, or washcloths, the facility would re-wash those items. She further stated all clean linens were visually checked daily by housekeeping staff and disposed if stains remained present after being laundered. However, the Housekeeping Supervisor stated linens were not checked again when sent to the resident floor. Per the Housekeeping Supervisor, resident rooms were checked weekly for cleanliness. She stated staff was expected to pick up soiled linen, laundry, and trash from resident rooms timely to ensure a clean environment for residents. She stated this was expected to be done daily.

2. Observation on 07/27/2021 at 11:45 AM revealed Resident #316 and Resident #86's shared a restroom and the toilet was full of feces and urine. Significant odor was noted throughout both resident rooms.

Interview with Resident #316, on 07/27/2021 at 11:45 AM, revealed his/her restroom toilet had been full of feces and urine for a couple of days and smelled bad. Resident #316 stated he/she

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could not use the restroom and he/she was having to go across the hall to another resident's room to use the restroom. He/she further stated the facility said they would fix it, but they had not.

Interview with Resident #86, on 07/27/2021 at 11:55 AM, revealed his/her toilet had been out of order and full of feces and urine for about two (2) days. He/she further stated it was a shared restroom, "it stinks", and no one had come to fix it yet.

Interview with Resident #15, on 07/27/2021 at 12:15 PM revealed Resident #316 and Resident #86, were having to use his/her restroom because their restroom was out of order and full of feces and urine. Resident #15 stated it was bad Resident #316's and Resident #86's toilet was not fixed and it was not their fault.

Interview with the Maintenance Supervisor, on 07/27/2021 at 4:00 PM, revealed maintenance issues were reported by staff placing repair slips in the maintenance boxes located on each resident floor. He stated the boxes were checked two (2) to three (3) times daily, and if immediate attention was needed, maintenance would make repairs immediately. The Maintenance Supervisor stated he was not aware until "today" that Resident #86 and Resident #316's shared toilet was clogged and full of feces/urine.

3. Observation of 5th floor shower room on 07/27/2021 at 12:20 PM revealed a new shower head had been installed with the old showerhead in the tub in the shower room.

Interview with Resident #96, on 07/27/2021 at 12:10 PM, revealed the shower head on the

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unit/floor was not working and had been broken for about a week.

Interview with SRNA #7, on 07/27/2021 at 12:15 PM, revealed the shower head on the fifth floor had been broken. She stated staff reported to maintenance when repairs were needed. They could fill out a slip and put in maintenance box or call maintenance.

Interview with the Maintenance Supervisor, on 07/27/2021 at 4:00 PM, revealed he was not aware the shower head on the 5th floor was broken until two (2) days ago. He stated he had replaced it just that morning. Per the Maintenance Supervisor, maintenance issues were reported by staff placing repair slips in the maintenance boxes located on each floor. He further stated the boxes were checked two (2) to three (3) times daily, and if immediate attention was needed, maintenance would repair them immediately.

Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she expected resident rooms to be clean and free of trash and no soiled linen or laundry on the floor. She further stated resident rooms were expected to be mopped and odors minimized. She stated housekeeping was expected to check rooms for cleanliness. The Administrator stated staff was expected to call and notify maintenance of any immediate repairs and those repairs were expected to be done timely. The Administrator stated unclean rooms, soiled linens, or non-working toilets and shower equipment were not acceptable.

4. Review of Resident #92's medical record revealed the facility re-admitted him/her on 04/15/2021 with Diabetes, Chronic Kidney

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F 584	Continued From page 42 Disease and Cellulitis. Review of his/her Quarterly MDS assessment dated 06/30/2021 revealed the resident had moderately impaired cognition with a BIMS' score of 09. Observation of Resident #92's toilet on 08/05/2021 at 11:00 AM revealed an elevated toilet seat with stool smeared on the back rim. Interview with Resident #92 revealed that the stool has been there for hours and the "staff will not clean it when {he/she} tells them". The resident stated that the facility not being clean "bothers" him/her. Observation of Resident #92's elevated toilet seat on 08/05/2021 at 11:54 AM revealed stool still smeared on the back rim. Resident #92, again stated that the facility not being clean "really bothers" him/her.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §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. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		

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F 585	Continued From page 43 §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 grievances submitted anonymously, issuing written grievance decisions to the resident; and	F 585		

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F 585	Continued From page 44 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:	F 585		

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Based on interview, record review, and a review of the facility grievance policy, it was determined the facility failed to resolve grievances related to dietary/food complaints for one (1) of fifty-seven (57) sampled residents (Resident #156). Resident #156 complained to the facility about dietary/food service on 04/26/2021; however, there was no documented evidence the facility utilized their grievance procedure to investigate, document and resolve the grievance for Resident #156.

The findings include:

Review of the facility's grievance policy titled "Grievances/Complaints, Recording and Investigating" with a revision date of April 2017, revealed the grievance/complaint form would be completed for all grievance and complaints and a grievance officer would investigate the grievance/complaint. The Grievance Officer would report findings to the administrator and attach the investigation to the grievance/complaint form and the grievance results were made available to the person acting on behalf of the resident.

Review of the closed medical record for Resident #156 revealed the facility admitted the resident on 03/05/2021 with diagnoses, which included Diabetes Mellitus Type II and Morbid Obesity Due To Excess Calories.

Review of Resident #156's Quarterly Minimum Data Set (MDS) Assessment, dated 04/02/2021, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) Score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact.

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F 585	Continued From page 46 A review of Resident #156's Nutrition Progress Notes, dated 04/27/2021 at 05:53 PM, revealed the Dietitian and Dietary Manager had spoken with the resident on 04/26/2021 for forty-five (45) minutes and the resident had voiced complaints regarding dining services. According to the note, the resident expressed satisfaction with the outcome of the conversation. Interview with the Dietary Manager (DM), on 06/17/2021 at 8:05 PM, reveled the DM had not completed a grievance/complaint form because she was not aware of the facility's grievance procedure. The DM stated she was unaware she was required to complete a grievance/complaint form and send the form to the facility grievance officer or the administrator. Further interview revealed the DM had started at the facility in January 2021 and was not trained on the facility grievance/complaint procedure. Interview with the Social Worker, on 06/17/2021 at 2:12 PM, revealed she was the person responsible for reviewing and investigating grievances and was not aware of any complaints related to food for Resident #156. The Social Worker stated she had not received any grievance forms/investigations related to food complaints or dietary concerns for Resident #156. Interview with the Former Administrator, who was the administrator of record on 04/26/21, on 06/17/2021 at 8:25 PM, revealed he was aware of Resident #156's food complaints. According to the Administrator, he instructed Dietary to talk with the resident to attempt to resolve the resident's food complaints/concerns and was not aware grievance forms had not been completed.	F 585		

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F 585	Continued From page 47 According to the Administrator, he did not consider the complaints grievance because the resident complained often about the food and would often change his/her mind. Per the Administrator, if grievance forms were not completed there was a potential for the resident's grievance not being resolved or addressed. Interview with the current Administrator, on 06/19/2021 at 1:30 PM, revealed she started employment at the facility in early June 2021. The Administrator stated this week during the morning meetings staff had discussed concerns with grievances and how staff, including the Social Worker, were not investigating the grievances. The Administrator stated all grievance should be forwarded to her for action.	F 585		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility policy it was determined the facility failed to have an effective system to ensure four (4) of fifty-seven (57) sampled residents were free from abuse (Resident #64, #82, #86 and #322).

Interviews and record reviews revealed the facility admitted Resident #82 on 05/12/2021 and since admission, the resident exposed him/herself numerous times to other residents, wandered in/out of other resident's rooms and was verbally/physically abusive to other residents. However, the facility failed to implement effective interventions to prevent Resident #82 from abusing other residents. Resident #82's ongoing behaviors resulted in resident-to-resident abuse incidents and on 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear. On 06/04/2021, Resident #82 grabbed Resident #64's wrist and would not let go; On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave; On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm and on 07/31/2021, Resident #82 hit Resident #64 on the left wrist.

Interviews with residents and staff revealed Residents #64, #86 and #322 were afraid of Resident #82. Interview with Resident #86 on 07/27/2021 revealed he/she was afraid when

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he/she went to sleep because Resident #82 still came in his/her room and the facility had taken no action to protect the resident.

The facility's failure to have an effective system in place to ensure residents were free from abuse, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656) 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Review of the facility's "Abuse Prohibition/Investigative" Policy, last revised in November 2016, revealed the facility would

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F 600	Continued From page 50 prohibit abuse/neglect. Per the policy, the facility would ensure it was doing all, that was within its control to prevent occurrences of abuse and neglect. According to the policy, abuse was defined as the willful infliction of injury, and deprivation by an individual, which included a caretaker, of goods or services which were necessary to attain or maintain physical, mental and psychosocial well-being. The policy also stated verbal abuse was the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. Sexual abuse was defined in the policy as non-consensual sexual contact of any type with a resident and neglect was defined as the facility's failure to provide goods and services to a resident, which were necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy also stated the facility would take actions to prevent abuse in the facility which included identifying, correcting and intervening in situations in which abuse was more likely to occur and developing a care plan that identified appropriate interventions to prevent occurrences of abuse. Examples of abuse, per the policy, included incidents of resident to resident abuse and suspicious bruising, and any injury of unknown origin. The policy also stated the Administrator was responsible for implementation of the policies/procedures which prohibit abuse and neglect in the facility. Review of the facility's Brief Interview for Mental Status (BIMS) list for facility residents indicated Resident #322 was interviewable with a BIMS score of twelve (12) and Resident #86 was also interviewable with a BIMS score was ten (10).	F 600		

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F 600	Continued From page 51 The list also indicated Resident #64's BIMS score was eight (8). Review of the medical record revealed the facility admitted Resident #82 on 05/12/2021 with diagnoses, which included Unspecified Dementia with behavioral disturbances and Parkinson's Disease. Review of Resident 82's Quarterly Minimum Data Set (MDS) assessment, dated 07/14/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15), indicating the resident was not interviewable. According to the MDS, Resident #82 had physical behaviors directed towards others, rejected care and wandered, one (1) to three (3) days during the assessment period. Resident #82's MDS also revealed he/she required extensive assistance of one (1) staff member when transferred between surfaces and walking. Review of Resident #82's Comprehensive Care Plan revealed on 05/20/2021, staff identified the resident had behavior symptoms that were not easily directed such as: wandering, agitation and the resident was also physically/verbally abusive to others. Review of Resident #82's care plan also revealed he/she wandered into other residents rooms and sometimes urinated. Further review of the care plan revealed interventions developed on 05/20/2021 included to approach the resident calmly/quietly, attempt to discover reason for behavior such as pain, wants, needs or toileting, administer medications and review medications as needed, psychiatric consults and send to hospital as needed. Further review revealed even though Resident #82 exhibited	F 600		

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ongoing behaviors in the facility, the only time staff reviewed/revised his/her care plan was on 07/14/2021, when interventions were added for staff to check for toileting needs, thirsts and hunger.

Observations conducted of Resident #82, on 07/27/2021 at 12:20 PM and at 4:20 PM, revealed the resident was wandering in the facility hallways going in/out of other resident's rooms.

1. Review of an incident report dated 05/18/2021 at 8:02 AM, revealed Resident #322 reported to staff another resident wandered into his/her bathroom while he/she was "in there". Further review revealed when Resident #322 attempted to remove the other resident, he/she "grabbed" Resident #322's arm which resulted in a 1 centimeter (cm) x 1 cm skin tear to his/her arm.

Review of Resident #82's medical record revealed no documented evidence of the incident reported on 05/18/2021.

Interview with Resident #322, on 07/27/2021 at approximately 12:30 PM, revealed he/she was afraid of Resident #82. According to the resident, "a while back" Resident #82 entered his/her bathroom while he/she was toileting and when he/she attempted to remove Resident #82 from his/her bathroom, Resident #82 grabbed Resident #322's arm and "ripped" the residents skin. Resident #322 stated he/she had reported to staff he/she was afraid of Resident #82 Continued interview revealed Resident #82 had also exposed him/herself to Resident #322 and had tried to get in the bed with the resident on multiple occasions. However, he/she stated nothing had been done to protect the resident

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and Resident #82 still wandered in/out of his/her room.

Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she completed the incident report for Resident #322 when the resident reported to her Resident #82 wandered into his/her bathroom. The resident reported he/she attempted to remove Resident #82 from his/her bathroom the resident grabbed his/her arm and caused a skin tear. The RN acknowledged the incident was resident to resident abuse and stated she reported the incident immediately to the Assistant Director of Nursing (ADON). However, the ADON failed to direct staff to take any actions to prevent any further incidents of resident to resident abuse concerning Resident #82. RN #1 stated Resident #82 has continued to wander in/out of Resident #322's room, as well as other residents rooms and also stated Resident #322, Resident #64 and Resident #86 verbalized to her that they were fearful of Resident #82.

Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, revealed she initially stated in interview she was not aware Resident #82 exhibited abusive behaviors towards other residents in the facility. However, when asked about the incident that occurred on 05/18/2021 with Resident #322, she was able to recall the incident and acknowledged staff reported the incident to her. The ADON stated the incident was an allegation of resident to resident abuse and interventions should have been implemented to protect residents from abuse; however, she stated no action was taken. Per the ADON, she reported the incident to the Administrator at the

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time the incident occurred, but was unsure if he had reported it to State Agencies or not and he was no longer employed at the facility. According to the ADON, she was not responsible to report abuse allegations to State Agencies; however she was responsible to investigate allegations of abuse, but had not investigated this incident because she was not directed to do so.

2. Continued review of Resident #82's medical record revealed on 05/21/2021 at 10:20 AM and on 05/22/2021 at 3:29 AM, the resident continued to wander in/out of other resident's rooms and was "becoming verbally abusive with other residents."

Interview with RN # 1, on 07/30/2021 at 9:50 AM, revealed she made an entry in Resident #82's medical record on 05/21/2021 regarding the resident being verbally abusive with other residents. She stated the resident was wandering in other resident rooms and would "yell and argue back" with the other residents, as they were asking Resident #82 to exit their personal space. She could not recall which residents were involved "that was a while back" but stated, she had not filled out an incident report. The RN stated she reported the abuse incidents to "someone but don't remember who;" however, stated she was not directed to take any actions to prevent further abuse from occurring.

Interview with RN # 9, on 07/29/2021 at 9:30 PM, revealed she documented Resident #82's behaviors on 05/22/2021 regarding the resident's abuse towards other residents, which had been ongoing since he/she was admitted at the facility and Administrative staff have taken no action to his/her behaviors. Continued interview revealed

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F 600	Continued From page 55 Resident #82 wandered into other residents personal space "constantly" and was difficult to redirect. She stated he/she would go into others rooms, go through their personal belongings and when residents got upset due to this behavior, and ask him/her to leave their rooms, Resident #82 "yells and makes growling noises and scares the other residents." According to the RN, she had not filled out incident reports related to the witnessed events, but the incidents were reported to the previous Administrator, the current ADON and the Administrator "too many times to count"; however, nothing had been done to prevent further abuse from occurring. Review of Resident #82's medical record revealed, on 06/02/2021, he/she was evaluated by the facility Psychiatry services for the first time since admission. Review of documentation indicated the resident's initial complaints were behaviors and confusion and the findings indicated the resident was "compliant with current treatment" and recommendations were made to monitor/document any associated side effects, evidence of psychosis and/or changes in mental status, mood, behavior, sleep, or appetite. 3. Review of Resident #82's facility reported incident, dated 06/04/2021, revealed at 1:15 PM RN #1 heard a noise coming from the hallway and when staff evaluated where the noise was coming from, Resident #82 was found in Resident #64's room "holding onto" Resident #64's wrist and arm and would not let go. Review of the incident revealed staff "had to remove" Resident #82's hand from Resident #64's arm and physically assist Resident #82 from Resident #64's room because the resident was not able to be verbally redirected. According to the facility	F 600		

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reported incident, Resident #82 was transferred to the hospital for an "overnight" evaluation on 06/04/2021 and when the resident returned from the hospital the following day, Resident #82 was placed on an increased level of supervision; every fifteen (15) minute checks for seven (7) hours, every thirty (30) minutes for twelve (12) hours, and every hour for twelve (12) hours (totaling approximately thirty-one (31) hours), and a stop sign was placed over Resident #64's door and the facility psychiatrist was ordered to evaluate Resident #82's behaviors.

Review of Resident #82's medical record revealed on 06/04/2021 at 1:10 PM, staff heard someone "yelling" and when staff "went to check and see what was wrong" one resident was observed in another residents room and he/she had his/her "hand wrapped around" the other residents right forearm and wrist. Continued review of the record revealed the resident (no resident specified) "would not lessen grip" and "staff had to remove" his/her hand and assist the resident back to his/her room. The record also revealed the resident was transferred to the hospital on 06/04/2021 at 2:10 PM.

Review of Resident #82's medical record revealed the resident returned to the facility on 06/05/2021 at 6:30 AM. Even though the resident was to be on an increased level of supervision, review of the nurses notes revealed he/she continued to wander in/out of other resident's rooms and was difficult to redirect. Further review of the record revealed at 8:30 AM on 06/05/2021, Resident #82 was "walking in front of other residents and trying to grab them both male and female" and the resident continued to wander into other residents rooms and "they start yelling and

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screaming." Continued review of Resident #82's medical record revealed the resident continued to wander in/out of other residents rooms on 06/07/20 21 and again on 06/10/2021.

Interview with Resident #64, on 07/27/2021 at 12:45 PM, revealed he/she had been abused by Resident #82 and he/she was afraid of the resident, and had reported his/her fear to facility staff. However, the resident stated nothing was done to protect him/her and even though Resident #82 wandered into his/her room and "grabbed my arm and wouldn't let go". The resident stated Resident #82 continued to wander in/out of his/her room at times, and "no one does anything to stop" him/her from coming "in here on me again."

Review of Resident #82's medical record revealed he/she was evaluated by the facility psychiatric services again, on 06/14/202,1 and his/her chief complaints were wandering/inappropriate behaviors, the resident was hard to redirect, talked to him/herself and had a history of violence towards others. According to the evaluation, the resident's family reported he/she had a history of violence and staff reported the resident would become "wild as a buck," was hard to redirect and he/she went into other resident rooms and residents were "uncomfortable" around Resident #82. Documentation also indicated the residents treatment recommendations was "psychiatric medication management." However, no medication changes were recommended during the evaluation.

Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was

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working when the incident occurred with Resident #64 on 06/04/2021 and she notified the Administrator. She stated even though the resident was transferred to the hospital and returned the following day, his/her behaviors continued. The RN stated, Resident #64 reported he/she was afraid of Resident #82; however, the resident continued to wander in/out of other resident's rooms and no actions had been taken to protect the residents.

Review of facility reportable incidents indicated the facility reported the incident that occurred on 06/04/2021 which involved Resident #82 and Resident #64. According to the reported incident, RN #1 heard a noise coming from the hallway and when the nurse went to investigate she found Resident #82 in Resident #64's room and the resident had hold of Resident #64's wrist and arm and would not let go. Staff intervened and removed Resident #82 from his/her room and he/she was sent to the hospital for an overnight evaluation and returned to the facility on 06/05/2021.

Further review of the facility reported incident, dated 06/04/2021, revealed the facility did "substantiate the allegations" that Resident #82 "did in fact hold on to" Resident #64's wrist, was not able to be redirected which resulted in "non-injury to resident" #64. The facility recommended psychiatric services to evaluate the resident's behaviors. The report failed to indicate if abuse was substantiated or not.

4. Review of a facility reported incident revealed on 06/30/2021 Resident #82 wandered into Resident #317's room. Resident #317 was asking the resident to leave his/her room and

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Resident #317 was "holding onto" Resident #82's wrist. Staff escorted Resident #82 out of his/her room. According to the facility reported incident, the facility determined they did not substantiate abuse between Resident #82 and Resident #317. Continued review of the report revealed due to "medical condition of Dementia and Alzheimer's Disease" Resident #82 "inadvertently entered room, looking for" his/her room and he/she was transferred to the hospital for evaluation and treatment.

Review of Resident #82's medical record revealed the resident was transferred to an inpatient psychiatric stay on 07/01/2021 and returned to the facility on 07/08/2021; however, according to staff there were no changes in Resident #82's behaviors when he/she returned from the hospital stay.

5. Review of Resident #86's medical record revealed, on 07/13/2021 at 11:15 AM, Resident #86 called the State Police because Resident #82 was coming in his/her room and was exposing him/herself. However, review of the record revealed RN #1 informed the Police that "95% of our residents had Dementia and some do wander". Per the record, the RN informed the Police a resident had not been exposing him/herself to Resident #86 or others. The RN also documented she informed the Police Resident #86 "has been known to exaggerate."

Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was working on 07/13/2021, when Resident #86 contacted the State Police. The nurse stated the incident were reported to the Administrator; however, no actions had been taken to protect

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the resident or to investigate the resident's allegation. She stated she informed the police the incident had not occurred because she had not witnessed it; however, acknowledged the incident was an allegation of abuse which should have been reported/investigated and interventions should have been implemented to protect the resident.

6. Review of Resident #86's facility reported incident, dated 07/15/2021, revealed Resident #82 wandered into Resident #86's room and "picked up" Resident #86's shoes and then turned to leave the residents room. According to the incident report, Resident #86 pressed his/her personal alarm provided by the facility and threw water on Resident #82. Documentation on the report also indicated a stop sign had been implemented to prevent residents from wandering into his/her room, however Resident #86 "frequently takes it down." Continued review of the investigation revealed the facility determined Resident #82 was abused by Resident #86, and the report also stated steps taken to prevent further abuse was that the facility would encourage Resident #86 to keep his/her stop sign up when he/she was in her room.

Review of Resident #86's medical record, dated 07/15/2021, revealed at approximately 5:50 PM Resident #82 had wandered into Resident #86's room and "picked up" the residents shoes. According to the record Resident #86 informed staff that he/she was asleep and when the resident woke up, the other resident was in her room and the resident stated "I was afraid" he/she was going to hit me so I threw water on" him/her and also informed staff he/she "would get" him/her "before" he/she "gets me." The

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medical record also revealed Resident #86 informed staff his/her stop sign was not in use at the time of the incident, and he/she stated he/she preferred not to utilize the stop sign.

Observations conducted of Resident #86, on 07/27/2021 at 1:00 PM, revealed no stop sign was in place and no personal alarm was in use on the resident's person, to prevent other residents from entering his/her room. Further observations revealed a large bruise, approximately 6 x 8 inches in size, and red/purple in color to the resident's left upper arm. The resident informed the surveyor he/she sustained the bruising when Resident #82 hit him/her with a shoe.

An interview with Resident #86, on 07/27/2021 at approximately 1:00 PM, revealed he/she felt like the facility was not trying to help him/her, and the resident did not know what else to do. The resident stated Resident #82 entered his/her room, "beat me up" and then "asked me how I liked it". Per the resident, Resident #82 had exposed him/herself to the resident numerous times since Resident #82's admission to the facility. The resident stated he/she reported the incidents to facility staff; however, no one here is helping me. Resident #86 stated he/she had even contacted the Police, but again, "no one has done anything" to help the resident. The resident also stated he/she was "moved down here" (to the opposite end of the hall) to keep Resident #82 away from him/her; however, Resident #82 continues to come in/out of his/her room, even after he/she was hit by the resident. Resident #86 stated, on 07/15/2021, he/she was lying in his/her bed and Resident #82 entered his/her room again, exposed him/herself to the resident

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and picked up the residents shoe and hit him/her, with the shoe on the left upper arm. The resident stated he/she threw water on the resident to get him/her out of his/her room, and he/she reported to staff that Resident #82 exposed him/herself to him/her again; however, no actions have been taken to protect him/her from further abuse from Resident #82.

Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed she cared for Resident #82 since he/she has been admitted to the facility and he/she wandered into other residents rooms, "picks up their" personal belongings and exposes him/herself to other residents. The SRNA stated Resident #82 had been exposing him/herself to Resident # 86 for "a long time." She stated the concern had been reported to RN #9 and the RN had contacted the facility Administrator; however, staff were instructed to move Resident #86's room when he/she "hadn't done anything wrong," because the residents resided across the hall from each other when the incident occurred, sometime in "early June" 2021. According to the SRNA, even though the resident's room had been moved, Resident #82 continued to wander in/out the resident's room, and continued to expose him/herself to the resident. SRNA #16 stated incidents continued to be reported to nursing staff, which informed the SRNA they had reported to ongoing concerns to the Administrator; however, no actions had been taken to protect Resident #86 or others from abuse. The SRNA stated she worked the night shift (6 PM-6 AM) beginning on 07/15/2021 after the incident occurred between Resident #82 and Resident #86. She stated upon her initial rounds at approximately 6:30 PM, Resident #86 reported

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the incident and stated Resident #82 came in his/her room, exposed him/herself to the resident again and hit him/her with a shoe. The SRNA also stated, Resident #86 had a "large purple bruise" to his/her left arm at the beginning of his/her shift, and she reported the resident's injury to Licensed Practical Nurse (LPN) #8. She stated the Administrator was on the unit after the incident occurred; however, she had not been questioned about the incident until questioned by the surveyor. According to the SRNA, Resident #82 continued to wander in/out of other resident's rooms and no actions were taken to protect residents from abuse.

Interview with SRNA #18, on 07/27/2021 at 10:00 PM, revealed he/she also worked the night shift on 07/15/2021 and observed a large bruise and a "knot" to Resident #86's left upper arm. The SRNA stated Resident #86 reported that Resident #82 entered his/her room, exposed him/herself to the resident and hit the resident with a shoe. The SRNA stated Resident #82 frequently wandered into other resident's rooms, and Resident #86 had reported, on numerous occasions Resident #82 exposed him/herself to the resident and wandered in/out of his/her room; however, no actions were taken to protect the resident. The SRNA stated he/she could not understand why Administration "punished" and "acted like it was" Resident #86's fault, especially since this was not the first time the resident had exposed him/herself to Resident #86. According to the SRNA, the resident's large bruise and "knot" was reported to LPN #8.

Interview with LPN #8, on 07/27/2021 at 9:30 PM, revealed she worked the night shift (6 PM-6 AM) on 07/15/2021 when the incident occurred, and

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also stated the incident occurred right before she arrived for her shift. She acknowledged Resident #86 informed staff Resident #82 entered his/her room, exposed him/herself to the resident, and hit the resident with a shoe. She also stated staff reported a large bruise on Resident #86, which she observed and reported the bruising to the ADON; however, the ADON failed to implement any interventions to protect residents from abuse.

Interview with the ADON/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, she was aware Resident #86 was afraid of Resident #82; however, stated she thought the resident was just "afraid in general in the facility" and felt like his/her fear was unrelated to Resident #82, and he/she "just didn't like" Resident #82. She also stated she came to the unit, on 07/15/2021, when Resident #82, wandered into Resident #86's room; however, stated no one informed her Resident #86 reported to staff Resident #82 exposed him/herself to the resident that day, or any other day. She also stated staff had notified her of a bruise on Resident #86's left arm; however, stated she felt the residents bruise was self-inflicted because someone told her Resident #86 had been observed "poking at" his/her arm.

7. Review of Resident #64's record revealed Resident #82 entered his/her room again on 07/31/2021 at approximately 4:50 AM, was going through the residents personal belongings and when Resident #64 asked Resident #82 to exit his/her room, Resident #82 hit Resident #64 on the right wrist. According to the record, a small red area was observed to his/her right wrist.

Interview with RN #9, on 07/29/2021 at 9:30 PM, and again on 08/02/2021 at 2:00 PM, revealed

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she provided cared to Resident #82 since he/she was admitted to the facility in May 2021, and his/her abusive behavior towards staff and other residents had been continuous since admission. The RN stated Resident #82 had wandered in/out of other resident's rooms, "yelled/growled" at other residents and created fear in others. She also stated Resident #64, Resident #322 and Resident #86 had reported they were afraid of Resident #82 and even though the concerns have been reported to the ADON and the Administrator, on more than one occasion, no actions have been taken to protect the residents. However, the RN stated sometime in June 2021, exact date unknown, a SRNA reported to her that Resident #86 informed staff that Resident #82 exposed him/herself to the resident. According to the RN, she reported the resident's allegation to the Administrator and the Administrator instructed the RN to move Resident #86 to the other end of the hall, because the residents resided across the hall from each other. She stated Resident #86 was moved as directed by the Administrator; however, Resident #82 continued to wander down the hall, into his/her room and expose him/herself and has also hit Resident #86 with a shoe, resulting in a large bruise and a hematoma since he/she had been moved. According to the RN, Resident #82 wandered into Resident #64's room and hit the resident again on 07/31/2021. She stated Resident #64 was already afraid of the resident because he/she had previously hit the resident, and when she assessed Resident #64 on 07/31/2021 after the incident occurred, the resident was "in tears." The 07/31/2021 incident was reported to the Administrator, and the RN was instructed to keep the resident a 1:1; however, the RN stated she informed the Administrator due to staffing, that was not

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F 600	Continued From page 66 possible, and no further direction was taken to protect the residents. Review of nursing documentation, on 08/01/2021 at 3:15 PM, Resident #82 was alert, and "wandering into rooms," approximately 10 hours after he/she hit Resident #64 for the second time. Interview with the ADON/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, she had worked at the facility for approximately one (1) year and had just been moved into the position of interim DON within the last few weeks. She also stated since being ADON at the facility, she had worked the floor as a staff nurse, more than she had been able to conduct morning meetings, or complete any monitoring in the facility for the residents. She also stated the facility had no system in place to monitor resident behaviors which could result in resident to resident abuse incidents; however, stated residents should be free from abuse in the facility and should not be afraid. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was the Abuse Coordinator and was aware Resident #86 informed staff he/she was afraid of Resident #82. However, the Administrator stated she felt Resident #86 targeted Resident #82 and also stated she thought Resident #86 "hit" his/her self and stated she felt the residents bruising was self-inflicted. When asked what interventions she had implemented to ensure Resident #86 was free from abuse in the facility, she stated she had provided the resident with a personal alarm to ring when incidents occurred, and had staff place a stop sign at his/her door; however, the resident refused to utilize the interventions and stated	F 600		

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F 600	Continued From page 67 nothing else had been implemented to protect the resident or to help him/her feel safe in the facility. She acknowledged however, Resident #82's wandering into other residents rooms did trigger resident to resident abuse incidents, and when asked what interventions had been implemented to protect other residents from abuse, as well as Resident #82 she stated, "I can attempt to place" him/her somewhere else because he/she wanders. She also stated she had no system in place to monitor resident's behaviors in the facility because this was a "nursing thing." She also stated meetings were being held Monday-Friday to discuss nursing issues; however, she was not sure who attended those meetings. Per interview the ADON frequently worked the floor as a staff nurse due to short staffing in the facility. Further she stated she had not attended any of those meetings since she became Administrator on 06/07/2021 because "this place is such a mess" and she had "a lot of issues in the facility kitchen."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		

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F 609	Continued From page 68 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure all alleged violations involving abuse or neglect, were reported immediately, but no later than two (2) hours after the allegation was made, if the events that caused the allegation involved abuse, to the State Survey Agency and Adult Protection for two (2) out of fifty-seven (57) sampled residents (Resident #206	F 609		

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F 609	Continued From page 69 and Resident #64). Review of a facility investigation, dated 05/26/2021, revealed Resident #206 complained of hip pain on 05/26/2021. An x-ray was ordered and revealed a Left Femoral Neck Fracture (fractured left hip). The facility investigated the fracture as an injury of unknown source but failed to report the allegation to the state agencies. In addition, on 06/04/2021, Resident #82 grabbed Resident #64's arm and refused to let go. The facility failed to report the allegation of abuse to the state agencies. The findings include: Review of the facility's policy, "Abuse Investigation and Reporting", with a revision date of December 2016, revealed all reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin shall be reported to local, state, and federal agencies and thoroughly investigated by facility management. Findings of abuse would also be reported. The policy stated the Administrator would assign the investigation to an appropriate individual. The policy stated all alleged violations involving abuse, neglect, exploitation, mistreatment, or injuries of unknown origin, or misappropriation of resident's property would be reported by the Administrator or his/her designee to the state licensing /certification agency, the Ombudsman, the Responsible Party of record, Adult Protective Services, Law Enforcement Officials, the resident's physician, and the Medical Director within two (2) hours. 1. Review of Resident #206's closed medical record, revealed the facility admitted the resident	F 609		

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F 609	Continued From page 70 on 05/19/2021, with diagnoses which included Polyarthritis, Vascular Dementia, Lack of Coordination, Atrial Fibrillation, Insomnia, Paranoid Personality Disorder, Chronic Pain Syndrome, Osteoporosis, and Stress Incontinence. The medical record revealed the resident had been discharged to the hospital from the facility on 05/26/2021. Review of a Discharge Minimum Data Set (MDS) Assessment for Resident #206, dated 05/26/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating cognitive impairment. No Admission MDS had been completed due to the resident had been discharged from the facility before the assessment was completed. Review of nurses notes for Resident #206, revealed an entry, dated 05/26/2021 at 7:35 AM, by RN #1 which stated the resident complained his/her head, stomach and left hip hurt. Per the note, the left hip pain was diffuse, and the hip was tender to touch. The resident's physician was notified with an order received for an X-ray of the left hip. Review of an X-ray report of Resident #206's left hip, dated 05/26/2021 at 6:54 PM, revealed the resident had an Acute Displaced Left Femoral Neck Fracture. Further review of Resident #206's nurses notes revealed an entry, dated 05/26/2021 at 7:44 PM, by the Director of Nursing (DON) which stated the resident was transferred to the hospital via ambulance for evaluation of a fractured hip.	F 609		

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F 609	Continued From page 71 Review of a facility investigation, dated 05/26/2021, revealed Resident #206 was observed by staff to have left hip pain and guarding. Registered Nurse (RN) #1 notified the physician and an X-ray was obtained. The investigation revealed upon the nurse notification of the Responsible Party (RP), the RP had alleged to the nurse he/she felt the resident had been neglected. The investigation revealed Resident #206 had sustained a Left Femoral Neck Fracture (fractured left hip) which was an injury of unknown origin. According to the investigation, Resident #206 had initially told staff she had fallen, and then later denied he/she had fallen. However, there was no documented evidence the facility had notified the state agencies, per the facility's policy. Interview conducted with State Registered Nursing Assistant (SRNA) #7, on 06/18/2021 at 1:30 PM, and SRNA #3, on 06/18/2021 at 1:35 PM, revealed when they went in to assist Resident #206 to the bathroom, on 05/26/2021 at approximately 7:30 AM, the resident was complaining of pain in his/her left hip. The SRNAs stated RN #1 was notified. Interview conducted with RN #1, on 06/18/2021 at approximately 1:40 PM, revealed she had been notified by SRNA #3 and SRNA #7 that Resident #205 was complaining of left hip pain. The RN stated she assessed the resident, and the resident was complaining of head, stomach, and left hip pain. The RN stated she had first made rounds at approximately 6:45 AM to 7:00 AM, the resident was sleeping and no apparent signs of pain. The RN stated she had notified the physician and had obtained an order for an X-ray of the left hip. Continued interview revealed she	F 609		

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had initially attempted to reach the resident's RP unsuccessfully, but had reached the RP a few minutes later. The RN stated when she had initially asked the resident what happened, the resident had told her he/she had fallen. The RN stated when she had gone with Licensed Practical Nurse (LPN) #7 later the resident had stated he/she had not fallen. The RN stated the resident was very confused. Further interview revealed the resident's RP had told her she felt the resident was neglected. The RN stated she had immediately informed the Administrator.

Interviews conducted with LPN #7, on 06/18/2021 at 7:55 PM, SRNA #10 on 06/18/2021 at 8:05 PM, and SRNA #11 on 06/18/2021 at 8:20 PM, revealed they had provided care for Resident #206 on the 6:00 PM to 6:00 AM shift, on 05/25/2021 into 05/26/2021. The staff revealed Resident #206 had slept all night and they had not been aware of any falls. The staff further revealed Resident #206 had not complained of any pain until SRNA #10 and SRNA #11 had went into the resident's room at approximately 5:00 AM, and the resident had complained of back pain which they immediately reported to LPN #7. However, when LPN #7 went into the room, the resident had already fallen back asleep, and the LPN had observed no signs of pain.

Interview conducted with Department of Community Based Services (DCBS) Worker, on 06/18/2021 at 3:30 PM, revealed there was no evidence DCBS had been notified of the allegation of neglect or of the injury of unknown source.

Interview conducted with the Director of Nursing (DON), on 06/19/2021 at 9:00 AM, revealed she

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had assisted with the investigation. The DON stated she was now the Abuse Coordinator, but the Abuse Coordinator had previously been the former Administrator. The DON stated she had faxed the report to the State Agencies but did not have a confirmation the report had went through. The DON stated she had not been aware she had needed a confirmation. The DON stated staff had on previous occasions observed Resident #206 ambulating in his/her room unassisted. The DON stated she felt at some point the resident had fallen but nothing had been witnessed.

Attempted to reach the former Administrator on 06/19/2021 at 8:30 AM, and 06/19/2021 at 9:30 AM were unsuccessful.

Interview conducted with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator for two (2) weeks. The Administrator stated all allegations of abuse should be reported to State Agencies within two (2) hours. The Administrator stated she would now be using both fax and email to report all allegations of abuse and would ensure the facility had a confirmation.

2. Review of the facility investigation titled, "Facility Investigation" dated 06/04/2021, revealed RN #1 on 06/04/2021 at 1:15 PM, heard a noise coming from the hallway and upon investigation RN #1 found Resident #82 in Resident #64's room holding onto Resident #64's wrist and arm. After trying to redirect Resident #82 without success, RN #1 and SRNA #7 had to remove Resident #82's hand from Resident #64's arm. Immediately after the release, Resident #82 and Resident #64 were assessed for injuries. RN #1 contacted the Abuse Coordinator (former

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Administrator) and reported the incident. Resident #82 was placed on one-to-one supervision by staff until the ambulance arrived to have the resident assessed at the Emergency Room. Resident #64 had an x-ray ordered for his/her arm and was found to have no injury.

Review of the medical record for Resident #64 revealed the resident was admitted by the facility on 04/28/2021 with diagnoses including Unspecified Dementia without Behavioral Disturbance, Anxiety Disorder and Hypertension.

Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/05/2021, for Resident #64, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15), and determined the resident was moderately cognitively impaired.

Review of the medical record for Resident #82 revealed the resident was admitted by the facility on 05/12/2021 with diagnoses including Parkinson Disease, Unspecified Dementia with Behavioral Disturbance and Alzheimer's Disease.

Review of Resident #82's Admission MDS Assessment, dated 05/18/2021, revealed the facility assessed the resident to have a BIMS score of zero (00) out of fifteen (15), and determined the resident was severely cognitively impaired.

Interview with the DCBS worker, on 06/18/2021 at 11:46 AM, revealed the agency had not received an abuse report from the facility regarding Resident #64 and Resident #82.

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F 609	Continued From page 75 Interview with RN #1, on 06/18/2021 at 1:58 PM, revealed as soon as the incident happened and the residents were safe and secure, she phoned the Abuse Coordinator (former Administrator) and reported the abuse. RN #1 revealed an investigation was initiated immediately; however, she did not know who was responsible to report to the state agencies. Interview with the DON, on 06/19/2021 at 12:27 PM, revealed the former Administrator was the Abuse Coordinator and she was the Assistant Coordinator. The DON also revealed the facility has two (2) hours to report to the state agencies any allegation of abuse that is witnessed or made. The DON revealed she had faxed a report of the incident to the state agencies; however, she did not have any confirmation showing it had been received by the agency. Interview with the Administrator, on 06/19/2021 at 2:14 PM, revealed she had only been the Administrator for the past two (2) weeks. The Administrator further revealed it was the responsibility of the Abuse Coordinator to notify state agencies within two (2) hours of the abuse occurring or an allegation of abuse.	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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	F 623		

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F 623	Continued From page 76 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 (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	F 623		

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F 623	Continued From page 77 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. 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	F 623		

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F 623	Continued From page 78 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 interview, record review, and review of the facility's policies, it was determined the facility failed to provide one (1) of fifty-seven (57) sampled residents (Resident #82) with a written discharge notice. On 08/09/2021, Resident #82 was transferred to the hospital due to tachypnea (abnormally rapid breathing). On 08/13/2021, the hospital case management documented that the facility was unable to readmit Resident #82 back to the facility due to his/her behavior of wandering. The facility discharged the resident on 08/09/2021, without issuing the resident a discharge notice. The findings include: Review of the facility's policy "Transfer or Discharge, Preparing a Resident for" revised December 2016, revealed residents would be prepared in advance for discharge. When a resident was scheduled for transfer or discharge, the business office would notify nursing services of the transfer or discharge so that appropriate procedures could be implemented. A post-discharge plan was developed for each resident prior to his/her transfer or discharge. This plan would be reviewed with the resident, and/or his/her family, at least 24 hours before the resident's discharge or transfer. Further review of	F 623		

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the policy revealed nursing services was responsible for obtaining orders for the discharge or transfer, completing the discharge note in the medical record, and preparing the discharge summary and post discharge plan. Nursing services was also responsible for providing the resident or the resident's representative with required documents, including the discharge summary and plan.

Review of the facility's policy "Resident Rights" dated December 2016, revealed the policy did not address resident rights concerning resident discharge.

Review of Resident #82's medical record revealed the facility admitted Resident #82 on 05/12/2021, with diagnoses that included Parkinson's Disease, Alzheimer's Disease, and Unspecified Dementia with Behavioral Disturbances.

Review of Resident #82's Quarterly Minimum Data Set (MDS) Assessment, dated 07/14/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15), indicating the resident had severe cognitive impairment.

Review of a Situation Background Assessment Review (SBAR), dated 08/09/2021 at 12:45 PM, revealed Resident #82 was experiencing respiratory distress and needed to be transferred to a hospital.

Review of Resident #82's hospital record revealed a Case Management Note, dated 08/13/2021. Per the note,the resident was pending discharge back to the facility and per the

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F 623	Continued From page 80 facility, the resident would not be readmitted due to wandering behaviors. Interview with Resident #82's family member was attempted on 08/30/2021 at 1:17 PM with a message left to return the call. However, no return call was received. Interview with the Social Services Director (SSD), on 09/01/2021 at 2:40 PM, revealed she was not aware that she was required to send the resident, his/her family, or the Ombudsman a discharge notice. She stated she was employed in this position approximately one (1) and a half months ago and was not trained on discharge notices. Interview with the Administrator, on 09/10/2021 at 6:49 PM, revealed Resident #82 did not receive a discharge notice but should have. She stated the SSD was responsible to ensure appropriate notices were sent to residents and responsible parties.	F 623		
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 interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for two (2) of fifty-seven (57) sampled residents (Resident #65 and Resident #323).	F 641		

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F 641	Continued From page 81 Review of Resident #65's medical record revealed on 04/06/2021, the resident sustained a 36.6 pound, or 20.28% weight loss in less than thirty (30) days. Further on 05/02/2021, the resident developed a deep tissue injury to the coccyx/sacrum while a resident at the facility. However, the facility completed an MDS on 05/05/2021 that stated the resident had not sustained a weight loss and the pressure ulcer was present on admission. The facility also completed an MDS on 08/05/2021 that stated the pressure ulcer was present on admission. Review of Resident #323's medical record revealed the resident had two (2) pressure ulcers, the right and left buttock. However, the facility completed an MDS assessment on 07/13/2021 and documented that the resident had one (1) pressure ulcer. The findings include: Review of the policy, "Resident Assessments", revised November 2019, revealed, "The Interdisciplinary Assessment Team must use the Minimum Data Set (MDS) form currently mandated by Federal and State regulations to conduct the resident assessment". 1. Review of the MDS Manual, mandated by Federal and State regulation, Section M0300, revealed the facility must determine whether a pressure ulcer was "present on admission". The instructions stated, "For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current	F 641		

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F 641	Continued From page 82	F 641		

and historical levels of tissue involvement".

Further review of the MDS Manual, Section K0300, revealed when completing a resident MDS assessment for Section K0300, the facility must answer whether the resident had sustained weight loss of five percent (5%) or more in the last month or less or a loss of ten percent (10%) or more in the last six (6) months. According to the manual, staff were required to code "2", indicating yes, when the resident was not on physician-prescribed weight-loss regimen and had experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

Review of Resident #65's medical record revealed the facility admitted the resident on 03/24/2021, with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia.

Review of Resident 65's Admission Minimum Data Set (MDS) assessment, dated 03/30/202,1 revealed the resident was totally dependent on two (2) staff with Activities of Daily Living, was occasionally incontinent of bowel, had an indwelling catheter, and had no pressure ulcers. Further review revealed Resident #65 weighed 179 pounds and had no weight loss/gain or the resident's weight history was unknown.

Review of the medical record revealed Resident #65 was discharged to the hospital on 04/08/2021 for shortness of breath. Continued review of the resident's medical record revealed Resident #65 was re-admitted to the facility on 4/29/2021 with

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F 641	Continued From page 83 diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure, and Urinary Tract Infection. The record revealed the was no documented evidence the facility weighed the resident upon readmission to the facility. Review of an Admission/Readmission Nursing Evaluation for Resident #65, dated 04/29/2021 at 6:00 PM, revealed the resident had "scratches" to his/her bilateral buttocks upon readmission from the hospital, with no other impaired skin integrity noted. Review of Resident #65's weight record revealed on 04/06/2021, the resident weighed 142.7 pounds (a weight loss of 36.6 pounds since admission or 20.28% loss). Review of a change of condition form, dated 05/02/2021 at 10:35 AM, revealed Resident #65 had developed a deep tissue injury (DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx. A new physician's order was obtained to "clean coccyx with soap and water, pat dry, apply zinc oxide and cover with border gauze every day". Continued review of Resident #65's weight record revealed on 05/04/2021, the resident weighed 135 pounds, another 7.7 pound weight loss (5.4% in one month and 24.58% in less than 180 days). However, review of Resident #65's Quarterly MDS assessment, dated 05/05/2021, revealed the facility documented the resident's pressure ulcer was present upon admission and the resident had sustained no weight loss.	F 641		

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F 641	Continued From page 84	F 641		

Review of Resident #65's Quarterly MDS assessment, dated 08/05/2021, revealed the facility identified the resident had sustained a weight loss. However, the facility continued to document that Resident #65's pressure ulcer was present upon admission to the facility.

Interview with MDS Nurse #1, on 09/10/2021 at 4:55 PM, revealed she utilized the Resident Assessment Instrument (RAI) MDS manual as a guide for coding resident MDS assessments and was responsible for completing Section M for Resident #65. She stated she failed to accurately code Resident #65's pressure ulcer because it was not present upon admission. She stated she also failed to accurately code Resident #65's March 2021 MDS regarding weight loss, stating the MDS should have reflected a weight loss for the resident.

2. Review of the MDS Manual, mandated by Federal and State regulation, Section M0300, revealed the facility must answer the question, "Current number of unhealed pressure ulcers/injuries at each stage".

Review of Resident #323's medical record revealed the resident was admitted by the facility on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Type 2 Diabetes, Dysphagia, Pneumonia and Aphasia.

Review of progress notes, dated 07/12/2021, revealed Resident #323 had an "Unstageable" pressure ulcer to the right buttock and one to the left buttock. However, a review of Resident #323's Admission MDS assessment, completed on 07/13/2021, revealed the facility documented

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F 641	Continued From page 85 in Section M0300 that the resident had one (1) current unhealed pressure ulcer/injuries. Interview with the MDS Nurse #1, on 08/09/2021 at 1:53 PM, revealed she utilized the Resident Assessment Instrument (RAI) manual for coding of resident MDS assessments. She revealed that she was responsible for completing Section M for Resident #323. She stated that she overlooked and failed to accurately code the resident's pressure ulcers on the Admission MDS. Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/DON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one year, and was placed in the interim DON position, a few weeks ago, when the Director of Nursing (DON) resigned from the facility. The ADON/Interim DON stated MDS assessments should be completed accurately to ensure residents received care they required. She stated she had never monitored any clinical processes in the facility, including assessments because she had worked as a staff nurse "all the time." Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was responsible for the facility operated within the regulatory guidelines and stated MDS assessments should be accurate. However, according to the Administrator, she had had no systems in place to monitor accuracy of assessments.	F 641		
F 655 SS=J	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		

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F 655	Continued From page 86 §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 87 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to have an effective system in place to ensure baseline care plans were developed with instructions and minimum healthcare information necessary to provide effective person-centered care and failed to provide a summary of the services and treatments to be provided by the facility for two (2) of fifty-seven (57) sampled residents (Resident #321 and #323). Resident #321 was admitted to the facility on 07/16/2021 with diagnoses of diabetes, Urosepsis, and invasive bladder cancer. The facility failed to develop a baseline care plan related to the resident's diabetes diagnosis and monitoring of the resident's blood sugar. Subsequently, the facility failed to monitor the resident's blood sugar to ensure the resident's blood sugar was stable. At approximately 12:00 AM to 12:30 AM on 07/19/20201, a laboratory staff person found Resident #321 unresponsive. the resident's blood sugar was 32. Staff administered Glucagon again and attempted oral glucose. The resident began having trouble breathing and EMS was notified. The resident was transferred to the hospital where he/she was diagnosed with acute metabolic Encephalopathy secondary to hypoglycemia and hypoxia. The record stated there was also some concern for aspiration due to attempted administration of oral glucose gel. Resident #321 was non-responsive,	F 655		

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had hypoxic respiratory failure, and required intubation.

Resident #323 was admitted to the facility on 07/06/2021 following a hospital admission for Respiratory Failure. According to the resident's family, the resident required BiPAP to assist the resident with breathing at night. The facility failed to develop a baseline care plan for Resident #323 related to the resident's history of respiratory failure and failed to provide a summary of the care to be provided to the resident's responsible party. Subsequently, the facility failed to ensure the resident received a BiPAP machine until 07/14/2021, eight (8) days after admission and failed to monitor/assess Resident #323's respiratory status. On 07/20/2021, Resident #323's family visited and found the resident was having difficulty breathing. They requested the resident be transferred to the hospital. Resident #323 was admitted to the hospital with diagnoses that included Dyspnea, Stridor, Acute Hypoxic Respiratory Insufficiency requiring high flow nasal cannula with Vapotherm (high flow oxygen), Left Lower Lobe Pneumonia versus Atelectasis, and Elevated Lactate. Review of the nurses notes upon admission to the emergency room revealed the resident had mild wheezes bilateral, use of accessory muscle for breathing, increased respiratory effort and audible Stridor.

The facility's failure to have an effective system in place to ensure baseline care plans were developed and implemented, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from

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Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Review of a facility policy titled "Care Plans-Baseline," dated December 2016, revealed a baseline care plan to meet the resident's immediate needs would be developed within forty-eight (48) hours of the resident's admission. Further review revealed the Interdisciplinary Team (IDT) would implement a baseline care plan to meet the resident's immediate care needs, including but not limited to, initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, Preadmission Screening, and Resident Review (PASARR). The policy stated resident and their representative would be provided a summary of the baseline care plan that included, but not

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limited to, the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility, and any updated information based on the details of the comprehensive care plan as necessary.

1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021 with diagnoses of Urosepis, Diabetes Mellitus, and Invasive Bladder Cancer.

Review of Admission Minimum Data Set (MDS) assessment, dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact.

Review of the Physician's order, dated 07/16/2021, revealed an order to monitor Resident #321 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift (two times daily) for diabetic monitoring, and may complete finger stick per required need (PRN). Further review revealed staff were required to notify the physician if the resident's blood glucose was below seventy (70) or greater than three-hundred and fifty (350).

Review of Resident #321's baseline care plan, dated 07/16/2021, revealed there was no documented evidence to identify the resident had Diabetes Mellitus, and no focus area or interventions in place for monitoring the resident's blood glucose level or managing the resident's Diabetes Mellitus.

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F 655	Continued From page 91 Interview with Licensed Practical Nurse (LPN) #2, on 07/28/2021 at 6:52 AM, revealed she was assigned to care for Resident #321 at 3:00 AM on 07/16/2021, when the resident was admitted to the facility. She stated she only provided care for the resident for a few hours then LPN #6 completed the admission process and took over care of the resident at 7:00 AM. LPN #2 stated day shift nurses completed resident admissions and she did not know a lot about the admission process or development of the baseline care plan. Interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed she provided care to Resident #321 on 07/16/2021 and 07/17/2021 during the day shift (7:00 AM to 7:00 PM) and completed his/her admission paperwork. LPN #6 stated the admitting nurse was responsible for completing the baseline care plans She stated the baseline care plan should include information regarding Diabetes; however, there was no place to add that information on the baseline care plan form. Review of nursing notes, dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM, LPN #6 obtained a blood glucose on Resident #321 of 67 mg/dL, then delivered a tray to the resident and obtained a repeat blood glucose (exact time unknown) of 139 mg/dL. Further review revealed Resident #321 had a visitor arrive at approximately 10:45 AM. Interview with Family Member #3, on 08/02/2021 at 5:30 PM, revealed she arrived to the facility at 10:45 AM on 07/18/2021 for a scheduled visit. She stated Resident #321 was awake and alert talking to her as normal during the visit. She stated Resident #321 told her that his/her blood	F 655		

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sugar had dropped to sixty-seven (67) milligram per deciliter (mg/dL) that morning. However, she stated she left at approximately 3:00 PM and staff had not obtained a repeat blood sugar during her visit.

Interview with Family Member #1, on 07/28/2021 at 2:19 PM, revealed she had spoken with Resident #321 on the phone on 07/18/2021 and was aware the resident's blood sugar was low that morning. She further stated that Resident #321 told staff his/her blood sugar was low repeatedly on 07/18/2021, and at 4:00 PM on 07/18/2021 when she last spoke to him/her, it had taken staff an hour to respond to the resident's call light and staff had still not checked his/her blood sugar.

Interview with State Registered Nurse Aide (SRNA) #1, on 08/03/2021 at 3:19 PM, revealed she entered Resident #321's room sometime after lunch, late afternoon on 07/18/2021 (unsure of exact time) , and found the resident non-responsive. She stated she alerted LPN #6 and the resident's blood sugar was low. She further stated that she did not recall what the resident blood sugar was at that time, but that the resident was better prior to shift change that evening between 6:00 PM and 6:30 PM.

Continued interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed Resident #321 had a hypoglycemic episode late afternoon on 07/18/2021, (could not recall the exact time). She stated when she entered the room, the resident was not responsive and the resident's blood sugar was approximately forty (40) mg/dL. She stated she administered an injection of Glucagon (quickly raises the blood sugar) and oral glucose.

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The LPN stated she thought the blood sugar came up to approximately one hundred and thirty-nine (139) mg/dL, but was unsure. Continued review of Resident #321's medical record revealed no documentation of the incident and no further documented evidence the facility monitored the resident's blood sugar after the incident.

Review of nursing notes, dated 07/19/2021 at 12:23 AM, revealed Registered Nurse (RN) #7 was alerted to Resident #321's room by a SRNA and the resident was found to be clammy and non-responsive, a blood glucose was obtained and was thirty-two (32) mg/dL. After administering Glucagon and oral glucose, the resident continued to be non-responsive and the resident began experiencing labored breathing. According to the nursing notes, the resident was transferred to the hospital at 1:00 AM on 07/19/2021.

Review of emergency room record, dated 07/19/2021, revealed resident #321 arrived to the emergency room at 1:36 AM, was non-responsive and unable to follow commands. Further review revealed Resident #321 was intubated at 1:50 AM following arrival to the hospital and admitted to the Intensive Care Unit (ICU) with a diagnosis of Altered Mental Status, Hypoxia, and Pneumonia with Acute Metabolic Encephalopathy (problem in the brain caused by chemical imbalance in the blood) most probable from hypoglycemia and hypoxic respiratory failure.

Interview with MDS Coordinator #1, on 08/10/2021 at 11:30 AM, revealed the facility utilized a computerized form to complete for a baseline care plan and the form did not ask about

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specific diagnoses/conditions like Diabetes. She further stated that if a resident was a Diabetic, it would not be on the care plan until the comprehensive care plan was developed. MDS Coordinator #1 stated, she had identified that specific resident problems were not listed on baseline care plans and had also identified that they were not reviewed with residents/resident representatives, and had brought it to the attention of the Director of Nursing (DON).

Interview with Assistant Director of Nursing (ADON)/Acting Director of Nursing (DON), on 08/11/2021 at 12:05 PM, revealed she was unsure if all nursing staff had been trained regarding admissions and baseline care plans. She stated she was aware there was not a place on the baseline care plan to include resident problems such as Diabetes.

Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed baseline care plans were not reviewed with the resident or resident representative. She stated care plans were not reviewed with the resident or family until a comprehensive care plan was developed. The Administrator stated resident diagnoses, such as Diabetes should be included in the baseline care plan and implemented on admission by the admitting nurse.

2. Review of Resident #323's medical record revealed the resident was admitted by the facility on 07/06/2021 after a hospital stay for respiratory failure. The resident had diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Type 2 Diabetes, Dysphagia, Pneumonia, and Aphasia.

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Review of the hospital Discharge Summary revealed prior to admission to the facility, Resident #323 was admitted to the Intensive Care Unit (ICU) after being found unresponsive at home. The summary stated the resident had a diagnosis of Autism and drank an entire bottle of hand sanitizer resulting in severe Alcohol Intoxication. The resident was also diagnosed with Pneumonia and had Cardiopulmonary Arrest while in the ICU. According to the discharge summary, the resident was discharged to the skilled nursing facility for rehabilitation with orders for nebulizer treatments and to return to Emergency Department if worsening. According to the discharge summary, the resident's lungs were clear upon discharge from the hospital.

Review of Resident #323's baseline care plan, developed by the facility and effective on 07/06/2021 at 5:19 PM, revealed no information regarding Resident #323's care needs or interventions/instructions for staff to use to care for the resident to meet his/her needs regarding the resident's respiratory status or BiPAP machine. According to the form, the baseline care plan was reviewed with the resident's family; however, a copy was not provided.

Review of Resident #323's Admission Minimum Data Set (MDS) assessment, on 07/13/2021, revealed the facility identified the resident required non-invasive mechanical ventilation (BiPAP/CPAP), and oxygen.

Review of Resident #323's medical record revealed there was no documented evidence the facility developed/implemented a care plan to address Resident #323's respiratory status until 07/27/2021 (after the resident discharged from

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the facility). There was no documented evidence the facility provided Resident #323 with a BiPAP machine until date 07/14/2021.

Interview with Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed upon admission to the facility, she notified nursing staff the resident required BiPAP (a machine that provides non-invasive ventilation via a mask, usually with added oxygen, under positive pressure) at night. Continued interview with the resident's family revealed the facility did not review the resident's baseline care plan with them, nor did they receive a copy. Subsequently, they were not aware the resident did not receive a BiPAP machine upon admission.

Interview with LPN #3 revealed she was the nurse assigned to Resident #323, on 07/20/2021. She stated that at approximately 7:30 AM she realized "something was going on" with the resident. She stated the resident was breathing fast and using accessory muscles to aide in breathing. She stated the resident received a breathing treatment and the resident's condition "stayed about the same". Continued interview revealed the resident's family came to visit at approximately 10:00 to 11:00 AM and requested the resident be sent to the ED.

Review of Resident #323's hospital record revealed the resident was admitted on 07/20/2021 at 12:48 PM with diagnosis that included Dyspnea and Stridor. Review of the nurses notes upon admission to the emergency room revealed the resident had mild wheezes bilateral, use of accessory muscle, increased respiratory effort and audible Stridor. Further review of the progress note, on 07/20/2021 at

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F 655	Continued From page 97 10:44 PM, revealed diagnosis that included Acute Hypoxic Respiratory Insufficiency requiring high flow nasal cannula with Vapotherm (high flow oxygen), Left Lower Lobe Pneumonia versus Atelectasis and Elevated Lactate. Interview with Interim Director of Nursing (DON), on 08/11/2021 at 12:05 PM, revealed she expected staff to develop and implement a baseline care plan upon resident admission to the facility, within twenty-four (24) hours of admission. Continued interview revealed she was responsible for ensuring baseline care plans were completed, but did not recall reviewing Resident #323's baseline care plan to ensure it was complete and accurate. According to the Interim DON, she was not aware the facility was required to complete a baseline care plan within forty-eight (48) hours of a resident's admission, or provide a summary of care to the resident/resident representative. She further stated if the baseline care plan summary of care was completed properly, it could have potentially identified the facility's failure to timely obtain wound care and BiPAP for the resident. Interview with the Administrator, on 08/10/2021 at 1:48 PM, revealed she expected staff to develop the pertinent baseline care plans to ensure resident care needs were met. She further revealed that she was not aware the facility was required to complete a baseline care plan within forty-eight (48) hours of a resident's admission, or provide a summary of care to the resident/resident representative.	F 655		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 98 §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 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	F 656		

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F 656	Continued From page 99 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to develop a comprehensive care plan for one (1) of five (5) sampled residents (Resident #65) who had pressure ulcers, and for one (1) of fifty-seven (57) sampled residents at risk for pressure ulcers (Resident #66). The facility failed to implement the care plan for one (1) of fifty-seven (57) sampled residents (Resident #82) who exhibited abusive behaviors towards other residents and exposed himself/herself to other residents. The facility also failed to implement the care plan for one (1) of fifty-seven (57) sampled residents (Resident #14) who had a pressure ulcer. The facility admitted Resident #65 on 03/23/2021 with no pressure ulcers. According to the Braden Scale dated 03/23/2021, the resident was at risk for pressure ulcers due to being chair fast, limited	F 656		

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mobility, potential for friction and shearing. Review of the resident's Minimum Data Set (MDS), also revealed the resident was at risk for pressure ulcers. However, the facility failed to develop and implement a comprehensive care plan, including measurable objectives and timeframes to meet the resident's risk for pressure ulcers.

On 05/02/2021, Resident #65 developed a deep tissue injury (DTI) to the coccyx. On 05/11/2021, staff documented the pressure ulcer had worsened and was unstageable. On 05/26/2021, the pressure ulcer had increased in size, measuring 16.5 centimeters (cm) long by 10 cm wide. The facility continued to fail to develop a care plan to address the resident's pressure ulcer and risk for pressure ulcers.

On 05/28/2021, Resident #65's pressure ulcer had worsened and he/she was transferred to the hospital. Review of the resident's hospital record revealed the resident had a pressure ulcer that "smells like dead flesh". The resident was admitted due to "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65's pressure ulcer required debridement on 05/30/2021, "all necrotic tissue was removed and excision was down to the bone infected decubitis [pressure ulcer] with gas gangrene".

In addition, Resident #14 was admitted to the facility on 05/24/2018 and assessed to be at risk for pressure ulcers. On 09/10/2020, the facility developed a comprehensive care plan stating that Resident #14 was at risk for development of a pressure ulcer due to decreased mobility,

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Diabetes Mellitus (DM), and a diagnosis of Peripheral Vascular Disease (PVD). The comprehensive care plan listed interventions that included to follow facility policies/protocols for the prevention/treatment of skin breakdown. Observe/document/report as needed (PRN) any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth), and stage.

Resident #14 developed abrasions to the left hip and on 06/22/2021, documentation revealed Resident #14 had new skin impairment, three (3) Stage II (two) pressure ulcers the left trochanter (hip). However, the facility failed to assess the pressure ulcers weekly, failed to refer the resident to a wound clinic/specialist, and failed to photograph Resident #14's pressure ulcers weekly as required by the resident's care plan.

Interviews with staff and record review revealed Resident #82 wandered in and out of other residents' rooms, exposed himself/herself to other residents and exhibited abusive behaviors towards other residents. Resident #82's behaviors resulted in five (5) resident-to-resident incidents between 05/18/2021 and 07/31/2021. However, the facility failed to implement the resident's plan of care in an attempt to decrease/prevent Resident #82's behaviors.

The facility further failed to develop a comprehensive care plan with measurable interventions for Resident #66 regarding turning and repositioning the resident to prevent pressure ulcers.

The facility's failure to ensure residents' care plans were developed to prevent and/or treat

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pressure ulcers has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of the facility's documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Review of the facility's policy, "Care Plans, Comprehensive Person-Centered", revised December 2016 revealed the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. Further, the policy stated each resident's comprehensive person-centered care plan would

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be developed within seven (7) days of the completion of the required comprehensive assessment (MDS). According to the policy, assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition changed.

Review of the facility's Prevention of Pressure Injuries Policy, revised April 220, revealed the purpose of the policy was to provide interventions for specific risk factors. The policy revealed staff were required to keep the skin clean and hydrated, clean promptly after episodes of incontinence, and reposition all residents with or at risk of pressure ulcers on an individualized schedule as determined by the Interdisciplinary Team (IDT).

1. Review of Resident #65's medical record revealed the facility admitted the resident on 03/23/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia.

Review of a Braden Scale for Predicting Pressure Sore Risk form dated 03/23/2021 at 3:03 PM, revealed Resident #65 was "at risk" for pressure ulcers with a score of eighteen (18), due to being chair fast, having slightly limited mobility, with adequate nutrition, friction, and shearing being a potential problem.

Review of Resident 65's Minimum Data Set (MDS) admission assessment, dated 03/30/2021, revealed the resident was totally dependent on two (2) staff with Activities of Daily Living, was occasionally incontinent of bowel, had a indwelling catheter, and had no pressure ulcers. Further review revealed the resident was at risk

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for pressure ulcers based on a formal assessment instrument (Braden) and clinical assessment. According to the MDS dated 03/30/2021, Resident #65 did not have a pressure reduction device for the chair; was not on a turning/repositioning program, and did not have nutrition or hydration intervention to manage skin problems. Further review revealed the resident weighed 179 pounds and had no weight loss/gain or his/her weight loss/gain history was unknown, and the resident had complaints of difficulty or pain when swallowing. Further review revealed Resident #65 did not have a condition or chronic disease that may result in a life expectancy of less than six (6) months. According to the MDS, Resident #65 had malnutrition or was at risk for malnutrition.

Review of Resident #65's medical record revealed no documented evidence the facility developed a comprehensive care plan for the resident with interventions to address the resident's pressure ulcer risk in an attempt to prevent pressure ulcers. Further review revealed no evidence the facility addressed the resident's malnutrition/malnutrition risk with interventions to address the risk.

Review of Resident #65's weight record revealed the resident weighed 179.3 pounds upon admission to the facility and 142.7 pounds on 04/06/2021 (36.6 pound weight loss).

Review of the medical record revealed no evidence the facility developed a care plan that addressed Resident #65's weight loss, with interventions to prevent further weight loss. Resident #65 was discharged to the hospital on 04/08/2021 for shortness of breath.

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F 656	Continued From page 105 Review of the medical record revealed Resident #65 was re-admitted to the facility on 04/29/2021 with diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure and Urinary Tract Infection. The record revealed no evidence the resident was weighed upon admission to the facility. Review of the Situation, Background, Assessment and Recommendation (SBAR) Communication form dated 05/02/2021 at 5:29 PM revealed Resident #65 developed a deep tissue injury (DTI) to the coccyx (a DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx. Interview with Licensed Practical Nurse (LPN) #4 on 08/25/2021 at 4:00 PM revealed she identified the deep tissue injury to Resident #65's coccyx/sacrum area. She stated that the area was reddened and round and approximately the size of a quarter. However, there was no documented evidence the facility developed a care plan to address the resident's pressure ulcer. Review of the medical record revealed the facility obtained a weight for Resident #65 on 05/04/2021 of 135 pounds. Review of a Nutrition Data Collection revealed the facility's Registered Dietitian assessed the resident for the first time and documented the resident's weight was down 5.4% in 30 days and 24.7% in 60 days. The Registered Dietitian recommended adding fortified foods three (3) times a day and to add a frozen cup at dinner. According to the Nutrition Data Collection assessment the resident had severe malnutrition related to weight loss. Again,	F 656		

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there was no documented evidence the facility developed a care plan to address the resident's weight loss, nor the resident's risk for further weight loss.

Review of Resident #65's Quarterly MDS assessment dated 05/05/2021 revealed the facility documented the resident weighed 135 pounds. According to the assessment the resident had not lost any weight, but had malnutrition or was at risk for malnutrition. In addition, the facility documented the resident had an unhealed pressure ulcer, a deep tissue injury and was at risk for developing pressure ulcers. According to the assessment, Resident #65 had a pressure reducing device for the chair and bed and received pressure ulcer care. However, there was no documented evidence the facility developed a comprehensive care plan after the MDS assessment with interventions to guide staff on the care needs of the resident.

Review of a Head to Toe Weekly Skin Check for Resident #65 dated 05/08/2021 at 3:38 PM, revealed the resident's suspected deep tissue injury measured 6.5 centimeters (cm) in length by 9.3 cm wide, with no depth.

Review of a Change of Condition form on 05/11/2021 at 2:40 PM revealed Resident #65's pressure ulcer to the resident's coccyx was "worsening". The deep tissue injury was now an unstageable pressure ulcer (full thickness tissue loss (death) in which the base of the ulcer is covered by slough (yellow, tan, green or brown) and/or eschar (tan, brown, or black) in the wound bed) that measured 6.5 cm long and 9.7 cm wide.

Review of a Head to Toe Weekly Skin Checks for

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Resident #65, revealed the next day, 05/12/2021 at 3:17 PM, the unstageable pressure ulcer to the resident's coccyx had increased in size to 10 cm long by 10 cm wide.

Record review revealed there was no documented evidence the facility developed a comprehensive care plan to address Resident #65's pressure ulcer with interventions to prevent worsening.

Review of the Nutrition Progress Note on 05/18/2021 at 10:46 PM revealed Resident #65 weighed 142.6 pounds, which was a significant weight loss of 3% in 7 days and 20.5% in 90 days.

Continued review of Resident #65's Head to Toe Weekly Skin Checks revealed on 05/19/2021, the pressure ulcer to the coccyx now included the sacrum and measured 9.5 cm in length and 10 cm in width. Continued review of the Head to Toe Weekly Skin Checks dated 05/26/2021 at 5:37 PM revealed the resident's pressure ulcer to the sacrum increased in size, measuring 16.5 cm long and 17.7 cm wide.

Review of a Change of Condition form on 05/28/2021 at 3:54 PM revealed Resident #65 had a "worsening wound". Review of the form revealed the physician ordered a wound culture and laboratory testing. However, per the change of condition form, "MD later called back and decided to send resident to Emergency Room for evaluation and treat for possible debridement of area."

Review of Resident #65's hospital record, revealed he/she was admitted to the hospital on

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05/28/2021. Review of a Progress Note dated 05/28/2021 at 9:24 PM revealed Resident #65 was "clinically septic with large decubitus [pressure] ulcer with associated infection including cellulitis and possible developing abscess". The record stated the pressure ulcer "smells like dead flesh".

Review of Resident #65's Emergency Department (ED) nurse's notes dated 05/28/2021 at 5:36 PM revealed the resident had a "large decubitus (pressure) ulcer proximally 15 cm by 8 cm with central skin sloughing and underlying necrosis, the wound has surrounding erythema with mild purulent drainage to bandage". Review of the wound pictures dated 05/29/2021 at 5:40 AM revealed the resident's sacrum was black with red wound edges. The pressure ulcer measured 14 cm long by 15 cm wide. Review of the Infectious Disease Consult on 06/01/2021 revealed the resident "underwent debridement on 05/30/2021, per operative note, all necrotic tissues were removed and the excision was down to the bone. Intraoperative specimen culture grew gram-negative rods/Proteus mirabilis ESBL".

Interview with Surgeon #1 on 08/31/2021 at 1:30 PM revealed Resident #65 had a large stage IV (4) pressure ulcer to the sacrum. He debrided the slough, necrotic and non-viable tissue in the pressure ulcer on 05/30/2021 to bone depth. The surgeon stated failure to turn and reposition, improper nutrition and an improper mattress could contribute to pressure ulcers and the progression of the wound. Surgeon #1 stated, "Nutrition is a big key" in the development/worsening of pressure ulcers.

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F 656	Continued From page 109 Continued review of Resident #65's medical record revealed the resident was readmitted to the facility on 06/09/2021. Further review of Resident #65's medical record revealed no documented evidence the facility developed a comprehensive care plan for the resident until 06/16/2021. The facility identified the resident had a stage IV (4) pressure ulcer to the sacrum, over two (2) months after the pressure ulcer developed. Further review revealed on 06/21/2021, over two (2) months after the resident sustained a significant weight loss, the facility identified the resident had a potential for weight concerns and/or at risk for malnutrition related to a history of weight loss. Interview with Minimum Data Set (MDS) Nurse #1 on 08/27/2021 at 11:10 AM revealed she was responsible for initiating care plans when residents were admitted and re-admitted and was responsible for and updating/revising care plans. She revealed Resident #65 did not have a comprehensive care plan completed timely according to the Resident Assessment Instrument (RAI) that the facility utilized for standard of practice. She stated the comprehensive care was utilized to provide care for the residents and should have been in place to allow staff to know Resident #65's needs. She further stated Resident #65's comprehensive care plan was likely not completed because she was the only person completing MDS assessments and care plans in May 2021. She further revealed that the facility did not have a process for communicating new and/or worsening pressure ulcers, weight loss, etc. Therefore, the information was not being transcribed to the care plan to reflect the resident accurately.	F 656		

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F 656	Continued From page 110 Interview with the Administrator on 09/03/2021 at 5:02 PM revealed she expected nursing staff to perform skin assessments and wound assessments weekly. She stated she had not identified that weekly wound assessments were not being performed until immediate jeopardy was identified. She stated the Interdisciplinary Team (IDT) reviewed comprehensive care plans weekly to ensure they were up to date and implemented. She stated she began reviewing care plans in mid June 2021 and identified that care plans were not updated and implemented appropriately. 2. Review of Resident #14's medical record revealed the resident was admitted to the facility on 05/24/2018 and was readmitted to the facility on 05/21/2021 with diagnoses of Type II Diabetes Mellitus with Diabetic Polyneuropathy, Stage III Chronic Kidney Disease, Peripheral Vascular Disease, and a History of COVID-19. Review of a comprehensive care plan dated 09/10/2020 revealed Resident #14 had the potential for pressure ulcer development related to decreased mobility, Diabetes Mellitus (DM), and a diagnosis of Peripheral Vascular Disease (PVD). The facility developed interventions to include: follow facility policies/protocols for the prevention/treatment of skin breakdown; and observe/document/report as needed (PRN) any changes in skin status, appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), and stage. Review of Head to Toe Weekly Skin Checks dated 05/10/2021, revealed Resident #14 had developed an abrasion to his/her left hip and received barrier cream. There was no evidence that measurements or an assessment (color,	F 656		

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drainage, odor, etc) of the area was completed and documented as required by the resident's care plan.

Continued review of a Head to Toe Weekly Skin Checks dated 05/24/2021 and 05/31/2021, 06/07/2021, 06/14/2021, and 06/21/2021 revealed Resident #14 continued to have an abrasion to his/her left hip; however, there was no documented evidence the appearance of the area was assessed.

Review of a Head to Toe Weekly Skin Check dated 06/22/2021, revealed Resident #14 developed three (3) Stage II (two) pressure ulcers the left trochanter (hip). The pressure ulcers measured as follows: wound one (1) was 1.4 centimeters (cm) long by 1.4 cm wide, wound two (2) was 1.4 cm x 2 cm, and wound three (3) was 1 cm x 1 cm. However, there was no description of the wound's color, whether odor or drainage was present, etc. as required by the resident's care plan.

Further review of a Weekly Head to Toe Skin Check forms dated 07/05/2021, 07/12/2021, and 07/19/2021, revealed the facility continued to document Resident #14 had skin impairment/pressure ulcers to the left hip. However, there was no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present.

Review of Resident #14's Comprehensive Care Plan dated 07/23/2021, revealed the facility revised the resident's care plan to include the Stage II Pressure Injury (ulcer) to the left hip and the new physician orders. Review of interventions revealed the facility was required to

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arrange for evaluation at outpatient wound clinic as needed; encourage frequent position changes when up in chair, if possible; encourage resident to lift weight from side to side while up in chair; avoid prolonged sitting; limit time out of bed; encourage the use pillows to help with positioning off affected area; measure and monitor wound status progression or deterioration every week; notify MD and family of changes; wound care to follow up weekly and as needed; nurse to perform head to toe skin assessment weekly and as needed; weekly photo and measurement of wounds-refer to skin assessment for specific locations; and may consult with Wound Physician Clinic to screen, evaluate, and treat as indicated; and Wound clinic as needed/as prescribed per physician.

However, continued review of Resident #14's medical record revealed no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present; took weekly photos, nor consulted with a Wound Clinic/Physician as ordered by the physician and/or required by the resident's care plan.

Review of Resident #14's Weekly Head to Toe Skin Check dated 07/26/2021 revealed the resident had one (1) Stage II (2) pressure ulcer (the three areas became one pressure ulcer) that measured 4.0 cm long by 4.5 cm wide by 0.5 cm deep to the left hip. Further review revealed a Weekly Head to Toe Skin Check dated 08/02/2021, 08/11/2021, 08/23/2021, and 08/24/2021 revealed the facility documented the resident continued to have a Stage II (2) to the left hip. However, there was no documented assessment of the pressure ulcer as required by

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F 656	Continued From page 113 the resident's care plan. Interview with Licensed Practical Nurse (LPN) #5 on 08/27/2021 at 10:45 AM revealed she "tried" to measure Resident #14's pressure ulcer, but was told the wound nurse was responsible for weekly wound measurements. LPN #5 stated, "So, I really don't know who is responsible to measure the wounds. We have to ask the wound nurse if she is going to do treatments or not on any given day." Interview with Registered Nurse (RN) #3 on 08/27/2021 at 8:30 PM the wound care nurse (RN #4) was responsible for completing weekly wound measurements/assessments. RN #3 stated, "I was told she would be doing the wound measurements and wound care when I was hired." Interview with RN #4/Wound Nurse on 08/25/2021 at 8:30 PM revealed she reviewed Physician #1/Medical Director's orders for 07/23/2021 and since the order stated "May" consult the wound clinic, she made the decision not to consult the clinic for Resident #14's pressure ulcer. She further stated pictures had not been taken of Resident #14's pressure ulcer. According to the RN, the Administrator was supposed to purchase a camera; however, the Administrator had not purchased one. She stated she worked the floor just as much, if not more, than performing her duties as the Wound Nurse. She stated she thought the floor nurses were performing weekly skin assessments and wound measurements when she was not. She further stated she had not received any formal education on wound care.	F 656		

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Interview with the Administrator on 09/03/2021 at 5:02 PM revealed she expected nursing staff to perform skin assessments and wound assessments weekly. She stated she had not identified that weekly wound assessments were not being performed until immediate jeopardy was identified.

3. Review of the medical record revealed the facility admitted Resident #82 on 05/12/2021 with diagnoses, which included Unspecified Dementia with behavioral disturbances and Parkinson's Disease.

Review of Resident 82's Quarterly Minimum Data Set (MDS) assessment, dated 07/14/2021, revealed the facility had assessed the resident to have a BIMS score of zero (00) out of fifteen (15), indicating he/she was not interviewable. Continued review of the MDS revealed the facility had assessed the resident to have physical behaviors directed towards others, rejected care/wandered, one (1) to three (3) days during the assessment period.

Review of Resident #82's Baseline Care Plan revealed staff identified he/she had Dementia and was cognitively impaired on 05/12/2021. Interventions implemented on 05/12/2021 included; staff to administer medications and monitor side effects/effectiveness, call the resident by his/her first name, staff to identify themselves when interacting with the resident, reduce distractions, cue/reorient and supervise him/her.

Review of Resident #82's Comprehensive Care Plan, dated 05/20/2021, revealed staff identified he/she had behavior symptoms that were not easily directed such as: agitation, wandering, and

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he/she was physically/verbally abusive to others. According to his/her care plan, he/she wandered into other residents rooms and sometimes urinated. Further review of the care plan revealed interventions developed on 05/20/2021 included to approach him/her calmly/quietly, attempt to discover reason for behavior such as pain, wants, needs or toileting, administer medications and review medications as needed, psychiatric consults and send to hospital as needed. Continued review of Resident #82's care plan indicated staff revised his/her Dementia care plan on 06/16/2021 with the following interventions: ask him/her yes/no questions, keep the resident's routine consistent/provide consistent caregivers, monitor/document/report as needed changes in his/her cognitive function.

The care plan review revealed the only other revision to Resident #82's care plan was on 07/14/2021, when interventions were added for staff to check for toileting needs, thirsts and hunger.

Review of Resident #82's medical record revealed on 05/21/2021 at 10:20 AM and on 05/22/2021 at 3:29 AM, he/she was wandering in/out of other resident's rooms and was "becoming verbally abusive with other residents."

Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she documented in Resident #82's medical record on 05/21/2021 regarding him/her being verbally abusive with other residents. She stated he/she was wandering in others rooms and would "yell and argue back" with the other residents, as they were asking Resident #82 to exit their personal space. The RN acknowledged the staff failed to

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implement the resident's plan of care and attempt to determine the cause of the resident's behavioral symptoms.

Review of an incident report, dated 05/18/2021 at 8:02 AM, revealed Resident #82 Resident #322 reported to staff another resident wandered into his/her bathroom while he/she was "in there". When Resident #322 attempted to remove the other resident, he/she "grabbed" Resident #322's arm and caused a 1 centimeter (cm) by 1 cm skin tear to his/her arm.

Interview with Registered Nurse (RN) #1, on 07/30/2021 at 9:50 AM, revealed she completed the incident report for Resident #322 when the resident reported Resident #82 wandered into his/her bathroom, and when he/she attempted to remove Resident #82 from his/her bathroom Resident #82 grabbed his/her arm and caused a skin tear.

Further review of Resident #82's MAR/Behavior Monitoring, for May 2021, revealed no documented evidence the resident wandered or exhibited abuse to Resident #322.

Review of Resident #82's medical record and an incident reported dated 06/04/2021 revealed at 1:10 PM, staff heard "someone yelling" and when staff "ran toward the sound" the resident was in Resident #64's room and he/she had his/her hand "around" Resident #64's right forearm and wrist. The incident report indicated Resident #82 refused to remove his/her hands off the resident, so "staff had to remove" his/her hands off Resident #64 and escort him/her back to his/her room.

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According to the incident report and review of his/her record, Resident #82 was transferred to the hospital for an "overnight" evaluation at 8:25 PM on 06/04/2021. When he/she returned from the hospital the following day (06/05/2021) the report indicated Resident #82 was placed on an increased level of supervision; every 15 minute checks for 7 hours, every 30 minutes for 12 hours, and every hour for 12 hours (for approximately thirty-one (31) hours and a stop sign was placed over Resident #64's door and the facility psychiatrist was ordered to evaluate Resident #82's behaviors.

According to Resident #82's medical record, the resident returned to the facility on 06/05/2021 at 6:30 AM. Even though the report indicated he/she should have been on an increased level of supervision, documentation indicated he/she continued to wander in/out of other resident's rooms and was difficult to redirect.

Further review of the record revealed at 8:30 AM on 06/05/2021, Resident #82 was "walking in front of other residents and trying to grab them both male and female" and as he/she continued to wander into other residents rooms and "they start yelling and screaming." Resident #82's record also indicated he/she continued to wander in/out of other residents rooms on 06/07/2021 and again on 06/10/2021.

Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was working when the incident occurred with Resident #64 on 06/04/2021 and she notified the Administrator. She stated even though the resident was transferred to the hospital and returned the following day, his/her behaviors

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F 656	Continued From page 118 continued. Review of Resident #82's record revealed on 06/14/2021, he/she was evaluated by psychiatric services again and his/her chief complaints were wandering/inappropriate behaviors, he/she was hard to redirect, talked to him/herself and he/she had a history of violence towards others. According to the evaluation, the resident's family reported he/she had a history of violence and staff reported the resident would become "wild as a buck," was hard to redirect and he/she went into other resident rooms and residents were "uncomfortable" around Resident #82. The evaluation also indicated Resident #82's treatment recommendations were "psychiatric medication management." However, no medication changes were recommended during the evaluation. Review of another facility reported incident, dated 06/30/2021, revealed Resident #82 wandered into Resident #317's room. According to the report, Resident #317 was asking the resident to leave his/her room and Resident #317 was "holding onto" Resident #82's wrist. Staff escorted Resident #82 out of his/her room, and the resident was transferred to an inpatient psychiatric stay on 07/01/2021 and returned to the facility on 07/08/2021. However, according to interviews with Registered Nurse (RN) #9 on 07/29/2021 at 9:30 PM and RN #1 on 07/30/2021 at 9:50 AM there were no changes in Resident #82's behaviors when he/she returned from the hospital. Continued review of the report revealed due to "medical condition of Dementia and Alzheimer's Disease" Resident #82 "inadvertently entered	F 656		

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F 656	Continued From page 119 room, looking for" his/her room and he/she was transferred to the hospital for evaluation and treatment. Review of Resident #82's Medication Administration Record (MAR) dated June 2021, revealed staff were monitoring the resident for wandering/agitation; his/her behavior monitoring indicated no documented evidence staff monitored the resident for his/her abusive behaviors directed towards other residents. Review of Resident #86's record revealed on 07/13/2021 at 11:15 AM, Resident #86 called the State Police because Resident #82 came in his/her room and was exposed him/herself. However, the record revealed the police were informed by RN #1 that "95% of our residents had Dementia and some do wander". Per the record, the RN informed the Police a resident had not been exposing him/herself to Resident #86 or others. The RN also documented she informed the Police Resident #86 "has been known to exaggerate." Interview with Registered Nurse (RN) # 1, on 07/30/2021 at 9:50 AM, revealed she was working on 07/13/2021, when Resident #86 contacted the State Police. The nurse stated the incident was reported to the Administrator; however, the RN took no action to determine the cause of the resident's behaviors in an attempt to prevent further behaviors. The RN also stated the only way to monitor Resident #86's ongoing behaviors, to ensure the safety of others, was to provide the resident with an increased level of supervision; however, stated the residents behavior was unable to be properly monitored because the facility was short staffed.	F 656		

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F 656	Continued From page 120 Review of Resident #86's medical record and an incident report dated 07/15/2021 revealed at approximately 5:50 PM Resident #82 had wandered into Resident #86's room again and "picked up" the residents shoes. According to the report, Resident #86 pressed his/her personal alarm provided by the facility (exact date unknown) and threw water on Resident #82. Documentation also indicated a stop sign had been implemented to prevent residents from wandering into his/her room, however Resident #86 "frequently takes it down." The incident report indicated the investigation determined Resident #82 was abused by Resident #86 because he/she threw water on him/her when he/she entered the residents room and steps taken to prevent further abuse was that the facility would encourage Resident #86 to keep his/her stop sign up when he/she was in his/her room. Interview with SRNA # 18, on 07/27/2021 at 10:00 PM, revealed Resident #82 frequently wandered into other resident's rooms, attempted to take their personal belongings and exposed him/herself to other residents. The SRNA stated these behaviors had occurred since Resident #82 was admitted. However, the aide was not aware of any interventions implemented to protect other residents from Resident #82's ongoing behaviors. Observations conducted on 07/27/2021 at 1:00 PM of Resident #86 revealed Resident #86 raised his/her sleeve and a large bruise red/purple in color, approximately 6 x 8 inches was observed to his/her left upper arm, and the resident informed the surveyor he/she sustained the bruising when Resident #82 hit him/her with a shoe.	F 656		

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F 656	Continued From page 121 Observations conducted of Resident #82 on 07/27/2021 at 12:20 PM and at 4:20 PM revealed he/she was wandering in the facility hallways going in/out of other resident's rooms. Facility staff were not observed to attempt to determine the cause of the resident's behaviors or attempt to determine if the resident was hungry, thirsty or needed to use the restroom. After observations of Resident #82's wandering was observed, staff was not observed to implement further monitoring of his/her behaviors, as outlined in the care plan. Review of Resident #64's record revealed Resident #82 entered his/her room again on 07/31/2021 at approximately 4:50 AM, was going through the residents' personal belongings and when Resident #64 asked him/her to exit his/her room, Resident #82 hit Resident #64 on the right wrist. According to the record, a small red area was observed to his/her right wrist. Interview with RN #9, on 07/29/2021 at 9:30 PM and again on 08/02/2021 at 2:00 PM, revealed she cared for Resident #82 since he/she was admitted to the facility in May 2021, and his/her abusive behavior towards staff and other residents had been continuous since admission. The RN stated Resident #82 had wandered in/out of other resident's rooms, "yelled/growled" at other residents and created fear in others. RN #9 also stated Resident #64, Resident #322 and Resident #86 has reported they were afraid of Resident #82. The RN stated she felt the only intervention which would be effective with Resident #82 would be 1:1 monitoring of his/her behaviors; however, the facility was not staffed to monitor the residents behaviors to ensure the safety of others.	F 656		

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F 656	Continued From page 122 Review of nursing documentation on 08/01/2021 at 3:15 PM revealed Resident #82 was alert, and "wandering into rooms," approximately 10 hours after he/she hit Resident #64 for the second time. Review of Resident #82's MAR, dated July 2021, revealed no documented evidence staff monitored him/her and the MAR provided no documented evidence he/she exposed him/herself to others, or he/she displayed abusive behavior toward Resident #86 or Resident #64. Interview with Minimum Data Set (MDS) Nurse #2, on 08/10/2021 at 12:00 PM, revealed it was the staff nurses responsibility to ensure resident care plans were implemented in the facility. The MDS nurse also stated the facility had no process to ensure resident care plans were implemented, but stated she expected staff to ensure they were implemented as required. The MDS Nurse stated she was unaware why Resident #82's care plan had not been implemented as required, but stated it should have been. Interview with the ADON/Interim Director of Nursing, on 08/11/2021 at 12:00 PM, revealed Resident #82 had exhibited ongoing behaviors, which affected other residents in the facility. The ADON also stated staff nurses were responsible to ensure resident care plans were implemented in the facility. According to the ADON, the facility had no process in place to ensure resident care plans were implemented as required. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she expected nursing to implement care plan interventions, to prevent further behaviors from occurring. However, the	F 656		

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Administrator stated she had no system in place to monitor/ensure resident care plans were implemented when behaviors occurred in the facility.

4. Record review revealed the facility admitted Resident #66 to the facility on 02/15/2021 with diagnoses to include: Adult Failure to Thrive, Dementia, and Atherosclerotic Heart Disease without Angina Pectoris.

Review of Resident #66 Minimum Data Set (MDS) Annual assessment dated 05/05/2021 revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine (9), indicating moderate cognitive impairment. The facility had assessed the resident to be total assist of two (2) staff members for bed mobility. Further review of the MDS revealed the facility had no rejection of care during the look back period.

Review of Resident #66 Care plan, dated 04/23/2021, revealed under Activities of Daily Living (ADL) Care Plan focus the facility identified the resident required assistance with ADL's related to decreased mobility, multiple medical condition, and receiving hospice services. The facility developed an intervention that stated the resident was totally dependent upon two (2) staff for repositioning and turning in bed. Further review of the resident's care plan revealed the facility identified the resident was at risk for pressure ulcers and developed interventions that included following facility policies/protocols for the prevention/treatment of skin breakdown. The care plan did not include specifics on how often the resident required turning and repositioning.

Review of Resident #66 "Nurse Tech Information

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Kardex," not dated, revealed the resident required assistance of two (2) staff for bed mobility, and stated "Resident doesn't get up". There was no direction how often staff should turn/reposition Resident #66.

Review of Resident #66 "Hospice Plan of Care", dated 06/02/2021 revealed the resident was bedridden incontinent of bowel and bladder for more than 2 years." According to the plan of care the resident's skin was intact.

Interview with State Registered Nursing Assistant (SRNA) #5, on 06/17/2021 at 10:15 AM, revealed Resident #66 "should be turned ever two (2) hours to keep from developing skin breakdown." The SRNA stated she was unaware of the location or content of Resident #66's care plan or Kardex (nurse aide care plan). When asked how the SRNA knew the care the resident required, she was unable to provide details and stated, she "thought all residents should be turned every 2 hours".

Interview with the MDS Coordinator, on 06/18/2021 at 3:50 PM, revealed she was responsible for developing the care plan. The MDS Coordinator stated residents requiring assistance with bed mobility needed a care plan with interventions to turn and reposition every two (2) hours as the resident would be at high risk for pressure ulcer development. The MDS Coordinator reviewed Resident #66's care plan and could not find the intervention to turn and reposition the resident. The MDS Coordinator stated the care plan for Resident #66 should have included that intervention (turn and reposition). She further stated the Care Plan would trigger the State Registered Nurse Aide (SRNA) care plan;

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F 656	Continued From page 125 therefore, because the intervention was not on the Comprehensive Care Plan, the intervention did not carry over on the SRNA care plan. Interview with Director of Nursing (DON) on 06/19/2021 at 12:29 PM revealed all residents should be turned and repositioned every two (2) hours. She stated if residents were not repositioned, the outcome could be skin breakdown. The DON stated the SRNA should have turned Resident #66 every two (2) hours and the RN should have been observing to ensure the resident was turned. She further stated she was unaware of any concerns with turning and repositioning residents.	F 656		
F 657 SS=G	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 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 657		

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F 657	Continued From page 126 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policies, it was determined the facility failed to revise the care plan for one (1) of fifty-seven (57) sampled residents (Resident #65); and failed to ensure three (3) of fifty-seven (57) sampled residents (Resident #57, Resident #27, and Resident #17) and/or the resident's representative was involved in developing the resident's care plan and making decisions about his/her care. Resident #65 developed five (5) pressure ulcers. The facility failed to revise the resident's care plan after the development of each pressure ulcer to address treatment for the ulcer and interventions to prevent the development of new ulcers. Resident #1 developed a Stage I (one) pressure ulcer to the left heel on 06/23/2021, a DTI (deep	F 657		

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tissue injury) to the right heel on 06/26/2021, an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021, and two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021.

The findings include:

1. Review of the facility's policy, "Care Plans, Comprehensive Person-Centered", revised December 2016 revealed assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed.

Review of the facility's Prevention of Pressure Injuries Policy, revised April 2020, revealed the purpose of the policy was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy stated the facility should evaluate report and document potential changes in the skin, and review interventions and strategies for effectiveness on an ongoing basis.

Review of Resident #65's medical record revealed the facility admitted the resident on 03/23/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease (COPD) and Paraplegia.

Review of Resident #65's Quarterly Minimum Data Set (MDS) assessment dated 05/05/2021 revealed the facility documented the resident weighed 135 pounds and had an unhealed pressure ulcer, and a deep tissue injury.

Review of Resident #65's care plan dated 06/16/2021, revealed the facility identified the

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resident had a Stage IV (4) pressure ulcer to the sacrum. The facility developed interventions to address the pressure ulcer that included turning and repositioning approximately every two (2) hours; weekly treatment documentation to include measurement of each area of skin breakdown; width, length, depth, type of tissue and exudate and any other notable changes or observation; encourage good nutrition and hydration; obtain blood work (including culture and sensitivities) of any open wounds as ordered by the physician; and, follow the facility's protocols for treatment.

Review of a change of condition note for Resident #65 dated 06/23/2021 at 10:30 AM revealed the resident had acquired a new Stage one pressure ulcer to the left heel that measured 6.5 cm (centimeters) (length) by 4 cm (width). The resident's physician ordered, "Bilateral heel protectors while in bed, apply sure prep to left heel daily". However, there was no documented evidence that the facility revised the resident's care plan to reflect the new area to the left heel, and no documented evidence the care plan was revised to include the new Physician's Orders for bilateral heel protectors while in bed.

Review of Resident #65's change of condition note dated 06/26/2021 at 10:10 PM revealed the resident had acquired a new deep tissue injury (DTI) pressure ulcer to the right heel. The facility received a new order for a treatment to the pressure ulcer; however, the facility failed to revise the care plan to reflect the new pressure ulcer with interventions to address healing and prevention of the new pressure ulcers.

Continued review of Resident #65's care plan revealed on 07/14/2021, the facility implemented

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F 657	Continued From page 129 a new care plan for the Stage IV (4) pressure ulcer to the sacral area. The facility revised the care plan to include interventions to administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the physician; monitor dressings every shift, and as needed to ensure intact and adhering; report loose dressings to the treatment nurse; and two (2) staff were required to turn and reposition the resident at least every two (2) hours, more often as needed or requested because the resident was totally dependent on staff. However, the facility continued to fail to revise the care plan with interventions to address the Stage I pressure ulcer to Resident #65's left heel and the Deep Tissue Injury (DTI) to the right heel. Review of Resident #65's Quarterly MDS assessment dated 08/05/2021 revealed the facility identified the resident had a weight loss, and had malnutrition or was at risk. In addition, the MDS revealed the facility was aware the resident had one Stage I (1) pressure ulcer, one Stage IV pressure ulcer, and one pressure ulcer that was unstageable. However, there was no documented evidence the facility revised Resident #65's care plan with interventions to address care of the pressure ulcers to the heels and no documented evidence the facility developed interventions to prevent further pressure ulcers. Review of a Head to Toe Weekly Skin Check (assessment) dated 08/12/2021 at 11:52 AM, for Resident #65 revealed the resident had developed an unstageable pressure ulcer to the back of his/her left, lower leg. The facility	F 657		

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obtained a Physician's Order to treat the ulcer with Santyl Ointment daily. However, there was no documented evidence the facility revised the care plan to reflect the new unstageable pressure ulcer to Resident #65's lower left leg, nor did the facility revise the care plan with interventions to prevent further pressure ulcers.

Review of a change of condition assessment dated 08/26/2021 at 6:39 PM for Resident #65 revealed the resident developed a Stage II (2) pressure ulcer to the left hip. The resident's physician was notified and new orders were received to treat the area with sure prep. Continued review of the resident's care plan revealed no documented evidence the facility revised the care plan to reflect the newly developed pressure ulcer nor revised the care plan to prevent new pressure ulcers.

Interview with MDS Nurse #1 on 08/27/2021 at 11:10 AM revealed she was responsible for updating/revising care plans. She stated Resident #65's care plan was not revised regarding the resident's new pressure ulcers and worsening pressure ulcer until 08/16/2021. According to MDS Nurse #1, the facility did not have a system/process for communicating new and/or worsening pressure ulcers, weight loss, etc. Subsequently, residents' care plans were not being revised to accurately reflect the residents' needs.

Interview with MDS Nurse #2 on 08/27/2021 at 10:43 AM revealed Resident #65's care plan should have been updated to reflect the resident's pressure ulcers. MDS Nurse #2 also stated the facility did not have a process/procedure to communicate this information to MDS staff. She

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stated if she was not aware a resident had weight loss and/or pressure ulcers she could not revise the care plan.

Interview with the Administrator on 09/03/2021 at 5:02 PM revealed the Interdisciplinary Team (IDT) reviewed comprehensive care plans weekly to ensure they were accurate and up-to-date. She stated she began reviewing care plans in mid-June 2021 and identified that care plans were not updated appropriately.

2a). Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", revised in December 2016, revealed, "Each resident's comprehensive person-centered care plan will be consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: participate in the planning process."

Record review revealed the facility admitted Resident #57 on 04/23/2021. The facility completed a Minimum Data Set (MDS) Admission Assessment dated 04/29/2021 in which the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) sore of 15 indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence the facility invited the resident to the care plan meeting.

Interview on 06/16/2021 at 10:19 AM, with Resident #57 revealed he/she had care plan meetings at another facility where he/she lived. However, the facility had not invited him/her and he/she had not attended a care plan meeting since admission to the facility.

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F 657	Continued From page 132 2b). Record review revealed the facility admitted Resident #27 on 01/20/2015. Review of a Quarterly MDS Assessment dated 03/30/2021, revealed the facility assessed the resident to have a BIMS score of 15, indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence the facility invited Resident #27 the care plan meeting for this assessment. Interview on 06/16/2021 at 9:27 AM, with Resident #27 revealed the resident could not remember anyone talking to him/her about their plan of care 2c). Record review revealed the facility admitted Resident #17 on 03/15/2021. The facility completed an Admission MDS assessment dated 03/21/2021, and the facility assessed the resident to have a BIMS score of 15, indicating no cognitive impairment. Further review of the resident's record revealed no documented evidence in the progress notes of the resident being invited to a care plan meeting. Interview on 06/16/2021 at 9:55 AM, with Resident #17 revealed he/she was not sure what a care plan meeting was and when explained, the resident stated facility staff had not discussed his/her care or care plan with him/her. Interview with the MDS Coordinator, on 06/18/2021 at 3:50 PM, revealed the facility had not had care plan meetings since December 2020 due to COVID-19. She stated prior to December 2020, the facility invited residents with a BIMS of eight (8) or above, or asked them if they would like to have a family member attend	F 657		

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F 657	Continued From page 133 the care plan meeting. She stated if the resident did not wish to attend or had someone attend for them, staff was required to document the conversation in the resident's medical record. Interview with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been at the facility for two (2) weeks and was not aware whether the facility was having care plan meetings. The Administrator stated a potential problem with not having care plan meetings would be missed or unidentified problems.	F 657		
F 684 SS=J	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:	F 684		

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F 684	Continued From page 134 Based on interview, record review and review of the facility's policies, it was determined the facility failed to ensure two (2) of fifty-seven (57) sampled residents (Resident #321 and Resident #323) received treatment and care in accordance with professional standards of practice. On the morning of 07/18/2021, before breakfast, staff obtained Resident #321's blood glucose level, which was 67 mg/dL (milligrams per deciliter) (normal range 70 mg/dL to 110 mg/dL). Although the nurse held the resident's insulin injection, she administered the resident an oral hypoglycemic medication. The nurse stated that after breakfast she re-checked the resident's blood glucose level, which was then 139 mg/dL. However, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until sometime later that afternoon, sometime after 3:00 PM, when staff found Resident #1 unresponsive with a blood glucose level of 40 mg/dL. Interviews with staff revealed they administered Resident #321 both, injectable and oral glucose, and the resident regained consciousness. However, there was no documentation made in the resident's medical record regarding the resident's second episode of hypoglycemia, including staff finding the resident unresponsive. In addition, there was no evidence the staff continued to monitor the resident or re-check the resident's blood glucose level, until approximately 12:30 AM on 07/19/2021,when Resident #321 was found unresponsive and clammy. Interviews and record review revealed the resident's blood glucose was 32 mg/dL. Staff again administered the resident injectable glucagon and oral glucose. Resident #321 remained unresponsive and developed difficulty breathing. The facility transferred Resident #321	F 684		

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to the hospital, where he/she was diagnosed with acute metabolic encephalopathy and hypoxia secondary to prolonged hypoglycemia. Resident #321 was admitted to the Intensive Care Unit (ICU).

In addition, the facility admitted Resident #323 on 07/06/2021 after being on a ventilator at the hospital. At approximately 7:30 AM on 07/20/2021, a nurse aide entered the resident's room and discovered the resident was sweaty, clammy, and having difficulty breathing. Although interview with a nurse revealed she administered the resident two (2) breathing treatments, there was no evidence staff re-assessed the resident until the resident's family came to visit and insisted the facility transfer the resident to the hospital. Upon Resident #323's arrival to the hospital, the resident required high flow oxygen, and was diagnosed with acute hypoxic respiratory insufficiency, and left lower lobe pneumonia versus atelectasis (lung collapse).

The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

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An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

Findings include:

Review of the facility's policy titled, "Acute Condition Changes-Clinical Protocol", dated March 2018, revealed if a resident had a change in condition, the nursing staff would collect pertinent details to report to the physician, such as the history of present illness and previous and recent test results for comparison. Further review, revealed the nurse would assess, document, and report baseline information including, vital signs, neurological status, current pain level, level of consciousness, cognitive and emotional status, onset, duration and severity of illness, recent labs, history of psychiatric disturbances, mental illness or depression, all active diagnoses, and all current medications.

Review of the facility's policy titled, "Management of Hypoglycemia", dated November 2020, revealed the facility had adopted a hypoglycemia protocol that classified hypoglycemia as follows. Level 1 hypoglycemia was a blood glucose level below 70 mg/dL, but above 54 mg/dL, Level 2 hypoglycemia- was a blood glucose level below

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54 mg/dL, and a Level 3 hypoglycemia- was altered mental and/or physical status requiring assistance for treatment of hypoglycemia. Further review of the protocol revealed, if a resident had Level 3 hypoglycemia and was unresponsive staff should call 911, administer glucagon, notify the provider immediately, remain with the resident, place resident in a comfortable safe place and monitor vital signs.

1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer.

Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicating the resident was cognitively intact.

Review of Resident #321's Baseline Care Plan dated 07/16/2021, revealed the care plan did not include the resident's diagnosis of Diabetes Mellitus.

Review of Physician's Orders dated 07/16/2021, revealed an order for staff to monitor Resident #321 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift.

Review of Nursing Notes dated 07/18/2021 at 3:20 PM, and interview with Licensed Practical Nurse (LPN) #6 on 07/27/2021 at 4:10 PM, revealed at approximately 7:30 AM on 07/18/2021, LPN #6 obtained a blood glucose reading for Resident #321, which was 67 mg/dL

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(milligrams per deciliter). The note further stated staff delivered the resident's breakfast tray (exact time unknown) and LPN #6 obtained a repeat glucose level after breakfast which was documented as 139 mg/dL. However, there was no further documentation or evidence found to indicate LPN #6 continued to monitor the resident's condition or obtain further glucose levels for the resident. Continued review of Resident #321's Nursing Note revealed at approximately 1:30 PM, Resident #321's Spouse called the facility and spoke to LPN #6. The note stated the Spouse was upset related to information his/her daughter, who was at the facility visiting the resident at the time, was calling and reporting to him/her. LPN #6 documented the Spouse requested to speak with someone regarding getting the resident out of the facility and transferred to another facility. The LPN documented she gave the Spouse the contact information for the Administrator and Director of Nursing (DON) and made the DON aware of the Spouse's call.

Interview with Resident #321's Daughter (Family Member #3) on 08/02/2021 at 5:30 PM, revealed she arrived at the facility for a scheduled visit on 07/18/2021 at 10:45 AM. She stated Resident #321 was awake, alert, and talking to her normally during the visit. The Daughter stated Resident #321 told her that his/her blood sugar had dropped to 67 mg/dL that morning. However, Family Member #3 stated that she left the facility at approximately 3:00 PM that day and no staff member obtained the resident's blood glucose level during her visit. She stated the resident had not received a lunch meal when Family Member #3 left the facility. Continued interview with Family Member #3 revealed when she came for the visit

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F 684	Continued From page 139 on 07/18/2021, she brought Resident #321 a mobile phone and left it with the resident to use. She stated she left the phone because when the family attempted to call and check on the resident, the facility's phone would frequently go unanswered. Interview with Resident #321's Spouse on 07/28/2021 at 2:19 PM, revealed his/her her daughter visited Resident #321 on 07/18/2021. The Spouse stated the daughter reported that the resident's glucose was low that morning, the facility smelled of urine, the resident's blanket and washcloths were soiled from the resident's unemptied nephrostomy (bags that collected urine drained from the kidney) bags were leaking, and the daughter was told the facility had no clean blankets/washcloths to give the resident. The Spouse further voiced talking to Resident #321 on the telephone numerous times that day. Continued interview revealed the resident had told the spouse that he/she could tell his/her blood sugar was running low because of the way he/she felt. However, the resident told the Spouse that as of 4:00 PM, the staff still had not re-checked his/her blood sugar since that morning prior to the daughter's arrival to the facility at 10:45 AM. The Spouse confirmed speaking with LPN #6 on 07/18/2021 but, he/she did not contact the DON or Administrator because the resident was sent to the hospital that night. Further interview revealed the spouse stated at approximately 4:00 PM on 07/18/2021, was the last time he/she spoke to Resident #321. The spouse stated, that at that time, the resident reported that he/she had rang the call light (exact time unknown) and it had taken an hour before staff answered the light. The Spouse stated they had only admitted Resident #321 to the facility for	F 684		

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short-term rehabilitation and the resident had planned to return home.

Interview with State Registered Nursing Assistant (SRNA) #1, on 07/27/2021 at 4:40 PM, and on 08/03/2021 at 3:19 PM, revealed she was working on 07/18/2021 from 7:00 AM to 7:00 PM, and remembered Resident #321's blood glucose being low that morning. She stated she took the resident some juice. The SRNA stated she later entered Resident #321's room sometime after lunch in the late afternoon (exact time unknown) and found the resident non-responsive. SRNA #1 stated she immediately notified LPN #6, who summonsed Registered Nurse (RN) #1 from the other end of the unit, and both nurses were working with the resident. SRNA #1 stated she did not recall what the resident's blood sugar was at that time. However, SRNA #1 stated the resident was "better" prior to shift change, which was between 6:00 PM-6:30 PM.

Continued interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed she did recall Resident #321 having another hypoglycemic episode during the late afternoon on 07/18/2021 (exact time unknown). She stated when she entered the resident's room, she found the resident unresponsive. LPN #6 stated she obtained the resident's blood glucose level and recalled it "was around 40 mg/dL". She stated she then got Registered Nurse (RN) #1 from the other end of the unit to assist her and administered Resident #321 an injection of glucagon (Hormone injection used to treat a critically low blood glucose). LPN #6 stated she also administered the resident oral glucose also after the resident began to respond. The LPN stated the best she could recall, the resident's blood glucose increased to "around

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139 mg/dL" but, she could not recall exactly. Continued interview with LPN #6 revealed by that time it was nearing time for the supper meal, so she gave the resident an oatmeal pie to eat before the supper trays arrived.

Review of Resident #321's medical record revealed no evidence the LPN documented the resident's hypoglycemic incident or any of the resident's blood glucose levels. In addition, there was no evidence the LPN monitored the resident's condition or blood glucose levels the remainder of her shift. Further interview, on 07/30/2021 at 11:30 AM, with LPN #6 revealed it was standard nursing practice to document when staff found a resident unresponsive, when a resident had a hypoglycemic episode, and when a resident was administered emergency Glucagon. However, the LPN was unable to explain why she had not documented all these occurrences for Resident #321. LPN #6 stated that it was difficult to care for all the residents and complete documentation.

Interview with RN #8, on 07/30/2021 at 10:54 AM, revealed she was worked on 07/18/2021, and recalled LPN requesting her assistance with Resident #321, due to the resident being unresponsive and having a blood glucose level of 40 mg/dL. She stated she could not recall the exact time the incident occurred but, it was late afternoon sometime probably between 4:00 PM and 5:00 PM. She stated LPN #6 administered the resident a glucagon injection and the resident began to wake up. However, RN #8 stated the resident's blood glucose remained low, (unable to recall exact reading) and LPN #6 administered the resident oral glucose. RN #8 stated following the oral glucose administration, the resident's

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blood glucose increased to 111 mg/dL. She stated she stayed with the resident until he/she was fully awake. RN #8 stated she called down to the kitchen and requested orange juice with sugar be brought up to the floor for the resident. However, RN #6 stated she returned to her side of the unit and did not know if the kitchen delivered the juice to the resident.

Review of Resident #321's Nursing Notes revealed an entry dated 07/19/2021 at 12:23 AM, stating a SRNA found the resident un-responsive and clammy. The documentation stated staff obtained the resident's blood glucose and it was 32 mg/dL. Staff administered the resident a glucagon, and the resident's blood glucose came up to 52 mg/dL. The documentation then stated staff administered Resident #321 the oral glucose, and the resident's blood glucose dropped to 48 mg/dL. Continued review revealed staff administered a second glucagon injection and the resident's blood glucose came up to 110 mg/dL. However, the resident remained un-responsive and experienced labored breathing. Review of the Nursing Notes revealed at 1:00 AM, Emergency Medical Services (EMS) arrived at the facility and transported Resident #321 to the hospital. Further review of the documentation revealed staff notified the resident's family that the facility had transferred the resident to the hospital.

Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed she worked from 6:00 PM on 07/18/2021 until 6:00 AM on 07/19/2021, and was assigned to care for Resident #321. SRNA #4 stated when she came on shift at 6:00 PM on 07/18/2021 she was told in report that the resident's blood glucose level had dropped to 50

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mg/dL earlier in the day but was "good" the remainder of day shift. SRNA #4 stated supper trays were late on 07/18/2021 and she did not come out of the kitchen until sometime after 6:00 PM. However, SRNA #4 stated she had checked on the resident, emptied the nephrostomy bags and changed the resident's clothes prior to supper. She stated she observed Resident #321 at approximately 8:45 PM, and the resident was fine. SRNA #4 stated she was about to begin her next round sometime after 11:00 PM, when the laboratory technician arrived on the floor to begin drawing labs. SRNA #4 stated soon after the laboratory technician arrived, she came and found SRNA #4, to report that Resident #321 was not responding. SRNA #4 stated she found RN #7, and the nurse went to check on Resident #321.

Interview with RN #7 at 4:25 PM, on 07/28/2021, revealed she was working on 07/18/2021 from 7:00 PM until 07/19/2021 at 7:00 AM. RN #7 stated she received in shift report that Resident #321's blood glucose levels had been low during the day. RN #7 stated sometime between 7:30 PM and 8:00 PM, Resident #321 rang the call light and reported he/she thought his/her blood sugar was low. The nurse stated she checked the resident's blood glucose level, and it was 106 mg/dL. However, RN #7 stated she did not document that she obtained the resident's blood glucose or the result in the resident's medical record. RN #7 stated that she and and one SRNA were the only staff working the floor that night, and she was busy and probably forgot to document. Continued interview revealed she took the resident some peanut butter and crackers, and the resident stated that he/she "just felt funny". RN #7 stated at approximately 9:00 PM,

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she returned to check on the resident. The nurse stated Resident #321 had not eaten the peanut butter and crackers, so she offered the resident pudding or juice, but the resident declined and reported feeling better. The RN stated she did not re-check the resident's glucose level.

Continued interview with RN #7 at 4:25 PM, on 07/28/2021 revealed she completed her medication pass and sat down to chart at approximately 10:45 PM-11:00 PM. RN #7 stated the laboratory technician arrived on the unit. She stated although she did not look at the clock, the technician usually arrived around 12:00 AM. RN #7 stated she had gone into another resident's room, when SRNA #4 came in the room and told her Resident #321 would not wake up. She stated when she entered Resident #321's room, the resident was unresponsive, and she could immediately tell the resident's blood glucose was low because the resident was clammy. RN #7 stated she checked the resident's blood glucose, and it was 32 mg/dL. RN #7 stated she administered a glucagon injection to the resident, waited fifteen (15) minutes, and rechecked the blood sugar, which was then 52 mg/dL. She stated the resident was still not responding so she attempted to give the resident oral glucose under the tongue. RN #7 stated that she and SRNA #4 worked the entire floor, so she called for staff from other floors to assist her and call the physician. Continued interview revealed the physician directed her to administer the resident a second glucagon injection and call an ambulance to send the resident to the hospital for further evaluation. RN #7 stated she administered the second Glucagon injection, while waiting for the ambulance to arrive. She stated Resident #321 remained non-responsive and developed agonal

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breathing (gasping for air). RN #7 stated they tried to obtain an intravenous access (IV) on Resident #321, because they thought the resident was going to code (require cardiac resuscitation). RN #7 stated when EMS arrived to transport the resident to the hospital, the resident's blood sugar was "around 67 mg/dL".

Interview with the Laboratory Technician (LT) #1, on 08/02/2021 at 4:45 PM, revealed she arrived at Resident #321's unit on 07/19/2021, at approximately 12:15 AM. She stated she went into Resident #321's room to obtain labs and the resident would not respond to her. She stated she found the SRNA on the floor and asked if the resident was hard of hearing. She stated the SRNA accompanied her back into the resident's room and stated the resident was not acting normal and went to find the nurse. The LT stated the resident did not respond at any time while she was present, and the nurse stated she thought the resident's blood glucose was low. LT #1 stated she left the facility before EMS arrived.

Interview with the Emergency Department (ED) Physician on 07/19/2021, and review of Resident #321's ED record dated 07/19/2021, revealed resident #321 arrived at the emergency room at 1:36 AM, was non-responsive and unable to follow commands. Further review revealed hospital staff intubated Resident #321 at 1:50 AM and admitted the resident to the Intensive Care Unit (ICU) with diagnoses of hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia.

Interview with Administrator, on 08/10/2021 at 1:50 PM, she was not aware that staff found

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F 684	Continued From page 146 Resident #321 unresponsive on the afternoon of 07/18/2021. She stated staff had never notified her that the resident's family was upset. The Administrator stated staff should have documented all hypoglycemic incidents in the resident's medical record. In addition, the Administrator stated staff should have re-assessed Resident #321 on 07/18/2021, after the resident's blood glucose level was low that morning and continued to re-assess the resident and call the physician as warranted. 2). Review of Resident # 323's medical record revealed the facility admitted the resident on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Admission MDS assessment dated 07/13/2021, revealed the facility assessed the resident to have severely impaired cognition and rarely/never understands. In addition, the assessment stated Resident #323 utilized oxygen therapy and a Positive Airway Pressure machine (Bi-pap/C-pap). Further review revealed Resident #323 did not exhibit shortness of breath with exertion, at rest, sitting, or when lying flat. Interview with SRNA (State Registered Nurse Aide) #14 on 07/28/2021 at 11:43 AM, revealed on the morning of 07/20/2021 at approximately 7:00 AM to 7:30 AM, she found Resident #323 sweaty, clammy, and having difficulty breathing. SRNA #14 stated she notified Registered Nurse (RN) #6 of the change in the resident's condition, and the nurse administered the resident a breathing treatment. However, SRNA #14 stated the resident continued to have difficulty breathing,	F 684		

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and she was "worried" about the resident, who was "breathing pretty hard". SRNA #14 stated she did not see RN #6 go back into the resident's room to check on the resident after the breathing treatment was administered, until the resident's family came to visit the resident around 10:30 AM. The SRNA stated when the family arrived and observed the resident, they insisted the facility send the resident to the hospital.

Interview with SRNA #15 on 07/28/2021 at 2:35 PM revealed on 07/20/2021 at approximately 7:00 AM to 7:30 AM, she observed that Resident #323 was having trouble breathing and the resident's face was red. SRNA #15 stated RN #6 administered the resident a breathing treatment, however, the resident still appeared to be having difficulty breathing. Continued interview revealed that RN #6 administered a second breathing treatment to the resident "a couple hours later." However, SRNA #15 stated the resident continued with labored breathing, but to her knowledge, RN #6 took no further action. SRNA #15 stated she did not visualize any staff go back in the room to assess Resident #323 until the family came in to visit at approximately 10:30 AM, and requested the facility send Resident #323 to the hospital.

Interview with RN #6 on 07/28/2021 at 3:45 PM revealed on 07/20/2021 at approximately 7:00 AM to 7:30 AM, one of the nursing assistants notified her that Resident #323 was "congested". She stated she was not the nurse assigned to care for Resident #323; however, she went to the resident's room. She stated when she entered the room, she could hear the resident wheezing and observed the resident using accessory muscles to breathe (having to use more muscle than just

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the diaphragm muscle to breathe). RN #6 stated she had last seen Resident #323 at approximately 6:15 AM. The RN stated the resident having difficulty breathing was "new" for the resident. RN #6 stated she administered a breathing treatment to the resident at 7:43 AM, and it initially improved the resident's breathing. However, RN #6 stated the improvement did not last long and the resident's status declined. She stated she thought LPN #3, the resident's assigned nurse, notified the resident's physician while she gave the resident a second breathing treatment.

Interview with LPN #3 revealed she was the nurse assigned to Resident #323 on 07/20/2021. She stated at approximately 6:30 AM on 07/20/2021, Resident #323 "seemed ok". However, at approximately 7:30 AM she realized "something was going on" with the resident. She stated the resident was breathing fast and using accessory muscles to aide in breathing. LPN #3 stated she notified the resident's physician, Physician #1, around 8:15 AM, and received a new order to obtain a chest x-ray for the resident. LPN #3 stated following the breathing treatments administered by RN #6, Resident #323's condition "stayed about the same". LPN #3 stated Resident #323's family arrived at the facility at approximately 10:30 AM, and insisted the facility send the resident to the ED. The LPN stated she notified Physician #1 of the family's request and the facility sent the resident to the hospital at approximately 12:30 PM (approximately five hours after the resident began having trouble breathing).

Interview with Resident #323's family member on 08/02/2021 at 8:50 AM, revealed she arrived at

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the facility on 07/20/2021 at approximately 11:00 AM. She stated that upon arriving to the unit, she could hear the resident trying to breathe from the hallway approximately two (2) doors down. She stated the breathing was a high-pitched sound, as if the resident was trying to breathe through a straw. The family member stated it sounded as if the resident had a narrow or partially blocked airway. Continued interview revealed she insisted the facility send the resident to the hospital for evaluation.

Further review of Resident #323's medical record for 07/20/2021, revealed after the family arrived at the facility and requested the resident be sent to the hospital, staff documented the resident was having shortness of air, abnormal lung sounds, rapidly labored breathing, and cough. In addition, staff completed a change of condition form at 12:12 PM, which stated they notified Physician #1 at 11:45 AM of the resident's assessment and received new orders to send the resident to the ED.

Review of Resident #323's ED record revealed the ED staff assessed the resident to have audible stridor, increased respiratory effort, was using accessory muscles to breathe and had mild wheezing to bilateral lungs. Continued review of Resident #323's hospital record revealed the resident was admitted to the Intensive Care Unit at 10:54 PM, and diagnosed with Acute Hypoxic Respiratory Insufficiency, Left Lower Lobe Pneumonia versus Atelectasis (collapsed lung), and an elevated Lactate level (results from low flow of oxygen level).

Interview with Physician #1 on 08/04/2021 at 1:00 PM revealed he could not recall if he spoke to

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F 684	Continued From page 150 LPN #3 about Resident #323 once or twice on 07/20/2021. However, he stated he expected staff to assess a resident when a change in their condition occurred. He further stated that if a resident was experiencing respiratory distress, he would expect staff to increase monitoring and assessment of the resident and monitor for further decompensation of respiratory status. Interview with the Administrator on 08/10/2021 at 1:48 PM, and the Interim Director of Nursing on 08/11/2021 at 12:05 PM, revealed they expected staff to immediately assess a resident when a change in condition occurred. Further interview revealed that they expected the staff to document nursing assessments in the medical record.	F 684		
F 686 SS=J	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.	F 686		

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F 686	Continued From page 151 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy review, it was determined the facility failed to ensure two (2) of five (5) sampled residents (Resident #65 and Resident #66) received care to prevent pressure ulcers and failed to ensure care and treatment was provided for four (4) of seven (7) residents with pressure ulcers (Resident #65, Resident #45, Resident #14, and Resident #323) to promote healing, prevent infection and/or prevent new pressure ulcers from developing. The facility admitted Resident #65 on 03/23/2021 without pressure ulcers. The facility failed to turn and reposition the resident. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements, appearance, drainage, odor, etc.). Subsequently, the facility also failed to identify the pressure ulcer had worsened. On 05/28/2021, Resident #65 was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer and was "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent debridement on 05/30/2021, when all necrotic tissue was removed the "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65; and, failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure ulcers and the resident's sacral pressure ulcer	F 686		

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F 686	Continued From page 152 worsened. In addition, the facility identified Resident #45 had a Stage III (3) pressure ulcer on 06/01/2021 to the left sacrum. However, there was no documented evidence the wound was assessed in accordance with the facility's wound assessment form, including measurements, appearance, etc. On 06/30/2021, a wound care specialist assessed Resident #45 and noted the pressure sore to the left buttock was a Stage IV (four) and required excisional debridement to the level of the muscle. The facility failed to assess the resident's pressure ulcer during weekly skin assessments from 07/02/2021 through 08/08/2021. On 08/13/2021, a foul-smelling odor and increased depth and drainage from the wound bed was noted. The resident was transferred to the ED where he/she required antibiotics and inpatient wound care. The pressure ulcer extended to the level of the left ischial tuberosity (hip bone). Resident #45 was diagnosed with Osteomyelitis (infection of the bone). Review of Resident #14's medical record revealed the facility identified three (3) Stage II pressure ulcers on the resident's left trochanter (hip) on 06/22/2021. The facility failed to assess the resident's skin and the pressure ulcers weekly as required. Further, the facility admitted Resident #323 on 07/06/2021 with Physician's Orders to treat his/her pressure ulcer with Santyl ointment (collagenase). The facility failed to provide the treatment to the resident's pressure ulcer until 07/11/2021, five (5) days after admission to the	F 686		

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F 686	Continued From page 153 facility. In addition, the facility failed to turn and reposition Resident #66 on 06/16/2021 from 9:27 AM until after 4:14 PM. The facility's failure to ensure residents received care to prevent pressure sore development and failure to ensure a resident with pressure ulcers received the necessary care and treatment to promote healing and prevent infection has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. The findings include:	F 686		

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F 686	Continued From page 154 Review of the facility's Prevention of Pressure Injuries Policy, revised April 2020, revealed the purpose of the policy was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. The policy stated a risk assessment should be completed upon admission, weekly, and with any changes in condition. A skin assessment was also required upon admission and with each risk assessment, as indicated according to the resident's risk factors. Further review of the policy revealed staff were required to keep the skin clean and hydrated, clean promptly after episodes of incontinence, reposition all residents with or at risk of pressure ulcers on an individualized schedule as determined by the Interdisciplinary Team (IDT), choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. The policy further stated the facility should evaluate, report and document potential changes in the skin, and review interventions and strategies for effectiveness on an ongoing basis. Review of the facility's policy titled, "Repositioning", dated May 2013, revealed, "Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief." Further review of the policy revealed, "Residents who are in bed should be on at least an every two hour (q 2 hour) repositioning schedule". Interview with the Assistant Director of Nursing (ADON)/Acting Director of Nursing (DON) on 08/11/2021 at 12:05 PM revealed the facility did not have a policy regarding pressure ulcer	F 686		

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assessment, but the expectation was for staff to assess pressure ulcers upon admission and weekly, including measurements and to assess for changes in status. According to the ADON, all residents should be turned and repositioned at least every two (2) hours; and, incontinent care should be provided every two (2) hours.

Further interview with the ADON, on 08/11/2021 at 12:05 PM, revealed staff should conduct a weekly skin assessment and document the assessment on a Head to Toe Weekly Skin Check form. In addition, if a resident had a pressure ulcer, staff should assess the wound, document the findings, and notify the resident's physician/family when required.

Review of the "Weekly pressure wound note" form revealed staff were required to document the location and stage of a pressure ulcer; wound bed appearance and percentage of wound tissue coverage; whether drainage was present and the amount; whether an odor or tunneling/undermining was present; a description of the wound edges; whether there were signs of infection; the progress of the wound (improved, unchanged, worsening, etc.); notifications for any changes in condition or new orders; whether the care plan was reviewed and updated; and any other pertinent progress notes.

1. Review of Resident #65's medical record revealed the facility admitted the resident on 03/24/2021 and re-admitted the resident on 04/29/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia.

Review of Resident 65's Minimum Data Set

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F 686	Continued From page 156 (MDS) admission assessment dated 03/30/2021 revealed the resident was totally dependent on two (2) staff with Activities of Daily Living, was occasionally incontinent of bowel, had a indwelling catheter, and had no pressure ulcers. Further review revealed the resident was at risk for pressure ulcers based on a formal assessment instrument (Braden) and clinical assessment. According to the MDS dated 03/30/2021, Resident #65 did not have a pressure reduction device for the chair, was not on a turning/repositioning program, and did not have nutrition or hydration interventions to manage skin problems. Review of a Braden Scale for Predicting Pressure Sore Risk form dated 03/23/2021 revealed Resident #65 was "at risk" for pressure ulcers with a score of eighteen (18), due to being chair fast; slightly limited mobility; and, problems with adequate nutrition, friction, and shearing. Review of the Admission/Readmission Nursing Evaluation on 04/29/2021 at 6:00 PM revealed a Braden Scale assessment was completed for Resident #65. The resident scored a fourteen (14), indicating the resident was at "high risk" for pressure ulcers. The risk was due to slightly limited sensory problems; occasionally moist; confined to bed (bedfast); very limited mobility; potential problems with adequate nutrition; and, friction, and shearing. Review of Resident #65's Baseline Care Plan dated 03/23/2021 at 11:00 AM revealed even though the resident was at high risk for pressure ulcers, the facility did not implement any pressure ulcer prevention interventions.	F 686		

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F 686	Continued From page 157 Further review of Resident #65's medical record revealed no documented evidence the facility completed a comprehensive care plan for the resident with interventions to address the resident's high risk for pressure ulcers in an attempt to prevent pressure ulcers in March, April, or May 2021. Subsequently, there was no documented evidence the IDT determined an individualized turning and repositioning schedule, as required by the facility's policy, and based on the resident's risk factors. Continued review of Resident #65's medical record review revealed Resident #65 was discharged to the hospital on 04/08/2021 for shortness of breath and was re-admitted to the facility on 04/29/2021 with diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure, and Urinary Tract Infection. Review of an Admission/Readmission Nursing Evaluation for Resident #65 dated 04/29/2021 at 6:00 PM revealed the resident had "scratches" to his/her bilateral buttocks upon readmission from the hospital, with no other impaired skin integrity noted. Continued review of Resident #65's medical record revealed no documented evidence the facility turned/repositioned the resident at least every two (2) hours as the ADON stated was a requirement. Review of a change of condition form dated 05/02/2021 at 10:35 AM revealed Resident #65 had developed a deep tissue injury (DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx. A Physician's Order was	F 686		

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obtained to "clean coccyx with soap and water, pat dry, apply zinc oxide and cover with border gauze every day". There was no documented evidence the facility assessed the pressure ulcer (measurements, appearance, etc.) and completed a Weekly Pressure Wound Note on 05/02/2021, when the DTI was identified.

Interview with Licensed Practical Nurse (LPN) #4 on 08/25/2021 at 4:00 PM revealed she identified the deep tissue injury (DTI) to Resident #65's coccyx/sacrum area. She stated that the area was reddened, round, and approximately the size of a quarter. LPN #4 stated she should have measured the area but she was "probably overwhelmed" related to not enough staff. She further stated that no one had ever provided her education regarding measuring and/or assessing a pressure ulcer. Continued interview revealed prior to the "new company" taking over the facility, the wound care nurse assessed and measured all pressure ulcers. However, she was unsure of the protocol for assessing, measuring pressure ulcers.

Review of a Head to Toe Weekly Skin Check (skin assessment) for Resident #65 dated 05/08/2021 at 3:38 PM, revealed the facility measured the resident's 'Suspected Deep Tissue Injury" as 6.5 centimeters (cm) in width by 9.3 cm deep, and 0 cm in depth. However, there was no documented evidence the facility assessed the wound per the Weekly Pressure Wound Note (assessment of the pressure ulcer including the wound bed appearance, a description of the wound edges; the progress of the wound [improved, unchanged, worsening, etc.]).

Review of a "Change of Condition" form on

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F 686	Continued From page 159 05/11/2021 at 2:40 PM revealed Resident #65's pressure ulcer to the coccyx was "worsening". The deep tissue injury (DTI) was now an unstageable pressure ulcer (full thickness tissue loss [death] in which the base of the ulcer is covered by slough [yellow, tan, green or brown] and/or eschar [tan, brown, or black] in the wound bed) that measured 6.5 cm long and 9.7 cm wide. According to the note, the resident's physician was contacted and new orders were obtained to clean the coccyx with soap and water, pat dry, apply calcium alginate (Ag) and cover with a dressing every day. Review of a Head to Toe Weekly Skin Checks for Resident #65, revealed the next day, 05/12/2021 at 3:17 PM, the unstageable pressure ulcer to the resident's coccyx had increased in size to 10 cm long by 10 cm wide. Seven (7) days later, on 05/19/2021, the pressure ulcer to the coccyx/sacrum measured 9.5 cm in length and 10 cm in width. Continued review of the Head to Toe Weekly Skin Checks dated 05/26/2021 at 5:37 PM revealed the resident's pressure ulcer to the sacrum increased in size, measuring 16.5 cm long and 17.7 cm wide. Further review revealed there was no documented evidence the facility assessed the wound's appearance, or whether drainage or odor was present for any date. The facility continued to treat Resident #65's wound with calcium alginate. However, there was no documented evidence the resident's physician was notified that the pressure ulcer had increased in size. Interview with Licensed Practical Nurse (LPN) #6 on 08/25/2021 at 7:45 PM revealed Resident #65's wound "progressed rapidly". She stated she worked the fourth floor and provided care for	F 686		

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Resident #65. However, she was unable to recall if she notified the physician of the decline in the resident's pressure ulcer. She stated the wound care nurse was responsible for measuring and monitoring pressure ulcers; therefore, she "assumed" the wound care nurse was contacting the physician. LPN #6 stated if she noticed a change in a pressure ulcer or a new pressure ulcer she would notify the wound care nurse, who should notify the physician.

Review of a Change of Condition form on 05/28/2021 at 3:54 PM revealed Resident #65 had a "worsening wound". Review of the form revealed the physician ordered a wound culture and laboratory testing. However, per the Change of Condition form, "MD later called back and decided to send resident to Emergency Room for evaluation and treat for possible debridement of area."

Interview with State Registered Nurse Aide (SRNA) #4 on 08/26/2021 at 12:36 PM revealed Resident #65's pressure ulcer had an odor for about a month and nursing staff was aware. She stated she knew the resident's wound "looked bad and smelled bad". SRNA #4 stated she provided care to Resident #65 and approximately 40 other residents until August 2021. She stated Resident #65 and other residents who had pressure ulcers, were turned and repositioned, but not every two (2) hours because there was not enough staff.

Interview with Registered Nurse (RN) #7 on 08/24/2021 at 3:49 PM revealed she had seen Resident #65's pressure ulcer prior to the resident being sent to the hospital on 05/28/2021. She stated that she had identified that the

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resident's pressure ulcer had declined quickly and felt "lack of nutrition" could be contributing to the pressure ulcer.

Review of Resident #65's hospital record, revealed he/she was admitted to the hospital on 05/28/2021. Review of a Progress Note dated 05/28/2021 at 9:24 PM revealed Resident #65 was "clinically septic with large decubitus [pressure] ulcer with associated infection including cellulitis and possible developing abscess". According to the record, the pressure ulcer "smells like dead flesh".

Review of Resident #65's Emergency Department (ED) Nurse's Notes dated 05/28/2021 at 5:36 PM revealed the resident had a "large decubitus (pressure) ulcer proximally 15 cm by 8 cm with central skin sloughing and underlying necrosis, the wound has surrounding erythema with mild purulent drainage to bandage". According to the record, the pressure ulcer "smells like dead flesh". Review of the wound pictures dated 05/29/2021 at 5:40 AM revealed the resident's sacrum was black with red wound edges. The pressure ulcer measured 14 cm long by 15 cm wide.

Review of Resident #65's Operative Report dated 05/30/2021 revealed the resident presented with a large necrotic appearing area on his/her sacrum. The operative report stated, "It was extremely extensive down to the base large amount of fat necrosis was encountered as well as necrotic tissue". The Operative Report further read, "debrided all devitalized tissue down to the level of the bone".

Interview with Surgeon #1 on 08/31/2021 at 1:30

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F 686	Continued From page 162 PM revealed Resident #65 had a large Stage IV (4) pressure ulcer to the sacrum. He debrided the slough, necrotic and non-viable tissue in the pressure ulcer on 05/30/2021 to bone depth. Based on the operative report, Surgeon #1 stated the pressure ulcer measured 6 cm in depth prior to debridement. He further revealed that post debridement the area measured 15 cm in length by 10 cm in width and that the wound was very extensive. Surgeon #1 stated he was unaware of any terminal illness or diagnosis that contributed to the pressure ulcer. He stated failure to turn and reposition, improper nutrition and an improper mattress could have contributed to the pressure ulcers and the progression of the wound. Record review revealed the facility readmitted Resident #65 on 06/09/2021. Upon return to the facility, staff documented the resident had a pressure ulcer to the "coccyx" and a treatment order for calcium AG to the wound. Review of a Weekly Pressure Wound Note dated 06/11/2021, revealed the facility assessed the pressure ulcer to Resident #65's coccyx/sacrum for the first time utilizing this form since the pressure ulcer developed on 05/02/2021. According to the note, the pressure ulcer measured 17 cm (length) by 12 cm (width) and 1.3 cm (depth), with undermining between three (3) and nine (9) o'clock from 2 cm to 2.3 cm. Further review revealed the facility staged the wound as a Stage IV (4), described as full-thickness skin and tissue loss with slough tissue present covering 50% of the wound, with epithelializing wound edges. The facility assessed the resident's pressure ulcer to be free of drainage, odor, and signs of infection. The treatment to the pressure ulcer was changed to	F 686		

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F 686	Continued From page 163 apply a wet to dry kerlix to the wound twice daily. However, there was no documented evidence the facility assessed the pressure ulcer and completed a Weekly Pressure Wound Note until 06/11/2021 at 2:00 PM, approximately six (6) weeks after the pressure ulcer developed. Review of Resident #65's Change of Condition note dated 06/23/2021 at 10:30 AM revealed the resident had acquired a new Stage I (1) pressure ulcer to the left heel. Review of the note revealed the pressure ulcer measured 6.5 cm long by 4 cm wide. The facility received a new order for "bilateral heel protectors while in bed, apply sure prep to left heel daily". Continued review of Resident #65's assessments revealed no documented evidence the facility assessed the resident's sacrum until fifteen (15) days later, 06/26/2021. Review of the Head to Toe Weekly Skin Check assessment dated 06/26/2021 at 10:03 PM and a Weekly Pressure Wound Note dated 06/26/2021 at 10:25 PM, revealed the Stage IV (4) pressure ulcer to the resident's sacrum measured 11 cm long by 15 cm wide by 1.3 cm deep. The left heel measured 5.8 cm (length) by 4.4 cm (width) and 0 cm (depth). Continued review of the assessment revealed the resident had a new deep tissue injury (DTI) to the right heel that measured 3.1 cm (length) by 3 cm (width) and 0 cm (depth). The physician was notified and an order was obtained for treatment for the right heel. Review of the Wound Note revealed the pressure ulcer to Resident #65's sacrum was noted to have slough tissue covering 50% of the wound with a small amount of serosanguinous drainage. Further review revealed the note stated the wound edges were rolled, wound progress was improving, and all	F 686		

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three (3) areas were free of odor and signs of infection. The facility continued to provide wet to dry kerlix dressings to the resident's sacral wound.

Continued review of Resident #65's Head to Toe Weekly Skin Checks and Weekly Pressure Wound Notes revealed no documented evidence the facility assessed the resident's skin and pressure ulcers until 07/05/2021, nine (9) days later. On 07/05/2021 at 7:10 AM, the facility documented the pressure ulcer to the sacrum measured 11 cm (length) by 14 cm (width) and 1.5 cm (depth). The "left heel deep tissue injury appears to be healing and has went from one large DTI to two smaller DTI's" on the left inner and outer heel. The left inner heel measured 3.2 cm (length) by 2.8 cm (width) by 0 cm (depth) and the left outer heel measured 1.8 cm (length) by 1.3 cm (width) by 0 cm (depth). Further review revealed the pressure ulcer to the right heel measured 3 cm (length) by 2.5 cm (width) and 0 cm (depth). According to the Weekly Pressure Wound Note dated 07/05/2021 at 7:23 AM, Resident #65's pressure ulcer to the sacrum had an odor, moderate amount of serosanguinous drainage, and signs of infection.

Review of a Change of Condition form dated 07/05/2021 at 7:33 AM, revealed the resident's physician was notified and a new order was obtained for a wound culture with the next dressing change. Review of the Resident #65's Treatment Administration Record (TAR) for July 2021, revealed the resident's next dressing change was to be completed on 07/06/2021 at 12:00 PM. However, review of the Progress Notes for Resident #65 revealed on 07/06/2021 at 9:43 AM, the resident's family requested the

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resident be sent to the ED for evaluation of the sacral pressure ulcer.

Review of the Emergency Room record revealed Resident #65 arrived to the hospital on 07/06/2021 at 11:09 AM for "wound check". The record revealed the resident "complained of mild pain on (his/her) buttocks but states it is no worse than normal". Review of the Physical Exam Notes revealed the resident had a "15 cm in diameter wound on buttocks that goes to the bone, appears to be healing, no drainage, no surrounding cellulitis had packing inside." The resident was transferred back to the facility on 07/06/2021.

Further review of the Progress Notes dated, 07/06/2021 at 2:45 PM revealed a wound care appointment was made for Resident #65 on 07/15/2021 at 8:30 AM with Wound Care Advanced Practice Registered Nurse (APRN) #1.

Review of the wound culture report for 07/07/2021 revealed the facility obtained a wound culture of Resident #65's sacral pressure ulcer on 07/07/2021. However, the laboratory noted the swab had been "expired since 02/28/2021." The laboratory was unable to complete the wound culture. Further record review revealed there was no documented evidence the facility obtained a culture of the pressure ulcer as ordered by the resident's physician.

Record review revealed that on 07/08/2021 at 3:15 PM, the facility completed a Head to Toe Weekly Skin Check assessment. The pressure ulcer to Resident #65's sacrum measured 14.5 cm (length) by 11 cm (width) and 1.5 cm (depth), the right heel measured 2.8 cm (length) by 2.5

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cm (width) and 0 cm (depth), the left inner heel measured 3 cm (length) by 2.5 cm (width) and 0 cm (depth) and the left outer heel measured 1.2 cm (length) by 1.5 cm (width) and 0 cm (depth). However, there was no documented evidence the facility assessed the pressure ulcers per the Weekly Pressure Wound Note. The Weekly Pressure Note required staff to document the stage of a pressure ulcer; wound bed appearance and percentage of wound tissue coverage; whether drainage was present and the amount; whether an odor or tunneling/undermining was present; a description of the wound edges; whether there were signs of infection; and the progress of the wound (improved, unchanged, worsening, etc).

Further review of Resident #65's medical record revealed no documented evidence the facility assessed the resident's skin from 07/08/2021 until 08/12/2021; and no documented evidence the facility assessed Resident #65's pressure ulcers and completed a Weekly Pressure Wound Note from 07/05/2021 to 08/25/2021.

Review of the Wound Care Office Visit notes for Resident #65 dated 07/29/2021 revealed the "context consists of bed ridden, friction/rubbing and infrequent position changes." The note further revealed the sacrum wound had increased in size since the facility's last assessment on 07/05/2021, and measured 15.5 cm (length) by 15 cm (width) and 1.8 cm (depth). Further, the note revealed moderate serosanguinous exudate with no foul odor. The wound was assessed to have 67%-100% granulation and 34%-66% necrosis of muscle, with bone exposed. The physician conducted an "Excisional debridement to the level of the muscle, removing all non-viable

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tissue, biofilm, slough and exudate from the wound bed to healthy granular borders". The physician changed the wound care to treat with Aquacel Ag daily and cover with a mepilex border

Review of the Head to Toe Weekly Skin Checks assessment dated 08/12/2021 at 11:52 AM, (the first skin assessment since 07/08/2021); revealed Resident #65 had developed an unstageable pressure ulcer to the back of the left, lower leg. However, there was no documented evidence the facility assessed the new pressure ulcer and no evidence the facility notified the resident's physician that the resident had developed a new pressure ulcer.

Interview with LPN #7 on 08/25/2021 at 7:56 PM revealed if a new pressure ulcer was identified, she was required to complete a change of condition form and notify the physician. However, she stated she was never notified that she was responsible for measuring wounds. LPN #7 stated she should have notified the physician on 08/12/2021, when the pressure ulcer was identified to the back of Resident #65's left leg.

Review of Resident #65's Head to Toe Weekly Skin Checks assessment revealed the facility completed another skin assessment on 08/19/2021 at 11:02 AM. This assessment revealed the resident continued to have a pressure ulcer to the left heel (Stage I), the right heel (deep tissue injury), the sacrum (Stage IV), and an unstageable ulcer to the left lower leg (rear). However, there was no documented evidence the facility measured or assessed the pressure ulcers.

Observation of wound care on 08/25/2021 at 1:33

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F 686	Continued From page 168 PM (the facility had not completed a pressure ulcer assessment since 07/05/2021) with RN #4 (Wound Care Nurse) and the ADON/Acting DON, revealed the skin to Resident #65's left heel was intact. RN #4 stated the area was healed; however, the heel remained "boggy". Continued observation revealed the right heel measured 0.4 cm (length) by 0.3 cm (width) and 0 cm (depth). RN #4 (Wound Care Nurse) stated the area was a "scabbed area." RN #4 measured the resident's left inner leg to be 3.2 cm (length) by 1.8 cm (width) and 0 cm (depth). The RN stated the wound had pink edges with slough and eschar in the center of the wound. Further observation revealed the sacral pressure ulcer measured 13 cm (length) by 13.3 cm (width) with no measurement obtained for depth. Undermining was noted at 11 o'clock at 1.9 cm with rolled edges of the wound from 12 to 4 o'clock. Per RN #4, the pressure ulcer had granulation tissue, 10% slough, eschar at 6 o'clock, and eschar and undermining at 10 o'clock to 12 o'clock. Review of the Change of Condition assessment dated 08/26/2021 at 6:39 PM revealed Resident #65 had a new Stage two (2) pressure ulcer to the left hip. The resident's physician was notified and new orders were received to cleanse the area with soap and water, pat dry, apply sure prep to area area and cover with a dressing. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the "context consists of bed ridden and infrequent position changes." "Treatment consists of changing positions frequently, debridement of necrotic tissue and Aquacel Ag". "Pertinent negatives include blackened tissue, blistering, erythema,	F 686		

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fever, numbness and swelling". Further review of the note revealed the sacrum wound measured "13 cm (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel AG; however, there was no evidence the faculty provided "frequent position changes".

Continued interview with LPN #7 on 08/25/2021 at 7:56 PM revealed if a pressure ulcer worsened, she was required to complete a change of condition form and notify the physician. However, she stated she had not identified a change in Resident #65's pressure ulcer stating, "It looked the same". The LPN further stated she was unsure what the protocol was regarding measurements of the wounds. She believed the wound care nurse usually completed wound measurements and was responsible for both the wound assessments and measurements.

Interview with SRNA #1 on 8/5/2021 at 5:15 PM and with SRNA #10 on 08/27/2021 at 11:15 AM revealed they provided care for Resident #65. The SRNAs stated there was not enough staff to turn and reposition Resident #65 every two (2) hours.

Interview with SRNA #11, on 08/27/2021 at 3:00 PM, revealed she could not perform rounds (turning, repositioning, check and changes) every two (2) hours when there were only one (1) or two (2) SRNAs to care for 40 residents. She stated when they were short staffed it sometimes took three (3) or four (4) hours to perform resident

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F 686	Continued From page 170 rounds. Interview with RN #3 on 08/27/2021 at 9:55 AM revealed staff had not been able to turn and reposition residents every two (2) hours because they were so short staffed. She stated, "It is horrible!", stating she had worked by herself for two (2) days in a row. She further stated SRNAs had notified her they could not do rounds (including turning and repositioning) every two (2) hours. She stated she directed them to notify the DON. RN #3 further stated she had completed Resident #65's wound care and she never felt that the wound was getting better (prior to the debridement in May). Interview with RN #7 on 08/01/2021 at 11:40 AM and on 08/24/2021 at 3:49 PM revealed she worked the fourth floor with one SRNA. She stated there was not enough staff to turn and reposition residents as required. She further revealed skin assessments were required weekly; however, they were not always being completed because there was not enough staff and due to confusion about when skin assessments were due. RN #7 further stated she was unaware that she was responsible for measuring and assessing wounds. Interview with Registered Nurse (RN) #4/Wound Care Nurse on 08/25/2021 at 8:30 PM revealed she became the wound care nurse when she returned from maternity leave in the middle of June 2021. She stated she knew nothing about pressure ulcers and the facility provided no training. She stated the facility did not educate her regarding her responsibilities as the wound nurse. RN #4 stated she was aware wounds should be measured every week; however, she	F 686		

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stated she worked the floor as much as she performed duties as the wound care nurse. The Wound Care Nurse stated since she could not provide wound care/assess wounds as required, staff nurses were providing wound care and assisting with assessments. However, she stated there were no systems in place to ensure the assessments were completed; subsequently, they were not being completed and it was hard to determine if a wound declined or improved. She further stated, "I'm not monitoring the wounds, I can't physically do them all."

Interview with the ADON/Interim DON on 08/18/2021 at 10:00 PM revealed nursing staff were responsible for assessing wounds, including measurements, a nursing assessment, and notifying the physician and family with any change of condition. She stated she and the former DON had been working the floor and no oversight was provided to ensure wounds were being managed appropriately. She further stated she was aware that Resident #65's wound had significantly declined, but she was unaware of what caused the resident to decline. Further interview with the ADON/Interim DON revealed the facility's IDT did not address wounds and there was no system in place to ensure pressure ulcers were identified and assessed.

Interview with Advanced Practice Registered Nurse (APRN) #1, who worked at the Wound Care Clinic on 08/27/2021 at 3:14 PM, revealed Resident #65's pressure ulcer developed over a bony prominence. He stated the resident did not appear to be able to turn and reposition himself/herself and was unable to move on his/her own when examined. APRN #1 further stated that he evaluated Resident #65 on

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07/29/2021 and assessed the wound to have slough and fibrotic tissue. He stated the wound infection could have contributed to the decline of the wound. Furthermore, APRN #1 stated if a resident had to wait more than two (2) hours to be repositioned, it could cause wound decline. APRN #1 was unable to identify any terminal illness or medical condition that would require palliative care.

Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he was aware Resident #65 had a pressure ulcer to his/her bottom, but was not aware the resident had developed other pressure ulcers. He further stated he was not aware residents were not being turned and repositioned every two (2) hours due to decreased staffing. He stated a pressure ulcer could develop and/or decline if a resident was not turned and repositioned, or incontinence care provided for more than two(2) hours. He stated it was reasonable to expect residents at risk for pressure ulcers and/or residents with pressure ulcers to be turned and repositioned every two (2) hours and incontinence care provided at least every two (2) hours. Furthermore, he stated he was not aware that wound measurements were not performed weekly, he stated it would be hard to determine the status of a wound without weekly measurements.

Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she was responsible to ensure resident care was provided in accordance with professional standards of practice and that the facility operated within the regulatory guidelines. However, according to the Administrator she had no systems in place to monitor the care delivered to residents in the facility to ensure pressure

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ulcers were prevented or to ensure residents with pressure ulcers received the necessary care and services.
2. Review of Resident #45's medical record revealed the facility admitted the resident on 10/07/2020 with diagnoses of Chronic Osteomyelitis, Paraplegia, History of COVID-19, and a Right Above the Knee Amputation.

Review of Resident #45's Quarterly Minimum Data Set (MDS) assessment dated 04/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident was cognitively intact. Further review of the MDS assessment revealed the resident required assistance with bed mobility and transfers. The facility assessed Resident #45 to be at risk for development of pressure ulcers, but had no pressure ulcers when the assessment was conducted.

Review of Resident #45's Comprehensive Care Plan initiated 01/11/2021 revealed the facility identified the resident had the potential for pressure ulcer development due to a history of ulcers, immobility, and incontinence. Interventions in place included: educate the resident/family/caregivers as to causes of skin breakdown: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning.

Interview with Resident #45 on 08/23/2021 at 4:50 PM revealed he/she developed a pressure ulcer to his/her left lower buttock from utilizing a sliding board to transfer himself/herself. The resident stated the area worsened because he/she liked to sit in bed and color. The resident

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stated he/she could not color when positioned on his/her side. Resident #45 stated he/she did not have any concerns with wound care.

Review of Resident #45's Weekly Skin Assessment dated 06/01/2021 revealed a Stage III pressure ulcer was identified to the resident's left sacral area. The skin assessment noted the area had minimal drainage and the skin surrounding the wound bed was pink. According to the skin assessment, the resident had a history of a pressure ulcer in the same location. However, there was no documented evidence the wound was assessed for size, color, etc., in accordance with the Pressure Wound Assessment.

Review of the Situation Background Appearance Review Form (SBAR) dated 06/01/2021, stated Resident #45 had a Stage III pressure ulcer to his/her left sacral area. The SBAR stated the resident preferred to lie on his/her back and would not turn when encouraged by staff. Staff encouraged the resident to turn/reposition every two (2) hours and as needed (PRN) to relieve pressure from the affected area. New treatment orders were obtained from Physician #1 to cleanse the area with wound cleanser, pat dry, apply Aquacel to the wound bed, and cover with a dry, sterile dressing daily and, PRN if needed, for dislodgement or soiled dressing.

Interview with Licensed Practical Nurse (LPN) #5 on 08/27/2021, at 10:45 AM, revealed she identified the pressure ulcer to Resident #45's left, lower buttock on 06/01/2021. She stated she should have assessed the wound and documented wound measurements. LPN #5 stated she thought the wound care nurse was

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F 686	Continued From page 175 measuring/assessing wounds weekly. Review of a Nurse's Note dated 06/10/2021 at 4:58 AM revealed when completing wound care to Resident #45's buttock, odor and yellowish drainage were present. The note further stated that the physician was notified. Review of a SBAR dated 06/10/2021 at 12:28 PM revealed Resident #14's physician ordered a wound culture. However, there was no further assessment of the resident's pressure ulcer. Continued review of Resident #45's medical record revealed no documented evidence the facility conducted another skin assessment until 06/12/2021, (eleven {11} days since the resident's skin had been assessed). Further review of the skin assessment revealed the resident had existing skin impairment with a Stage III pressure ulcer to his/her right buttock. However, there was no documentation the facility assessed the pressure ulcer's appearance. Review of a Nurse's Note dated 06/13/2021, at 3:03 PM, revealed changes were noted to Resident #45's pressure ulcer. The wound bed had yellow/beige slough and drainage, the surrounding peri-wound tissue was blanchable and pink, and the depth was unable to determined due to the present of slough. The note stated a wound culture was pending and the physician was notified with a new order received for treatment. According to the note, Resident #45 was educated on the importance of turning and repositioning due to the resident's ability/independence to turn and reposition himself/herself, and the resident verbalized understanding.	F 686		

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Review of Resident #45's Wound Culture report dated 06/14/2021 revealed heavy growth of MRSA (Methicillin Resistant Staphylococcus Aureus is a staph infection that is difficult to treat because of resistance to antibiotics), Enterococcus Faecalis, Streptococcus Agalactiae-Group B, Diphtheroid Bacillus, and two (2) different Gram Negative Rod (GNR) infections.

According to a Nurse's Note dated 06/17/2021 at 1:28 PM, revealed Resident #45's Physician ordered Zyvox 600 mg twice daily for ten (10) days to treat the wound infection and Lactobacilli's capsule three (3) times daily for fourteen (14) days.

Review of a Wound Care Weekly Evaluation dated 06/16/2021, revealed the resident was seen by a wound care specialist. According to the note, Resident #45's pressure ulcer had worsened. The specialist documented the pressure ulcer had become unstageable, measuring 3.5 centimeters (cm) by 2.5 cm by 0 cm, with slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) present to the wound bed, scant serosanguinous exudate, and the surrounding skin tissue was pink with peripheral tissue edema noted to the wound edges.

Review of a Head to Toe Weekly Skin Check dated 06/25/2021, (thirteen (13) days since the facility completed the last assessment of Resident #45's skin) revealed the facility identified the resident's pressure ulcer was now a Stage IV pressure injury that measured 3.3 cm long by 2.3 cm wide, and had worsened to 3 cm deep.

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Review of a SBAR Form dated 06/26/2021, revealed Resident #45's physician was notified of the measurements and that yellow slough was no longer present on wound bed. The note stated the peri- wound was pink and blanchable, and serosanguineous drainage was noted. The physician ordered a normal saline (NS) wet-to-dry dressing daily, and to follow-up with the wound care clinic as scheduled.

Review of the Wound Clinic Progress Note dated 06/30/2021 revealed Resident #45 was assessed by the wound clinic for the assessment and treatment of a Stage IV pressure ulcer to his/her left buttock. The assessment stated the pre-debridement ulceration measured 3.5 cm x 2.1 cm x 3.4 cm with slough present and good granulation tissue. Documentation revealed that the resident stated he/she was utilizing a sliding board when the injury occurred and worsened over time. Review of the patient plan revealed excisional debridement to the level of the muscle was performed with removal of all non-viable tissue, biofilm, slough, and exudate from the wound bed to healthy granular borders. Wound care orders were to cleanse the wound daily with normal saline, apply Aquacel AG, and cover with a Mepilex border dressing. Further review of the Progress Note revealed recommendations for the facility to obtain a wound vac (Vacuum-assisted closure of a wound is a device placed on the wound that removes the pressure over the area to help the wound heal more quickly) for the resident's wound. Resident #45 was to follow up with the wound clinic in four (4) weeks.

Review of the Head to Toe Weekly Skin Checks for Resident #45 dated 07/02/2021, 07/09/2021, 07/17/2021, and 07/23/2021, revealed no

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documented evidence that the facility conducted wound measurements weekly, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.).

Review of a Wound Clinic Progress Note dated 07/28/2021, revealed measurements of the wound prior to debridement were 3.5 cm x 2.1 cm x 3.4 cm. Excisional debridement to the level of the muscle was performed removing all non-viable tissue, biofilm, slough, and exudate from the wound bed to healthy granular borders. Wound measurements performed after debridement were 3.5 cm x 1.0 cm x 4.2 cm. Review of the Patient Plan revealed staff were to continue with Wound Vac and Aquacel AG. Resident #45 was to follow up with the wound clinic in three (3) weeks.

Review of a Head to Toe Weekly Skin Check dated 07/30/2021 and 08/06/2021, revealed staff documented Resident #45 had a pressure ulcer and a wound vac was in use. However, again, there was no documented evidence that facility staff assessed the pressure ulcers' size, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.)

Review of an SBAR dated 08/13/2021 revealed Resident #45 had a foul-smelling odor from the wound bed. The depth of the wound had increased and had drainage. Physician #1 was present at facility. He assessed Resident #45 and transferred the resident to the emergency department (ED) for possible wound debridement.

Review of the hospital record History and

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Physical dated 08/13/2021 revealed Resident #45 arrived at the ED due to a left buttock wound with redness and drainage. The record stated the resident had a three (3) cm decubitus ulcer that would likely need antibiotics and inpatient wound care. Review of the assessment/plan revealed the pressure ulceration extended to the level of the left ischial tuberosity (hip bone) where there was cortical irregularity of the ischial tuberosity, the finding was most compatible with a component of Osteomyelitis (infection of the bone). Resident #45 was started on Vancomycin and Cefepime (antibiotics), and had infectious disease and wound care consults.

Review of Resident #45's Hospital Discharge Summary dated 08/18/2021, the resident was discharged back to the facility with diagnoses of Osteomyelitis and Stage IV Pressure Ulcer. The resident had an order to continue Ceftriaxone NA (antibiotic) two (2) grams (GM) daily for 37 days and to continue local wound care.

Review of the Admission/Readmission Nursing Evaluation dated 08/18/2021, revealed no documented evidence the facility assessed Resident #45's pressure ulcer upon readmission to the facility.

Further review of the Head to Toe Skin Assessment forms revealed on 08/24/2021, staff documented Resident #45 had a pressure ulcer. However, again, there was no documented evidence that facility staff assessed the pressure ulcer's size, nor assessed the appearance of the resident's pressure ulcer (drainage, odor, or slough present, etc.)

Observation of wound care to Resident #45's left

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buttock on 08/25/2021 at 3:19 PM revealed the dressing was changed per Physician's Order.

Review of a Nursing Services Basic Skin Assessment dated 08/26/2021, revealed Resident #45 had a Stage IV Pressure Ulcer to his/her left buttock fold measuring 2.9 cm x 2.6 cm x 4.6 cm, with no foul odor and moisture was within normal limits.

Interview with State Registered Nurse Aide (SRNA) #11 on 08/27/2021 at 3:00 PM revealed Resident #45 often refused to turn and reposition. She stated the resident liked to sit straight up in bed so he/she could color. She stated she encouraged the resident to turn and reposition often.

Interview with Registered Nurse (RN) #4/Wound Care Nurse on 08/25/2021 at 8:30 PM revealed she often worked the floor as a staff nurse and could not measure/assess pressure ulcers weekly. She stated when she was working the floor, staff nurses were required to complete assessments. However, she stated there were no systems in place to ensure the assessments were completed.

Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he was aware Resident #45 was noncompliant with turning and repositioning and wound vac treatment. He stated the resident wanted to stay in the same position all the time. However, he stated he was not aware wound measurements/assessments were not conducted weekly, He stated it would be hard to determine the status of a wound without weekly measurements.

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3. Review of Resident #14's medical record revealed the facility admitted the resident on 05/24/2018. Resident #14 was readmitted to the facility on 05/21/2021 with diagnoses of Type II Diabetes Mellitus with Diabetic Polyneuropathy, Stage III Chronic Kidney Disease, Peripheral Vascular Disease, and a History of COVID-19.

Review of Resident #14's Quarterly Minimum Data Set (MDS) assessment dated 05/27/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was cognitively impaired. The facility assessed the resident to be independent with bed mobility. Further review of the MDS assessment revealed the resident was at risk for pressure ulcers, and no ulcers were present when the assessment was conducted.

Review of a comprehensive care plan initiated 09/10/2020 revealed Resident #14 had the potential for pressure ulcer development related to decreased mobility, Diabetes Mellitus (DM), and a diagnosis of Peripheral Vascular Disease (PVD). The facility developed interventions that included: follow the facility's policies/protocols for the prevention/treatment of skin breakdown; and observe/document/report as needed (PRN) any changes in skin status, appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth), and stage.

Observation of wound care for Resident #14 on 08/24/2021 at 2:32 PM revealed the resident had a diabetic ulcer to his/her left great toe, due to toe amputation, and a Stage II (2) pressure ulcer to his/her left hip. Observation and interview with Resident #14 on 08/25/2021 at 9:19 AM revealed the resident was sitting on the side of the bed with

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a bandage to his/her left foot intact. The resident stated he/she repositioned himself/herself. Resident #14 stated he/she preferred to lay on his/her left side, even though staff had educated the resident.

Review of a Physician's Order dated 05/09/2021 revealed an order to wash Resident #14's left hip with soap and water, pat day, apply barrier cream, and cover with a dry protective dressing (DPD) every shift for 14 days until 05/24/2021. According to a Head to Toe Weekly Skin Checks dated 05/10/2021, revealed Resident #14 had an abrasion to his/her left hip and received barrier cream. There was no evidence that measurements or an assessment (color, drainage, odor, etc) of the area was completed and documented.

Review of a Physician's Order dated 05/10/2021, revealed an order to change the treatment to Resident #14's left hip to calmospetine cream every shift.

Review of a Head to Toe Weekly Skin Checks dated 05/24/2021 and 05/31/2021, 06/07/2021, 06/14/2021, and 06/21/2021 revealed Resident #14 had an abrasion to his/her left hip. However, there was no documented evidence the appearance of the area was assessed.

Review of a Head to Toe Weekly Skin Check dated 06/22/2021, revealed Resident #14 had new skin impairment, three (3) Stage II (two) pressure ulcers to the left trochanter (hip). The pressure ulcers measured as follows: one (1) wound was 1.4 centimeters (cm) long by 1.4 cm wide; wound #2 was 1.4 cm x 2 cm; and, wound #3 was 1 cm x 1 cm. However, there was no

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F 686	Continued From page 183 description of the wound's color, whether odor or drainage was present, etc. Review of a Situation Background Appearance Review Form (SBAR) dated 06/22/2021 revealed Resident #14's physician was notified of the new pressure ulcers. Review of a Physician's Order dated 06/22/2021 and 07/06/2021 revealed an order to cleanse the three (3) Stage II pressure ulcers with wound cleanser and/or soap and water, pat dry, apply Opticel, and cover with DPD daily and as needed. Review of Resident #14's Physician's Orders dated 07/23/2021, revealed an order that stated, "May" consult with wound physicians to screen, evaluate, and treat as indicated and an order to measure and photo the pressure ulcers to the left hip every Monday. Review of Resident #14's Comprehensive Care Plan dated 07/23/2021, revealed the facility revised the resident's care plan to include the Stage II Pressure Injury (ulcer) to the left hip and the new Physician's Orders. Review of interventions revealed the facility was required to arrange for an evaluation at an outpatient wound clinic as needed; encourage frequent position changes when up in chair, if possible; encourage resident to lift weight from side to side while up in chair; avoid prolonged sitting; limit time out of bed; encourage the use of pillows to help with positioning off affected area; measure and monitor wound status progression or deterioration every week; notify MD and family of changes; wound care to follow up weekly and as needed; nurse to perform head to toe skin assessment weekly and as needed; weekly photo and measurement of wounds-refer to skin	F 686		

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assessment for specific locations; and may consult with Wound Physician Clinic to screen, evaluate, and treat as indicated; and wound clinic as needed/as prescribed per physician.

However, continued review of Resident #14's medical record revealed no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present; took weekly photos, nor consulted with a Wound Clinic/Physician as ordered by the physician and/or required by the resident's care plan.

Review of a Weekly Head to Toe Skin Check forms dated 07/05/2021, 07/12/2021, and 07/19/2021, revealed the facility documented Resident #14 had skin impairment/pressure ulcers to the left hip. However, there was no documented evidence the facility assessed the pressure ulcer's size, color, nor whether odor/drainage was present.

Review of Resident #14's Weekly Head to Toe Skin Check dated 07/26/2021 revealed the resident had one (1) Stage II (2) pressure ulcer that measured 4.0 cm long by 4.5 cm wide by 0.5 cm deep to the left hip. Further review revealed Weekly Head to Toe Skin Checks dated 08/02/2021, 08/11/2021, 08/23/2021, and 08/24/2021 revealed the facility documented the resident had existing skin impairment, a Stage II (2) to the left hip. However, there was no documented assessment of the pressure ulcer. Further review revealed the resident refused a skin assessment on 08/09/2021, and there was no documented skin assessment or pressure ulcer assessment for 08/15/2021

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Review of a Nursing Services Basic Skin Assessment dated 08/26/2021, revealed RN #4/Wound Nurse completed measurements of Resident #14's left hip which measured 3.6 cm x 3.4 cm. Review of the skin assessment documentation revealed no foul odor or moisture was present.

Interview with Licensed Practical Nurse (LPN) #5 on 08/27/2021 at 10:45 AM revealed she "tried" to measure Resident #14's pressure ulcer, but was told the wound nurse was responsible for weekly wound measurements. LPN #5 stated, "So, I really don't know who is responsible to measure the wounds. We have to ask the wound nurse if she is going to do treatments or not on any given day."

Interview with Registered Nurse (RN) #3 on 08/27/2021 at 8:30 PM revealed the Wound Care Nurse (RN #4) was responsible for completing weekly wound measurements/assessments. RN #3 stated, "I was told she would be doing the wound measurements and wound care when I was hired."

Interview with RN #4/Wound Nurse on 08/25/2021 at 8:30 PM revealed she reviewed Physician #1/Medical Director's orders for 07/23/2021 and since the order stated "May" consult the wound clinic, she made the decision not to consult the clinic for Resident #14's pressure ulcer. She further stated pictures had not been taken of Resident #14's pressure ulcer. According to the RN, the Administrator was supposed to purchase a camera; however, the Administrator had not purchased one. She stated she worked the floor just as much, if not more, than performing her duties as the Wound Nurse.

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She stated she thought the floor nurses were performing weekly skin assessments and wound measurements when she was not. She further stated she had not received any formal education on wound care.

Interview with Physician #1/Medical Director on 08/27/2021 at 1:18 PM revealed he ordered weekly pictures of Resident #14's left hip pressure ulcer on 07/23/2021 to track the healing of the wound. He stated, "Pictures are a good thing." He stated he expected all wounds to be measured weekly to monitor improvement/decline of the wound. He stated a wound consult should have been completed as ordered on 07/23/2021 and he was not aware it had not been.

4. Review of Resident #323's medical record revealed the facility admitted the resident on 07/06/2021, with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Type 2 Diabetes, Dysphagia, Pneumonia, and Aphasia.

Review of Resident #323's Admission/Readmission Nursing Evaluation dated 07/06/2021 at 5:06 PM revealed the resident had a pressure ulcer (no stage) to the coccyx measuring six (6) centimeters (cm) in length and four (4) cm in width.

Review of Resident #323's hospital Discharge Summary revealed orders for the facility to continue Santyl (collagenase ointment treatment for pressure ulcers) apply a thin layer to the wound bed. However, review of Resident #323's facility Admission Orders, dated 07/06/2021, revealed the facility did not transcribe the pressure ulcer ointment to the admission orders.

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F 686	Continued From page 187 Continued review of Resident #323's medical record revealed on 07/10/2021, four (4) days after admission, the facility contacted the resident's physician for a treatment for the pressure ulcer. The physician ordered the pressure ulcers be cleansed with soap and water, pat dry, and apply Santyl Ointment topically to sloughed areas (dead tissue). Review of Resident #323's Treatment Administration Record (TAR) for July 2021, revealed no treatment was provided for the resident's pressure ulcers until 07/11/2021 at 12:00 PM, five (5) days after admission. Further review of the Nursing Notes dated 07/12/2021 at 10:13 AM, revealed Resident 323's pressure area had worsened to an unstageable wound to both sides of the buttocks. The note stated the pressure ulcer to the right buttock measured two (2) cm by three (3) cm and the left buttock pressure ulcer measured four (4) cm by five (5) cm. Interview with Registered Nurse (RN) #6 on 07/28/2021 at 9:48 AM revealed the admitting nurse was responsible for transcribing and verifying physician's orders. She stated she was the nurse who admitted Resident #323 and was aware of the Physician's Order for Santyl ointment. RN #6 stated she wanted to evaluate the resident's pressure ulcer before the facility treated the wound with Santyl ointment. However, there was no documented evidence the RN ensured treatment was provided to the resident's pressure ulcer. Interview with the Interim Director of Nursing on 08/11/2021 at 12:05 PM revealed the assigned nurse was responsible for obtaining and verifying physician's orders for residents admitted to the	F 686		

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facility. She stated the nurse should have notified the physician to ensure there was an appropriate treatment in place and medications ordered. Continued interview revealed she attempted to check medical records for new admissions and re-admissions to ensure physician's orders were obtained and implemented. However, she stated she worked the floor as a floor nurse preventing her from having time for DON duties. She stated she did not recall reviewing Resident #323's admission record.

Interview with the Administrator on 08/11/2021 at 5:55 PM revealed nursing management was responsible for oversight of Admission Physician's Orders. She further revealed she was not aware of any issues related to physician's orders for Resident #323.

5. Record review revealed the facility admitted Resident #66 on 02/15/2021 with diagnoses that included Adult Failure to Thrive, Dementia, and Atherosclerotic Heart Disease without Angina Pectoris.

Review of Resident #66 Minimum Data Set (MDS) Annual assessment dated 05/05/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderate cognitive impairment. The facility assessed the resident to be total assist of two (2) staff for bed mobility. Further review of the MDS revealed the resident had no rejection of care during the look back period.

Review of Resident #66 Care plan, dated 04/23/2021, revealed under the Activities of Daily Living (ADL) Care Plan focus the facility identified

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the resident required assistance with ADL's (activities of daily living) related to decreased mobility, multiple medical conditions, and receiving Hospice services. The facility developed an intervention that stated the resident was totally dependent upon two (2) staff for repositioning and turning in bed. However, the care plan did not direct staff how often the resident was to be turned and repositioned.

Review of Resident #66's Nursing Notes, revealed Registered Nurse (RN) #3 documented on 06/16/2021 at 9:04 AM, that she observed a SRNA "straightened resident up to move" the resident off his/her "right side."

Observation of Resident #66 on 06/16/2021 at 9:27 AM revealed a Hospice Assistant was giving the resident a bath. When the Assistant finished with care, the Assistant placed the resident on his/her right side and positioned the resident with pillows. Continued observation of the resident revealed the resident remained on his/her right side on 06/16/2021 at 11:47 AM, at 1:40 PM, at 3:13 PM, and at 4:14 PM.

Observation on 06/17/2021 at 10:00 AM of Resident #66's skin revealed the resident had no skin breakdown or pressure ulcers.

Attempts to interview Resident #66 on 06/16/2021 at 5:21 PM and on 06/17/2021 at 10:00 AM were unsuccessful. The resident did not respond verbally to questions.

Interview with State Registered Nursing Assistant (SRNA) #5, on 06/17/2021 at 10:15 AM, revealed she had not attempted to reposition Resident #66 on 06/16/2021, because the resident "seemed

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F 686	Continued From page 190 comfortable". The SRNA stated the resident was unable to reposition himself/herself in bed. Interview with Registered Nurse (RN) #2, on 06/17/2021 at 10:30 AM, revealed she was not aware Resident #66 had not been turned from 9:30 AM until 4:14 PM on 06/16/2021. RN #2 stated "breakdown" could be the outcome from the resident lying on his/her side for that amount of time. Interview with the Director of Nursing (DON) on 06/19/2021 at 12:29 PM revealed all residents should be turned and repositioned every two (2) hours. She stated if residents were not repositioned, the outcome could be skin breakdown. The DON stated the SRNA should have turned Resident #66 every two (2) hours. She stated the RN should have been observing to ensure the resident was turned. The DON further stated she was unaware of any concerns with turning and repositioning residents.	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.	F 689		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the environment remained as free from accident hazards as possible for one (1) of fifty-seven (57) sampled residents (Resident #12) related to medication found in resident's rooms.

Observation on 06/15/2021, revealed a medication cup containing Valproic Acid two hundred and fifty (250) milligrams (mg) (antiseizure medication), Metoprolol Tartrate fifty (50) mg (blood pressure medication), and Quetiapine twenty-five (25) mg (antipsychotic medication) sitting on Resident #12's overbed table.

The findings include:

Review of a facility policy titled,"Administering Medications", dated April 2019, revealed medications were administered in a safe and timely manner, and as prescribed. However, the policy did not address ensuring the resident had ingested the medication prior to leaving the resident.

Review of Resident #12's medical record revealed the facility admitted the resident on 09/22/2017, with diagnoses which included

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F 689	Continued From page 192 Cerebral Infarction, Ischemic Heart Disease, Hypertension, Seizure Disorder, and Traumatic Brain Injury. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12, dated 03/10/2021, revealed the resident had been assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), which indicated the resident was interviewable. Review of Resident #12's physician's orders, dated 06/01/2021, revealed the resident was to receive Metoprolol Tartrate seventy-five (75) mg twice daily (blood pressure lowering medication); Quetiapine twenty-five (25) mg one half tablet twice daily (antipsychotic); and Valproic Acid two hundred and fifty (250) mg twice daily (antiseizure medication). Observation in Resident #12's room, on 06/15/2021 at 3:34 PM, revealed a medication cup containing Valproic Acid two hundred and fifty (250) milligrams (mg) (antiseizure medication), Metoprolol Tartrate fifty (50) mg (blood pressure lowering medication), and Quetiapine twenty-five (25) mg (antipsychotic) one half tablet sitting on the resident's overbed table. Interview with Resident #12, on 06/15/2021 at 3:35 PM, revealed the nurse had set the medications on the overbed table and he/she had not taken them yet. Interview with Licensed Practical Nurse (LPN) #3, on 06/15/2021 at 3:40 PM, revealed she was supposed to observe the resident until the resident swallowed the medication. The LPN	F 689		

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F 689	Continued From page 193 stated she did not know why she had not observed the resident taking the medications; however, she should have. The LPN stated another resident could have picked up the medication intended for Resident #12 and taken it. Interview with the Director of Nursing (DON), on 06/19/2021 at 12:00 PM, revealed she monitored medication administration randomly and had not identified any concerns. The DON stated nurses were required to ensure residents had ingested their medications prior to leaving the resident. The DON stated the resident missing a dose of medication as well as another resident picking up the medication and taking it were some of the hazards which could be caused by the resident's medication being left on the overbed table. Interview with the Administrator, on 06/19/2021 at 12:36 PM, revealed nurses were required to ensure residents had taken their medication prior to leaving the resident and should never leave a medication at a resident's bedside due to the medication being missed it could be detrimental to the resident as well as another resident could pick up the medication and ingest it.	F 689		
F 692 SS=K	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		

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F 692	Continued From page 194 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure eight (8) of fifty-seven (57) sampled Residents (Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81), maintained acceptable parameters of nutritional status and/or body weight. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss as a result of the facility's	F 692		

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F 692	Continued From page 195 failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure resident's were served adequate portions to prevent weight loss. The facility's failure to ensure residents maintained acceptable parameters of nutritional status and/or body weight, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656) 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The	F 692		

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F 692	Continued From page 196 Immediate Jeopardy is ongoing. The findings include: Review of the facility's policy titled "Weight Assessment and Intervention," not dated, revealed the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. According to the policy, nursing staff would measure resident weights on admission, the next day and weekly for two weeks thereafter. According to the policy, weight changes of five (5) percent or more since the last weight assessment, would result in obtaining the weight again the next day for confirmation. If nursing staff verified the weight, they would notify the dietitian immediately and staff would document the notification. Further review of the policy revealed the dietitian would respond within twenty-four (24) hours of receipt of written notification and would review the unit weight record by the fifteenth of the month to follow individual weight trends over time. The treatment team would evaluate negative trends and determine if the resident had met the criteria for significant weight change. The policy defined significant weight change as, a five (5) percent weight loss in one month, greater than five (5) percent considered severe; seven and one-half (7.5) percent weight loss in ninety (90) days was significant and greater than seven and one-half (7.5) percent considered severe; ten (10) percent weight loss in six (6) months was significant and greater than ten (10) percent considered severe. According to the policy, the facility should base the interventions for undesirable weight loss on careful consideration of resident choices and preferences and nutritional needs of facility residents.	F 692		

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F 692	Continued From page 197 1. Review of Resident #65's medical record revealed the facility admitted him/her on 03/23/2021 with diagnosis that included Cerebral Infarction, Dysphagia, Polyarthritis and Paraplegia. Review of Resident 65's Admission MDS assessment, dated 03/30/202,1 revealed the facility assessed the resident weighed one hundred and seventy-nine (179) pounds, and was totally dependent on two (2) staff with Activities of Daily Living, including eating. Further review revealed the resident had no weight loss/gain or his/her weight loss/gain history was unknown and had no pressure ulcers. The MDS revealed Resident #65 had complaints of difficulty or pain when swallowing and had malnutrition or was at risk for malnutrition. Review of Resident #65's weight record revealed on 04/06/2021, the resident's weight was one hundred forty-two and seven tenths (142.7) pounds, a weight loss of thirty-six and six tenths (36.6) pounds since admission to the facility on 03/23/2021. Review of the medical record revealed there was no documented evidence the RD evaluated Resident #65 after the weight loss and no documented evidence the facility addressed the weight loss. Medical record review revealed Resident #65 was discharged to the hospital on 04/08/2021 for shortness of breath. and was re-admitted to the facility on 4/29/2021 with diagnoses that included Sepsis, Pneumonia, Acute Respiratory Failure, and Urinary Tract Infection. The record revealed there was no documented evidence the facility weighed the resident upon readmission to the	F 692		

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F 692	Continued From page 198 facility. Review of the Situation, Background, Assessment and Recommendation (SBAR) Communication form, dated 05/02/2021 at 5:29 PM, revealed the Resident #65 had developed a deep tissue injury (DTI) to the coccyx. Review of the medical record revealed Resident #65 weighed one hundred and thirty-five (135) pounds on 05/04/2021, another seven and seven tenths (7.7) pound weight loss from the previous weight on 04/06/2021. Approximately one (1) month after the resident's initial weight loss, the RD assessed Resident #65. Review of a Nutrition Data Collection assessment, dated 05/06/2021, revealed the resident's weight was 135 pounds, and the RD calculated the resident's weight was down five and four tenths (5.4) percent in thirty (30) days and twenty-four and seven tenths (24.7) percent in sixty (60) days. According to the RD's assessment, Resident #65 had severe malnutrition related to weight loss. The RD recommended fortified foods three (3) times a day and a frozen cup at dinner. There was no documented evidence the RD identified the resident had a DTI and addressed whether the resident needed anything for wound healing. Interview with the RD, on 08/26/2021 at 12:16 PM, revealed the facility had not been notifying her of resident skin breakdown and weight loss. She stated she was unaware that Resident #65 had a pressure ulcer when she assessed the resident on 05/06/2021. She stated had she known she would have increased the resident's protein to aide in pressure ulcer healing. She	F 692		

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F 692	Continued From page 199 stated ideally she would like to be notified weekly of new pressure ulcers. Review of a change of condition form for Resident #65, dated 05/11/2021 at 2:40 PM, revealed the pressure ulcer to the resident's coccyx was "worsening". Continued review revealed the deep tissue injury (DTI) was now an unstageable pressure ulcer (full thickness tissue loss (death) in which the base of the ulcer was covered by slough (yellow, tan, green or brown) and/or eschar (tan, brown, or black) in the wound bed) that measured six and one-half (6.5) centimeters (cm) long and nine and seven tenths (9.7) cm wide. Review of a Nutrition Progress Note, dated on 05/18/2021 at 10:46 PM, revealed Resident #65's weight was one hundred forty-two and six tenths (142.6) pounds, a significant weight loss of three (3) percent in seven (7) days, twenty and one-half (20.5) percent in ninety (90) days. Further review revealed the RD was aware the resident had an unstageable pressure ulcer to the sacrum. Based on the progress note, the resident was receiving fortified foods three (3) times a day and a frozen nutrition cup at dinner. The resident's ideal body weight (IBW) was one hundred forty-eight (148) pounds. The RD had no recommendations. Continued interview with the RD, on 08/26/2021 at 12:16 PM, revealed she was unaware Resident #65's pressure ulcer was worsening when she assessed the resident on 05/18/2021. She stated, had she known she would have implemented new interventions to address the pressure ulcer decline.	F 692		

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Further review of Resident #65's weight record revealed the resident weighed one hundred fifty-one and one-half (151.5) pounds on 5/27/2021.

Review of a Nutrition Data Collection assessment, dated 06/13/2021, revealed the resident had a twelve and two tenths (12.2) percent weight gain in thirty (30) days and had sustained a fifteen and one-half (15.5) percent weight loss in ninety (90) days. Further review revealed the resident's intake was greater than his/her needs; however, the resident was at risk for malnutrition due to a weight loss in ninety (90) days, a pressure wound, and the resident required a therapeutic diet. Continued review revealed no nutritional recommendations were made.

Review of a change of condition form, dated 05/28/2021 at 3:54 PM, revealed Resident #65 had a "worsening wound". The physician ordered a wound culture and laboratory testing. However, per the change of condition form, "MD later called back and decided to send resident to Emergency Room for evaluation and treat for possible debridement of area".

Review of Resident #65's hospital record, revealed he/she was admitted to the hospital on 05/28/2021. Review of the resident's Emergency Department (ED) nurse's notes, dated 05/28/2021 at 5:36 PM, revealed the resident had a "large decubitus (pressure) ulcer approximately fifteen (15) cm by eight (8) cm with central skin sloughing and underlying necrosis, the wound had surrounding erythema with mild purulent drainage to bandage". Review of a progress note, dated 05/28/2021 at 9:24 PM, revealed

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F 692	Continued From page 201 Resident #65 was "clinically septic with large decubitus [pressure] ulcer with associated infection including cellulitis and possible developing abscess". According to an Infectious Disease Consult note, dated 06/01/2021, the resident "underwent debridement on 05/30/2021, per operative note, all necrotic tissues were removed and the excision was down to the bone". Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed he debrided the large stage four-(4) pressure ulcer to Resident #65's sacrum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be debrided down to the bone. He stated the pressure ulcer measured ten (10) cm in length by six (6) cm in depth prior to debridement, and post debridement the area measured fifteen (15) cm in length by ten (10) cm in width and was very extensive. Surgeon #1 stated, "Nutrition is a big key" in the development/worsening of pressure ulcers. Further review of the hospital record revealed, on 05/28/2021 at 11:38 PM, Resident #65's Albumin (low albumin can indicate malnutrition) was "low" at one and three tenths (1.3) gram per deciliter (g/dL) with normal range of three and four tenths (3.4) to five (5.0) g/dL. Further review revealed the resident's Total Protein (measures the total amount of albumin and globulin in blood) was "low" at five and six tenths (5.6) g/dL with normal range of six and four tenths (6.4) to eight and four tenths (8.4) g/dL (low protein levels can be seen in severe malnutrition). Resident #65 was discharged back to the facility on 06/09/2021. Continued Review of Resident #65's weight record revealed no readmission weight was documented for the resident. The resident	F 692		

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weighed one hundred fifty-two and two tenths (152.2) pounds on 06/15/2021, one hundred fifty and six tenths (150.6) pounds on 06/22/2021 and one hundred forty-three and one tenth (143.1) pounds on 06/29/2021.

Review of a Nutrition Progress Note, dated 06/29/2021 at 9:52 PM, revealed Resident #65 had sustained a significant weight loss of six (6) percent in less than thirty (30) days and twenty and two tenths (20.2) percent weight loss in ninety (90) days. The resident's ideal body weight (IBW) was one hundred forty-eight (148) pounds. Further review revealed the resident had developed a Deep Tissue Injury (DTI) to the right and left heels and continued to have a Stage IV (4) pressure ulcer to the coccyx. According to the progress note, the resident continued to receive fortified foods three (3) times a day; however, the current intake was inadequate to meet the resident's protein needs for healing. The RD recommended adding large protein portions at breakfast and dinner to better meet energy needs for healing.

Continued review of Resident #65's medical record revealed on 07/08/2021, the resident weighed one hundred forty-two and seven tenth (142.7) pounds.

Review of the resident's Nutrition Progress Note, dated 07/13/2021, revealed the resident had a significant weight loss of six and three tenths (6.3) percent in thirty (30) days and twenty and one-half (20.5) percent in less than one hundred eighty (180) days. The resident also had a DTI to the right heel, two (2) stage one (1) pressure ulcers to left heel, and stage four (4) to coccyx. The note revealed the resident received fortified

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F 692	Continued From page 203 foods three times a day and large protein portions at breakfast and dinner. According to the RD, the resident's intake greatly exceeded the resident's needs and no nutritional recommendations were made. Review of Resident #65's tray card revealed the resident was to receive large protein portions and fortified foods with meals. Observation of Resident #65 dinner tray, on 08/05/2021 at 7:50 PM, revealed no evidence the resident received large protein portions. Review of Resident #65's weight record revealed the resident was not weighed again until approximately one (1) month later on 08/06/2021. The resident weighed one hundred thirty three and two tenths (133.2) pounds, a six and six tenths (6.6) percent weight loss in less than thirty (30) days. There was no documented evidence the RD assessed the resident and no documented evidence that the facility addressed the resident's weight loss. Continued review revealed the resident weighed one hundred thirty one and four tenths (131.4) pounds on 08/11/2021, a seven and nine tenths (7.92) percent loss in approximately five (5) weeks. There was no documented evidence the RD assessed the resident until 08/22/2021. Review of Resident #65's Nutrition Progress note, dated 08/22/2021 at 2:41 PM, revealed the resident's weight was one hundred thirty-seven and eight tenths (137.8) pounds, which was a significant loss of nine (9) percent in ninety (90) days and twenty-three and one tenth (23.1) percent in one hundred eighty (180) days. According to the progress note, the resident	F 692		

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F 692	Continued From page 204 continued to have a DTI to right heel, a stage one-(1) pressure ulcer to left heel, a stage four-(4) pressure ulcer to sacrum, and had developed an unstageable pressure ulcer to left lower extremity. Review of the note revealed the resident had a desired weight gain of four and six tenths (4.6) pounds over the "past few weeks" and no recommendations were made. Further review of Resident #65's weight record revealed the resident continued to lose weight. The resident weighed one hundred thirty-two (132) pounds on 08/23/2021, one hundred thirty-one and seven tenths (131.7) pounds on 08/24/2021 and one hundred thirty-one and four tenths (131.4) pounds on 08/25/2021. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she was not aware the facility was not fortifying foods, nor providing large protein portions as recommended. She stated if the facility had fortified Resident #65's foods and added large protein portions as recommended, the on-going significant weight loss that occurred for this resident would have been prevented. Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, revealed he debrided the large stage four-(4) pressure ulcer to Resident #65's sacrum on 05/30/2021. He stated there was non-viable tissue in the wound and it had to be debrided down to the bone. He stated the pressure ulcer measured ten (10) cm in length by six (6) cm in depth prior to debridement, and post debridement the area measured fifteen (15) cm in length by ten (10) cm in width and was very extensive. Surgeon #1 stated, "Nutrition is a big key" in the development/worsening of pressure ulcers.	F 692		

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2. Review of Resident #90's medical record revealed the facility admitted the resident on 10/07/2016 with diagnoses including Dementia, Unspecified Protein-Calorie Malnutrition and Dysphagia.

Review of Resident #90's Minimum Data Set (MDS) assessment dated 02/19/2021, revealed the facility assessed the resident to have a BIMS score of eight (8) out of fifteen (15), indicating the resident had moderate cognitive impairment. The MDS also revealed the resident was totally dependent on staff for eating. The assessment stated the resident weighed ninety-seven (97) pounds and was at risk for malnutrition.

Review of Resident #90's weight record revealed the resident weighed ninety-seven (97) pounds on 02/02/2021.

Review of Resident #90's comprehensive care plan in place on 02/19/2021, revealed the facility identified on 11/20/2020 that the resident had a potential for weight concerns and was at risk for malnutrition due to dependence on staff for eating, diagnosis of dysphagia and Vitamin B12 deficiency.

Review of Resident #90's weight record revealed on 03/06/2021, the resident weighed eighty-six and eight tenths (86.8) pounds, a loss of ten (10) pounds in thirty-two (32) days. However, there was no documented evidence the facility notified the RD of the resident's weight loss as required by policy.

Continued review of Resident #90's weight record revealed on 04/04/2021, the resident weighed eighty-six and six tenths (86.6) pounds.

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F 692	Continued From page 206 Review of RD documentation, dated 04/09/2021, revealed the RD noted Resident #90 had sustained an eight and eight tenths (8.8) percent weight loss in thirty (30) days, and ten and one-half (10.5) percent in one hundred eighty (180) days. The documentation stated the RD recommended serving the resident fortified foods with meals, ice cream with lunch and supper, whole milk with meals and administer the resident Med Pass (nutritional supplement) one hundred twenty (120) milliliters (ml), three (3) time per day. However, review of Resident #90's medication administration records (MAR), dated April 2021 through July 2021, revealed staff continued to administer the resident ninety (90) ml of the House Supplement three (3) times a day, instead of one hundred twenty (120) ml as recommended by the RD on 04/09/2021. Continued review of Resident #90's weight record revealed on 05/04/2021, the resident had gained weight and weighed ninety-three and six tenths (93.6) pounds. However, there was no documented evidence the facility re-weighed the resident the next day to ensure the increased weight was accurate as required by the facility's policy. Review of Resident #90's weight record revealed on 06/08/2021, the resident's weight was eighty-four and seven tenths (84.7) pounds, and on 06/15/2021, the resident's weight was eighty-two and one-half (82.5) pounds. Review of Resident #90's RD documentation, on 06/16/2021, revealed the RD noted an eleven and nine tenths (11.9) percent weight loss in thirty (30)	F 692		

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days, a twelve and nine tenths (12.9) percent weight loss in ninety (90) days, and an eleven and one-half (11.5) percent weight loss in one hundred eighty (180) days. However, the RD documented the resident's intake "greatly exceeds the resident needs yet continues to lose weight". The RD recommended increasing the resident's Med Pass to four (4) times per day.

Review of Resident #90's Medication Administration Records, for June 2021 and July 2021, revealed the Med Pass continued to be administered to the resident three (3) times per day.

Review of Resident #90's weight record revealed on 06/29/2021, the resident weighed eight-two and three tenths (82.3) pounds.

Review of RD documentation dated 07/07/2021, revealed the RD documented Resident #90 had lost thirteen and one tenth (13.1) percent in ninety (90) days and eleven and seven tenths (11.7) percent loss in one hundred eighty (180) days. However, the RD made no new recommendations.

Further review of Resident #90's weight record revealed on 07/08/2021, the resident's weight was eighty and two tenths (80.2) pounds.

Review of Resident #90's meal tray card on 07/27/2021, revealed the card listed fortified foods at meals and ice cream with lunch and supper meals.

Observations of Resident #90 during the lunch meal services, on 07/27/2021 and 07/28/2021, revealed the resident's tray did not include ice

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cream on either day.

Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, reveled Resident #90 weighed eighty-one and one tenth (81.1) pounds. However, there was no documented evidence the facility notified the RD that the resident was continuing to lose weight.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if the facility had fortified Resident #90's foods as recommended and provided the resident with the recommended supplements and snacks, it would have prevented the on-going significant weight loss that occurred for this resident. The RD stated she assumed if she made a recommendation the facility implemented it, unless she was notified otherwise. The RD stated she did not conduct any type of monitoring to ensure residents were getting the recommendations she had made, such as meal observations. The RD stated the facility did not routinely notify her if a resident had experienced weight loss, and the only way for her to obtain that information was to run a report when she came to the facility.

3. Review of Resident #327's medical record revealed the facility admitted the resident on 03/15/2021 with diagnoses including Dementia, Anemia, and Hyperlipidemia. The facility documented the resident's admission weight as two hundred one and one-half (201.5) pounds.

Review of Resident #327's admitting physician orders, dated 03/15/2021, revealed staff were to provide the resident with a mechanical soft diet with thin liquids and provide the resident with Med

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F 692	Continued From page 209 Pass four (4) times per day. Review of RD documentation, dated 03/17/2021, for Resident #327 revealed she recommended staff to provide fortified foods with all meals, snacks three (3) times a day and finger foods when available. Review of Resident #327's Admission MDS assessment, dated 03/22/2021, revealed the facility assessed the resident to be severely cognitively impaired. The assessment also stated the resident complained of difficulty or pain with swallowing, and was independent with meals requiring set up help only, and the resident weighed two hundred and five (205) pounds. Review of Resident #327's baseline care plan, initiated on 03/15/2021, revealed the plan failed to address nutritional status. Review of a RD evaluation, dated 03/26/2021, revealed Resident #327 weighed one hundred ninety-four and two tenths (194.2) pounds, and the RD documented the resident had sustained a five (5) percent weight loss in one week. The RD recommended adding whole milk and ice cream to the resident's lunch and supper meals. Review of a RD documentation, dated 04/09/2021, revealed on 04/06/2021, Resident #327 weighed one hundred eighty-four and two tenths (184.2) pounds, a significant weight loss of ten (10%) percent in thirty (30) days. Further review of the report revealed the RD recommended referring the resident to the physician for a medication review due to the facility's documentation that the resident's intake was "fair", but continued to experience weight	F 692		

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loss. However, there was no documented evidence in the resident's medical record to indicate the facility implemented the recommendation and no documented evidence the staff notified the resident's physician of the weight loss or that a medication review was completed.

Review of RD documentation, dated 05/07/2021, revealed she evaluated Resident #327 on 05/07/2021, because the resident weighed one hundred eighty-two and one-half (182.5) pounds on 04/27/2021. The RD documented the resident had lost six (6) percent of body weight in the past thirty (30) days and ten and eight tenths (10.8) percent of body weight in the past ninety (90) days. However, the RD made no further recommendations, stating the resident's intake was likely adequate, because the resident's weight was stable since the last review.

Review of Resident #327's care plan, developed on 05/09/2021, revealed the facility documented the resident was at risk for impaired nutrition related to dementia and chronic medical problems. The resident's care plan also stated that although the resident had sustained weight loss, the resident was still above ideal body weight. The interventions on the resident's care plan included assisting the resident with meals as needed, RD consults as needed, obtain weights, and administer the resident the House Supplement as ordered.

Review of RD documentation revealed on 06/06/2021, the RD evaluated Resident #327 because the resident weighed one hundred seventy-eight and one-half (178.5) pounds on 06/01/2021, a significant weight loss of eleven

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and four tenths (11.4) percent in ninety (90) days. However, the RD made no recommendations for Resident #327.

Review of RD documentation revealed on 07/07/2021, the RD evaluated Resident #327, who weighed one hundred seventy-nine and nine tenths (179.9) pounds on 07/06/2021. The RD made no new recommendations stating the resident's weight had remained stable in the past thirty (30) days.

Observation of Resident #327 during the lunch meal, on 07/27/2021 at approximately 2:00 PM, revealed the resident was not served ice cream with the meal, per the RD recommendation.

Continued review of Resident #327's record revealed the resident weighed one hundred seventy (170) pounds on 08/03/2021, which was a five and one-half (5.5) percent weight loss in thirty (30) days, however, there was no evidence the RD re-evaluated the resident.

Observation of staff weighing residents in the facility on 08/05/2021, from 2:00 PM until 5:00 PM, revealed Resident #327 weighed one hundred seventy and three tenths (170.3) pounds.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed in her opinion, if the facility had consistently followed the resident's diet orders and recommendations, the resident would not have experienced on-going significant weight loss. The RD stated the facility's failure to provide fortified foods, snacks, and supplements such as ice cream could have all contributed to the resident's continued weight

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loss. The RD stated facility staff had never informed her of Resident #327's weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. Therefore, the RD stated she was not aware that the resident had sustained additional significant weight loss from 07/06/2021 to 08/03/2021.

4. Review of Resident #82's medical record revealed the facility admitted the resident on 05/12/2021 with diagnoses including Parkinson's Disease, Alzheimer's Disease, Insomnia and Vitamin D Deficiency. Further review of the admission data revealed the resident's weight was one hundred fifty-three and six tenths (153.6) pounds on 05/12/2021.

Review of the Physician Admission orders, revealed Resident #82 was to receive a mechanical soft diet with thin liquids, and on 05/18/2021 the physician ordered the house supplement to be provided to the resident four (4) times per day and on 07/27/2021 the physician ordered Periactin (appetite stimulant) to be administered every six (6) hours.

Review of Resident #82's Admission MDS assessment, dated 05/18/2021, revealed the resident was severely cognitively impaired, but was independent with eating, requiring set up only. The assessment also stated the resident's weight was one hundred forty-eight (148) pounds, a five and six tenths (5.6) pound weight loss in one (1) week.

Review of Resident #82's baseline care plan, initiated on 05/12/2021, revealed no information related to nutritional status was on the care plan.

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F 692	Continued From page 213 Review of Resident #82's weight record revealed on 06/01/2021, the resident weighed one hundred forty-five and one tenth (145.1) pounds, a five and one-half (5.5) percent weight loss in less than thirty (30) days. However, there was no documented evidence the RD evaluated Resident #82 until 06/05/2021, twenty-four (24) days after admission and eighteen (18) days after the resident sustained a weight loss. Review of the RD assessment, dated 06/05/2021, identified Resident #82 had sustained a five and one-half (5.5) percent weight loss in thirty (30) days, and a thirteen and four tenths (13.4) percent loss in ninety (90) days. The RD recommended to add a nighttime snack and fortified foods to the Resident's diet. Continued review of Resident #82's weight record revealed on 06/08/2021, the resident weighed one hundred forty-three and two tenths (143.2) pounds. Review of Resident #82's nutritional care plan, developed on 06/17/2021, revealed the facility identified the resident had a potential for weight loss, and was at risk for malnutrition due to Alzheimer's Disease and a history of weight loss. Interventions implemented on 06/17/2021, included honoring the resident's food requests/preferences, the RD to evaluate and make dietary changes/recommendations as needed, obtain weights as ordered, and monitor and report and signs/symptoms of malnutrition to the physician. The facility identified malnutrition signs/symptoms as significant weight loss of three (3) or more percent in one a week, a five (5) percent weight loss in one (1) month, a seven	F 692		

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F 692	Continued From page 214 and one-half (7.5) percent weight loss in three (3) months and a ten (10) percent weight loss in six (6) months. Further review of Resident #82's record revealed the resident weighed one hundred forty-two and one-half (142.5) pounds on 07/13/2021, one hundred thirty-nine and one tenth (139.1) pounds on 07/20/2021, one hundred thirty-seven and three tenths (137.3) pounds on 07/27/2021 and 132.9 pounds on 08/03/3021, a significant weight loss of 13.4% in the last 90 days. However, there was no evidence the RD re-evaluated the resident after 06/05/2021, and no evidence the facility notified the resident's physician of the weight loss. Observation of staff weighing residents on 08/05/2021 from 2:00 PM thru 5:00 PM, revealed Resident #82 weighed 140 pounds. Interview with the RD on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed in her opinion, if the facility had fortified Resident #82's foods as recommended and provided the resident with an adequate amount of food and snacks, it would have prevented the resident's on-going significant weight loss. The RD stated facility staff had never informed her of Resident #327's weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. However, the RD stated she did not always run that report and at times, staff failed to enter the resident's weights into the system, so a weight loss would not trigger. Therefore, the RD stated she was not aware that the resident had sustained additional significant weight loss since 06/05/2021.	F 692		

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F 692	Continued From page 215 5. Review of Resident #330's medical record revealed the facility admitted the resident on 03/11/2020 with diagnoses including Cerebral Infarction, Diabetes Mellitus, Hemiplegia and Aphasia. Review of Resident #330's physician orders for May 2021, revealed the resident was to receive a mechanical soft diet with thin liquids. Review of Resident #330's Annual MDS assessment, dated 05/12/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15), indicating the resident was cognitively impaired, had swallowing difficulties and held residual food in mouth. Further review of the assessment revealed the facility assessed the resident to require limited assistance of one (1) staff member at meals. The assessment stated the resident's weight was two hundred thirty-nine (239) pounds. Review of Resident #330's care plan, in place on 05/12/2021, revealed the resident was at risk for potential weight concerns/malnutrition because of the resident's diagnosis of dysphagia. However, the facility identified the resident was above ideal body weight and was obese. The note indicates the resident had a feeding tube, not utilize for nutrition. Interventions initiated on the care plan included RD consults as needed, obtain weights and monitor/report any signs/symptoms of malnutrition to the physician. The facility identified signs/symptoms of malnutrition to report included weight loss of three (3) pounds in a week, five (5) percent of body weight in one month, seven and one-half (7.5) percent of body weight in three (3) months and ten (10) percent of body weight in six	F 692		

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(6) months. The care plan also directed staff to "Explain and reinforce to (the resident) the importance of maintaining the diet ordered. Explain consequences of refusal, obesity/malnutrition risk factors", despite the resident being severely cognitively impaired and requiring staff assistance with meals.

Review of Resident #330's weight record revealed on 06/08/2021, the resident's weight was two hundred thirteen and six tenths (213.6) pounds. However, there was no documented evidence the RD evaluated the resident until 06/28/2021, twenty (20) days after the resident sustained a ten and six tenths (10.6) percent weight loss in approximately thirty (30) days.

Review of a RD assessment, dated 06/28/2021, revealed the RD documented Resident #330 had lost ten and six tenths (10.6) percent of his/her body weight in one hundred eighty (180) days, but made no dietary recommendations.

Continued review of Resident 330's weight on 07/06/2021, revealed the resident weighed two hundred fifteen and one-half (215.5) pounds.

Review of a nurse's note, dated 07/18/2021 at 4:15 PM, revealed staff took Resident #330 down to the third floor for an in-person visit with spouse. The note stated within ten (10) minutes, the third floor staff were calling up to the resident's floor, stating the resident's spouse was very upset. The noted stated the spouse told staff "they were starving the resident". The nurse's note indicated the writer went to the third floor and found the resident crying, and the spouse stating the "resident was hungry and facility was starving (him/her)". The spouse stated the resident had

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F 692	Continued From page 217 "visibly lost weight." The note further stated the resident says he/she was not hungry. Interview with Resident #330's spouse, on 08/03/2021 at 7:30 PM, confirmed the spouse was visiting the resident on 07/18/2021. The spouse stated the resident all of a sudden wanted to come home and was crying. The spouse stated the resident had never acted that way on prior visits and the resident looked like he/she had lost weight. The spouse reported caring for the resident at home after the stroke, which had left the resident unable to speak. The spouse stated when the resident was home, they had learned to communicate through actions and symbols. The spouse stated when the resident made a "gnawing motion" on the arm it meant the resident was hungry. The spouse stated when he/she realized during the visit on 07/18/2021, that the resident was crying, the spouse reported asking the resident what was wrong. The spouse stated the resident immediately began making a gnawing motion on his/her arm. The spouse reported asking the resident are you hungry and stated the resident answered yes by shaking his/her head. The spouse then told the resident that he/she had purchased a "pop and bag of chips" on the way to the facility and asked the resident if he/she wanted it. The Spouse reported giving the food to the resident who immediately ate the chips and drank the soda. The spouse began to cry during the interview and voiced trying to arrange to care for the resident at home or finding another facility to transfer the resident to, because the resident was "going hungry." Review of Resident #330's weight on 08/03/2021, revealed the resident weighed two hundred and ten (210) pounds, a five and one-half (5.5) pound	F 692		

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weight loss since 07/06/2021. However, there was no documented evidence the RD re-evaluated the resident after 06/28/2021. In addition, there was no documented evidence staff notified Resident #330's physician that the resident had sustained significant weight loss in the facility.

Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, revealed Resident #330 weighed two hundred and ten (210) pounds.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed although Resident #330 had sustained a significant weight loss on 06/28/2021, when she evaluated the resident, the resident still remained significantly above ideal body weight, so therefore the RD stated no interventions were warranted. However, the RD stated facility staff had never informed her of Resident #330's continuing weight loss. She stated the only way she was aware of the resident's weight loss, was to run a report when she was at the facility. However, the RD stated she did not always run that report and at times, staff failed to enter the resident's weights into the system, so a weight loss would not trigger. Therefore, the RD stated she was not aware that the resident had continued to lose weight.

6. Review of Resident #39's medical record revealed the facility admitted the resident on 11/25/2011, and re-admitted the resident to the facility on 04/03/2018 with diagnoses including Diabetes Mellitus, GERD, and Chronic Diastolic Heart Failure.

Review of Resident #39's Quarterly MDS

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assessment dated 03/01/2021 revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. The assessment also revealed the resident was independent with eating, weighed two hundred ninety-six (296) pounds, and was not on a physician ordered weight loss plan.

Review of Resident #39's weight record revealed the resident weighed two hundred ninety (290) pounds on 04/04/2021, and refused to be weighed in May 2021.

Review of Resident #39's comprehensive care plan, dated 06/17/2021, revealed the facility identified the resident was at risk for impaired nutrition related to receiving a mechanical soft diet and the diagnosis of Diabetes. Interventions implemented on 06/17/2021 included staff honoring the resident's food requests/preferences, monitoring the residents weight and providing the resident with diet as ordered.

Review of Resident #39's weight record revealed the resident weighed two hundred fifty-three and three tenths (253.3) pounds on 06/22/2021, representing a fourteen (14) percent weight loss in approximately one hundred eighty (180) days.

Review of an RD assessment, dated 06/22/2021, revealed the RD recommended to honor the resident's dietary preferences and serve the resident fortified foods at meals.

Further review of Resident #39's weight record revealed documentation that the resident refused to allow staff to obtain weight in July 2021.

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F 692	Continued From page 220 Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, revealed Resident #39 weighed two hundred sixty-one and seven tenths (261.7) pounds. Interview with Resident #39, on 07/27/2021 at 10:45 AM, revealed the facility had no snacks available for residents and the facility served the same food several times a week, especially for the supper meal. Resident #39 also stated, "You hardly get anything at supper to eat anyway". The resident stated the facility never passes snacks and stated, "I get hungry". Interview with Resident #39 and during the lunch meal, on 08/17/2021 at 1:20 PM, revealed the resident preferred salads for lunch, and liked to eat Fruit Loops cereal. However, the facility had not served the resident a salad for the meal. The resident stated, "I've lost a lot of weight in the past year because the food here is always late and cold". The Resident stated he/she had requested salads for lunch but had never received a salad for lunch. The resident reported asking staff in the past, why he/she never received salads, and stated, "It's always a different excuse, they forgot, or they're out of lettuce." Resident #39 also stated he/she had requested Fruit Loop cereal, stating that was his/her favorite cereal before admission into the facility. However, Resident #39 stated, "they won't give me that here either." The resident stated, "Why would someone ask me what I liked or wanted to eat, if they're not gonna give it to me, makes no sense." The resident stated breakfast was frequently cold and he/she remains hungry until lunch. However, the resident stated "but if I could get some cereal I could eat that, I could	F 692		

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make it myself." Resident #39 also denied ever refusing to allow staff to weigh him/her.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if Resident #39's food preferences had been honored, the resident would most likely not have experienced a significant weight loss. The RD stated a gradual weight loss would have been beneficial for the resident, but a sudden significant weight loss was not desirable.

7. Review of Resident #332's medical record revealed the facility admitted the resident on 03/12/2021 with diagnoses including Diabetes, Chronic Kidney Disease, Gastro-Esophageal Reflux Disease, Hypertension, Atrial Fibrillation, and Femoral Neck Fracture.

Review of Resident #332's diet orders, dated 03/12/2021, revealed the resident was to receive a two thousand (2000) calorie ADA (American Diabetes Association) and Renal Diet.

Review of a Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed Resident #332's weight was one hundred ninety-nine and nine tenths (199.9) pounds and the resident's intake was inadequate to meet the resident's needs. Further review of the assessment revealed a recommendation to add fortified foods to the resident's meals to meet energy needs.

Review of Resident #332's Quarterly MDS assessment, dated 03/19/2021, revealed the facility assessed the resident to have a BIMS score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review of the

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assessment revealed the resident was independent with eating, and weighed two hundred (200) pounds.

Review of Resident #332's weight record revealed the resident weighed one hundred eighty-two and six tenths (182.6) pounds on 04/05/2021.

Review of the Nutrition Progress Note by the RD, dated 04/11/2021, revealed Resident #332 had sustained a nine (9) percent weight loss in thirty (30) days. Further review revealed the resident's intake remained inadequate to meet the resident' needs. The progress note stated the resident was receiving fortified foods, large protein portions at dinner, and a snack at bedtime.

Review of Resident #332's weight record revealed the resident weighed one hundred eighty-four and nine tenths (184.9) pounds on 05/04/2021.

Review of a Nutrition Progress Note for Resident #332, dated 05/27/2021, revealed the resident had a seven and six tenths (7.6) percent weight loss in ninety (900 days. However, according to the note the resident's "current intake exceeds needs, yet (he/she) has remained weight stable".

Further review of the RD evaluations revealed the RD evaluated Resident #332 on 06/29/2021 and noted the resident received two (2) bologna sandwiches with tomato and mayonnaise at lunch and dinner per the resident's request. However, the RD again notes "has a history of weight stability despite exceeding (his/her) needs so do not recommend adjusting interventions at this time".

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F 692	Continued From page 223 Review of a subsequent RD evaluation for Resident #332, on 07/25/2021, revealed there was "no new weight since 05/04/2021". The RD documented "current intake exceeds needs", so the RD made no new dietary recommendations. Review of the Restorative Weight Record Book revealed staff weighed Resident #332 on 06/07/2021, 07/05/2021, and 08/03/2021. However, staff failed to enter the weights into the resident's electronic medical record. Review of the weights revealed Resident #332 continued to lose weight, weighing one hundred eighty-three and six tenths (183.6) pounds on 06/07/2021, one hundred eighty-two and nine tenths (182.9) pounds on 07/05/2021 and one hundred seventy-nine and nine tenths (179.9) pounds on 08/03/2021. Observation of staff weighing residents on 08/05/2021, from 2:00 PM thru 5:00 PM, revealed Resident #332 weighed one hundred and eighty (180) pounds. Observation of Resident #332's supper meal tray, on 08/05/2021 at 7:28 PM, revealed the resident did not have bologna sandwiches or large protein portions on the meal tray. Interview with Resident #332, on 7/27/2021 at 11:00 AM, revealed the food was always cold, and the resident reported losing weight since admission. The resident stated he/she was supposed to get a bologna sandwich on the meal tray at lunch and supper. However, the resident stated he/she never got the sandwiches at lunch or supper. The resident further stated when asked about where the sandwich were, staff	F 692		

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would usually state the kitchen was out of bologna. In addition, Resident #332 stated the facility never had snacks especially at night and reported going to sleep hungry. The resident stated staff would tell me I have to wait till in the morning when the kitchen opens.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed the facility was out of bologna, and had been out for weeks.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed if the facility had fortified Resident #332's foods, added large protein portions, provided the resident with two (2) bologna sandwiches at lunch and supper, and provided a nightly snack, it would have prevented the resident's on-going significant weight loss. In addition, the RD stated, "most likely the resident would have gained weight". The RD stated she only looks at weights documented in the resident's electronic medical record, and denied having knowledge of a "weight book". The RD stated she could only assume the facility was providing the resident with the diet he/she was ordered and the recommendations she made. However, the RD stated she had never discussed the resident's weight or diet with the resident. The RD stated when she was at the facility she reviewed records and weights, but did not physically observe or talk to residents.

8. Review of Resident #81's medical record revealed the facility admitted the resident on 10/12/2015, and re-admitted the resident on 09/30/2019 with Dementia, Anemia, Anxiety and Major Depressive Disorder.

Review of Resident #81's Quarterly MDS

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assessment dated 05/18/2021, revealed the facility assessed the resident to have a BIMS score of six (6) out of fifteen (15), indicating the resident was cognitively impaired. Further review of the MDS assessment revealed the resident required extensive assistance for eating, and the resident weighed one hundred and seventeen (117) pounds.

Review of Resident #81's comprehensive care plan, in effect on 05/18/2021, revealed the resident had a history of unplanned weight loss and poor nutritional intake and was at risk for malnutrition.

Review of Resident #81's weight record revealed on 06/01/2021, the resident weighed one hundred nine and two tenths (109.2) pounds.

Review of a RD assessment for Resident #81, completed on 06/05/2021, revealed the resident sustained a six and one-half (6.5) percent weight loss in thirty (30) days and an eight and nine tenths (8.9) percent weight loss in ninety (90) days. Further review of the assessment revealed the resident's current intake was inadequate to meet resident needs. The assessment further stated the resident met criteria for severe malnutrition due to weight loss. The assessment stated Resident #81 was "already supposed" to get fortified foods, whole milk and sandwiches with meals, and an ice cream cup with dinner. The RD recommended discontinuing the ice cream cup and adding a frozen nutrition cup with dinner.

Review of a Nutrition Progress Note for Resident #81, dated 07/07/2021, revealed on 07/06/2021, the resident's weight was one hundred eight and

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seven tenths (108.7) pounds, representing a nine and four tenths (9.4) percent weight loss in ninety (90) days. However, the RD also documented the resident's weight was stable for thirty (30) days, and implemented no new recommendations.

Review of Resident #81's weight on 08/03/2021, revealed the resident weighed one hundred seven and one tenth (107.1) pounds.

Observation of staff weighing Resident #81, on 08/05/2012, revealed Resident #81 weighed one hundred seven and nine tenths (107.9) pounds.

Observation of Resident #81's lunch tray, on 08/05/2021 at 3:10 PM, revealed the resident received two (2) percent milk with the meal and received no sandwich.

Review of a Nutrition Progress note for Resident #81, dated 08/22/2021, revealed the resident had sustained a significant weight loss of eight and three tenths (8.3) percent in ninety (90) days and ten and seven tenths (10.7) percent in less than one hundred eighty (180) days. The note stated the resident's weight had remained stable for sixty (60) days. However, the note also stated the resident's body mass index (BMI) was below normal limits for the resident's age and body weight of one hundred seven and one tenth (107.1) pounds. In addition, the note stated the resident's current nutritional intake greatly exceeded the resident's need to maintain weight and nutritional status.

Further interview with the RD, on 08/11/2021 at 4:10 PM, and 08/18/2021 at 10:30 AM, revealed when she documented that a resident's current intake greatly exceeded the resident needs, that

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F 692	Continued From page 227 was saying, "We have a problem". The RD went on to explain that if the resident was receiving what was ordered and the resident's intake was documented correctly, then the resident would not be losing weight. Review of Resident #40's progress note, dated 08/26/2021 at 2:33 PM, revealed staff had notified the resident's daughter of the resident's weight loss. The progress note stated the resident's appetite was improving, and the resident required cueing for meals. The note further stated the caller told the daughter the RD was assessing the resident and the resident received nutritional supplements. Observations of the snack refrigerator and snack storage areas on the third floor, on 07/27/2021 at 11:30 AM, revealed no snacks, drinks or juices were available for the residents. Observations of the snack refrigerator and snack storage areas on the fourth floor, on 07/27/2021 at 11:45 AM, , revealed no snacks, drinks or juices were available for the residents. Observations of the snack refrigerator and snack storage areas on the fifth floor, on 07/27/2021 at 12:05 PM, , revealed no snacks, drinks or juices were available for the residents. Interviews on 07/27/2021, at 4:40 PM, with SRNA #1, and at 5:00 PM with SRNA #2, and on 07/28/2021 at 5:10 PM, with SRNA #4, revealed the facility did not provide enough snacks for the residents. In addition, the SRNAs stated they had all had resident's tell them they were hungry, but had nothing to give them.	F 692		

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F 692	Continued From page 228 Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed the facility's residents complain of being hungry and stated it had been an ongoing problem at the facility. RN #9 stated she routinely works from 6:00 PM until 6:00 AM, and at times, resident supper trays do not arrive on the floor until 7:30 or 8:00 PM. Per interview the facility staffed with only one SRNA to pass all the trays and assist/feed all residents who required assistance, stating, "It's impossible for the residents to get adequate nutrition. The RN stated she assisted the aide with meal service the best she could; however, she was the only nurse for approximately forty (40) residents, and she had to pass evening medications at that time. Review of the menu for the lunch meal on 08/05/2021, revealed the residents should have received three (3) ounces of protein, 1/2 cup of mashed potatoes, and ½ cup of vegetable. In addition, the "Diet Roster" provided by the facility indicated forty-two (42) residents required fortified foods, including Residents #90, #327, #82, #39, #332, #81, and #65. Observation of the lunch meal, on 08/05/2021, revealed staff served the residents 1/3 cup of mashed potatoes and 3/8 cup of vegetable. In addition, when staff was asked to weigh the protein to ensure it was adequate, there was no functioning scale in the kitchen to weigh the meat. In addition, there was no food prepared and designated as "fortified". Continued observation revealed three (3) residents were supposed to get sandwiches with meals including Residents #332 and #81, and three (3) other residents were supposed to get salads for the lunch meal including Resident #39. However, continued observation and interview with dietary staff	F 692		

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revealed the facility did not have lunchmeat, lettuce, or other sandwich ingredients available. In addition, observations revealed that although the meal was scheduled to be served to residents at approximately 12:00 PM, the last food tray did not exit the kitchen until 2:45 PM.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full time at the facility for approximately one (1) year. Cook #2 stated no one had ever trained her or directed her to fortify foods for facility residents. She stated she worked five (5) days a week and cooks all three (3) meals on the days she works, and had never seen "a recipe" or had instruction on how to fortify foods. Therefore, Cook #2 stated she had never prepared or served fortified foods for the residents. Cook #2 also stated she had never received instruction or training on scoop sizes or appropriate portions to serve residents. In addition, Cook #2 stated she never knew she was supposed to weigh meat or protein. She stated the facility was frequently out of food items. The cook stated two (2) residents continuously asked for Fruit Loop cereal, but the Administrator refused to order the food item. The cook also stated the dietary department should prepare and send out snacks for residents, especially those at risk for weight loss. However, the cook stated, "we haven't sent out snacks in six months or longer." She stated there was not an adequate amount of food items purchased to fulfill the menu, and "definitely not enough" purchased at the facility to provide snacks.

Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed the facility was always out of multiple items that the residents wanted and required to fulfill dietary interventions.

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F 692	Continued From page 230 DA #1 also stated the facility rarely had bologna, lettuce, ice cream and other food items that were on resident tray cards. Interview with Dietary Manager (DM) #1, on 08/18/2021 11:40 AM, revealed the facility did not have a Dietary Manager at this time, but she was the DM at a sister facility and had placed some food orders for the facility. The DM stated she conducted no monitoring of resident weights or was involved in meetings or discussions related to resident weight loss. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year and had never been provided a list of resident to evaluate. The RD stated she ran her own reports in the system and formulated her own list of residents to evaluate. The RD stated she had many ongoing concerns in the facility. The RD stated she had identified concerns with weight loss for the residents, concerns that her recommendations were not being implemented, resident choice/preference not honored, and communication with nursing staff. The RD stated she had discussed the concerns on multiple occasions with the Administrator; however, the facility had taken no action to correct the problems. The RD stated meals were always late and there was not enough food purchased to provide snacks to the residents. The RD stated she was not aware staff did not know how or did not have "instruction" on fortifying foods. The RD stated not fortifying foods, not utilizing the correct scoop size to portion out residents servings, failing to provide snacks, not weighing protein portions, not supplying supplements she had	F 692		

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recommended such as ice cream, and not serving residents their preferences, could all lead to weight loss and malnutrition for the residents. According to the RD, the dietary department was also frequently out of food items to follow the menu. The RD stated nursing staff had never notified her that any of the resident had a sustained a weight loss. The RD stated the only way she knew as much as she did, was by running reports and investigating on her own. The RD also stated she believed for each of the resident's reviewed, if the facility had implemented her recommendations, provided the residents with the planned meals, and offered the resident's snacks, the majority, if not all the residents would not have sustained significant weight loss. The RD also stated in the year the facility had contracted her services, she had never been invited or attended a nutrition meeting to discuss weight loss or any nutritional concerns for facility residents. The RD stated she could evaluate residents on a daily basis, however, if the facility did not implement recommendations, buy enough food to feed residents or ensure menus were followed, it would not prevent weight loss and malnutrition from occurring in the facility.

Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year, and was placed in the IDON position a few weeks ago when the Director of Nursing (DON) resigned from the facility. The ADON/IDON stated since she had been at the facility, there had been very few morning clinical meetings conducted, because there was no staff available to participate. The ADON/IDON stated her and the former DON

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worked as floor nurses more often than not. The ADON/IDON stated she had never monitored weights in the facility, and stated the facility had not conduct weekly Nutrition At Risk (NAR) meetings since she had been at the facility. The ADON/IDON stated she was not sure who was responsible to monitor or ensure staff was implementing RD recommendations. The ADON/IDON Stated the RD sent her recommendations to the DON, ADON and the Administrator after her visits, but she did not have time to follow-up on them because she was working the floor. The ADON/IDON stated she had never provided the RD with a list of residents to evaluate and was not sure who was responsible to monitor residents for weight loss in the facility and who was responsible to notify the RD when a resident lost weight. Per interview, the facility had no unit managers to track weights. In addition, the ADON/IDON, stated she conducted no monitoring to ensure residents received meal trays timely, the food was palatable, that snacks were available and served, that staff implemented RD recommendations, and that staff were able to get meals passed and residents requiring assistance were assisted timely. She stated, "I just don't have time to monitor that".

Interview with the Administrator, on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator denied having knowledge that staff were not fortifying foods, that the facility did not have snacks to provide residents, that staff was not weighing food/protein portions, that nursing was not communicating nutritional /weight loss concerns with the RD, or that recommendations were not being

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F 692	Continued From page 233 implemented. The Administrator stated the facility had no systems in place to monitor resident weight loss or nutritional needs. The Administrator stated she received e-mails from the RD after she conduced visits. However, the Administrator stated she was not sure what information was in them, because she had not read them. The Administrator acknowledged that resident preferences could not always be honored at the facility, and stated she had planned on talking to the RD about all the items on the resident's tray cards that the facility did not provide. The Administrator stated that the RD should be able to make recommendations to prevent weight loss with items the facility routinely ordered. The Administrator confirmed the facility had not conducted NAR meetings since she had been the Administrator, but stated she was working on getting those established. The Administrator could not voice any monitoring or tracking she did to ensure the facility was doing everything possible to prevent resident weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		

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F 695	Continued From page 234 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide respiratory care for one (1) of fifty-seven (57) sampled residents (Resident #323), a resident that required a bilevel positive airway pressure (BiPAP) machine (a machine that provides non-invasive ventilation via a mask, usually with added oxygen, under positive pressure). Resident #323 was admitted by the facility on 07/06/2021 with a diagnosis of Acute Respiratory Failure and required the use of a BiPAP machine when sleeping. The facility failed to obtain physician orders for the machine and set up a machine for the resident's use until 07/14/2021, eight (8) days after admission. The findings include: Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON), on 08/11/2021 at 12:05 PM, revealed the facility did not have a policy regarding BiPAP machines. She stated the facility used a respiratory company to supply and maintain residents' BiPAP machines and had machines available at the facility for use. She stated they should be utilized per physician's order. Review of Resident #323's medical record revealed the resident was admitted by the facility on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Type 2 Diabetes, Dysphagia, Pneumonia and Aphasia.	F 695		

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Review of the Admission Minimum Data Set (MDS) Assessment, dated 07/13/2021, revealed Resident #323 was rarely/never understood. Continued review of the MDS revealed the resident was coded to utilize a non-invasive mechanical ventilator (BiPAP/CPAP) while a resident in the facility.

However, further review of Resident #323's medical record revealed the facility failed to obtain a physician's order for the BiPAP machine until 07/14/2021. Review of the Physicians order, dated 07/14/2021, revealed Resident #323 required "BiPAP at 12/5, 18, 50% QHS [at night]" for diagnosis of Respiratory Failure.

Review of the resident's Medication Administration Record (MAR) revealed there was no documented evidence Resident #323's BiPAP was applied until 07/14/2021.

Interview with Resident #323's family member, on 08/02/2021 at 8:50 AM, revealed she notified the nursing staff at the facility, approximately 07/11/2021, that Resident #323 required a BiPAP to be worn at night. She stated Resident #323 wore BiPAP well at home with no problems. She further revealed she felt Resident #323 not wearing BiPAP contributed to the re-hospitalization of the resident.

Interview with State Registered Nurse Aide (SRNA) #13, on 07/28/2021 at 6:28 AM, revealed she worked on the unit where Resident #323 resided on 07/07/2021, 07/08/2021, 07/13/2021, 07/16/2021, 07/17/2021 and 07/18/2021, and she never observed Resident #323 wearing BiPAP during the night.

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Interview with SRNA #16, on 07/28/2021 at 8:00 PM, revealed she worked night shift and provided care for Resident #323 on 07/07/2021, 07/08/2021, 07/12/2021, 07/13/2021 and multiple other shifts prior to the resident leaving the facility. She stated she never observed Resident #323 wear his/her BiPAP.

Interview with SRNA #18, on 07/28/2021 at 9:54 PM, revealed he provided care for Resident #323 on 07/06/2021, 07/09/2021, 07/10/2021 and the resident did not wear a BiPAP that night. He stated after those dates, (exact date unknown), he did recall the resident wearing BiPAP at night.

Interview with Licensed Practical Nurse (LPN) #3, on 07/28/2021 at 4:16 PM, revealed she was working on 07/06/2021 when Resident #323 was admitted to the facility. She stated she was aware Resident #323 required a BiPAP machine; however, there was no order from the hospital. She stated she and Registered Nurse (RN) #6 got a BiPAP machine from facility stock on 07/06/2021; however, they did not set up the machine because they did not have an order for machine settings for Resident #323. She stated she reported to the oncoming nurse, LPN #8, that orders were needed for the settings for the resident's BiPAP. However, LPN #3 stated the facility did not place the resident on BiPAP until 07/14/2021, when Respiratory Therapist (RT) #1 identified no setting orders had been obtained.

Interview with LPN #8, on 07/28/2021 at 9:29 PM, revealed she was not notified Resident #323 needed orders for his/her BiPAP. She stated the resident should have had orders for the BiPAP if he/she required one for breathing. She further revealed not wearing a BiPAP could have

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F 695	Continued From page 237 negative impact on breathing. Interview with Registered Nurse (RN) #9, on 07/29/2021 at 9:17 PM, revealed Resident #323 did not wear his/her BiPAP for several nights after admission. She stated the family notified her the resident required a BiPAP; however, she was unable to obtain a physician's order for BiPAP machine settings. She stated a physician's order was not obtained until the Interim Director of Nursing/Assistant Director of Nursing (ADON) obtained an order on 07/14/2021. RN #9 stated the resident should have had an order for the BiPAP prior to 07/14/2021 because not wearing BiPAP could have a negative impact on breathing. Interview with RN #6, on 07/28/2021 at 9:48 AM and 3:45 PM, confirmed she assisted with getting Resident #323 a BiPAP machine from the facility stock on admission on 07/06/2021; however, the facility did not have the settings for the resident's machine and treatment was not initiated. On 07/14/2021, the Respiratory Therapist (RT) #1 came to the unit to determine any residents who required respiratory equipment. RN #6 stated she notified RT #1 about Resident #323; however, the RT did not have a physician order for the equipment. RN #6 revealed at that time, she identified the resident had went several nights without the BiPAP machine. She stated Resident #323 should have had the BiPAP before 07/14/2021. She stated not wearing BiPAP could have potential negative impacts on breathing. Interview with Respiratory Therapist (RT) #1, on 08/04/2021 at 8:28 AM, revealed she was new to the facility and was unaware Resident #323 did not have settings for his/her BiPAP machine until	F 695		

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F 695	Continued From page 238 07/14/2021. She stated she entered the resident's room on 07/14/2021 and resident was not wearing BiPAP and did not notice whether the resident had a machine in the room. Interview with Emergency Room Physician #1, on 08/03/2021 at 10:47 AM, revealed Resident #323 presented to the Emergency Department (ED) on 07/20/2021, exhibiting stridor. He stated his medical assessment revealed the resident had an upper airway problem. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (ADON), on 08/11/2021 at 12:05 PM, revealed she was aware there were concerns with obtaining Resident #323's BiPAP. She revealed she was unable to recall how the order was obtained, however, she expected staff to obtain orders for new admissions timely (within 24 hours) including those orders for BiPAP machines. She stated a resident not having a BiPAP could result in decline in respiratory status. Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she had been at the facility since June 2021, and had not developed any systems to monitor to ensure resident's received respiratory care as required.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure pain management was provided for one (1) of fifty-seven (57) sampled residents (Resident #326) who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Observations and record review revealed Resident #326 complained of severe pain in his/her head and back, from 10:01 AM until 5:15 PM on 08/05/2021 (approximately 7.25 hours) before staff administered the resident pain medication, because the resident's prescribed medication was not available in the facility.

The findings include:

Review of the facility's policy titled, "Pain Assessment and Management", dated March 2020, revealed the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices. Further review revealed the facility defined "pain management" as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals.

Review of Resident #326's medical record revealed the facility admitted the resident on Friday 07/30/2021, with diagnoses that included Rhabdomyolysis, Respiratory Failure with

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F 697	Continued From page 240 Hypercapnia, Myocardial Infarction, and Spinal Compression Fractures. Review of Resident #326's Minimum Data Set (MDS) assessment dated 08/06/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9), indicating the resident was moderately cognitively impaired. Review of Resident #326's care plan revealed the only care developed for the resident as of 08/05/2021, was the resident's Baseline Care Plan, which had been initiated on admission (six days prior). The Base Line Care Plan did not contain any information related to the resident's pain or pain management. Review of Resident #326's Physician's Orders dated 07/30/2021, revealed the only ordered pain medication for the resident was Oxycodone Acetaminophen (Percocet) to be administered by mouth every six (6) hours as needed for moderate/severe pain. The order start date was 07/31/2021. Review of the Nurse's Notes dated 08/05/2021 at 10:01 AM, revealed Resident #326 was complaining of head and back pain, and rated the pain as an eight (8) out of ten (10) on a pain scale with one (1) representing minimal discomfort and ten (10) representing severe pain. However, further review of the note revealed no pain medication was available to administer to the resident. The note stated staff notified the pharmacy and requested a "STAT" (urgent) delivery of the medication. Observation and interview with Resident #326 on	F 697		

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F 697	Continued From page 241 08/05/2021 at 11:09 AM, revealed the resident stated he/she was "hurting all over", and was waiting on pain medication. The resident voiced he/she had been in pain "all morning" and rated it an eight (8) on the pain scale. Review of Resident #326's admission Medication Administration Record (MAR) revealed the Percocet medication was on the MAR to be administered every six (6) hours, as needed, for pain. However, none of the medication was documented as being administered to the resident. Interview with Licensed Practical Nurse (LPN) #4 on 08/05/2021 at 11:11 AM, revealed Resident #326 did not have any pain medication at the facility and they were waiting on the medication from pharmacy. She further stated that Resident #326 was not her resident, but she was assisting RN (Registered Nurse) #8 with trying to get the medication for the resident. LPN #4 stated she had no idea why Resident #326 did not have pain medication at the facility, six (6) days after the physician had ordered it. Interview with RN #8 on 08/05/2021 at 11:57 AM, revealed they were attempting to get Resident #326's medication from the pharmacy and was unaware of any emergency medication kit in the facility. RN #8 stated she did not know why Resident #326's pain medication was not available. Observation and interview with Resident #326 on 08/05/2021 at 1:42 PM, revealed the resident still had not received the pain medication. Resident #326 stated, "My head is still killing me". The resident continued to rate the pain as an eight (8)	F 697		

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F 697	Continued From page 242 on a scale of one (1) to ten (10). Continued interview with RN #8 on 08/05/2021 at 1:50 PM, revealed the nurse had not administered pain medication to Resident #326, because "there is nothing in the building to give (him/her)". The nurse stated she knew the resident needed something for pain, because the resident was in severe pain. Further interview revealed she did not know how to get the resident's medication any sooner. Observation and interview with Resident #326 on 08/05/2021 at 4:45 PM, revealed the resident was still in pain, and continued to rate it as an eight (8). Interview with RN #8 on 08/05/2021 at 4:47 PM, revealed the pharmacy had just directed her to pull the medication from the facility's emergency kit and administer it to the resident. Interview with RN #8 on 08/05/2021 at 5:00 PM, revealed she was not aware, prior to this incident, that the facility had an emergency kit with medications available. She stated no one had ever trained her or told her about the emergency medications. Observation of the facility's medication administration pass on 08/05/2021 at 5:15 PM, revealed RN #5 administered Resident #326 a Percocet tablet from the facility's emergency kit. Resident #326 continued to rate his/her pain at an eight (8). Interview with Pharmacist #1, on 07/28/2021 4:05 PM revealed the pharmacy was unable to find any record of receiving the request for Resident	F 697		

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#326's Percocet. However, the pharmacy was able to confirm they had not sent the Percocet to the facility for Resident #326. The pharmacy Representative stated they did maintain an Emergency Kit at the facility, which contained Percocet. However, the representative stated that the nurse requesting the medication was required to submit certain resident information to the pharmacy. Subsequently, the pharmacy would then give the nurse an electronic code to withdraw that specific dose of medication.

Interview with RN #10 on 08/25/2021 at 4:28 PM, revealed it had been more difficult lately to get prescription refills for narcotics. The RN stated when the facility admitted a resident on a weekend, the resident may not have any or only some of their medications available for administration, and frequently they did not have narcotic medications available. RN #10 stated it was a "routine" problem for residents not to get narcotics refilled timely. However, RN #10 did not know specifically why Resident #326 did not have medication at the facility.

Interview with RN #1 on 08/05/2021 at 1:55 PM, revealed she often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or a refill for narcotic medications. The nurse stated residents "often" go multiple days without medication while waiting for a refill or arrival of the medication. RN #1 stated she did not know why Resident #326's medications were not available.

Interview with Certified Medication Aide (CMA) #1 on 08/05/2021 at 1:00 PM revealed residents often run out of narcotic medications. CMA #1 stated residents must go without medication until

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F 697	Continued From page 244 the facility could obtain a refill. Interview with Physician #1 on 08/04/2021 at 1:05 PM, and on 08/27/2021 at 1:26 PM, revealed he was aware there were problems with obtaining narcotic pain medications for residents at the facility. However, he stated he was not aware that residents were going several days without pain medication. The physician also stated it was not acceptable for a resident to be in pain for several hours and not have medications available for administration. Continued interview revealed he expected medications to be available to residents upon admission to the facility and he expected staff to follow admission orders and implement immediate care to residents. The Physician stated he had ordered the resident's pain medication upon admission to the facility and he did not know why the facility did not have it available for administration. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (IDON) on 08/27/2021 at 12:00 PM, revealed the facility did not have a back-up pharmacy. She stated she was aware that residents were going several days without narcotic pain medications due to medications not being available. The ADON/IDON stated Physician #1 was aware that there was an issue with narcotic pain medications not being available for administration. Continued interview revealed she had "no idea why (Resident #326) didn't have pain medication" at the facility. In addition, the ADON/IDON stated she was unaware that the nurses were not aware of the facility's emergency medication kits. However, the ADON/IDON, stated she had never conducted any training in the facility regarding the emergency medication kits. The ADON/IDON	F 697		

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F 697	Continued From page 245 stated the facility had no system in place to track medications. She stated the facility had not figured out what the problem was yet. The ADON/IDON stated she was not aware that Resident #326 was without pain medication and complained of severe pain on 08/05/2021, for approximately seven hours and fifteen minutes. The ADON/IDON stated that a resident being in pain that long without medication was not an acceptable standard of practice. Interview with Administrator on 08/10/2021 at 1:50 PM, revealed she expected the admission orders would be followed, and that medications would be available for residents prior to admission to facility. She stated the facility reviewed new admissions to ensure the facility could meet their needs prior to admitting the resident. The Administrator stated she was not aware Resident #326's pain medication was not available at facility on 08/05/2021. She further stated that it was not acceptable for residents to wait several hours before receiving pain medication.	F 697		
F 725 SS=J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		

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F 725	Continued From page 246 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and review of the facility's assessment, it was determined the facility failed to ensure sufficient staff was available to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being for seven (7) of fifty-seven (57) sampled residents (Residents #321, #65, #320, #308, #314, #311 and #3). Review of Resident #321's medical record revealed the resident had a diagnosis of Diabetes, which required staff to monitor the resident's blood glucose. However, interviews with staff revealed due to the lack of staff it was difficult to monitor the resident closely for signs/symptoms of hypoglycemia/hyperglycemia (low/high blood sugar). On 07/18/2021, Resident #321 experienced two (2) episodes of critically low blood glucose levels, requiring staff to intervene and administer emergency treatment.	F 725		

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However, due to the facility's lack of available staff the resident's level of monitoring was not increased. On 07/19/2021, at approximately 12:30 AM, staff found Resident #321 unresponsive with a critically low blood glucose level. The facility transferred the resident to the hospital where he/she was intubated. The hospital admitted Resident #321 to the Intensive Care Unit (ICU) with diagnoses of Hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and Acute Respiratory Failure, secondary to prolonged Hypoglycemia (low blood glucose).

Review of Resident #65's medical record revealed the resident was at risk for pressure ulcers and required assistance of staff for turning, repositioning, and incontinent care. Interviews with staff revealed there was not enough staff to turn and reposition residents, including Resident #65. The resident developed a Stage IV (4) pressure ulcer to the sacrum that became infected and required hospitalization on 05/08/2021. According to the resident's hospital record, the pressure ulcer required debridement (removal of dead and infected tissue) down to the bone. The facility re-admitted Resident #65 to the facility on 06/09/2021. Resident #65 developed four (4) additional pressure ulcers. On 08/26/2021, the wound care clinic documented the wound had blackened tissue, blistering, erythema, fever, numbness and swelling consistent with the resident being bed ridden and having infrequent position changes.

In addition, observations conducted during the survey revealed residents' hair was oily, one (1) resident had the same clothes on for three (3) days and (1) resident had body odor.

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F 725	Continued From page 248 Additionally, interviews with staff, residents, and resident family members revealed staff did not answer call lights timely, did not assist with toileting timely, residents were not receiving scheduled showers; and, residents' meals were late and the food was cold, due to insufficient staffing. The facility's failure to ensure sufficient staff was available to provide nursing services has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656) 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of the facility's documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. The findings include:	F 725		

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Review of the facility's policy titled "Staffing," last revised October 2017, revealed the facility would provide sufficient numbers of staff with the skills/competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment. The policy stated licensed nurses and nursing assistants would be available twenty-four (24) hours a day and staffing numbers would be determined based on residents' needs and each resident's plan of care.

Review of the "Facility Assessment Staffing Plan," dated 08/18/2017, revealed the facility required eight (8) to nine (9) licensed nurses, thirteen (13) to fifteen (15) State Registered Nursing Assistants (SRNA), and four (4) to six (6) dietary staff in a twenty-four (24) hour day to ensure the facility met resident needs.

Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed the facility's goal for staffing in the building was to have two (2) nurses and four (4) SRNAs on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses and three (3) aides for night shift (7:00 PM-7:00 AM).

Review of the mealtime schedule revealed the facility scheduled breakfast at 7:00 AM, lunch at 12:00 PM and the evening meal at 5:00 PM.

1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer.

Review of Resident #321's Admission Minimum Data Set (MDS) assessment, dated 07/19/2021, revealed the facility assessed the resident to have

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a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating the resident was cognitively intact.

Review of the Physician's Orders, dated 07/16/2021, revealed an order for staff to monitor Resident #321 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) every shift.

Review of Resident #321's baseline care plan, dated 07/16/2021, revealed the facility did not address the resident's diabetes and/or monitoring the resident's blood sugar.

Review of Nursing Notes, dated 07/18/2021 at 3:20 PM, revealed Resident #321's blood glucose was sixty-seven (67) milligrams per deciliter (mg/dL). The note stated staff delivered the resident's breakfast tray (exact time unknown) and Licensed Practical Nurse (LPN) #6 obtained a repeat glucose level after breakfast which was documented as one hundred thirty-nine (139) mg/dL. Interview with Licensed Practical Nurse #6 on 07/27/2021 at 4:10 PM, revealed at approximately 7:30 AM on 07/18/2021, LPN #6 obtained a blood glucose reading for Resident #321, which was sixty-seven (67) milligrams per deciliter (mg/dL). However, there was no documented evidence LPN #6 continued to monitor the resident's condition or obtain further glucose levels for the resident.

Review of a hospital record for Resident #321, revealed the resident arrived at the Emergency Department (ED) on 07/19/2021, at 1:36 AM, non-responsive and unable to follow commands. The resident required intubation and was admitted to the Intensive Care Unit (ICU) with

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diagnoses of hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia.

Interview with Resident #321's Daughter, on 08/02/2021 at 5:30 PM, revealed she arrived at the facility for a scheduled visit on 07/18/2021 at 10:45 AM. She stated Resident #321 told her his/her blood sugar had dropped to sixty-seven (67) mg/dL that morning. However, the daughter stated that she left the facility at approximately 3:00 PM that day and no staff member obtained the resident's blood glucose level during her visit. She stated Resident #321 had not received his/her lunch meal when she left the facility.

Interview with Resident #321's Spouse, on 07/28/2021 at 2:19 PM, revealed his/her her daughter visited Resident #321 on 07/18/2021. The Spouse stated the daughter reported that the resident's glucose was low that morning, the facility smelled of urine and the resident's blanket and washcloths were soiled from the resident's unemptied nephrostomy bags leaking. The spouse further stated he/she had talked to Resident #321 on the telephone numerous times that day, and the resident had told him/her that he/she could tell his/her blood sugar was running low because of the way the resident felt. However, the resident told the spouse the staff had still not re-checked his/her blood sugar as of 4:00 PM, since that morning and prior to the daughter's arrival to the facility at 10:45 AM. The spouse stated at approximately 4:00 PM on 07/18/2021, was the last time he/she spoke to Resident #321 and the resident reported ringing the call light (exact time unknown) and it had taken an hour before staff answered the light.

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F 725	Continued From page 252 Interview with State Registered Nursing Assistant (SRNA) #1, on 07/27/2021 at 4:40 PM, and on 08/03/2021 at 3:19 PM, revealed she was working on 07/18/2021 from 7:00 AM to 7:00 PM, and remembered Resident #321's blood glucose being low that morning. However, the SRNA stated she did not check on the resident again until sometime after lunch, when she found the resident non-responsive. SRNA #1 stated that she and one other SRNA were the only SRNAs on day shift for the entire floor that day, and was caring for approximately 40 residents. SRNA #1 stated that lunch had been very late arriving to the floor that day and it was probably after 4:00 PM when she found the resident. SRNA #1 stated it was difficult to check on residents multiple times during the shift because there was not enough staff to do that. The SRNA stated if a resident was able to ring the call light, staff probably checked on them less, because they could let you know if something was wrong. SRNA #1 stated she immediately notified LPN #6 of the resident's condition. Interview with Licensed Practical Nurse (LPN) #6, on 07/30/2021 at 11:30 AM, revealed she did recall Resident #321 having another hypoglycemic episode during the late afternoon on 07/18/2021 (exact time unknown). She stated SRNA #1 summonsed her to the resident's room, and she found the resident unresponsive. LPN #6 stated she obtained the resident's blood glucose level and recalled it "was around forty (40) mg/dL". The LPN stated to the best of her recollection, she had cared for the resident's nephrostomy around 1:00 PM, but had not been able to check on the resident since that time. LPN #6 stated she got Registered Nurse (RN) #1	F 725		

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from the other end of the unit to assist her and administered Resident #321 an injection of Glucagon (hormone injection used to treat a critically low blood glucose) and oral glucose. LPN #6 stated the resident regained consciousness and it was close to the supper meal, so she gave the resident an oatmeal pie to eat before the supper trays arrived. Review of Resident #321's medical record revealed no documented evidence the LPN documented the resident's hypoglycemic incident or any of the resident's blood glucose levels. In addition, there was no documented evidence the LPN monitored the resident's condition or blood glucose levels the remainder of her shift. LPN #6 stated it was difficult to care for all the residents and complete documentation.

Review of Resident #321's Nursing Notes, dated 07/19/2021 at 12:23 AM, revealed a SRNA found the resident unresponsive and clammy. The documentation stated staff obtained the resident's blood glucose and it was thirty-two (32) mg/dL. The facility subsequently transferred the resident to the hospital. The hospital admitted the resident to the ICU.

Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed she worked from 6:00 PM on 07/18/2021 until 6:00 AM on 07/19/2021, and was assigned to care for Resident #321. SRNA #4 stated she and the nurse were the only staff on the floor to care for approximately forty (40) residents. The SRNA stated at 8:45 PM, the resident was fine. She stated she did not check on the resident again. SRNA #4 stated she was about to begin her next round, when the laboratory technician arrived on the floor and found Resident #321 unresponsive. Continued

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interview with SRNA #4 revealed she had received in report that the resident's glucose levels had been low that day. However, the SRNA stated there was no way for her to check on the residents more frequently, when she was the only SRNA on the floor.

Interview with the Laboratory Technician (LT) #1, on 08/02/2021 at 4:45 PM, revealed she arrived at Resident #321's unit, on 07/19/2021 at approximately 12:15 AM, and found Resident #321 unresponsive.

Interview with RN #7, on 07/28/2021 at 4:25 PM, revealed she worked on 07/18/2021 from 7:00 PM until 07/19/2021 at 7:00 AM. RN #7 stated she received in shift report that Resident #321's blood glucose levels had been low during the day. The RN stated sometime between 7:30 PM and 8:00 PM, Resident #321 rang the call light and reported he/she thought his/her blood sugar was low. The nurse stated she checked the resident's blood glucose level, and it was one hundred and six (106) mg/dL. However, RN #7 stated she failed to document the blood glucose. RN #7 stated that she and one SRNA were the only staff that worked the floor that night, and she was busy and probably forgot to document. She stated she took the resident some peanut butter and crackers, and the resident stated he/she "just felt funny". RN #7 stated at approximately 9:00 PM, she returned to check on the resident. The nurse stated Resident #321 had not eaten the peanut butter and crackers, so she offered the resident pudding or juice, but the resident declined and reported feeling better. Further interview revealed RN #7 did not re-check the resident's glucose level. RN #7 stated at approximately 12:15 AM on 07/19/2021, the laboratory technician arrived

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on the floor, and soon after discovered that Resident #321 was unresponsive. She stated when she entered Resident #321's room, the resident was unresponsive, and she could immediately tell the resident's blood glucose was low because the resident was clammy. RN #7 stated she checked the resident's blood glucose, and it was thirty-two (32) mg/dL. RN #7 stated because it was only she and (1)SRNA that worked the entire floor, she called for staff from other floors to assist her and call the physician.

2. Review of Resident #65's medical record revealed the facility admitted the resident on 03/24/2021 and re-admitted the resident on 04/29/2021 with diagnoses that included Cerebral Infarction, Dysphagia, Polyarthritis, Chronic Obstructive Pulmonary Disease and Paraplegia.

Review of Resident 65's Admission Minimum Data Set (MDS) assessment, dated 03/30/2021, revealed the resident was totally dependent on two (2) staff with Activities of Daily Living. Further review revealed the resident was at risk for pressure ulcers based on a formal assessment. According to the MDS dated 03/30/2021, Resident #65 was not on a turning/repositioning program.

Review of a Braden Scale for Predicting Pressure Sore Risk form, dated 03/23/2021, revealed Resident #65 was at risk for pressure ulcers due to being chair fast and limited mobility.

Continued review of Resident #65's medical record revealed no documented evidence the facility turned/repositioned the resident at least every two (2) hours.

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Review of a Change of Condition form, dated 05/02/2021 at 10:35 AM, revealed Resident #65 had developed a deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the coccyx.

Interview with Licensed Practical Nurse (LPN) #4, on 08/25/2021 at 4:00 PM, revealed she identified the deep tissue injury to Resident #65's coccyx/sacrum area on 05/02/2021. However, the LPN stated she did not measure the area due to being "overwhelmed" with her workload due to not enough staff.

Review of a Change of Condition form, on 05/11/2021 at 2:40 PM, revealed the resident's pressure ulcer to the coccyx was "worsening" and measured six and one-half (6.5) centimeters (cm) long and nine and seven tenths (9.7) cm wide. Continued review of Resident #65's medical record, including Weekly skin checks, revealed the resident's pressure ulcer continued to decline. Review of a Change of Condition form, dated 05/28/2021 at 3:54 PM, revealed Resident #65 had a "worsening wound". The form stated the physician sent the resident to the Emergency Room for further evaluation and treatment.

Interview with State Registered Nurse Aide (SRNA) #4, on 08/26/2021 at 12:36 PM, revealed Resident #65's pressure ulcer had an odor for about a month and nursing staff were aware. She stated she knew the resident's wound "looked bad and smelled bad". SRNA #4 stated she provided care to Resident #65, and tried to keep the resident turned and repositioned, but stated she was unable to do so every two (2)

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hours, because she had forty other residents to care for. SRNA #4 stated staff were not able to turn and reposition residents with pressure areas as much as needed, due to not having enough staff.

Review of Resident #65's hospital record revealed the hospital admitted the resident on 05/28/2021, and diagnosed the resident as being Clinically Septic with a Pressure Wound and Associated Infection including Cellulitis and possible developing Abscess. According to the record, the pressure ulcer "smells like dead flesh".

Review of an Operative report, dated 05/30/2021, for Resident #65, revealed the resident presented with a large necrotic appearing area on his/her sacrum. The operative report stated, "It was extremely extensive down to the base large amount of fat necrosis was encountered as well as necrotic tissue". The operative report further read, "Debrided all devitalized tissue down to the level of the bone".

Interview with Surgeon #1, on 08/31/2021 at 1:30 PM, who debrided Resident #65's wound, revealed he was not aware of any terminal illness or diagnosis that contributed to the resident's pressure ulcer. He stated failure to turn and reposition and improper nutrition could contribute to pressure ulcers and progression of wounds.

Further review of facility records revealed the facility re-admitted Resident #65 to the facility on 06/09/2021. Per the medical record the resident's sacral wound again declined and the resident developed new pressure areas to bilateral heels, a Stage I (1) to the left heel on

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06/23/2021, and a deep tissue injury to the right heel on 06/26/2021.

Review of Wound Care Office Visit notes for Resident #65, dated 07/29/2021, revealed the resident's wounds were consistent with the resident being bed ridden, friction, rubbing and infrequent position changes. The note further revealed the sacrum wound had increased in size since the facility's last assessment, on 07/05/2021, and measured fifteen and one-half (15.5) cm (length) by fifteen (15) cm (width) and one and eight tenth (1.8) cm (depth).

Review of Head to Toe Weekly Skin Check Assessment, dated 08/12/2021 at 11:52 AM, revealed Resident #65 had developed a new pressure ulcer to the back of the left, lower leg and on 08/26/2021 the resident developed a new pressure ulcer to the left hip.

Review of a Wound Care note for Resident #65, dated 08/26/2021 at 9:00 AM, revealed the circumstances resulting in the resident's wounds was consistent with the resident being "bed ridden and infrequent position changes."

Interview, with SRNA #1 on 8/5/2021 at 5:15 PM and with SRNA #10 on 08/27/2021 at 11:15 AM, revealed they provided care for Resident #65. The SRNAs stated there was not enough staff to turn and reposition Resident #65 every two (2) hours.

Interview with SRNA #11, on 08/27/2021 at 3:00 PM, revealed she could not perform rounds and turn, reposition, and check/change residents, including Resident #65, every two (2) hours when there was only one (1) or two (2) nursing

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assistants to care for 40 residents. The SRNA stated when they were short staffed it sometimes took four (4) hours to complete just one round.

Interview with SRNA #14 on 07/28/2021 at 11:43 AM, SRNA #12 on 07/28/2021 at 6:08 AM, and LPN #2 on 07/28/2021 at 6:52 AM, revealed the facility did not have enough staff to turn and reposition residents every two (2) hours.

Interview with Registered Nurse (RN) #3, on 08/27/2021 at 9:55 AM, revealed staff had not been able to turn and reposition residents every two (2) hours, including Resident #65, because they were so short staffed. She stated, "It is horrible!" RN #3 stated she had worked by herself for two (2) days in a row with approximately forty (40) resident assigned to her care. She further stated the SRNAs have told her they cannot do rounds every two (2) hours. She stated she directed them to notify the DON.

Interview with RN #7, on 08/01/2021 at 11:40 AM and 08/24/2021 at 3:49 PM, revealed, there was not enough staff to turn and reposition residents as required. She further revealed skin assessments were required weekly; however, they do not always complete them because there was not enough staff.

Interview with Registered Nurse (RN) #4/Wound Care Nurse, on 08/25/2021 at 8:30 PM, revealed she could not take care of resident wounds appropriately, because she had to work the floor more than she worked as the wound nurse because of short staffing. The Wound Care Nurse stated since she could not provide wound care and assess the wounds as required, she was not monitoring the wounds and she

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F 725	Continued From page 260 physically could not assess them all. Interview with the Advanced Practice Registered Nurse (APRN) #1, who worked at the Wound Care Clinic on 08/27/2021 at 3:14 PM, revealed Resident #65's pressure ulcer developed over a bony prominence. He stated the resident did not appear to be able to turn and reposition self. Continued interview revealed if resident #65 had to wait more than two (2) hours to be repositioned, it could cause wound decline. Interview with Physician #1/Medical Director, on 08/27/2021 at 1:18 PM, revealed he was aware Resident #65 had a pressure ulcer to his/her bottom, but was not aware the resident had developed other pressure ulcers. He further stated he was not aware staff were not able to turn and reposition residents every two (2) hours due to decreased staffing. He stated a pressure ulcer could develop and/or decline if a resident was not turned and repositioned, or incontinence care not provided for more than two (2) hours. 3. Review of Resident #320's medical record revealed the facility admitted the resident on 09/30/2015 with diagnoses including Hemiplegia and Hemiparesis. Review of Resident #320's Annual MDS assessment, dated 06/17/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15), indicating the resident was moderately cognitively impaired. The MDS stated the resident required extensive assistance with personal hygiene. Observations of Resident #320, on 07/27/2021 at	F 725		

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F 725	Continued From page 261 11:20 AM, revealed the resident was wearing black jogging pants and a blue t-shirt. Observation on 07/28/2021 at 9:00 AM revealed the resident was wearing the same clothes as on 07/27/2021. Observation of Resident #320, on 07/29/2021 at 9:15 AM, revealed the resident continued to wear the same clothes as on 07/272021 and 07/28/2021. Continued observation revealed an unpleasant odor was noticeable when close to the resident and the resident's hair had an oily appearance. Interview with Resident #320, on 07/28/2021 at 9:00 AM, revealed the resident frequently had to ask staff to change his/her clothes. Resident #320 stated, "I usually have to ask two (2) or three (3) times before they will help me." The resident denied getting a shower twice weekly as scheduled, stating, there was "not enough help here". Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, revealed the facility had no shower record for Resident #320. 4. Review of Resident #308's medical record revealed the facility admitted the resident on 11/29/2019 with diagnoses that included a Lack of Coordination and Abnormal Gait/Mobility. Review of Resident #308's Quarterly MDS assessment, dated 07/26/2021, revealed the facility assessed the resident to have a BIMS score of twelve (12) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the resident required staff assistance with transfers and toileting. Observation of Resident #308, on 07/27/2021 at	F 725		

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11:10 AM, revealed the resident was in his/her room in bed or chair. Continued observation revealed the resident's hair was oily and uncombed.

Interview with Resident #308, on 07/27/2021 at 11:10 AM, revealed staff had not assisted him/her with a bath in nine (9) days. The resident stated, "For about a year it's been hard to get anyone to help you around here." Resident #308 stated meals were late and the food was "cold and not worth eating most of the time". Resident #308 stated it took up to an hour for staff to answer a call light. The resident reported complaining to everyone about not enough help and not being taken care. However, the resident stated nothing had been done to correct the problems.

Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #308.

5. Review of Resident #314's medical record revealed the facility admitted the resident on 06/03/2021 with diagnoses that included Lack of Coordination.

Review of Resident #314's Quarterly MDS assessment, dated 07/30/2021, revealed the facility assessed the resident to have a BIMS score of ten (10) out of fifteen (15), indicating the resident was moderately cognitively impaired. The facility assessed Resident #314 to require staff assistance with bathing.

Interview with Resident #314, on 07/27/2021 at 12:50 PM, revealed the resident reported he/she had received only one (1) bath each week since admission to the facility. Continued interview

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revealed the facility did not have enough help especially at night.

Interview with the DON/IDON, on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #314.

6. Review of Resident #311's medical record revealed the facility admitted the resident on 06/28/2021 with diagnoses that included Abnormalities of Gait.

Review of Resident #311's Admission MDS assessment, dated 07/04/2021, revealed the facility assessed the resident to have a BIMS score of eight (8) out of fifteen (15), indicating the resident had mild cognitive impairment. Resident #311 required assistance of one (1) staff member for bathing and dressing.

Interview with Resident #311, on 07/27/2021 at 12:40 PM, revealed the resident reported he/she only received three (3) showers since admission to the facility twenty-three (23) days go. Resident #311 stated the facility didn't have enough workers and he/she had stopped using the call light shortly after admission, because "no one ever came anyway."

Interview with the DON/IDON on 08/18/2021 at 9:50 PM, reveled the facility had no shower record for Resident #311.

7. Review of Resident #3's medical record revealed the facility admitted the resident on 01/27/2014, with diagnoses that included Parkinson's Disease and Diabetes Mellitus.

Review of Resident #3's Quarterly MDS

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assessment, dated 07/22/2021, revealed the facility assessed the resident to have a BIMS' score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review of the MDS revealed the resident required assistance with dressing and extensive assistance with toileting and personal hygiene.

Interview with Resident #3, on 07/28/2021 at 10:00 AM, revealed the resident routinely attended resident council meetings. The resident stated every meeting he/she attended the residents always voiced concerns over cold food, meals served late, call lights not answered, showers not given, and not enough staff to provide care. However, the resident stated, "Nothing has been done."

8. Observation on 08/05/2021 of the lunch meal service, revealed the first fourth floor meal cart arrived on the unit at 1:59 PM (approximately two hours later than scheduled) with twenty (20) trays on the cart. Further observation revealed RN #8 was the only staff passing meal trays from 1:59 PM until 2:04 PM. Staff passed the last tray at 2:16 PM.

Observation of the test tray food temperatures, on 08/05/2021 at approximately 2:16 PM, revealed the pureed meat was ninety (90) degrees Fahrenheit, potatoes ninety-two (92) degrees Fahrenheit , pureed green beans ninety (90) degrees Fahrenheit , pureed bread eighty (80) degrees Fahrenheit and cold chocolate pudding was sixty (60) degrees Fahrenheit .

Observation on 08/05/2021 revealed the second fourth floor meal cart arrived on the unit at 2:10 PM (approximately 2 hours and 10 minutes later

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than scheduled) with fifteen (15) trays. Observation revealed only one (1) staff person was passing trays. Staff delivered the last resident tray at 2:35 PM.

Observation of the second meal cart test tray food temperatures, on 08/05/2021 at approximately 2:35 PM, revealed chicken fried steak with gravy was one hundred and four (104) degrees Fahrenheit, whole kernel corn one hundred twelve (112) degrees Fahrenheit, mashed potatoes one hundred twenty-four (124) degrees Fahrenheit, two (2) percent milk was fifty-eight (58) degrees Fahrenheit, coffee one hundred eight (108 degrees Fahrenheit and cold chocolate pudding was sixty-eight (68) degrees Fahrenheit.

Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed especially at night. The SRNA stated there should be three (3) SRNAs for night shift. However, for months there had only been one (1) SRNA scheduled to care for forty (40) residents. SRNA #16 stated meal service was always late and at times, it was 8:00 PM before the kitchen delivered trays to the floor. The SRNA stated there was no way one (1) staff could pass trays and assist forty (40) residents, some of which required total feeding.

Interview with Registered Nurse (RN) #9, on 07/29/2021 at 9:30 PM, revealed the RN confirmed the facility was short staffed. RN #9 stated there should be three (3) SRNAs working on the fifth floor for the night shift 6:00 PM until 6:00 AM. However, RN #9 stated most of the time there was only one (1) SRNA. The RN stated she had reported staffing concerns to the

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ADON/IDON and the Administrator on multiple occasions. RN #9 also stated she reported resident call light complaints and shower complaints, but she had never received feedback or a resolution. Further interview revealed RN #9 recalled an incident which occurred a few weeks ago. RN #9 stated the Administrator directed her to provide 1:1 supervision to a resident. However, RN #9 stated she informed the Administrator that there were forty-seven (47) residents on the floor and that she and one SRNA were the only staff on the unit to care for them, and that level of resident supervision was not possible. RN #9 stated the Administrator directed her to do the best she could and did not attempt to find additional staff to provide assistance on the floor to ensure the resident's safety.

Interview with the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON), on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides since she had been there. The ADON/IDON stated she had worked the floor as a staff nurse more than she had been able to complete her administrative nursing tasks. The ADON/IDON stated she had worked the last six (6) of seven (7) nights on the floor due to short staffing. She stated she was aware that residents were not getting showers, not getting timely incontinent care, not being turned and re-positioned, and not receiving appropriate feeding assistance due to the lack of staff. The ADON stated she was also aware that meals were served consistently late, which made it difficult for staff and residents at meal times. The ADON/IDON stated when the food cart did not arrive on the floor until 7:00 or

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F 725	Continued From page 267 8:00 PM in the evening, it was difficult to serve and assist residents because there was only one (1) SRNA and the nurses were administering medications at that time and could not help. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed and did not have enough nurses or nurse aides. The Administrator stated optimally a "good ratio" was ten (10) residents per nursing assistant, and that was the goal for staffing in the facility. The Administrator stated there should be two (2) nurses and four (4) nurse aides on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses and three (3) aides for night shift (7:00 PM-7:00 AM). However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. The Administrator stated she was aware there was only one (1) SRNA and one (1) nurse providing care to approximately forty (40) residents because the facility was short staffed. However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. The Administrator stated when staff called in and was unable to come, there was no one to cover the shift resulting in short staffing. However, the Administrator stated she continued to accept new resident admissions, even though there was an inadequate number of staff to care for them. The Administrator stated that although she was aware that one (1) nurse and (1) SRNA were routinely caring for approximately forty (40) patients, she denied knowledge that residents were not receiving showers as scheduled or that residents were complaining of call light wait times.	F 725		
F 755 SS=J	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 268 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		

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F 755	Continued From page 269 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide pharmaceutical services to meet the needs of five (5) of fifty-seven (57) sampled residents (Resident #321, Resident #326, Resident #351, Resident #9, and Resident #324). The facility failed to acquire and administer prescribed medications to meet the needs of Resident #326, Resident #351, Resident #9 and Resident #324. In addition, the facility admitted Resident #321 on 07/16/2021 with the diagnoses of Urosepsis and Invasive Bladder Cancer with Physician's Orders to receive an antibiotic to treat the Urosepsis. The pharmacy required the facility to "cost over-ride" the medication before it could be dispensed. However, the facility failed to address the cost over-ride and Resident #321 did not receive the physician ordered antibiotic. The facility's failure to ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control	F 755		

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F 755	Continued From page 270 (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. The findings include: Review of the facility's policy titled, "Provider Pharmacy Requirements", revised 01/2021, revealed regular and reliable pharmaceutical services were available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. Further review revealed the provider agreed to perform routine and timely pharmacy services, and emergency pharmacy services twenty-four (24) hours per day, seven (7) days a week. In, addition, the pharmacy would assist the facility in determining the appropriate acquisition, receipt, dispensing and administration of all medications and biologicals to meet the medication needs of the residents, accurately dispense prescriptions based on authorized prescriber orders, and provide, maintain, and replenish emergency medication in a sealed and properly labeled container in a timely manner.	F 755		

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Review of the facility's policy titled, "Medication Ordering and Receiving from Pharmacy," dated as revised on 01/2021 revealed emergency pharmacy services were available on a 24-hour basis. Staff will obtain emergency medications by using the facility's approved emergency medication supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities, in the emergency kit in compliance with applicable state regulations. Further review revealed telephone/fax (facsimile) numbers for emergency pharmacy services were posted at the nurses stations and/or medication storage rooms, physician on call 24/7 and telephone numbers were posted at the nurses stations and/or medication storage rooms. Continued review revealed the pharmacy supplied emergency or "stat" medications according to the pharmacy agreement, and if available, should be obtained from the emergency kit until the provider pharmacy delivered the appropriate medications.

Review of the facility's policy titled, "Administering Medications", dated as revised on 04/2019 revealed medications were administered in a safe and timely manner, as prescribed. Further review revealed medications were administered in accordance with prescriber orders, including any required time-frames and medications were administered within one (1) hour of their prescribed time, unless otherwise specified, such as before or after meals.

1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021 with diagnoses of Urosepis, Diabetes

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Mellitus, and Invasive Bladder Cancer.

Review of Resident #321's Minimum Data Set Discharge assessment dated 07/19/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13), indicating the resident was cognitively intact.

Continued review of Resident #321's medical record revealed the facility transferred the resident to the hospital on 07/20/2021 related to Hypoglycemia (low blood sugar).

Review of Resident #321's admission Physician's Orders, dated 07/16/2021, revealed an order for the staff to administer Fosfomycin Thromethamine (antibiotic) by mouth every Saturday to treat the resident's diagnosis of Urosepsis. Staff was to administer the medication for three (3) months, starting on 07/17/2021 and ending on 10/17/2021.

Review of Resident #321's Medication Administration Record (MAR), dated 07/17/2021, revealed the Fosformycin Thromethamine medication was due at 9:00 AM on 07/17/2021, but was not administered because the medication was not available. Further review of the MAR revealed a "cost approval" was pending for the medication.

Interview with Licensed Practical Nurse (LPN) #6, on 07/27/2021 at 4:10 PM, revealed she contacted the pharmacy on 07/17/2021 in an attempt to obtain Resident # 321's medication. However, the pharmacy stated the antibiotic required cost approval from the facility before they could send it to the facility. She further stated

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she notified Physician #1 that the medication was not available and asked if he could order a substitute antibiotic. However, the physician instructed her that he could not substitute the medication, and the resident needed the medication as ordered. LPN #6 stated she notified the Director of Nursing/Interim Director of Nursing (DON/IDON) of the need for a cost approval. However, when she provided care for the resident the next day, on 07/18/2021, the medication was still not available for the resident. According to LPN #6, someone should have identified the medication required a cost approval prior to the resident's admission to the facility.

Interview with the Admission Coordinator, on 07/28/2021 at 11:34 AM, revealed before the facility admitted a resident from the hospital, the facility's Admission Coordinator met with the hospital's Case Manager for the referral, and she checked the resident's needs, bed availability, etc. She further stated staff faxed the resident's admission medication orders to the pharmacy prior to the resident's admission and the cost of each medication was reviewed. According to the Admission Coordinator, she had not had any issues with cost approvals, though she had only been at the facility for three (3) months. She stated the facility has knowledge of a resident's admission date and therefore, the resident's medications should be available and ready for the resident upon arrival to the facility.

Interview with Pharmacist #1 on 07/28/2021 at 4:05 PM, revealed the pharmacy received Resident #321's medication list on 07/16/2021 at 6:57 PM. She stated the pharmacy had not sent the medication to the facility because they were waiting cost approval from the ADON/IDON. She

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further stated any medication, which was non-formulary, expensive, or not approved by insurance, required a cost approval from the facility prior to delivery. She stated the pharmacy had a note on file that they attempted to reach the facility via telephone for a cost approval for Resident #321's antibiotic on 07/16/2021 at 11:25 AM, and then followed-up with an email to the ADON/IDON, requesting the cost approval.

Interview with Physician #1, on 08/04/2021 at 1:05 PM, revealed he expected medications to be available for residents upon admission to the facility and admission orders to be followed to provide immediate care to residents. He stated he recalled the nurse notifying him that Resident #321's antibiotic for Urosepsis was not available to administer on 07/17/2021. Physician #1 stated he told the nurse the resident needed the medication and he did not change the order. However, he did not recall the facility making him aware that Resident #321's antibiotic did not arrive for administration on 07/18/2021, nor that the medication was never administered to the resident.

Interview with the ADON/IDON, on 08/11/2021 at 12:05 PM, revealed that when the facility received a new admission, the Admission Coordinator reviewed the case to ensure the facility could meet the resident's needs. The ADON/IDON the Admission's Coordinator should have already handled any cost approvals during the pre-admission process. She further stated she did recall anyone notifying her that Resident 321's antibiotic medication needed a cost approval. The ADON/IDON stated she was unaware the medication was not sent or given to the resident.

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Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. She stated she expected staff to follow admission orders and medications to be available for the resident prior to admission to the facility. She stated she was not aware Resident #321's antibiotic was not available following his/her admission due to a cost approval issue. She stated the Admissions Coordinator should have resolved any issue related to cost approval prior to Resident #321's arrival to the facility.

2. Record review revealed the facility admitted Resident #9 on 11/01/2013 with diagnoses that included Multiple Sclerosis, Muscular Dystrophy, and Dementia.

Review of Resident #9's Annual MDS assessment, dated 06/09/2021, revealed the facility assessed the resident to be severely cognitively impaired.

Review of Resident #9's Comprehensive Care Plan, dated 07/09/2020, revealed the resident was at risk for decline related to Intellectual Disabilities and Muscular Dystrophy with a goal to maintain the highest level of comfort possible. Further review revealed Resident #9 had the potential for alteration in comfort and was at risk for pain related to Muscular Dystrophy and muscle spasms with a goal to keep the resident as comfortable as possible. Interventions included administering the resident's medications as ordered, notifying the physician of new onset pain, and if the pain medication was ineffective.

Review of Resident #9's Physician's Orders dated

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10/13/2020, revealed staff were to administer the resident Gabapentin by mouth three (3) times daily and Norco by mouth two (2) times daily, and Diazepam by mouth three (3) times daily beginning on 06/17/2021, for treatment of Multiple Sclerosis, Muscular Dystrophy, muscle spasms, restlessness and agitation.

Review of Resident #9's MAR, from 06/23/2021 thru 08/04/2021, revealed on 06/23/2021, 06/24/2021, and 07/27/2021, the facility failed to administer Resident #9's Diazepam three (3) times daily as prescribed and documented the medication was not available from pharmacy. On 08/02/2021, 08/03/2021 and 08/04/2021, the facility failed to administer Resident #9's Gabapentin three (3) times daily and documented the medication had not arrived from pharmacy. Further review of the MAR revealed, on 08/03/2021 the facility also failed to administer Resident #9's Norco pain medication two (2) times daily as prescribed and staff documented the medication was not in from pharmacy.

Interview with Registered Nurse (RN) #1, on 08/05/2021 at 1:00 PM, revealed Resident #9 had been out of Gabapentin medication for several days. She stated she had notified the pharmacy and Physician #1 multiple times, but the pharmacy had not delivered the medication until 08/04/2021. RN #1 stated obtaining refills on medications sometime took a long time. RN #1 stated often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or refill for narcotics for a resident. RN #1 stated nurses notified the physician and pharmacy when there were three (3) days of medication remaining, but often residents had to go without medication for several days while awaiting a refill

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or arrival of the medication.

Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 1:00 PM, revealed Resident #9 had been out of Gabapentin for several days, and she had notified RN #1. CMA #1 stated she documented the medication was unavailable.

3. Review of Resident #326's medical record revealed the facility admitted the resident on 07/30/2021 with diagnoses of Rhabdomyolysis, Respiratory Failure with Hypercapnia and Myocardial Infarction.

Review of Resident #326's Admission MDS assessment, dated 08/06/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status score of nine (9), indicating the resident was moderately cognitively impaired.

Review of Resident #326 Comprehensive Care Plan, dated 08/12/2021, revealed the resident was care planned for pain management and interventions included administering medications as ordered.

Review of Resident #326's Physician's Orders, dated 07/31/2021, revealed an order for Percocet (pain medication) to be administered by mouth every six (6) hours as needed for moderate/severe pain with a start date of 07/31/2021.

Review of Electronic Medication Administration Record (E-Mar), dated 08/05/2021, revealed Resident #326 received Percocet Tablet 5-325 mg (milligram), one (1) tablet by mouth for head and back pain at 5:14 PM, approximately six (6)

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hours after requesting pain medication and voicing severe pain to staff.

Review of a Nursing Note, dated 08/05/2021 at 10:01 AM, revealed Resident #326 complained of head and back pain and rated the pain as eight (8) of ten (10) on the pain scale. Further review revealed no pain medication was available for the resident, and staff requested a "STAT" (now) delivery of the medication.

Observation of Resident #326 on 08/05/2021, at 11:09 AM, revealed the resident was lying in bed holding his/her head. Interview with Resident #326, on 08/05/2021 at 11:09 AM, revealed the resident stated he/she was "hurting all over" and was waiting on pain medication. The resident stated he/she had been in pain "all morning" and rated his/her pain as an eight (8) on the pain scale.

Interview with Licensed Practical Nurse (LPN) #4, on 08/05/2021 at 11:11 AM, revealed Resident #326 did not have pain medication and they were awaiting the medication from pharmacy. LPN #4 stated RN #8 was the nurse assigned to the resident.

Interview with RN #8, on 08/05/2021 at 11:57 AM, revealed Resident #326 had no pain medication and they were attempting to get the medication from the pharmacy. The RN stated she was unaware of an emergency medication kit.

Interview with Resident #326, on 08/05/2021 at 1:42 PM, revealed he/she had not yet received his/her pain medication. Resident #326 stated, "My head is still killing me".

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F 755	Continued From page 279 Interview with RN #8, on 08/05/2021 at 1:50 PM, revealed she had not provided Resident #326 with any medication for pain because there was nothing in the building. However, the resident needed something for pain. She further stated she was unaware of how to obtain the resident's medication any sooner. Interview with Resident #326, on 08/05/2021 at 4:45 PM, revealed the resident still had not received any pain medication and was still in pain. Interview with RN #8, on 08/05/2021 at 4:47 PM, revealed, she had spoken to the pharmacy and they had instructed her on the facility's emergency medication kit and how to obtain Resident #326's pain medication from the kit. Observation of a medication pass, on 08/05/2021 at 5:15 PM, revealed RN #5 administered Resident #326 a Percocet tablet from the emergency kit. Interview with Physician #1, on 08/27/2021 at 1:26 PM, revealed he was aware there were issues with obtaining narcotic pain medications for residents at the facility. However, the physician stated he was unaware residents including Resident #326, were going days without pain medications. Interview with ADON/IDON, on 08/27/2021 at 12:00 PM, revealed she was aware residents were going several days without narcotic pain medications due to medications not being available. The ADON/DON stated the facility had no designated back-up pharmacy to supply medications.	F 755		

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F 755	Continued From page 280 Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. The Administrator stated she expected residents' medications to be available and administered as ordered. The Administrator stated she was not aware Resident #326's pain medication was not available following admission. 4. Record review revealed the facility admitted Resident #351 on 10/28/2002 with diagnoses that included Diffuse Traumatic Brain Injury, Hypertension, and Quadriplegia. Review of Resident #351's Quarterly MDS assessment, dated 05/26/2021 revealed the facility assessed the resident to have a BIMS score of three (3), indicating the resident was severely cognitively impaired. Review of Resident #351's the Comprehensive Care Plan, dated 09/04/2020, revealed Resident #351 had potential for alteration in comfort related to pain due to muscle spasms and chronic pain due to a motor vehicle accident. Further review revealed the goal for the resident was to be as comfortable as possible with interventions to administer medications as ordered, notify physician of new onset of pain, and notify the physician if pain medication was ineffective. Review of the Physician's Orders for Resident #351 dated 10/06/2020, revealed an order for Oxycodone-Acetaminophen (pain medication) by mouth every eight (8) hours, prescribed for intracranial injury without loss of consciousness.	F 755		

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F 755	Continued From page 281 Review of Resident #351's MAR from 04/01/2021 thru 08/06/2021, revealed the facility failed to administer Resident #351's Oxycodone tablet as prescribed on 04/01/2021, 04/02/2021, 08/02/2021, 08/03/2021, 08/04/2021 and 08/05/2021. Further review revealed the facility documented the medication was not available from pharmacy to administer to the resident. Interview with Certified Medication Technician (CMT) #1, on 08/05/2021 at 1:00 PM, revealed Resident #351 had been without Oxycodone for several days. The CMT stated she notified RN #1 and documented the medication was unavailable. She stated sometimes medications were not available to administer and she notified the nurse, and the nurse would notify the physician and the pharmacy. She further stated residents often run out of narcotic medication when waiting for a refill or the facility did not have the medication available to administer. Interview with RN #1, on 08/05/2021 at 1:55 PM, revealed she often had to notify Physician #1 and the pharmacy multiple times to obtain a prescription or refill for narcotics for a resident. The RN stated the nurse notified the physician and pharmacy when three (3) days were remaining of medication, and often residents would go multiple days without medication while awaiting a refill or arrival of the medication. 5. Record review revealed the facility admitted Resident #324 on 03/24/2021 with diagnoses including Quadriplegia, Gastro-Esophageal Reflux Disease (GERD), and Chronic Pain Syndrome. Review of Resident #324's Quarterly MDS	F 755		

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assessment, dated 07/06/2021, revealed the facility assessed the resident to have a BIMS score of fourteen (14), indicating the resident was cognitively intact.

Review of Resident #324's Comprehensive Care Plan, dated 06/18/2021, revealed Resident #324 had chronic pain with a goal to remain free of complications or discomfort. Further review revealed interventions included administering the resident medications as ordered and pain management as needed.

Review of Resident #324's admitting Physician Orders, dated 03/24/2021, revealed Resident #324 was prescribed Sertraline HCl daily, Lactulose Solution two (2) times daily, Gabapentin three (3) times daily, and Baclofen three (3) times daily. Further review of Physician Orders revealed on 03/28/2021, an order for Clonazepam (3) times a day and on 07/03/2021, revealed an order for Fentanyl via transdermal patch applied/changed every seventy-two (72) hours.

Review of Resident #324's MAR revealed that on 03/26/2021 the facility failed to administer Resident #324's Sertraline, Lactulose, Gabapentin, and Baclofen as ordered. The facility documented the medications were not available to administer to the resident. Additionally, on 03/29/2021, 06/04/2021, 06/05/2021, 06/06/2021 and 06/07/2021, the facility failed to administer the resident's Clonazepam and documented the medication was not available from pharmacy. Further, the facility failed to administer Resident #324's Baclofen from 07/02/2021-07/03/2021 and staff failed to change the resident's Fentanyl patch on

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07/09/2021 and 07/12/2021. Staff documented both the Baclofen and Fentanyl medications were not available from pharmacy.

Interview with Certified Medication Aide #1, on 08/05/2021 at 1:00 PM, revealed sometimes medications were not available to administer. She stated she notified the nurse, and the nurse called the physician and the pharmacy. Further interview revealed the facility often ran out of residents' narcotic medications when they were waiting on a refill or they did not have the medication available to administer. She stated when medications were not available to administer she notified the nurse, and the nurse called the physician and pharmacy. She further stated the facility ran out of residents' narcotic medications and the residents had to go without pain medicine for several days while waiting for a refill.

Interview with RN #10, on 08/25/2021 at 4:28 PM, revealed it had been more difficult to get prescription refills for narcotics. The RN stated when there was a three (3) day supply of medication remaining; the nurse would notify the physician and the pharmacy. RN #10 stated the pharmacy's "cut off time" was 4:00 PM to fax orders for prescriptions, and the pharmacy would not fill anything received after 4:00 PM until the next day. In addition, RN #10 stated if the facility admitted a resident on the weekend, none of the resident's medications might be available.
RN #10 stated there were frequent issues with residents not getting narcotic refills on time. She stated staff could remove medication from the emergency kit on the floor if there was an order for the medication. However, RN #10 stated if the medication needed was a narcotic, the process

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was different. RN #10 stated to obtain a medication from the emergency kit, staff faxed an order for the medication to the pharmacy along with specific resident information, and then a pharmacist would call the nurse at the facility and relay an electronic code to enter into the emergency kit, and obtain the narcotic. RN #10 stated she was unsure how the facility maintained the emergency kits to ensure medications were available. RN #10 stated she had never received training on the emergency kit, stating she just "figured it out".

Interview with RN #7, on 08/24/2021 at 4:28 PM, revealed there were issues with medications not being available to residents. She stated if a medication was not available, the nurse should check the emergency kit first and call the physician if the medication was not in the kit. She stated if it was narcotic medication needed, then nurse should call the pharmacy to find out if the medication was not available due to needing a refill. If the medication did require a refill, the nurse should call the physician and get an order so staff could get the medication from the facility's emergency kit until the medication arrived from pharmacy. RN #7 further stated the nurse was responsible to pull the sticker from the medication's container when there was seventy-two (72) hours of medication remaining for the resident. The staff then faxed the sticker to the pharmacy to obtain a refill of the medication. If there was no sticker available, because the medication required a refill, they would contact Physician #1's Nurse and she notified the physician to refill the medication. RN #7 stated the facility had not trained her on utilizing the kits, but she leaned it from other staff. RN #7 stated to access a narcotic from the emergency kit, the

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nurse would fax a physician's order to the pharmacy, and then the pharmacy would call and give the nurse a code to open the box.

Interview with Physician #1's Nurse on 08/27/2021 at 10:29 AM, revealed when a resident needed a medication refill, facility staff would notify the physician's office, and she would enter the medication into the electronic medication record (EMAR) for Physician #1 to electronically authorize the pharmacy to refill the medication. She further stated the office had no specific process in place to ensure medications were refilled, but if a medication did not arrive to the facility or the resident was completely out of a medication, the facility would call the office. She stated there have been issues with the pharmacy and having to resend prescriptions for medications because they said they did not have them, only to later find out they had them and did not see them.

Interview with Physician #1, on 08/04/2021 at 1:05 PM, revealed he expected medications to be available to residents upon admission to the facility and expected staff to follow the admission orders and implement care to residents immediately.

Continued interview with the physician #1, on 08/27/2021 at 1:26 PM, revealed he was aware there were issues with obtaining narcotic pain medications for residents at the facility. He stated he requested the facility send him a refill request when the resident's supply of medication was down to a ten (10) day supply. The physician stated he was not aware residents were going several days without pain medications. Continued interview with Physician #1, revealed he was

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F 755	Continued From page 286 aware there were issues with obtaining narcotic pain medications for residents at the facility. However, the physician stated he was unaware residents were going several days without pain medication. The physician stated residents in pain should have their needs addressed and treated as soon as possible. Interview with the ADON/IDON, on 08/27/2021 at 12:00 PM, revealed she expected nursing staff to notify the physician when a resident's narcotic pain medication was down to a three (3) day supply. The ADON/IDON stated the facility did not have a designated back-up pharmacy to obtain residents' medications. She stated she was aware residents were going several days without narcotic pain medications due to medications not being available and stated this was not acceptable. She stated Physician #1 was aware there was an issue with narcotic pain medications getting to the facility timely. Further interview reviewed that staff notified the physician and pharmacy in advance for refills. The ADON/IDON stated it was not standard practice to allow a resident to be in pain for several hours before administering a prescribed pain medication. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed she expected resident medications to be filled, available and administered as ordered. She stated the facility reviewed new admissions to ensure the facility could meet their needs prior to admission. The Administrator stated it was not acceptable for residents to wait several hours for pain medication.	F 755		
F 802 SS=F	Sufficient Dietary Support Personnel	F 802		

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F 802	Continued From page 287 CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. Observation of the residents' meal, on 08/05/2021, for lunch and dinner revealed dietary staff failed to serve fortified foods (foods with an increased content of essential nutrients that have been added to improve nutritional content) as recommended by the Registered Dietitian (RD) for forty-two (42) of forty-two (42) residents out of one-hundred thirteen (113) residents, which	F 802		

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F 802	Continued From page 288 received fortified foods. Staff interviews revealed they had not been educated on how to fortify foods. During the lunch meal on 08/05/2021, dietary staff failed to utilize the correct scoop size when plating the food; and, failed to weigh the protein portion of the meal to ensure the correct serving size. In addition, resident meals were consistently served late due to insufficient staffing in the kitchen. The findings include: Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. The policy also stated meals would be provided within forty-five (45) minutes of the scheduled mealtime. Review of the facility's policy titled, "Portion Control," undated, revealed portion size was determined by the nutritional needs of the residents, and portion sizes must be served according to the facility's menu and staff should weigh or measure ingredients as applicable. Review of the facility's Scoops/Ladles and Portion Servers guidance utilized in the facility's kitchen, undated, revealed a #10 scoop was equal to 3/8 cup, #8 scoop was equal to ½ cup and a #12 scoop was equal to 1/3 cup.	F 802		

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F 802	Continued From page 289 Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed the facility had no policy related to fortified foods. However, she stated residents that were assessed to require fortified foods should be provided them, as well as any interventions the physician and/or the Registered Dietician (RD) had determined the resident needed to maintain their nutritional status. 1. Review of the menu for the lunch meal on 08/05/2021, revealed the residents were being served their meal of choice. Further review of the menu revealed the residents should receive three (3) ounces of protein for the lunch meal. According to the menu, a #8 (1/2 cup) scoop should be utilized when mashed potatoes were served and a four (4) ounce- {1/2 cup} serving of green beans or other vegetables should be provided to the residents. Review of the, "Diet Roster" provided by the facility indicated forty-two (42) residents had been assessed to need fortified foods with all three meals, to assist in ensuring their nutritional needs were met. Observations of the tray line for the lunch meal service, on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Further observations of the tray line revealed no fortified foods had been prepared for the lunch meal for the residents. The facility assessed 42 residents to receive fortified foods. Further observations of the tray line revealed Cook #2 used a #10 scoop (3/8 cup) to serve the residents mashed potatoes and a #12 scoop (1/3	F 802		

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F 802	Continued From page 290	F 802		

cup) to serve the residents corn or green beans for the lunch meal. Cook #2 was asked to weigh the protein (meat) portion of the lunch meal; however, the kitchen had no functioning scale.

Observations of the kitchen scale available for staffs use, on 08/05/2021 at approximately 3:00 PM, revealed the scale was metal, dusty with chipped paint, was dated and rusty in appearance. Continued observations revealed the scale was a manual scale and was visibly not calibrated at zero (0).

Further observations of the tray line, on 08/05/2021, and review of the facility's "Diet Roster" revealed dietary staff failed to review resident tray cards to ensure their food preferences were honored.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. During her employment, the cook stated she had not been trained or directed to fortify residents' food. She also stated she had never seen a recipe at the facility, to provide any directions on how to fortify foods and she had never prepared fortified foods for the residents. Per the cook, she had been trained on scoop sizes to provide residents with appropriate portions. However, the cook acknowledged she utilized the wrong scoop sizes during the lunch meal. The cook stated the residents should have received larger portions of mashed potatoes and vegetables. Per the cook, the facility had not trained her or directed her to weigh meat/protein or any other food items to ensure residents receive adequate portions. She acknowledged she did not review tray cards "like I should" during the tray line for resident meals

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F 802	Continued From page 291 because there was not "enough of us and meals would be even more off schedule." 2. Interview with Cook #2, on 08/05/2021 at 12:00 PM, revealed the facility was serving lunch to one-hundred and thirteen residents (113). Review of the facility's mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM. Observations of the tray line for the lunch meal on 08/05/2021, revealed even though the meal time was scheduled for 12:00 PM, the first of three (3) tray carts hadn't exited the kitchen until 1:30 PM to go to the third floor. Further observation revealed the last tray cart exited the kitchen at approximately 2:45 PM (almost 3 hours late) which went to the 5th floor residents. Observations of the tray line for the supper meal on 08/05/2021, revealed even though the supper meal was scheduled to be served at 5:00 PM, staff did nit start the tray line until 6:15 PM. The first of three (3) tray carts did not leave the kitchen to be served to the residents until 6:50 PM. Continued observation revealed the last cart did not left the kitchen until 8:00 PM (three hours late) going to the residents on the 5th floor. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 2:30 PM, revealed the dietary department had been short staffed for months, meals were always late and there was not adequate time to review tray cards to ensure residents' preferences were honored because there should be three (3) dietary aides, but staff had worked with only two (2) for months.	F 802		

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F 802	Continued From page 292 Interview with DA #2, on 08/17/2021 at 2:15 PM, revealed the dietary department was short staffed and they should be working with three (3) dietary aides. However, they had worked with only two (2) aides for approximately one (1) year. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated she worked five (5) days a week and cooked all three (3) meals on the days she worked. She stated she had works this way for months due to short staffing. She also stated she worked "a lot" of overtime and had approximately 15-20 hours of overtime during the last pay period. She stated the meal services were late because they were short staffed in the kitchen. Per the cook, the facility had no Dietary Manager and they were short one (1) dietary aide and had been for months, which makes getting meals to residents on time, "impossible." She acknowledged she does not review tray cards "like I should" during tray line for resident meals "because there is not enough of us and meals would be even more off schedule." Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she was employed at another facility the company owned, and had been asked approximately three (3) weeks ago, to come provide assistance/oversight and retrain dietary staff on dietary processes, because the facility had no DM and concerns had been identified in the kitchen. The DM stated she had visited the facility approximately three (3) times. According to the DM, when she initially visited the facility she identified that staff had not been trained/directed to fortify foods for the	F 802		

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F 802	Continued From page 293 residents and there were no recipes available to guide staff on preparing fortified foods. The DM stated she had initiated training with staff; however, due to short staffing in the kitchen she had worked more hands on with staff and provided guidance on prepping certain food items before the meal time, to assist in getting the residents' food to them on time. Continued interview revealed she observed meal services at the facility, and meals were consistently late, due to inadequate staffing of dietary aides. Interview with the RD, on 08/11/2021 at 4:10 PM and on 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated meals were always served late. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/18/2021 at 9:50 PM, revealed she was aware meals were consistently late, which made it difficult for staff and residents during the evening meal. She stated the food cart did not come to the floor until 7:00 PM or 8:00 PM in the evening. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware of residents' cold food complaints and that meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen. However, the kitchen had worked with no Manager and only three (3) staff since she had been Administrator at the facility. She stated she was aware that was not enough staff in the kitchen to ensure meals were timely, and she was "working on it."	F 802		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		

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F 803	Continued From page 294 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure menus were followed for one hundred eight (108) out of one hundred nine (109) residents who received a	F 803		

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F 803	Continued From page 295 meal tray. Observation of the tray line for the lunch meal on 06/15/2021, revealed the residents were served green beans with small pieces of country ham in them, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with marshmallows. Review of the menu for the lunch meal on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread. The findings include: Review of the facility's policy titled,"Menu Substitutions and Alternatives", undated, revealed the food substitute would be consistent with the usual and ordinary food items. Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. 1. Review of the menu for the lunch meal, on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread. Observation of the tray line for the lunch meal service, on 06/15/2021 at 1:14 PM, revealed the residents were served green beans with small pieces of country ham in them, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with	F 803		

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F 803	Continued From page 296 marshmallows in it. Group interview conducted with six (6) residents (Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch meal on 06/15/2021 was not good. The residents stated they did not like both green beans and pinto beans served together. The residents stated they rarely got cake with icing. The residents also revealed menus were rarely followed. Observation and interview with Resident #27, on 06/16/2021 at 9:27 AM, revealed the resident was eating club crackers and stated that he/she did not know what was on the menu for lunch that day. The resident stated sometimes they asked for the alternate and sometimes they got it, but usually they did not. The resident laughed and stated that they asked for the alternate when the facility served mystery meat. Interview with Resident #307, on 06/16/2021 at 1:16 PM, revealed the resident lying in bed with a tray from lunch on the overbed table. The resident stated, "I would not feed a dog what they give me". The resident had a soda and peanut butter crackers beside his/her lunch tray. Interview with Resident #57, on 06/16/2021 at 10:25 AM, revealed the food was "horrible". Per interview, the milk was warm and the meat was too tough. The resident further stated that he/she would go hungry if it were not for food brought in from the outside. Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she cooked green beans instead of carrots because she liked them herself. The Cook stated she did not have enough country	F 803		

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F 803	Continued From page 297	F 803		

ham so the Dietary Manager had instructed her to chop the country ham up and put it in the beans. The Cook stated she did not have chocolate cake mix and only had white cake mix, so she had made white cake with marshmallows instead of Texas sheet cake. The Cook stated she had only worked at the facility for four (4) weeks.

Interview conducted with the former Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated she had told the Cook to put the country ham in both the green beans and the pinto beans because there was not enough country ham. The DM stated she was responsible for ordering and ensuring there was enough food to prepare the food on the menu. The DM revealed she had not reported to the Registered Dietician (RD) that she could not prepare the menu as directed.

Interview conducted with the RD, on 06/18/2021 at 4:18 PM, revealed she had been aware the facility was not following the menus she had approved. The RD stated she had previously spoken with the DM regarding her concerns of staff not following the menu and had been assured by the DM the situation had been corrected. The RD stated not following the menus could cause malnutrition, weight loss, and other health concerns. The RD stated staff were required to notify her anytime they changed the menu and they had not done so on 06/15/2021. The RD stated, "I work closely with the DM but I have no authority over her. "

Interview conducted with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. The Administrator stated she had spoken

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F 803	Continued From page 298 with both the RD and the DM and had not been aware of the problems in the kitchen. The Administrator stated on 06/14/2021, she went into the kitchen and found the DM had not ordered the food to be prepared for 06/15/2021. The Administrator stated she went to the grocery store and had purchased the needed food. The Administrator stated it was not until then that she realized the DM was not ordering what was needed to prepare the meals needed in the kitchen.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide food at palatable and safe temperatures for the evening meal on 06/16/2021 and the lunch meal on 08/05/2021 for residents on two (2) of the three (3) resident floors/units. Observations on 08/05/2021 at 2:16 PM revealed the food temperatures on the test tray included: pureed meat at ninety (90) degrees Fahrenheit (F), potatoes ninety-two (92) degrees F, pureed green beans ninety (90) degrees F, pureed bread	F 804		

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F 804	Continued From page 299 eighty (80) degrees F and chocolate pudding sixty (60) degrees F. The findings include: Review of the facility's policy titled,"Food: Quality and Palpability", undated, revealed food would be prepared by methods which conserve nutritive value, flavor, and appearance. According to the policy, food would be served at a safe and appetizing temperature. Observation of the evening meal, on 06/16/2021 at 6:05 PM, revealed a test tray on the third floor was obtained. The tray contained a chicken sandwich which tasted cool and bland at one hundred nine (109) degrees Fahrenheit, and coleslaw at sixty (60) degrees Fahrenheit which was cool, but tasted bland. Interview with the Acting Dietary Manager (DM), on 06/16/2021 at 6:05 PM, revealed cold foods should be less than forty-one (41) degrees. The DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. Observation on 08/05/2021 revealed the first fourth floor lunch meal cart arrived on the unit at 1:59 PM with twenty (20) trays on the cart. Further observation revealed Registered Nurse (RN) #8 was the only staff passing meal trays from 1:59 PM until 2:04 PM. Observation of the last tray (test tray) passed from the cart on 08/05/2021 at 2:16 PM, with the	F 804		

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F 804	Continued From page 300 Regional Dietitian revealed the food temperatures on the test tray were: pureed meat at ninety (90) degrees Fahrenheit (F), potatoes ninety-two (92) degrees F, pureed green beans ninety (90) degrees F, pureed bread eighty (80) degrees F and chocolate pudding sixty (60) degrees F. Interview with the Regional Dietitian, on 08/05/2021 at 2:16 PM, revealed that cold foods should be at or below forty-one (41) degrees F and hot foods should be at or above one hundred and thirty-five (135) degrees F. She stated the temperatures of the food on the test tray were not in acceptable parameters. Observation on 08/05/2021 revealed the second fourth floor lunch meal cart arrived on the unit at 2:10 PM with fifteen (15) trays. Observation revealed only one (1) staff person was passing trays until 2:30 PM. The last tray passed was delivered at 2:35 PM. Observation of the test tray delivered, on 08/05/2021 at 2:35 PM, revealed food temperatures as follows: chicken fried steak with gravy one hundred and four (104) degrees F, whole kernel corn one hundred twelve (112) degrees F, mashed potatoes one hundred twenty-four (124) degrees F, 2% milk fifty-eight (58) degrees F, coffee one hundred eight (108) degrees F and chocolate pudding sixty-eight (68) degrees F. Interview with Resident, #332 on 07/27/2021 at 11:00 AM, revealed the food was always cold. Interview with Resident #39, on 08/17/2021 at 1:20 PM, revealed he/she had "lost a lot of weight in the past year" because the facility's food was	F 804		

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F 804	Continued From page 301 always late and the food was cold. Interview with RN #6, on 07/28/2021 at 10:00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold and late. RN #6 also stated she, as well as other co-workers, had informed the Administrator of the resident's complaints and requested she direct the dietary department to send up snacks to have available for the residents; however, "that hasn't happened yet." Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed, "especially at night." The SRNA stated there should be two (2) SRNAs for night shift; however, for months they had worked short staffed with only one (1) SRNA to almost forty (40) residents. She stated meal service was always late and sometimes it was 8:00 PM before the trays were delivered to the floor. The SRNA stated, "There's no way one aide can pass the trays and feed the residents that require assistance and do it right." She also stated residents frequently complain of cold food "because it's cold before they're getting it. There's not enough help." Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed all hot foods should be one-hundred, forty degrees (140) F when it reaches the resident. She also stated coffee should be served at one hundred (120) degrees F and milk be served between thirty-six to forty (40) degrees F.	F 804		

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F 804	Continued From page 302 Interview conducted with the Registered Dietician (RD), on 06/18/2021 at 4:18 PM, revealed she completed a test tray once a month. The RD stated she had not had a concern with temperature, but food had very little taste. The RD stated cold food should be served at forty one (41) degrees Fahrenheit or less. The RD stated palatability concerns could lead to weight loss and malnutrition. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON), on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides during that time. She stated she was aware residents complained of cold food. However, she stated staff did the best they could with the number of staff at the facility. The ADON stated she was also aware meal times were consistently late, which made it difficult for staff and residents during the evening meal. She stated when the food cart did not come to the floor until 7:00 PM or 8:00 PM in the evening, it was difficult to serve and assist residents because there was only one (1) aide. She stated nurses were busy administering medications during that time and not everything could be completed timely. Per the ADON/IDON, she expected resident meals to be delivered timely and at the appropriate temperature. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed, there were not enough nurses and nurse aides. She stated there should be two (2) nurses and four (4) nurse aides on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses	F 804		

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F 804	Continued From page 303 and three (3) aides for the night shift (7:00 PM-7:00 AM). However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. Continued interview with the Administrator revealed she was aware of residents' cold food complaints and meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen; however, the kitchen had worked with no manager and only three (3) staff since she had been the Administrator at the facility. She stated she was aware there was not enough staff in the kitchen to ensure meals were timely, and was she "working on it."	F 804		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one hundred and eight (108) out of one hundred nine (109) residents who received meal trays were offered appealing options (substitutes or alternates) of similar nutritive value when the	F 806		

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residents chose not to eat food that was initially served. In addition, the facility failed to ensure food served accommodated residents' allergies, intolerance, and preferences for (3) of fifty-seven (57) sampled residents (Resident #350, #39 and #332) who were served food from the kitchen on 08/05/2021. Also, Resident #350 was to receive lactose free milk; however, the facility was out of the lactose free milk on 08/05/2021 and staff interviews revealed the facility was frequently out of the milk.

The findings include:

Review of the facility's policy titled, "Menu Substitutions and Alternatives" (not dated), revealed staff should ensure residents' nutritional needs were met and residents with known allergies, dislikes or who expressed a refusal of food were served a substitute of similar nutritive value. According to the policy, the resident's preference would be followed to the extent nutritionally/medically possible to encourage food acceptance, and food preference information would be placed on the tray card for use on the serving line.

Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration.

1. Review of the menu for the lunch meal, on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread. In addition to

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not serving what was listed on the menu, no alternate menu was listed or prepared.

Observation of the tray line for the lunch meal service, on 06/15/2021 at 1:14 PM, revealed the residents were served green beans with small pieces of country ham, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with marshmallows in it.

Group interview conducted with six (6) residents (Resident #3, #16, #38, #51, #92, and #96) on 06/16/2021 at 10:13 AM, revealed their lunch meal on 06/15/2021 was not good. In addition, the residents stated they were not provided with an alternate menu if they did not like what was served to them.

Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she was not aware she had to prepare an alternate menu and she had not prepared one.

Interview with the previous Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated she had not directed the Cook to prepare an alternate menu but, she (the DM) was aware an alternate menu was required. The DM stated she did not know why she did not ask the cook to prepare alternate foods. Continued interview revealed the residents could have weight loss if they were served meals they would not eat.

Interview with the Registered Dietitian (RD), on 06/18/2021 at 4:18 PM, revealed she was aware the facility was not following the menus and was not providing alternative menus. The RD stated

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she had previously spoken with the DM regarding her concerns of staff not following the menu and not providing an alternative menu. The RD stated the DM had assured her the situation had been corrected. The RD stated not providing an alternative to a resident who refused what was served could cause malnutrition, weight loss, and other health concerns. The RD stated, " I work closely with the DM but I have no authority over her."

Interview with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. The Administrator stated she had identified on Tuesday (06/15/2021) that no alternative menus had been prepared or served. She stated she had spoken with both the RD and the DM, but had not been made aware of the problems in the kitchen. The Administrator stated that on 06/14/2021, when she went into the kitchen she found that the DM had not ordered the food to be prepared for 06/15/2021. The Administrator stated she did not realize until 06/14/2021 that the DM was not ordering what was needed to prepare the meals needed in the kitchen.

2. Review of the tray line/tray cards and further review of the roster, indicated one (1) resident (Resident #350) required lactose free milk. However, there was no lactose free milk in the facility, so water and juice were provided to the resident instead.

Observations of the tray line for the lunch meal service, on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Continued observation of the

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lunch meal service revealed Resident #350 did not have lactose free milk on his/her tray as indicated on the dietary tray card.

Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed there was not enough food purchased and available to honor food preferences. The aide stated the facility was "always" out of multiple items the residents wanted and it had been this way since she started to work at the facility, a few months ago. According to the DA, lactose free milk wasn't a preference, "it was a need," however lactose free milk was rarely available for the resident.

Interview with Certified Medication Aide #1, on 08/05/2021 at 2:45 PM, revealed she contacted the kitchen and requested lactose free milk be sent to the floor for Resident #350 and was told it was unavailable. She stated she contacted the Administrator and the kitchen sent a supplement for the resident.

Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she visited the facility on three (3) different occasions, and the facility had been out of lactose free milk on each occasion. She stated residents that required lactose free milk, should have that available at all times to assist in ensuring their dietary needs were met.

3. Review of Resident #332's medical record revealed the facility admitted the resident on 03/12/2021 with diagnoses, which included Type 2 Diabetes, Chronic Kidney Disease, Gastro-esophageal Reflux Disease, Hypertension and Unspecified Atrial Fibrillation.

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Review of Resident #332's Quarterly MDS assessment, dated 06/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review revealed the resident was independent with eating and weighed one hundred eighty-four (184) pounds.

Review of Resident #332's plan of care, dated 06/16/2021, revealed a focused area related to the resident's therapeutic diet with interventions to provide the resident with his/her ordered diet and to offer substitutions as requested or indicated.

Review of Resident #332's physician ordered diet, dated 06/16/2021, revealed the resident was to receive a no added salt diet, regular texture, thin liquids consistency, with one (1) ounce extra protein with meals.

Review of Resident 332's Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed the resident's current intake was inadequate to meet the resident's needs. Further review revealed a recommendation to add fortified foods with meals to better meet the resident's energy needs. The dietary assessment stated the resident's ideal body weight was one hundred and ninety (190) pounds; however, the usual body weight was two hundred and one (201) pounds.

Review of Resident #332's Nutrition Progress Note, dated 04/11/2021 at 2:26 PM, revealed the resident had a nine (9) percent weight loss in thirty days. Further review revealed the resident's current intake was inadequate to meet the

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resident's needs. The Progress Notes stated the resident was receiving fortified foods and recommendations were made to liberalize the resident's diet to a regular diet, add large protein portions at dinner and add a snack at bedtime.

Interview with Resident #332, on 07/27/2021 at 11:00 AM, revealed the food was always cold,. Further interview revealed the resident had lost weight and he/she was supposed to get a bologna sandwich on his/her tray for lunch and dinner. However, the facility did not send the sandwiches. The resident stated that he/she had requested bologna sandwiches and the facility stated they were out of bologna. Resident #332 stated the facility never had snacks, especially at night when he/she was hungry. The resident stated that staff tell him/her that he/she must wait until morning when the kitchen opens.

Observation of Resident #332's tray, on 08/05/2021 at 7:28 PM, revealed the resident did not have a bologna sandwich or a large protein portion.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed the facility was out of bologna, ice cream, lettuce, lactose free milk, tomato juice and have been out of those items for weeks at a time. The cook also stated the dietary department should prepare and send out snacks for residents, especially those that have or have the potential to experience weight loss. However, Cook #2 stated, "We haven't sent out snacks in six months or longer." She stated there was not an adequate amount of food items purchased to fulfill the menu, and definitely not enough purchased at the facility to provide snacks to those that needed and wanted them. She also

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stated she had informed the Administrator on multiple occasions of the residents' requests/preferences which were included on the tray cards. However, the Administrator failed to ensure foods were purchased and available to honor the residents' preferences/requests.

4. Review of Resident #39's medical record revealed the facility admitted the resident on 04/03/2018 with diagnoses which included Type 2 Diabetes.

Review of Resident #39's Quarterly MDS, dated 07/10/2021, revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15), and was interviewable, was independent with meals and the assessment indicated it was unknown if he/she had experienced a significant weight loss. According to the MDS the residents most recent weight recorded was two hundred and fifty three (253) pounds.

Review of Resident #39's comprehensive care plan, dated 06/17/2021, revealed the facility identified the resident was at risk for impaired nutrition related to receiving a mechanical soft diet and the diagnosis of Diabetes. Interventions implemented on 06/17/2021 included staff honoring the resident's food requests/preferences, monitoring the residents weight and providing the resident with "ordered diet".

Further review of Resident #39's weight record revealed documentation that the resident refused to allow staff to obtain weight in July 2021.

Observation of staff weighing Resident #39, on

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F 806	Continued From page 311 08/05/2021, revealed the resident weighed two hundred sixty-one and seven tenths (261.7) pounds. Review of Resident #39's weight record and Registered Dietician (RD) documentation revealed he/she weighed two hundred ninety-four (294) pounds on 01/04/2021 and two hundred fifty three (253) pounds on 06/22/2021, which the RD identified was a twelve and eight tenths (12.8) percent significant weight loss in the past one hundred eighty (180) days. Recommendations were made to honor his/her dietary preferences and fortify the resident's foods at meals. Interview with Resident #39, on 08/17/2021 at 1:20 PM, revealed the resident preferred salads for lunch, and he/she liked "Fruit Loops" (type of cereal). However, a salad had not been provided to the resident for lunch as requested. The resident stated he/she had "lost a lot of weight in the past year" because the facility's food was always late and the food was cold. Resident #39 stated even though he/she had requested salads for lunch "a long time ago" he/she had never received a salad. The resident stated he/she had asked staff in the past, why he/she never received salads and he/she stated, "It's always a different excuse, they forgot, or they're out of lettuce." Resident #39 stated he/she had also requested Fruit Loops cereal, as that was his/her favorite cereal before admission into the facility. However, Resident #39 stated "They won't give me that here either." He/she also stated, "Why would someone ask me what I liked or wanted to eat, if they're not gonna give it to me, makes no sense." According to the resident, breakfast was frequently cold and sometimes the resident was hungry until lunch. Resident #39 stated, If I could	F 806		

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F 806	Continued From page 312	F 806		

get me cereal I could eat that, I could make it myself."

5. Review of the tray line/tray cards for the noon meal on 08/05/2021, revealed three (3) residents had requested bologna sandwiches for lunch and dinner, and three (3) other residents had requested salads for the lunch meal. However, the facility was out of bologna and lettuce, and no other sandwiches or substitutes were provided to the residents. Review of the diet roster also indicated two (2) residents preferred Fruit Loops cereal for breakfast; however, there was no Fruit Loops in the facility.

Observations of the cold cereal available in the facility at 4:30 PM on 08/05/2021 revealed there was one (1), nine (9) ounce bag of unsweetened corn flakes available for the residents.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated the facility was frequently out of food items. The cook stated two (2) residents continuously asked for Fruit Loops cereal for breakfast. However, the Administrator refused to order the food items timely, or at all, to meet the residents' nutritional request and needs. She also stated she had informed the Administrator on multiple occasions of the residents requests/preferences which were included on the tray cards. Continued interview revealed the Administrator failed to ensure the foods were purchased and available to honor the residents' preferences/request.

Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed there wasn't

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enough food purchased and available to honor food preferences. The aide also stated bologna, lettuce, ice cream and other food items the facility was out of, more than it was available for the residents.

Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated she had identified concerns with weight loss for the residents. Per interview, concerns of her recommendations not being addressed timely or at all, and resident choice/preference not honored. The RD stated these concerns had been discussed on multiple occasions with the Administrator. However, nothing had been done to correct the problem. Further interview revealed that even though the Administrator had been informed of residents that had ongoing requests for Fruit Loops, tomato juice, bologna and one (1) that required lactose free milk, those items continued to not be available for the residents. She stated if resident food preferences were honored and on-going interventions implemented, it could have prevented Resident #39's significant weight loss.

Interview with Dietary Manager (DM) #1, on 08/18/2021 at 11:40 AM, revealed she was the DM at another facility and had assisted the facility and placed some food orders for the building. DM #1 stated she looked at the menu "best I can" when she placed orders for the facility. She also stated she was not aware resident preferences weren't being honored or the menu was not always followed at the facility. The DM stated, if residents requested/preferred specific food/drink items or a certain cereal "we buy it," because we

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F 806	Continued From page 314 are "required to." The DM stated if the menu was not followed, weights were not monitored, RD recommendations were not implemented and resident preferences was not honored that could lead to further weight loss, resident decline and "lots of other problems" for the residents. Interview with the Administrator, on 08/11/2021 at 6:00 PM and 08/18/2021 at 3:30 PM, revealed she acknowledged residents had requested Fruit Loops cereal on multiple occasions. She stated, "We only offer two kinds of cereal here, Corn Flakes and Cheerios". She stated she planned on talking to the "RD about all the stuff that's on these tray cards." The Administrator declined to further discuss the need to talk with the RD related to honoring the residents' preference and again stated, "We only offer two kinds of cereal here." However, she acknowledged the facility's requirement to honor the residents' food preferences and also stated, "... as long as I feel" those preferences "are within reason." According to the Administrator, she as well as a DM from another facility placed the facility's food orders. The Administrator stated she had been notified of various things the kitchen had been out of and she felt like she provided everything staff had requested for the residents.	F 806		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		

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F 809	Continued From page 315 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure each resident received meals at regular times comparable to normal mealtimes in the community or in accordance with the residents' needs, preferences, requests, and facility policy. In addition, the facility failed to provide nourishing alternative meals and snacks for residents who wanted to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident's plan of care. Observation on 07/27/2021 on two (2) of the three (3) resident floors/units revealed the refrigerator and snack storage area contained no resident snacks. Staff and resident interviews revealed residents frequently did not receive snacks and, meals were later than scheduled for most meals. The findings include: Review of the facility's policy titled, "Food and	F 809		

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Nutrition Services" last revised October 2017 revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. The policy also stated meals would be provided within forty-five (45) minutes of the scheduled mealtime. The policy stated reasonable efforts would be made to accommodate resident choices/preferences and nourishing snacks should be available to resident's twenty-four (24) hours a day. Per the policy, residents could request snacks as desired or snacks could be scheduled between meals to accommodate the resident's typical eating patterns.

1. Observation of the 3rd floor refrigerator and snack storage on 07/27/2021 at 11:30 AM revealed no snacks or drinks were available for residents on the unit. The refrigerator contained five (5) cartons of expired milk dated 07/25/2021 and one (1) half gallon of expired buttermilk dated 07/21/2021. Additional observation revealed two (2) pudding cups labeled for medication pass. No additional snacks were observed on the unit/floor.

Observation of the 5th floor refrigerator and snack storage on 07/27/2021 at 12:05 PM revealed no snacks or drinks were available for residents on the floor. The refrigerator contained three (3) cartons of expired milk dated 07/25/2021 and one container of expired thickened dairy dated 07/07/2021. Further observation revealed four (4) pudding cups, two (2) of which were undated, and two (2) dated 07/27/2021. No additional snacks were observed on the floor.

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F 809	Continued From page 317 Observation of the 4th floor resident refrigerator on 07/27/2021 at 11:30 AM revealed no snacks. Additional observation of the 5th floor refrigerator and snack storage on 08/05/2021 at 1:50 PM revealed the refrigerator contained one (1) carton of milk and one (1) carton of med pass with no snacks available. Interview with Resident #39, on 07/27/2021 at 10:45 AM, revealed no snacks were available for residents and the same food was served multiple nights a week. The resident stated the facility did not provide him/her with snacks when he/she was hungry. Interview with Resident #3, on 07/27/2021 at 11:00 AM, revealed when he/she would get hungry snacks were not always available due to the facility being out of snacks a lot of the time. Interviews with Resident #332, at 11:00 AM on 07/27/2021 and Resident #308 on 07/27/2021 at 11:10 AM, revealed snacks were not always available. Resident #308 stated he/she had requested "a snack of some kind" on more than one occasion since he/she was admitted to the facility, and staff had informed him/her nothing was available to give him/her. The resident also stated he/she would have requested to be discharged and "go home"; however, no one was able to assist him/her at home. Resident #308 stated, "I have to stay here for now, I have no choice." Interviews on 07/27/2021 with Resident #45 at 11:30 AM, and Resident #309 at 11:40 AM, revealed snacks were not available, especially at night when they were hungry and requested	F 809		

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something to eat. According to the residents, staff informed them they would have to wait until the morning when dietary staff arrived before they would be able to get something to eat.

Observations and interview with Resident #343 on 07/27/2021 at 11:45 AM, revealed various food items, which included microwaveable soups, crackers and snack cakes were observed at the resident's bedside. The resident stated the meals were always late, food was cold and snacks had not been available to residents "for a long time." Resident #343 stated, "My sister brings me food to keep so I don't go hungry, if she didn't do that for me I would have starved to death in here a long time ago."

Interview with State Registered Nurse Aide #1, on 07/27/2021 at 4:40 PM, revealed there were not enough snacks for the residents and no juice at times. The SRNA stated if juice was available, staff had to call the kitchen to get it delivered to the unit/floor. In addition, the SRNA stated, "When residents say they are hungry there are times the facility is completely out of snacks."

Interview with SRNA #2, on 07/27/2021 at 5:00 PM, revealed when residents said they were hungry there were not many snacks available for the residents on the unit. She stated there were issues with getting juice for residents and it was frequently not available.

Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed staff was not provided enough snacks to give to the residents on the floor and often the kitchen only sent two (2) sandwiches and two (2) bowls of pineapple to the floor with nearly forty (40) residents on the unit. She further

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stated Administration was aware of the situation, and the kitchen staff said they did not have enough snacks available. SRNA #4 stated the facility was out of juice for a while and the residents were being served cold sandwiches two (2) to three nights out of the week. She stated staff often bought snacks out of their own pocket to give to the residents due to not having any available for them when they were hungry.

Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 1:30 PM, revealed the facility did not have snacks available for residents. She stated usually there were no snacks. CMA #1 stated that she and other staff would buy the residents snacks and drinks with their own money when they told them that they were hungry.

Interview with Registered Nurse #6, on 07/28/2021 at 10:00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold, late and if staff didn't purchase and provide snacks to the residents "they wouldn't have any." RN #6 also stated that she, as well as other co-workers, had informed the Administrator of the residents' complaints and requested she direct the dietary department send up snacks to have available for the residents. However, "that hasn't happened yet."

Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed the residents complained of being hungry to staff and stated, "That's been going on for so long and its pitiful." The RN stated she had

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informed the Administrator of the residents' complaints. The RN stated she worked the night shift, and no access or no one here to ask for food for the residents when "I am here." She stated she had purchased $84.00 worth of food/snacks from her personal funds and brought into the facility for staff to keep on her floor. Per the RN, she bought the snack so staff would have food/snacks to provide to the residents; however stated "someone told the Administrator I did that and she then informed me it was illegal and wouldn't allow me to keep the food here, she made me take it back home."

Interview with State Registered Nurse Aide (SRNA) #19, on 08/17/2021 at 1:50 PM, revealed she was also a restorative aide at the facility. She stated the facility "use to have snacks" provided/prepared by the dietary department, which was given to facility residents daily at 10:00 AM, 2:00 PM and at night. However, she stated there has not been snacks available/provided to residents "for months" at the facility.

Interview with SRNA #1, on 07/27/2021 at 11:35 AM, revealed there was no snacks on the unit. She further revealed the staff did not have access to snacks unless the dietary department send them to the unit.

Interview with SRNA #13, on 07/28/2021 at 6:28 AM, revealed there are not enough snacks on the units. She stated that the dietary department will bring up four (4) to five (5) sandwiches for the entire unit and staff have to determine who gets the snacks. She states that residents state they are hungry but the staff cannot get into the kitchen to get any additional food.

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F 809	Continued From page 321 Interview with Dietary Aide (DA) #1, on 08/17/2021 at 2:30 PM, and DA #2 on 08/17/2021 at 2:15 PM revealed the facility was out of ice cream, tomato juice, lactose free milk and bologna "constantly." The aides also stated two (2) residents request fruit loop cereal, which is also on their tray cards, "all the time"; however, that type of cereal was not purchased and available for the residents, even though the Administrator has been informed on multiple occasions of the residents' request. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. The cook also stated the dietary department should prepare and send out snacks for residents, especially those that have or have the potential to experience weight loss; however, "we haven't sent out snacks in six months or longer." She stated there is not an adequate amount of food items purchased to fulfill the menu, and definitely not enough purchased at the facility to provide snacks to those that need and want them. Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she was employed at another facility the company owns, and had been asked approximately three (3) weeks ago, to come provide assistance/oversight and retrain dietary staff on dietary processes, because the facility had no DM and concerns had been identified in the kitchen. She has visited the facility approximately three (3) times, and each time the facility had been out of ice cream, tomato juice, lactose free milk and bologna and other things she was unable to recall. She also stated resident preference was not honored at the facility and stated two (2) residents request fruit	F 809		

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F 809	Continued From page 322 loop cereal, as well as other items and she had personally went through the residents tray cards and made a list of needed food items to ensure the nutritional needs/preferences of the residents were met in the facility, and provided the list to the Administrator. However, the Administrator informed the DM, she "wasn't buying all those items and the residents could eat what was here." She also stated since she had been providing assistance to the facility, she had went to the grocery store on two (2) separate occasions and purchased food items for the residents, out of her own pocket, because the Administrator refused to purchase what the residents needed to eat/drink. She also she had purchased items on her own, because "I couldn't walk out of here knowing resident's weren't getting what they needed." Interview with the Administrator, on 08/11/2021 at 6:00 PM and 08/18/2021 at 3:30 PM, revealed she had been the facility Administrator since 06/07/2021 and she was not aware snacks were not being provided. She also acknowledged residents had requested fruit loop cereal on multiple occasions and stated "we only offer two kinds of cereal here, corn flakes and cheerios" and stated she planned on talking to the "RD about all the stuff that's on these tray cards." When asked to elaborate on why discussions needed to occur with the RD, when the RD was attempting to honor the residents preference she stated "we only offer two kinds of cereal here" however, acknowledged the facilities requirement to honor the resident's food preferences and also stated "as long as I feel" those preferences "are within reason." According to the Administrator, she as well as a DM from another facility placed the food orders for the facility, and stated she had been notified of various things the kitchen had	F 809		

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F 809	Continued From page 323 been out of and stated she felt like she provided everything staff had requested for the residents. 2. Interview with Cook #2, on 08/05/2021 at 12:00 PM, revealed the facility was serving lunch to one-hundred and thirteen residents (113). Review of the facility mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM. Review of the menu for the lunch meal on 08/05/2021, revealed the residents were being served the residents meal of choice. Observations of the tray line for the lunch meal service on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Observations of the lunch meal also revealed even though the meal time was scheduled for 12:00 PM the first of three (3) tray carts hadn't exited the kitchen until 1:30 PM to go to the third floor, and the last tray cart exited the kitchen at approximately 2:45 PM (almost 3 hours late) which went to the 5th floor residents. Review of the facility menu and Observations conducted of tray line for the supper meal on 08/05/2021, revealed the facility was serving a barbeque riblett sandwich, tater tots, three bean salad and two (2) gooey butter cookies. Continued observations revealed even though the supper meal was scheduled to be served at 5:00 PM, staff was not observed to start tray line until 6:15 PM. The first of three (3) tray carts had not left the kitchen to be served to the residents until	F 809		

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6:50 PM and the last cart had not left the kitchen until 8:00 PM (three hours late) going to the residents on the 5th floor.

Interviews on 07/27/2021 with Resident #332 at 11:00 AM, and Resident #308 at 11:10 AM indicated meals were never provided to the residents at the scheduled time in the facility.

Interviews on 07/27/2021 with Resident #45 at 11:30 AM, and Resident #309 at 11:40 AM, revealed meals were always served late in the facility.

Interview with Family Member #3 on 08/02/2021 at 5:30 PM revealed she arrived to the facility at 10:45 AM on 07/18/2021 for a scheduled visit with Resident #321. She stated when she left at approximately 3:00 PM, Resident #321 had not received the lunch meal.

Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed, "especially at night." She stated meal service was always late and was sometimes 8:00 PM before trays were delivered to the floor. The SRNA stated, "There's no way one aide can pass the trays and feed the residents that require assistance and do it right." She also stated residents frequently complain of cold food "because it's cold before they're getting it. There's not enough help."

Interview with LPN #2, on 07/28/2021 at 6:52 AM, revealed meal trays were often late. She stated at times it has been 8:00 PM before the supper trays have made it to the unit. She stated late meals messed with giving residents their medications like insulin.

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F 809	Continued From page 325 Interview with SRNA #16, on 07/28/2021 at 8:00 PM, revealed she primarily worked floor five (5). She stated the supper trays would come out to the floors as late as 9:00 PM and there was not enough staff to pass them timely. Interview with SRNA #18, on 07/28/2021 at 9:54 PM, revealed meal trays came to the unit at times at 8:00 PM. Interview with RN #7, on 08/01/2021 at 11:40 AM, revealed meal trays were often late. She stated at times it has been 8:00 PM before the supper trays have made it to the unit. She stated it messed with giving residents their medications like insulin. Interview with RN #6, on 07/28/2021 at 10:00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold/late. Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed she worked the 6 PM-6 AM shift and sometimes supper trays were not delivered to her floor until 7:30 PM - 8:00 PM. The RN stated most of the time, there was only one (1) aide to pass trays and assist the residents, which makes it "impossible for the residents to have a good meal service like that." The RN stated she assisted the aide with meal service the best she could; however, stated she was the only nurse to approximately 40 residents, and that was also a medication administration time and the residents "have to have their medicines too."	F 809		

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F 809	Continued From page 326 Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated she works five (5) days a week and cooks all three (3) meals on the days she works, and has for months due to short staffing in the facility. She also stated she worked "a lot" of overtime and had approximately 15-20 hours of overtime during the last pay period. She stated the meal services were late because they were short staffed in the kitchen. Per the cook, the facility had no dietary manager and were short one (1) dietary aide and had been for months, which makes getting meals to residents on time, "impossible." She acknowledged she does not review tray cards "like I should" during tray line for resident meals because there is not enough of us and meals would be even more off schedule. She also stated the facility was frequently out of food items. She also stated the facility was out of bologna, ice cream, lettuce, lactose free milk, tomato juice and have been out of those items for weeks at a time. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated meals are always served late, and there is not enough food purchased to provide snacks to the residents. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides since during that time. The	F 809		

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F 809	Continued From page 327 ADON stated she was also aware that meal times were consistently late, which made it difficult for staff and residents during the evening meal. She stated when the food cart did not come to the floor until 7 PM-8 PM in the evening, it was difficult to serve and assist residents because there was only one (1) aide. She stated nurses were busy administering medications during that time and not everything could be completed timely. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed, with not enough nurses and nurse aides. The Administrator stated she was aware of residents' cold food complaints and that meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen; however, the kitchen had worked with no Manager and only three (3) staff since she had been Administrator at the facility. She stated she was aware that was not enough staff in the kitchen to ensure meals were timely, and was "working on it."	F 809		
F 812 SS=F	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	F 812		

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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, interview, and facility policy review, it was determined the facility failed to prepare and serve food under sanitary conditions. Observation of the lunch tray line on 06/15/2021, revealed uncovered cake was sent on the residents' meal trays to the units. In addition, approximately two (2) inches of dried food was observed around the inside of the deep fryer. The deep fryer oil was observed to be dark brown.

Observation on 07/27/2021 of two (2) of the three (3) resident units/floors (3rd and 5th floor) refrigerators revealed each refrigerator contained expired milk, which was available for resident use.

The findings include:

Review of the facility's policy titled,"Cleaning and Sanitation of Dining and Food Service Areas," undated, revealed the food and nutrition services staff would maintain the cleanliness and sanitation of the dining room and food service areas through compliance with a written, comprehensive cleaning schedule.

Review of the facility's policy titled,"Food: Quality

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and Palatability", undated, revealed the Cook would prepare food in a sanitary manner.

Interview with the Administrator on 08/10/2021 at 1:50 PM revealed the facility had no policy/process in place to ensure foods/fluids stored in the refrigerators, which were available for resident use were safe for consumption.

1. Observation of the tray line for the lunch meal service on 06/15/2021 at 1:14 PM, revealed staff was observed to place uncovered cake on resident meal trays and send them to the units/floors. In addition, approximately two (2) inches of dried food was observed around the inside of the deep fryer which was being used to deep fry potato chunks for the lunch meal. The deep fryer oil was observed to be dark brown and in need of changing.

Review of the facility's daily cleaning log, revealed the deep fryer was not listed on the cleaning schedule.

Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she kept a razor blade in the kitchen to cut off the dried food particles on the inside of the deep fryer. The Cook stated she had only worked at the facility for four (4) weeks. She stated she had only cleaned the deep fryer one time since she had worked there. Continued interview revealed she was aware the deep fryer should be cleaned after every use. The Cook stated she was also unaware the cake should have been covered prior to sending it out to the residents.

Interview with the Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on

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06/15/2021. The DM stated she had trained the Cook. The DM stated the deep fryer should be cleaned after every use and the cake should have been covered. The DM stated the deep fryer should have been on the cleaning scheduled.

Interview with the Registered Dietitian (RD), on 06/18/2021 at 4:18 PM, revealed she had cleaned the deep fryer once in the past month because it was dirty. The RD stated cake should be covered prior to leaving the kitchen and being delivered to residents. The RD stated she was not aware the cleaning schedule did not list the deep fryer and stated it should have.

Interview conducted with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. She stated the deep fryer had been covered previously when she was in the kitchen. . The Administrator stated she had spoken with both the RD and the DM and had not been made aware of the problems in the kitchen, until 06/15/2021.

2 Observation of the 3rd floor refrigerator and snack storage on 07/27/2021 at 11:30 AM revealed the refrigerator contained five (5) cartons of expired milk dated 07/25/2021 and one (1) half gallon of expired buttermilk dated 07/21/2021.

Observation of the 5th floor refrigerator and snack storage on 07/27/2021 at 12:05 PM revealed the refrigerator contained three (3) cartons of expired milk dated 07/25/2021 and one container of expired thickened dairy dated 07/07/2021. Further observation revealed four (4) pudding cups, two (2) of which were undated, and

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F 812	Continued From page 331 two (2) dated 07/27/2021. Interview with Dietary Aide (DA) #2, on 08/17/2021 at 2:15 PM and DA #1 on 08/17/2021 at 2:30 PM, revealed neither aide had been trained/instructed to stock or monitor food/fluids in the refrigerators located on all three (3) floors to ensure they were in date and safe for resident consumption. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed food/fluids that were available for resident consumption should be in date and safe for residents. She also stated she was not sure who was responsible to monitor food/fluid items stored in the refrigerators on the units.	F 812		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Administrator's and the Director of Nursing (DON) Job Description, the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental and psychosocial well-being for each resident, and to	F 835		

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F 835	Continued From page 332 ensure quality care and services were provided that met the needs of the residents (Refer to F580, F600, F655, F656, F657, F684, F686, F692, F725, F744, F755, F867 and F880). Record review and staff interviews revealed the facility failed to have systems in place to ensure changes in resident changes in condition were addressed timely; failed to ensure residents were free from abuse; failed to ensure baseline and comprehensive care plans were developed and implemented; failed to ensure resident care was delivered in accordance with professional standards of practice; failed to ensure residents received care to prevent/treat and promote healing for pressure sores; failed to ensure residents maintained acceptable parameters of nutritional status and/or body weight; and failed to ensure the facility had adequate numbers of direct care and dietary staff. Staff interviews revealed the Administrator was aware of the failures, but had taken no action to correct the failures, and conditions were worse. The facility's failure to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental and psychosocial well-being for each resident, and to ensure quality care and services were provided that met the needs of the residents, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686)	F 835		

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(F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021.

An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Review of the "Administrators Manual" dated May 2021 revealed the facility corporation was committed to serving residents and their family members and would strive to create a homelike atmosphere, where the needs of the residents were of utmost importance. The manual also stated the facility offered dynamic services and the individual needs of each resident would be evaluated and services would be provided accordingly. According to the policy, the Administrator's primary purpose was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care was provided at all times to the residents. The Administrator was required to make daily rounds of the facility and evaluate the overall

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appearance of facility/equipment, evaluate care provided to the residents, and evaluate resident/family satisfaction. The manual also stated the Administrator's duties included developing and maintaining written policies/procedures and professional standards of practice which govern the operation of the facility.

Further review revealed the Administrator's daily duties included ensuring the Interdisciplinary Team Meetings (IDT) were occurring; review/manage staffing; observe facility systems, which included dining; and ensure personal assistance was provided to the residents. The Administrator's weekly duties included monitoring residents, which had identified problems, and reviewing weight and pressure ulcer reports for facility residents. Monthly Administrator duties included ensuring follow up had occurred for consultant reports, which included dietary reports; and to ensure QAPI meetings were conducted monthly as required. The manual also stated the Administrator would review all incident reports, would coordinate all investigations in the facility, and would ensure compliance for reporting of all events to State and Federal agencies. The Administrator should listen to and know their residents and ensure the individual needs of the residents were met. According to the manual, the Administrator should ensure menus were posted daily and that nourishments were offered to the residents.

1. Review of Incident Reports revealed Resident #82's ongoing behaviors resulted in resident-to-resident abuse incidents. On 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear. On 06/04/2021, Resident #82 grabbed Resident #64's wrist and

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would not let go. On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave. On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm. On 07/31/2021, Resident #82 hit Resident #64 on the left wrist. Interview with Resident #86 on 07/27/2021 revealed he/she was afraid when he/she went to sleep because Resident #82 still came in his/her room and the facility had taken no action to protect the resident.

Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was the Abuse Coordinator and was aware Resident #86 was afraid of Resident #82. She stated she was also aware Resident #82 wandered into other residents' rooms, triggering resident-to-resident abuse incidents. However, there was no evidence the Administrator had taken any action to protect residents from abuse.

2. Review of the facility's mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM.

Review of Resident #321's medical record revealed the resident had a diagnosis of Diabetes and required staff to monitor the resident's blood glucose. Review of Resident #321's Nursing Notes dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM on 07/18/2021, Resident #321's blood glucose was 67 mg/dL (milligrams per deciliter) (less than 70 is considered a low blood glucose result).

Interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed she cared for Resident #321 on

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F 835	Continued From page 336 07/18/2021. She stated the resident had two (2) hypoglycemic episodes, once at approximately 7:30 AM as noted in the nursing notes. The second episode was late afternoon on 07/18/2021 (exact time unknown). She stated she found the resident unresponsive, with a blood glucose level "around 40 mg/dL". Continued review of Resident #321's Nursing Notes revealed on 07/19/2021 at 12:23 AM, staff found the resident un-responsive and clammy. The resident's documented blood glucose and it was 32 mg/dL. Staff administered medication to raise the resident's blood glucose; however, the resident remained un-responsive and experienced labored breathing. Continued review of the Nursing Notes revealed at 1:00 AM, Emergency Medical Services (EMS) transported Resident #321 to the hospital. Review of the hospital record revealed the resident was diagnosed with hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia (low blood sugar). Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility had no system to monitor to ensure residents with Diabetes were receiving basic and consistent care to ensure the resident's blood glucose levels remained within acceptable parameters and did not have a system to ensure resident changes in condition were identified/addressed timely. The Administrator further stated there should always be two (2) nurses and two (2) aides on fifth floor at night. 3. Record review revealed the facility admitted	F 835		

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F 835	Continued From page 337 Resident #65 on 03/23/2021 without pressure ulcers. Continued review of the record revealed Resident #65's was at risk for pressure ulcers and required assistance of staff for turning and repositioning, and incontinent care. However, the facility failed to turn and reposition the resident. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements, appearance, drainage, odor, etc.). Subsequently, the facility also failed to identify the pressure ulcer had worsened. On 05/28/2021, Resident #65 was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer. Resident #65 was admitted to the hospital related to the sacral pressure ulcer that had worsened and was, "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent debridement on 05/30/2021, when all necrotic tissue was removed the "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65; and, failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure ulcers: a Stage I (one) to the left heel on 06/23/2021; a DTI (deep tissue injury) to the right heel on 06/26/2021; an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021; and, two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021. Further review revealed a wound care specialist assessed Resident #65's sacral pressure ulcer on 08/26/2021 at 9:00 AM, and documented the	F 835		

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F 835	Continued From page 338 wound had worsened. Interview with SRNA #4, on 07/28/2021 at 7:35 PM, SRNA #1 on 8/5/2021 at 5:15 PM, SRNA #10 on 08/27/2021 at 11:15 AM, and SRNA #11, on 08/27/2021 at 3:00 PM, revealed there was not enough staff to turn and reposition residents, nor provide incontinence care every two (2) hours. SRNA #10 stated the ADON/Interim DON and Administrator knew "we can't get our every two hours turns and repositions and checks and changes in" and "they don't help us with anything". SRNA #11 stated there were usually one (1) or two (2) nurse aides to provide care for over 40 residents and residents were only turned every two (2) to three (3) hours. SRNA #4 stated, "It can't be done by one person". Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she was required to review staffing daily. She stated she was aware there was not enough staff to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being for residents; however, stated she was still admitting new residents at the facility, even though she knew the facility was not adequately staffed to meet the resident's needs. The Administrator stated was also responsible to ensure resident care was provided in accordance with professional standards of practice and that the facility operated within the regulatory guidelines. However, according to the Administrator she had had no systems in place to monitor the care delivered to residents in the facility. She also stated she had not conducted any oversight meetings, which included daily, weekly or monthly Quality Assurance meetings since she became the Administrator (June 2021),	F 835		

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F 835	Continued From page 339 to ensure care plans were developed and implemented and care delivered to residents with pressure sores and at risk for pressure sores met professional standards of practice. 4. Observation of the lunch meal on 08/05/2021, and review of the menu for the lunch meal on 08/05/2021, revealed the residents should have received three (3) ounces of protein, 1/2 cup of mashed potatoes, and ½ cup of vegetable. However, observations revealed staff served the residents 1/3 cup of mashed potatoes and 3/8 cup of vegetable. In addition, when staff was asked to weigh the protein to ensure it was adequate, there was no functioning scale in the kitchen to weigh the meat. The "Diet Roster" provided by the facility indicated forty-two (42) residents required fortified foods, including Residents #90, #327, #82, #39, #332, #81, and #65. However, there was no food prepared and designated as "fortified". Continued observation revealed three (3) residents were supposed to get sandwiches with meals including Residents #332 and #81, and three (3) other residents were supposed to get salads for the lunch meal including Resident #39. However, continued observation and interview with dietary staff revealed the facility did not have lunchmeat, lettuce, or other sandwich ingredients available. In addition, observations revealed that although the meal due to be served to residents at approximately 12:00 PM, the last food tray did not exit the kitchen until 2:45 PM. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss as a result of the facility's	F 835		

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F 835	Continued From page 340 failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure residents were served adequate portions to prevent weight loss. Interview with the RD on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year and had never been provided a list of resident to evaluate for weight loss or because the resident had a pressure ulcer. The RD stated she had identified concerns with weight loss for the residents, concerns that her recommendations were not being implemented, resident choice/preference not honored, and communication with nursing staff. The RD stated she had discussed the concerns on multiple occasions with the Administrator. However, she stated the facility had taken no action to correct the problems. The RD stated meals were always late and there was not enough food purchased to provide snacks to the residents. The RD stated she was not aware staff did not know how or did not have "instruction" on fortifying foods. The RD stated not fortifying foods, not utilizing the correct scoop size to portion out residents servings, failing to provide snacks, not weighing protein portions, not supplying supplements she had recommended such as ice cream, and not serving residents their preferences, could all lead to weight loss and malnutrition for the residents.	F 835		

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F 835	Continued From page 341 Interview with the Administrator on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator stated the facility had no systems in place to monitor resident weight loss or nutritional needs, but stated the facility "was working on getting one in place". The Administrator confirmed the facility had not conducted NAR (Nutritional at Risk) meetings since she had been the Administrator, but stated she was working on getting those established. The Administrator could not voice any monitoring or tracking she did to ensure the facility was doing everything possible to prevent resident weight loss. Further interview with the Administrator revealed she was aware the dietary department was "a mess". She stated there was not enough kitchen staff to ensure meals were provided timely and was aware food was not available to ensure menus were followed. In addition, the Administrator was aware food preferences were not met/followed and snacks were not available for residents and stated she was "working" on a plan to correct the problems in the facility.	F 835		
F 837 SS=K	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is	F 837		

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F 837	Continued From page 342 required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: The Governing Body failed to ensure facility policies were developed and implemented regarding management and operation of the facility. The Governing Body failed to ensure compliance with 42 CFR 483.80 Infection Control during survey visits on 07/14/2020, 09/24/2020, 11/13/2020, and 12/10/2020. Immediate Jeopardy (IJ) was identified on 11/20/2020 and determined to exist on 11/17/2020, at 42 CFR 483.80 Infection Control, F-880 at a S/S of an "L" due to the facility's failure to prevent the spread of COVID-19. Immediate Jeopardy (IJ) was identified 11/25/2020 and determined to exist on 11/09/2020, in the area of 42 CFR 483.12 Freedom from Abuse, F-600 related to failure to protect Resident #21 from abuse. The facility submitted a Plan of Correction and achieved compliance effective 01/20/2021. However, the Governing Body failed to ensure the facility had an active Quality Assurance Performance Improvement program to ensure compliance was maintained. Immediate Jeopardy was identified again on 08/11/2021, at 42 CFR 483.80 Infection Control (F880) and at 42 CFR 483.12 Freedom from Abuse, F-600. The facility failed to isolate residents who were	F 837		

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F 837	Continued From page 343 positive for COVID-19 to prevent spread to other residents. Two (2) residents died due to COVID-19. Further, the facility failed to protect resident #86 (who was Resident #21 on the 12/12/2020 survey) from further abuse. The Governing Body further failed to ensure there were enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating. The Governing Body's failure to ensure policies were developed and implemented regarding management and operation of the facility to ensure compliance and to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75	F 837		

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Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing.

The findings include:

Interview by email with the Regional Nurse Consultant on 08/18/2021 at 2:20 PM, revealed the facility did not have a specific policy for the Governing Body. She stated the Chief Nursing Officer, Regional Vice President, and the Regional Nurse Consultant provided oversight at the facility.

Review of Statements of Deficiencies (SOD) for survey visits on 07/14/2020, 09/24/2020, 11/13/2020, and 12/10/2020, revealed the facility was found to be out of compliance with 42 CFR 483.80 Infection Control regulations for the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.

Review of the SOD initial comments for an abbreviated survey completed by the State Agency on 12/12/2020, revealed Immediate Jeopardy (IJ) was identified on 11/20/2020 and determined to exist on 11/17/2020, at 42 CFR 483.80 Infection Control, F-880 at a S/S of an "L", 42 CFR 483.21 Care Plan Timing and Revision, F-657 at a S/S of an "L", and 42 CFR 483.70 Administration, F-835 at a S/S of an "L". The facility was notified of the IJ on 11/20/2020.

According to the 12/12/2020 Statement of Deficiencies, observation and interviews revealed the facility failed to fully and consistently

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F 837	Continued From page 345 implement their COVID-19 Action Plan (AP), Infection Control (IC) policies and the Health Department's (HD) recommendations; failed to place IC/isolation signage on residents' door that were under precautions; failed to ensure adequate personal protective equipment (PPE)/supplies were available for use; and failed to ensure staff wore the PPE according to guidelines and policies. Facility staff from housekeeping, laundry, central supply and nursing were observed not following IC practices to prevent cross contamination between units set up for COVID-19 positive residents and units with residents testing negative. Additionally, there was no evidence Administration consistently monitored employee infection control practices to prevent the spread of COVID-19. Due to the facility's failure to follow their COVID-19 AP, IC Policies, CMS/CDC guidelines, and the HD recommendations, residents were unnecessarily exposed to COVID-19. On 10/13/2020, the facility identified one (1) staff member as positive for COVID-19 and four (4) residents to be positive for COVID-19 on 10/17/2020 and 10/28/2020. On 10/22/2020, ten (10) additional residents were identified to be positive for COVID-19. From 10/24/2020 through 11/13/2020 sixty-eight (68) tested positive for COVID-19 and there was a total of ten (10) resident deaths. Six additional residents tested positive of on 11/20/2020. Review of facility COVID-19 testing revealed on 07/22/2021, the facility conducted routine testing of staff and residents and all were negative. On 07/24/2021, two staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, interviews with staff revealed there was no attempt by the facility to determine what	F 837		

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F 837	Continued From page 346 residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus. In addition, the facility failed to immediately test residents for COVID-19 per the facility policy after the known exposure. Further review of facility testing, revealed residents were not tested until 07/28/2021, four (4) days after the staff members were positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for COVID-19. However, observation and interviews revealed the facility did not isolate the residents to prevent the spread of COVID-19 infection to others. Interviews with staff revealed they were unable to isolate Resident #311 due to wandering behavior; subsequently, the resident continued to wander the hallways without a mask. Observation and interviews revealed the facility made no attempts to isolate the residents until 08/05/2021, eight days after the residents tested positive, when a plastic zip barrier was placed over the resident's doorway. Further, continued review of facility testing revealed staff were routinely tested for COVID-19 on 07/30/2021. However, SRNA #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. From 07/28/2021 through 08/05/2021, an additional three (3) residents tested positive for COVID-19.	F 837		

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Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask. On 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on 08/12/2021, and on 08/19/2021, Resident #325 developed respiratory distress, had a decline in condition and was sent back to the hospital and expired on 08/26/2021. One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021 and was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital. Resident #82 and Resident #329 had also been hospitalized due to COVID-19.

Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist at 42 CFR 483.80 Infection Control (F880). The facility was notified of the Immediate Jeopardy on 08/11/2021.

Further review of the 12/12/2020 SOD revealed additional IJ and Substandard Quality of Care (SQC) was identified on 11/25/2020 and determined to exist on 11/06/2020, in the areas of 42 CFR 483.25 Quality of Care, F-689, Free from Accident Hazards/Supervision at a S/S of a "J", 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F-656, Develop/Implement Comprehensive Care Plan, at a S/S of a "J", and 42 CFR 483.70, Administration F-835, at a S/S of a "L". The facility was notified of the IJ on

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F 837	Continued From page 348 11/25/2020. Additional IJ and Substandard Quality of Care (SQC) was also identified on 11/25/2020 and determined to exist on 11/09/2020, in the areas of 42 CFR 483.12 Freedom from Abuse, F-600, Free from Abuse at a S/S of a "J", F-607, Develop and Implement Abuse Policy at a S/S of a "J", F-608, Reporting Reasonable Suspicion of a Crime at a S/S of a "J", F-609, Reporting Alleged Violations at a S/S of a "J", F-610, Investigation of Abuse at a S/S of a "J", and 42 CFR 483.70, Administration, F-835 at a S/S of an "L". The facility was notified of the IJ on 11/25/2020. Continued review of the 12/12/2020 SOD, revealed additional deficient practice was identified at 42 CFR 483.10 Resident Rights, F-550, Resident Rights, at a S/S of a "D" and F-580, Notification of Change, at a S/S of a "G"; 42 CFR 483.25, Quality of Care, F-697, Pain Management, at a S/S of a "G"; and 42 CFR 483.60, Food and Nutrition Services, F-804, Nutritive Value/Palatable/Preferred Temperature, at a S/S of a "D". Total census 92. According to the 12/12/2021 SOD, the facility failed to protect Resident #21 (Resident #86 in the 09/10/2021 survey) from abuse and failed to implement the facility's policy related to reporting, protecting and investigating allegations of abuse. On 11/09/2020, the facility transferred Resident #21 to the hospital for an evaluation related to behaviors. However, review of the Emergency Room (ER) records dated 11/09/2020, revealed the resident was assaulted by a staff member at the facility. The resident was diagnosed with a right wrist sprain. During interview with Resident #21, he/she stated that a week or two ago,	F 837		

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Registered Nurse (RN) #5 brutalized him/her; grabbed and twisted his/her arm; and hit him/her with a phone on his/her hand and arm. Observation at the time of the interview revealed bruising to the resident's right hand/thumb/wrist and forearm. SRNA #19 and SRNA #20 stated that on 11/09/2020, they found Resident #21 on the first floor of the facility crying and scared. The SRNAs stated the resident reported to them that RN #5 had broken his/her hand, twisted his/her arm, and hit him/her with the phone. SRNA #19 and SRNA #21 stated the resident's right thumb was twisted and swollen. Further staff interviews with the SRNAs revealed that on 11/09/2020, they observed RN #5 being aggressive towards Resident #21, threatening the resident with a "shot", and yelling at the resident. However, SRNA #19 and SRNA #20 failed to follow the facility's policy related to abuse and failed to report this to anyone. RN #5 continued to work the remainder of the shift and worked again on 11/10/2020. Interview with the Administrator on 11/17/2020 revealed he was not aware of Resident #21's allegation of abuse. He stated this was the first time he was hearing of the allegation. However, interview with Interim Director of Nursing (DON) on 11/17/2020 revealed she received a text message from RN #5 on 11/09/2020 stating Resident #21 was sent out to the hospital for behaviors. She further stated she did not review the resident's record upon return from the hospital, and had she done so, she would have seen the ER report with the allegation of assault.

Review of Resident #86's (Resident #21 from the 12/12/2021 survey) medical record revealed on 07/13/2021 at 11:15 AM, the resident called the State Police because Resident #82 was coming

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in his/her room and was exposing him/herself. However, review of the record revealed RN #1 informed the Police that "95% of our residents had Dementia and some do wander". Per the record, the RN informed the Police a resident had not been exposing him/herself to Resident #86 or others. The RN also documented she informed the Police Resident #86 "has been known to exaggerate."

Further review of Resident #86's medical record and an incident report dated 07/15/2021 revealed at approximately 5:50 PM Resident #82 had wandered into Resident #86's room again and "picked up" the resident's shoes. According to the incident report, Resident #86 pressed his/her personal alarm provided by the facility (exact date unknown) and threw water on Resident #82. Documentation also indicated a stop sign had been implemented to prevent residents from wandering into his/her room; however, the resident "frequently takes it down." The incident report indicated the investigation determined Resident #82 was abused by Resident #86 because he/she threw water on him/her when he/she entered the resident's room and steps taken to prevent further abuse was that the facility would encourage Resident #86 to keep his/her stop sign up when he/she was in her room.

An interview with Resident #86, on 07/27/2021 at approximately 1:00 PM, revealed he/she felt like the facility was not trying to help him/her, and the resident did not know what else to do. The resident stated Resident #82 entered his/her room, "beat me up" and then "asked me how I liked it". Per the resident, Resident #82 had exposed him/herself to the resident numerous times since Resident #82's admission to the

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facility. The resident stated he/she reported the incidents to facility staff; however, stated, "No one here is helping me". Resident #86 stated he/she had even contacted the Police, but again, no actions had been taken to protect the resident. The resident also stated he/she was "moved down here" (to the opposite end of the hall) to keep Resident #82 away from him/her; however, Resident #82 continued to come in/out of his/her room. Resident #86 stated on 07/15/2021, he/she was lying in bed and Resident #82 entered his/her room again. Resident #82 exposed him/herself to the resident, picked up the resident's shoe and Resident #86 on the left, upper arm. The resident stated he/she threw water on the resident to get him/her out of his/her room, and reported; however, no actions had been taken to protect the resident from further abuse from Resident #82.

Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist again at 42 CFR 483.12 Freedom from Abuse (F600). The facility was notified of the Immediate Jeopardy on 08/11/2021.

Interview with the Regional Vice President (RVP) on 08/30/2021, at 3:30 PM revealed he had been the RVP at the facility for 90 days, and was a member of the Governing Body. He stated a Governing Body meeting had not been held since he became the RVP. He stated he did not know who the RVP was previously. He stated he was not sure how the facility monitored to ensure care and services were provided to residents, except through clinical meetings and Quality Assurance/Performance Improvement (QAPI) meetings. However, he stated since he had been the RVP, he had not been involved in any QAPI

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F 837	Continued From page 352 or clinical meetings. He stated he was not aware there were not enough staff at the facility to turn and reposition residents every two (2) hours. He stated he hoped with SRNAs and nursing, they could get all the tasks done that needed to be done. The RVP stated the facility was always looking for staff, but had been "aggressively" looking recently. Further interview with the RVP revealed it was not brought to his attention that the facility needed more money for food, nor that residents were not getting snacks. He stated if it had been brought to the Administrator's attention and it had not been addressed, he should have been notified. The RVP further stated it "would have been ideal" if he had known about the Infection Control deviancies from December 2020; however, no one told him anything about any ongoing QAPI monitoring from the December 2020 survey. He stated he had heard the facility had been cited for Immediate Jeopardy in the past, but he did not know the specifics.	F 837		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		

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F 842	Continued From page 353 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 354 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain two (2) of fifty-seven (57) sampled residents' (Residents #321 and #323) medical records in accordance with accepted professional standards and practices that were complete and contained accurate documentation. Resident #321 had physician's orders to monitor blood glucose levels per the facility's protocol. However, the facility failed to obtain the Resident #321's blood glucose levels on 07/16/2021 and on 07/17/2021. In addition, Resident #323's Medication Administration Records (MAR) revealed staff failed to document that the resident's insulin (medication used to lower blood glucose) was administered on 07/13/2021. The findings include:	F 842		

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F 842	Continued From page 355 Review of the facility's policy titled, "Diabetes-Clinical Protocol", dated November 2020, revealed the facility would monitor a well-controlled diabetic's blood glucose level twice daily if the resident was receiving insulin. Continued review of the policy revealed the facility would monitor any resident on intensive insulin therapy or sliding scale insulin three (3) to four (4) times a day. The facility would also monitor as indicated, if a resident was fasting before a procedure, had returned to the facility after a significant absence, or had an acute illness or infection Review of the facility's policy titled "Charting and Documentation", undated, revealed changes in the resident's condition, event, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objective will be documented in the medical record. Further review revealed the documentation would include care-specific details including assessment date and/or any unusual findings obtained during the procedure/treatment, notification of family, physician or other staff, if indicated, and the signature and title of the individual documenting. 1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicating the resident was cognitively intact.	F 842		

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F 842	Continued From page 356 Review of Resident #321's baseline care plan dated 07/16/2021, revealed the care plan did not have the resident's diagnosis of diabetes listed. Further review revealed there were no interventions listed regarding obtaining or monitoring Resident #321's blood glucose levels. Review of the Physician's Orders dated 07/16/2021, revealed Resident #321 received an order for staff to obtain his/her blood glucose levels as required and as needed (PRN). Continued review of the Physician's Orders revealed staff was to administer the resident Glargine Insulin (long acting medication to lower blood sugar) every morning. Review of Resident #321's Medication Administration Record (MAR) and Treatment Administration Records (TAR) revealed no documentation that staff obtained the resident's blood glucose level after admission to the facility on 07/16/2021, until prior to breakfast on 07/18/2021. Although the resident's MAR directed staff to conduct diabetic monitoring every shift for hypoglycemia/hyperglycemia (low/high blood sugar), there was no documented evidence the staff completed the monitoring or obtained the resident's blood glucose readings on the evening of 07/16/2021, or on 07/17/2021. Interview with Licensed Practical Nurse (LPN) #6, on 07/30/2021, at 11:30 AM, revealed she admitted Resident #321 on 07/16/2021 and took care of the resident on 07/17/2021 from 7:00 AM until 7:00 PM. LPN #6 stated she checked the resident's blood glucose levels both days as ordered, and thought she documented them in the resident's medical record, but must have	F 842		

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forgotten.

Interview with Registered Nurse (RN) #7 ,on 07/28/2021 at 4:25 PM, revealed that she cared for Resident #321 on night shift from 7:00 PM-7:00 AM on 07/16/2021 and 07/17/2021. RN #7 stated she obtained the resident's blood glucose levels as ordered, but could not recall what they were. The RN stated she should have documented the blood glucose results in the resident's medical record, but she guessed she forgot. Continued interview revealed that it was routinely her and one State Registered Nurse Aide (SRNA) working the entire floor, and she struggled to get the charting completed.

Interview with Resident #231's Physician (Physician #1), on 08/04/2021 at 1:05 PM, revealed he expected nursing staff to obtain, document and monitor blood glucose levels for diabetic residents at a minimum every shift. He further stated his expectation was for staff to obtain blood glucose levels prior to administering diabetic medications to residents with a diagnosis of diabetes.

Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (IDON), on 08/11/2021 at 12:05 PM, revealed she expected nursing staff to obtain and document glucose levels on all diabetic residents at a minimum every shift. However, the DON stated that some residents might require more frequent monitoring. The DON stated she did not conduct any routine monitoring to ensure staff were obtaining and documenting diabetic residents' blood glucose levels.

Interview with the Administrator, on 08/10/2021 at

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1:50 PM, revealed she was unaware that staff were not documenting blood glucose levels in the resident's medical record. The Administrator was unable to say how the facility was monitoring residents to ensure their blood glucose levels were staying within acceptable parameters if the staff were not documenting the readings.

2. Review of Resident #323's medical record revealed the facility admitted the resident on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia.

Review of Resident #323's Physician's Orders dated July 2021, revealed orders to administer the resident Levemir insulin twice daily and Humulin-R insulin before meals and at bedtime.

Review of Resident #323's MAR for 07/13/2021 at 9:00 AM revealed no documented evidence staff administered the resident's Levemir insulin. Further review of the MAR for 07/13/2021 at 11:30 AM and 4:30 PM revealed no documented evidence staff administered the resident Humulin-R insulin.

Interview with RN #1, on 07/29/2021 at 9:55 AM, revealed she was responsible for Resident #323 on 07/13/2021 from approximately 6:30 AM to 6:30 PM. She stated that she administered Resident #323's Levemir and Humulin-R, however, must have failed to document the medication on the MAR.

Interview with the ADON/IDON, on 08/11/2021 at 12:05 PM, revealed she expected staff to document on the resident's MAR when they

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F 842	Continued From page 359 administered any medication to a resident. The ADON/IDON stated she had not identified a concern with staff documenting medication administration on the MAR. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she was unaware that staff were not documenting the administration of insulin on the resident's MAR.	F 842		
F 867 SS=K	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the facility's Plan of Correction submitted for the 12/12/2020 survey, it was determined the facility failed to have an effective performance improvement program which measured the success and tracked the performance of its plans to ensure interventions were implemented, deficiencies were corrected and the facility maintained substantial compliance The facility failed to ensure compliance was maintained at 42 CFR 483.80 Infection Control. Deficiencies were cited during the 07/14/2020, 09/24/2020, 11/13/2020, and 12/12/2020 surveys. On the 12/12/2020 survey, Immediate Jeopardy	F 867		

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F 867	Continued From page 360 (IJ) was identified and cited at a Scope and Severity of "L" due to the facility's failure to prevent the spread of COVID-19. The facility submitted a Plan of Correction and achieved compliance effective 01/20/2021. However, the facility failed to implement Quality Assurance Performance Improvement (QAPI) plans to ensure compliance was maintained. Immediate Jeopardy was identified again on 08/11/2021, at 42 CFR 483.80 Infection Control (F880). The facility failed to isolate residents who were positive for COVID-19 to prevent the spread to other residents. Two (2) residents died due to COVID-19. Refer to F880. The facility's failure to ensure an effective Quality Assurance Performance Improvement (QAPI) Program was in place has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR	F 867		

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F 867	Continued From page 361 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. The findings include: Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, dated May 2021, and the QAPI policy, last revised April 2014, revealed the facility should develop, implement and maintain an ongoing, facility wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality and resolve identified problems. According to the policy, QAPI data should be gathered and used in an organized and meaningful way. Areas that might be appropriate to monitor and evaluate included: staff turnover and assignments, State surveys and deficiencies, care plans, resident/family complaints, clinical outcomes such as pressure ulcers, infections and MDS (Minimum Data Set) assessment and data. The policy also indicated input would be gathered from staff, residents, family members and individuals who were involved in the care of the residents, and staff were encouraged to identify/report quality concerns as well as opportunities for improvement. The policy stated members of the facility's leadership was accountable for QAPI efforts and systems would be in place to monitor care and services and outcomes utilizing performance indicators. The policy also stated action plans would be developed and implemented to prevent recurrence of identified adverse events.	F 867		

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F 867	Continued From page 362 Review of the "Administrators Manual," dated May 2021, revealed the facility's corporation was committed to serving residents and their family members and would strive to create a homelike atmosphere, where the needs of the residents were of utmost importance. According to the policy, the Administrator's primary purpose was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care was provided at all times to the residents. The Administrator was required to make daily rounds of the facility and evaluate the overall appearance of facility/equipment, evaluate care provided to the residents, and evaluate resident/family satisfaction. The manual also stated the Administrator's duties included developing and maintaining written policies/procedures and professional standards of practice which govern the operation of the facility. Further review revealed the Administrator's daily duties included ensuring the Interdisciplinary Team Meetings (IDT) were occurring; review/manage staffing; observe facility systems, which included dining; and ensure personal assistance was provided to the residents. The Administrator's weekly duties included monitoring residents, identified problems, and reviewing weight and pressure ulcer reports for the residents. Monthly Administrator duties included ensuring follow up had occurred for consultant reports, which included dietary reports; and to ensure QAPI meetings were conducted monthly as required. The manual also stated the Administrator would review all incident reports, would coordinate all investigations in the facility,	F 867		

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and would ensure compliance for reporting of all events to State and Federal agencies. The Administrator should listen to and know their residents and ensure the individual needs of the residents were met. According to the manual, the Administrator should ensure menus were posted daily and that nourishments were offered to the residents.

Review of the Statement of Deficiencies (SOD) for the surveys, dated 07/14/2020, 09/24/2020 and 11/13/2020, revealed the facility had been cited at 42 CFR 483.80, infection control, for failure to prevent the possible spread of COVID-19. Review of the Statement of Deficiencies (SOD) for the survey date, 12/12/2020, revealed the facility was cited Immediate Jeopardy at 42 CFR 483.80, Infection Control at a Scope and Severity "L" for failure to prevent the spread of COVID-19.

Review of the facility's Plan of Correction (POC), for the 12/12/2020 survey, revealed the facility educated staff on the facility's infection control program and policies, COVID emergency plan, properly wearing face mask and PPE (personal protection equipment) and handwashing. In addition, all facility staff were required to complete three (3) modules of the Nursing Home Infection Preventionist training on the Centers of Disease Control and Prevention (CDC) website and were required to view videos on "Keep COVID-19 Out", "Clean Hands Combat COVID-19; and Use Personal Protective (PPE) Equipment Correctly". Also staff, were required to review the document entitled "Responding to Coronavirus (COVID-19) in Nursing Homes" Continued review of the POC revealed the facility would monitor to ensure compliance with infection control. The POC

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stated staff would adhere to the facility's PPE, Infection Control, and competency checks. The Infection Preventionist with oversite from the Director of Nursing (DON) or designee would complete weekly checks of four (4) random housekeeping and nursing staff to assure compliance with the facility's policy and procedures on cross contamination for four (4) weeks or until zero negative findings were determined by the Quality Assurance (QA) Committee. Per the plan, compliance would be reviewed by the QA Committee each month for six (6) months to determine if the POC had been effective to prevent the violations from recurring. The facility alleged and achieved compliance effective 01/11/2021.

However, the facility failed to ensure they continued to monitor and evaluate compliance with infection control per the Plan of Correction and the facility's QAPI plan/policy. Observation of the facility's fifth floor on 08/05/2021 at 10:54 AM, revealed although two (2) residents (Resident #311 and #314) tested positive for COVID-19 on 07/28/2021 and two (2) residents (Resident #329 and #82) tested positive on 08/02/21, the facility failed to isolate and segregate the residents as required by the facility's policy. The fire doors were open, all resident room doors were open, and residents were wandering the halls of the unit. Further observation revealed no designated zones existed to separate residents. Additionally, Resident #327 tested positive on 08/07/2021 and Resident #325 tested positive on 08/08/2021.

Review of the facility's COVID-19 test records, dated 07/28/2021, revealed both Resident #311 and Resident #314 tested positive for COVID-19. Continued review of COVID-19 test records

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F 867	Continued From page 365 revealed Resident #82 and #329 tested positive for COVID-19 on 08/02/2021. Observation on 08/05/2021 at 10:54 AM, revealed maintenance staff placed plastic zip barriers across the doorway of a room where both Resident #311 and Resident #314 resided. However, this was eight (8) days following the resident's positive COVID-19 results. In addition, observation of Resident #325, on 08/05/2021 at 10:54 AM, revealed the resident was wandering the hall walking past the red biohazard waste containers where staff were doffing COVID contaminated PPE on the outside of the residents' rooms who were COVID positive. Further observations, on 08/05/2021 at 11:00 AM, revealed Resident #325 was sitting in a chair in the hallway of the fifth floor with no facemask. This resident was seated adjacent to COVID positive residents' rooms. Further observation on the fifth (5th) floor, on 08/05/2021 at 10:54 AM, revealed large red biohazard cans in the hallway on each end of the floor. These cans contained large amounts of contaminated PPE, which had been used by staff while in residents' rooms who were COVID positive. Interview with SRNA #19, on 08/05/2021 at 11:15 AM, SRNA #16, on 08/09/2021 at 11:47 AM, and SRNA #3 on 08/05/2021 at 12:30 PM, revealed staff were doffing (remove) contaminated PPE from COVID-19 positive rooms in a red bio-hazard can in the hallway. Review of the facility's COVID-19 test records, dated 08/07/2021, revealed Resident #327 tested positive for COVID-19.	F 867		

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F 867	Continued From page 366 Review of Resident #327's Nurse Notes, dated 08/09/2021 at 5:19 PM, revealed the resident had two (2) episodes of diarrhea. The physician was notified and the resident was encouraged to increase oral fluid intake. Further review of Nurse Notes, dated 08/14/2021 at 12:05 AM, during routine vital signs, staff found Resident #327 to have a low blood pressure, low heart rate, and low oxygen saturation. The physician was notified and Resident #327 was sent to the emergency room via an ambulance for further evaluation. Review of Resident #327's hospital discharge summary, dated 08/15/2021 PM, revealed the resident expired at the hospital on 08/15/2021. The resident's admission diagnoses included Sepsis and COVID-19 Pneumonia. Per the discharge summary, the resident's Sepsis was likely due to the COVID-19 Pneumonia. The resident's diagnosis was COVID-19 Viral Pneumonia. Review of the facility's COVID-19 test records, dated 08/08/2021, revealed Resident #325 tested positive for COVID-19 on 08/08/2021. Review of the Nurse's Notes, dated 08/09/2021 at 2:45 PM, revealed Resident #325 had a change in condition and had cough, congestion and developed a fever of 100.2 F (Fahrenheit) and respiratory distress requiring transfer to the emergency room for evaluation. Review of a Nursing Readmission Assessment, dated 08/12/2021 at 4:40 PM, revealed Resident #325 was readmitted to the facility from the hospital.	F 867		

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F 867	Continued From page 367 Continued review of the Nurse's Notes, dated 08/19/2021 at 1:30 PM, revealed Resident #325 developed a low oxygen saturation of 89% and physician and resident representative were notified. The Physician ordered palliative care and a Fentanyl patch (pain medication skin patch) related to the resident's declined condition and a Do Not Resuscitate (DNR) status. Per the note, staff discussed the resident's condition, palliative care, DNR status, and new orders from the physician with resident representative. The resident's representative requested the facility send Resident #325 back to the hospital. The physician and DON were notified of request and an ambulance transported the resident to the emergency room for evaluation. Review of hospital discharge summary, dated 08/26/2021, revealed Resident #325 expired at the hospital on 08/26/2021 and the resident's diagnoses included Acute Hypoxic Respiratory Failure secondary to COVID-19 Pneumonia. On 08/23/2021 at 2:10 PM, an interview was conducted with a previous Administrator, who resigned effective 06/01/2021. The former Administrator stated prior to leaving, he continued to monitor all deficiencies cited during the December 2020 survey. He stated they continued to review all monitoring through Quality Assurance (QA) and when he left, he had not identified any concerns with information gathered. He stated he lead QA. Per the Former Administrator, the Director of Nursing, the Assistant Director of Nursing (ADON) and he worked together on QA by gathering the data and reviewing records. The Former Administrator stated the former DON quit right after he did.	F 867		

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F 867	Continued From page 368 Interview with the ADON/Interim Director of Nursing (IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year. The ADON stated she was also serving as the Infection Control Nurse since December 2020, and had assumed the role of Interim DON around 07/23/2021, she was unable to recall the exact date during the interview. She stated since she had been employed as the ADON, she had worked the floor as a staff nurse more than she had functioned as an ADON, due to the ongoing short staffing in the facility. She also stated the facility had no Unit Managers, no Staff Development Coordinator and no QA Nurse since she had worked at the facility. She stated she recalled one (1) Unit Manager being hired a few months ago, but the nurse left after the first week or so, because she was mandated to work the floor due to the ongoing staffing problems in the facility. According to the ADON, she was unaware of any monitoring conducted by the DON, prior to her leaving employment at the facility. She stated, "She (the former DON) always worked the floor too, due to short staffing." The ADON stated she was not currently and had never monitored any QA processes or gathered any data related to QA processes in the facility. Further interview revealed she had not attended any meetings, weekly or monthly, to discuss quality processes since her employment at the facility. According to the ADON, she was also responsible to monitor infection control processes in the facility. However, she stated at the time of the interview, she had worked the last six (6) out of seven (7) nights on the floor and was unable to complete the required monitoring. Interview with the Administrator, on 08/10/2021 at	F 867		

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F 867	Continued From page 369 1:50 PM, revealed she was not made aware of any ongoing audits of quality processes that were in place at the facility when she became the Administrator in June 2021. She also stated there had been no QA meetings conducted since she became Administrator in June 2021. The Administrator also stated she was the QA Coordinator and was responsible for the QA Program/Processes in the facility. However, she stated she had not conducted any monitoring in the facility related to infection control, because she expected the ADON to complete infection control monitoring. The Administrator also acknowledged the facility had no Unit Managers, no Staff Development or QA Nurse. She stated those positions were posted and have been posted for hire since she had been at the facility; however, no qualified applicants had expressed interests in those positions. She also acknowledged the ADON worked the floor as a staff nurse frequently. During the interview, when asked how the ADON could monitor, when she was working the floor as a staff nurse, she stated "Well I don't know."	F 867		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		

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F 880	Continued From page 370 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; (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	F 880		

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F 880	Continued From page 371 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, interview, record review, and review of the facility's policies, it was determined the facility failed to establish and maintain an infection prevention and control program to properly prevent and contain the spread of COVID-19 for seven (7) of 57 sampled residents (Resident #325, #314, Resident #311, Resident #327, Resident #82, Resident #328 and Resident #329. On 07/22/2021, the facility conducted routine COVID-19 testing of staff and residents and they were all negative. On 07/24/2021, two (2) staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, there was no attempt by the facility to determine which residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus.	F 880		

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F 880	Continued From page 372 In addition, the facility failed to immediately test residents for COVID-19 per the facility's policy. Residents were not tested until 07/28/2021, four (4) days after the staff members tested positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for COVID-19. However, the facility did not isolate the residents to prevent the spread of infection to others. Interviews with staff revealed they were unable to isolate Resident #311 due to his/her behavior of wandering; subsequently, the resident continued to wander the hallways without a mask. The facility made no attempts to isolate the residents until 08/05/2021, eight (8) days after the residents tested positive. Further, the facility documented staff were routinely tested for COVID-19 on 07/30/2021. However, State Registered Nurse Aide (SRNA) #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. From 07/28/2021 through 08/05/2021, an additional three (3 residents) tested positive for COVID-19. Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask.	F 880		

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F 880	Continued From page 373 Record review revealed on 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on 08/12/2021. Further review revealed on 08/19/2021, Resident #325 developed respiratory distress, had a decline in condition and was sent back to the hospital and expired on 08/26/2021. Interview with the Infection Control Preventionist/ADON/Acting Interim DON on 08/11/2021 revealed she was aware residents should have been tested immediately after the first COVID-19 positive staff member. She also stated she was aware residents who had COVID-19 should have been isolated. She stated not isolating residents with COVID-19 put others at risk for death. One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021 and was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital. Resident #82 and Resident #329 had also been hospitalized due to COVID-19. The facility's failure to maintain an infection prevention and control program has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686), (F692), 42 CFR 483.45 Pharmacy Services	F 880		

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F 880	Continued From page 374 (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. The findings include: Review of the facility's policy titled, "COVID-19-Pandemic Plan", dated 06/23/2020, revealed staff will be trained on the facility's Pandemic COVID-19 plan and related policies and procedures. Staff will be re-trained in Hand Hygiene and proper use of Personal Protective Equipment (PPE) including competency, and residents exhibiting signs and symptoms of COVID-19 will be isolated in a private room with the door closed and initiate transmission based precautions (TBP) based on CDC (Centers for Disease Control and Prevention) guidelines. Review of the facility's policy titled, "COVID-19 Emergency Operations Plan", undated, revealed in the event of an outbreak of COVID-19, the positive residents will be segregated away from the rest of the population and the resident unit will be separated into Red, Yellow, and Green zones.	F 880		

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F 880	Continued From page 375 Further review revealed zipper walls will be utilized to divide Red, Yellow and Green Zones, along with privacy curtains in semi-private rooms to act as a barrier and fire doors will be closed and remain closed. Assigned staff will work Red, Yellow, and Green zones, so multiple staff members are not assigned. Further review of the policy revealed staff were to be dedicated to work in a designated area (e.g. red zone). Review of the facility's policy titled, "CORONAVIRUS DISEASE (COVID-19)-TESTING RESIDENTS", (undated) revealed residents were tested for the SARS-CoV-2 virus to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility. Further review revealed all residents were screened daily for signs and symptoms of COVID-19, viral testing of all residents will be conducted if there is an outbreak in the facility. An outbreak is defined as any single new onset of SARS-CoV-2 infection in a resident or a single case of infection in healthcare personnel and, testing will be conducted as soon as a new confirmed case is confirmed. Residents who test positive, including asymptomatic and pre-symptomatic residents are cohorted and viral testing of all previously negative residents will be repeated every 3 to 7 days until testing identifies no new cases of SARS-CoV-2 infection among residents or healthcare personnel for at least 14 days since the most recent positive result. 1. Review of the facility's COVID-19 testing records revealed on 07/24/2021, Registered Nurse (RN) #2 and State Registered Nurse Aide (SRNA) #16 tested positive for COVID-19. Attempts to reach RN #2 for interview were unsuccessful.	F 880		

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F 880	Continued From page 376 Interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor and cared for residents throughout the unit. The SRNA stated she tested positive for COVID-19 on 07/24/2021. She stated she did not think staff were being tested regularly or prior to working if they had been off several days. SRNA #16 further stated her family member and coworker SRNA #13 tested positive while at work after being exposed to her. The SRNA stated SRNA #13 was not tested prior to starting her shift the night she became ill. Review of the facility's testing schedule revealed the next scheduled testing for staff was on 07/30/2021. However, SRNA #13 was not tested prior to starting her shift at 6:00 PM on 07/30/2021 Interview with SRNA #13 on 08/01/2021 at 5:40 PM revealed she tested positive for COVID-19 on 07/30/2021 while working at the facility She stated SRNA #16 was a family member and coworker and had tested positive on 07/24/2021. Although the facility reported screening all staff and visitors prior to entry to the facility, the SRNA stated the facility did not ask her any questions related to contact tracing or being exposed to SRNA #16. Per the SRNA, she worked on the fifth floor and cared for all residents on the floor. She further stated she began her shift at 6:00 PM on 07/30/2021 and began feeling ill in the middle of her shift. The SRNA stated she reported to the nurse that she felt ill. She stated she tested positive for COVID-19 and was sent home. Interview with Registered Nurse (RN) #9, on 08/09/2021 at 10:55 PM revealed she worked	F 880		

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F 880	Continued From page 377	F 880		

night shift on the fifth floor and cared for all residents on the floor. The RN stated the facility did not require staff to be tested prior to coming on shift or after being off for several days. RN #9 stated the facility was not testing staff on any specific days.

Interview with the Corporate Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the facility was conducting COVID-19 testing two (2) times weekly on Mondays and Thursdays for both staff and residents. She stated the nurses on the floor were responsible for testing residents on their floor/unit and the Infection Control/ADON/Interim DON tests all staff. She further stated staff used a roster to check off as the residents were tested and a staff list was checked off as staff came in for testing. However, the ADON was on leave on 07/30/2021 and it was unclear who was providing staff testing on night shift.

2. Continued review of the facility's COVID-19 testing records revealed the facility failed to immediately test residents for COVID-19, and did not initiate resident testing until 07/28/2021, four (4) days after the staff members tested positive.

(a) Record review revealed on 07/28/2021, Resident #311 (who resides on the fifth floor) tested positive for COVID-19.

Record review revealed the facility admitted Resident #311 on 06/28/2021 with diagnoses of Dementia, Alzheimer Disease, and Atrial Fibrillation. Review of the Minimum Data Set (MDS) dated 07/04/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident was moderately cognitively

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F 880	Continued From page 378 impaired. Review of the Nurse's Notes dated 07/30/2021, revealed staff had to redirect Resident #311 to keep him/her in his/her room for isolation and the resident became upset, though no cough or congestion was noted. Continued review of Nurse's Notes revealed on 08/10/2021, Resident #311 was doing well and was out of isolation. Interview with RN #9 on 08/09/2021 at 10:55 PM revealed Resident #311 wandered the halls of the unit after testing positive on 07/28/2021 and was difficult to redirect and would get upset. (b) Continued review of the facility's COVID-19 testing records revealed on 07/28/2021, Resident #314 (who resided in the same room as Resident #311) tested positive for COVID-19. Record review revealed the facility admitted Resident #314 on 06/03/2021 with diagnoses of Dementia and Cerebral Infarction. Review of the Minimum Data Set (MDS) dated 07/30/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10), indicating the resident was moderately cognitively impaired. Review of Nurse's Notes dated 07/29/2021, revealed Resident #314 had no complaints and no cough or congestion noted. Further review of Nurse's notes dated 08/10/2021, revealed Resident #314 was out of isolation and doing well with no cough or congestion noted. (c) Review of COVID-19 testing records revealed Resident #329 tested positive for COVID-19 on 08/02/2021. Resident #329's room was next door	F 880		

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F 880	Continued From page 379 to Resident #311 and #314's room on the fifth floor. Record review revealed the facility admitted Resident #329 on 05/07/2021 with diagnoses of Parkinson's Disease, Congestive Heart failure and Dementia. Review of Minimum Data Set (MDS) dated 05/14/2021 revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #329 Nurse's Notes dated 08/07/2021 at 5:29 AM revealed the resident developed at fever of 106.2 and was transported to the emergency room for further evaluation. Continued review of Nurse's Notes dated 08/10/2021 at 9:01 PM revealed Resident #329 was readmitted to the facility following hospitalization and treatment for Hypotension related to COVID-19. (d) Review of COVID-19 testing records revealed Resident #82 also tested positive for COVID-19 on 08/02/2021. Resident #82's room was located on the fifth floor, next to Resident #329's room. Record review revealed the facility admitted Resident #82 on 05/12/2021 with diagnoses of Parkinson Disease and Alzheimer Disease. Review of the Minimum Data Set (MDS) revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #82 Nurse's Notes dated	F 880		

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F 880	Continued From page 380 08/09/2021 at 12:55 PM revealed the resident developed tachypnea (rapid respirations). Resident #82 had a low oxygen saturation rate of 89-91% (95-100% normal reference range. The facility sent the resident to the emergency room for further evaluation and treatment. Continued review of Resident #82 clinical record revealed the resident did not return for readmission to the facility following discharge from the hospital. The resident was admitted to another facility. Interview with the Infection Control Coordinator, at the local Health Department on 08/09/2021 at 10:40 AM, revealed she was in contact with the facility approximately every other week in regards to newly diagnosed COVID-19 cases among facility staff and residents. She stated she was not responsible to conduct contact tracing inside the facility for residents or staff. The Infection Control Coordinator stated the facility was responsible for conducting the contact tracing inside the facility. She stated she was not aware staff was not conducting contact tracing for residents and staff inside the facility. The Infection Control Coordinator stated, "That is a big problem that they're not conducting contact tracing properly." Per the Infection Control Coordinator, the facility's failure to conduct contact tracing for residents and staff inside the facility could lead to an outbreak of COVID-19 amongst residents and staff. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed she thought the local health department did contact tracing in the facility. She stated she was not aware the facility was responsible to do their own	F 880		

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contact tracing within the facility. Per the Infection Control Nurse/ADON/DON, she was aware residents should have been tested immediately for COVID-19 following the initial staff member testing positive. However, she had no response as to why testing was delayed for four (4) days after staff tested positive in July, 2021.

Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she thought the local health department did contact tracing in the facility. She stated she was unaware the facility was responsible for completing their own contact tracing.

3. Observation of the facility's fifth floor on 08/05/2021 at 10:54 AM, revealed although two (2) residents tested positive for COVID-19 on 07/28/2021 and 08/02/2021, the facility failed to isolate and segregate the residents as required by the facility's policy. The fire doors were open, all resident room doors were open, and residents were wandering the halls of the unit at will. Further observation revealed no designated zones existed to separate residents.

Continued observation, on 08/05/2021 at 10:54 AM, revealed maintenance staff placed plastic zip barriers across the doorway of the room where both Resident #311 and Resident #314 resided. However, this was eight (8) days following the first resident on the floor testing positive for COVID-19.

Interview with Maintenance Assistant (MA) #1, on 08/11/2021 at 11:30 AM, revealed he placed the plastic zip barriers across the doorways of all COVID-19 positive resident rooms. MA #1 stated

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no none had instructed the Maintenance Department to install the barriers prior to 08/05/2021, and that was the first day the facility utilized the barriers. MA #1 stated staff was to notify the Maintenance Department if a resident in another room converted to positive so they could place one of the plastic zip barriers over the resident's doorway.

Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she denied having received any training related to PPE (personal protective equipment) or COVID-19 at the facility since the second wave of outbreaks began in late July. The SRNA stated she routinely worked the fifth floor caring for both COVID -19 positive and negative residents simultaneously. SRNA #3 stated the floor had no designated zones such as red for positive, yellow for quarantined or green for negative residents.

Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she routinely worked on the fifth floor. The SRNA stated as new residents became infected on the floor, they were not isolated or segregated to one area. She stated they continued to be interspersed with negative residents. SRNA #16 stated she cared for both COVID-19 positive and negative residents all at the same time. The SRNA stated the floor was the "unofficial dementia" floor and many of the residents who lived on the floor wandered. She stated many of the residents wander the hallways, in and out of other residents' rooms.

Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 11:45 AM, revealed staff who worked on the fifth floor attempted to keep

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residents isolated in their rooms, but they were unable to do so, because the residents did not understand and wanted to leave their rooms. The CMA stated maintenance placing the plastic zip barriers over the doorways of COVID-19 positive resident rooms, was the first time to her knowledge the facility had taken any action to isolate residents since the second wave of COVID-19 infections began.

Interview with RN #9, on 08/09/2021 at 10:55 PM, revealed COVID positive rooms "now" had plastic zip covers on the doorways, but not initially. She stated the only identifiers prior to the zip covers on the residents' doors was a hand written paper taped on the door saying if it was a red or yellow room. She stated the fire doors on that hall had never been closed. The RN stated she cared for residents on the entire unit, both positive for COVID-19 and those who were not.

Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed the facility had initially attempted to isolate the positive residents in their rooms. Observations, of residents who were positive for COVID wandering on the fifth floor and not isolated in one area, were discussed with the Infection Control Nurse/ADON/DON. She stated the facility tried to keep positive residents in one area on the floor. However, the Infection Control Nurse/ADON/DON stated the COVID virus could spread if positive residents were not in a closed off unit (isolated). Per the Infection Control Nurse/ADON/DON, she expected nursing staff to redirect residents to the closed off area on the unit if they were wandering and to ask them to wear a facemask if they were not wearing one. However, she mentioned no further actions for

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F 880	Continued From page 384 nursing staff to utilize if redirection was not effective. Interview with the facility's Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the facility has a red zone where COVID positive residents resided, a yellow zone for non-vaccinated, new admits or residents who had been out of the facility more than twenty-four (24) hours. She stated when a resident was COVID-19 positive, both the resident and their roommate were quarantined; a sign was placed on the door identifying the room as red zone; and, a plastic zip barrier curtain was immediately placed on the doorway of the room to isolate the room. The Nurse Consultant stated the positive rooms on the 5th floor were designated as red zone and all other rooms on the 5th floor should be yellow zone. She stated she was not aware yellow zone rooms were not designated or staff had not designated red zone room barriers after the initial positive cases. Observation on 08/05/2021 at 6:02 PM revealed Resident #42 was wandering the hall on the fifth floor outside the rooms of residents who were COVID-19 positive. The resident was not wearing a facemask. 4. Observation of the fifth (5th) floor on 08/05/2021 at 10:54 AM revealed large red biohazard cans in the hallway on each end of the floor containing large amounts of contaminated PPE, which had been used by staff while in COVID positive residents' rooms. Resident #325 was observed wandering the hall walking past the containers and staff were observed doffing COVID contaminated PPE into the red biohazard containers on the outside of the COVID positive	F 880		

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residents' rooms.

Interview with SRNA #19, on 08/05/2021 at 11:15 AM, revealed staff were doffing contaminated PPE from COVID-19 positive rooms in the red bio-hazard can in the hallway. The SRNA stated she was unsure why staff were not doffing PPE inside the resident's room. She further stated only a couple of rooms had cans inside the room to doff PPE. Continued interview with SRNA #19, on 08/05/2021 at 12:25 PM, revealed she had not received recent training on donning and doffing PPE or COVID-19 since the outbreak began this time. SRNA #19 stated she did not routinely work on the fifth floor, but was pulled on 08/05/2021 to work on that floor. The SRNA stated she was a restorative aide and worked with residents throughout the building.

Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she had not received any training on PPE or COVID-19 since the outbreak began this time. She stated staff doffed PPE in red bio-hazard cans in the hallway.

Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor caring for residents who had the COVID-19 virus and those who did not have the virus. The SRNA stated she had not received training recently on PPE, handwashing, or COVID-19. She further stated staff were doffing COVID contaminated PPE in large red biohazard containers in the hallway with no PPE receptacle in the rooms. SRNA #16 stated the only receptacles in the COVID positive resident rooms were the small personal trash cans.

Interview with Certified Medication Aide #1, on

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F 880	Continued From page 386 08/05/2021 at 11:45 AM, revealed she had not received recent training on COVID-19 or training on PPE donning and doffing since this outbreak began. She further stated she was unsure whether to doff contaminated PPE inside or outside of resident rooms who were COVID positive, or where to place contaminated PPE, so she and other staff had been placing it in the hallway in the provided red biohazard containers. She stated the only containers in the COVID positive rooms were for soiled linens and small personal trash receptacles. Interview with RN #1, on 08/05/2021 at 11:50 AM, revealed she had not received training on COVID-19 and had not been re-trained on donning and doffing PPE. She stated there were containers with bags in the COVID rooms for soiled linens and trash. RN #1 stated staff had been doffing contaminated COVID PPE into the containers in the hallway. She further stated staff should doff PPE in the room. Continued interview with RN #9, on 08/09/2021 at 10:55 PM, revealed she had not received any training on donning and doffing PPE, and had not been inserviced since COVID-19 outbreak began this time. She further stated the facility provided a large red bio-hazard can in the hallway and that was the only place for staff to doff COVID contaminated PPE. Interview with the facility's Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the red biohazard containers in the hallway on the fifth floor were not for the disposal of contaminated PPE. The Nurse Consultant stated she was not aware there were no trash containers in the residents' rooms for staff to doff PPE. She stated	F 880		

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she could not explain the intended use of the red biohazards containers in the hallway.

Interview with the Infection Control/ADON/Interim DON on 08/11/2021 at 12:05 PM, revealed staff had not received new or recent training or education on PPE or COVID-19 since the outbreak began in the facility. She stated staff were evaluated on donning and doffing PPE by supervisory and visual observation of competency. She stated she was not aware staff were doffing PPE in the hallway in the red biohazard containers. She stated staff should be doffing inside the residents' room. She further stated she had not been up on the 5th floor much since the COVID-19 outbreak began. Continued interview revealed residents wandering in the hall could touch contaminated PPE containers and spread COVID-19.

Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility ensured staff were competent in utilizing PPE through observation and trained using CDC (Centers for Disease Control and Prevention) guidelines. She stated she was unsure if any retraining had been conducted with staff since this COVID-19 outbreak began. Per the Administrator, she was also unaware staff were doffing contaminated PPE in red biohazard containers in the hallway where other residents were wandering. She stated there should be containers in COVID rooms to doff PPE. She further stated there was no specific auditing or documentation the facility was using to monitor infection control other than observational monitoring.

5. (a) Continued review of the COVID-19 testing records revealed on 08/05/2021 Resident #328

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tested positive for COVID-19. Resident #328 resided on the fifth floor on the opposite end of the unit from the other residents who were positive for COVID-19.

Record review revealed the facility admitted Resident #328 on 04/14/2021 with diagnoses of Transient Cerebral Ischemic Attack, Dementia and Alzheimer Disease.

Review of the Minimum Data Set (MDS) dated 07/05/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired.

Review of Resident #328 Nurse's Notes dated 08/05/2021 at 8:15 AM revealed the resident stated to staff that he/she wasn't feeling well and had a fever of 100.3 degrees Fahrenheit (F). The facility administered the resident a COVID-19 test. Resident #328 tested positive for COVID-19. Further review of the Nurse's Notes revealed on 08/09/2021 at 5:17 PM, Resident #328 stated to staff he/she was feeling better and ambulating in his/her room while continuing on isolation. Continued review of Nurse's Notes revealed on 08/10/2021 at 7:52 AM, Resident #328 was awake and alert with no cough or congestion noted.

(b) Review of the facility's COVID-19 test records revealed on 08/07/2021, an additional resident (Resident #327) tested positive for COVID-19. Resident #327's room was located on the fifth floor near Resident #82's room

Record review revealed the facility admitted Resident #327 on 03/15/2021 with diagnoses of

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F 880	Continued From page 389 Dementia, Anemia and Chronic Peptic Ulcers. Review of the Minimum Data Set (MDS) dated 07/22/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #327's Nurse's Notes dated 08/09/2021 at 5:19 PM revealed the resident had two (2) episodes of diarrhea. The physician was notified and the resident was encouraged to increase oral fluid intake and was drinking well. Further review of the Nurse's Notes revealed on 08/14/2021 at 12:05 AM during routine vital signs, staff found Resident #327 to have a low blood pressure, low heart rate, and low oxygen saturation. The physician was notified and Resident #327 was sent to the emergency room via an ambulance for further evaluation. Review of Resident #327 vital signs dated 08/14/2021 revealed the resident had a blood pressure of 75/44 (normal range 120/80), heart rate of 46 (normal range 60-100), and oxygen saturation of 80% (normal range 95-100%) on five (5) liters of oxygen. The resident's temperature was 100.1F (normal temperature 98.6) prior to being sent to emergency room. Review of Resident #327 hospital discharge summary reviewed the resident expired at the hospital on 08/15/2021. The resident's admission diagnoses included Sepsis and COVID-19 Pneumonia. Per the discharge summary, the resident's Sepsis was likely due to the COVID-19 Pneumonia. The resident's discharge diagnosis was COVID-19 Viral Pneumonia.	F 880		

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F 880	Continued From page 390 Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she worked the fifth floor caring for all residents on the floor, both residents who were COVID positive and those who were negative. She stated there was no designated yellow zone or green zone, only individual rooms designated as red zone rooms. Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor caring for residents who had the COVID-19 virus and those who did not have the virus. The SRNA stated many residents wandered on the fifth floor and had to be redirected. However, they did not stay in their rooms and wandered the hallways on the unit. Interview with RN #9, on 08/09/2021 at 10:55 PM, revealed the only identifiers prior to the zip covers on the resident doors was a hand written paper taped on door saying if it was a red or yellow room and the fire doors on that hall had never been closed. The RN stated she cared for residents on the entire unit, both positive for COVID-19 and those who are not. 6. Continued observations on 08/05/2021 at 11:00 AM revealed Resident #325 sat in the hallway on the fifth floor in a chair with no facemask. The resident was seated adjacent to COVID positive residents' rooms while maintenance placed plastic zip barrier to a doorway. In addition, the resident was observed on 08/05/2021 at 10:54 AM wandering the hall walking past the red biohazard waste containers where staff were doffing COVID contaminated PPE. Review of the facility's COVID-19 test records revealed Resident #325 tested positive for	F 880		

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F 880	Continued From page 391 COVID-19 on 08/08/2021. Record review revealed the facility admitted Resident #325 on 09/15/2017 with diagnoses of Dementia, Polyosteoarthritis, and Psychotic Disorder. Review of Minimum Data Set (MDS) dated 06/26/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10), indicating the resident was moderately cognitively impaired. An attempt to interview Resident #325 08/05/2021 at 11:05 AM was unsuccessful. Resident #325 was reluctant to engage in conversation. Resident #325 went into his/her room to lie down. Review of the Nurse's Note dated 08/09/2021 at 2:45 PM, revealed Resident #325 had a change in condition and had a cough, congestion and developed a fever of 100.2 F. Further review revealed the resident was in respiratory distress and required transfer to the emergency room for evaluation. Review of the Nursing Readmission Assessment dated 08/12/2021 at 4:40 PM revealed Resident #325 was readmitted to the facility from the hospital. Continued review of the Nurse's Notes dated 08/19/2021 at 1:30 PM revealed Resident #325 developed a low oxygen saturation rate of 89% and the physician and resident's representative were notified. The physician ordered palliative care and Fentanyl patch (pain medication skin patch) related to resident's declined condition and "Do Not Resuscitate" (DNR) status. Per the note, staff discussed the resident's condition, palliative	F 880		

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care, DNR status, and new orders from the physician with the resident's representative. The resident's representative requested the facility send Resident #325 back to the hospital. The physician and DON were notified of the request and an ambulance transported the resident to the emergency room for evaluation.

Review of the Hospital Discharge Summary revealed Resident #325 expired at the hospital on 08/26/2021 and the discharge diagnoses included Acute Hypoxic Respiratory Failure secondary to COVID-19 Pneumonia.

Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed many residents on the fifth floor would not stay in their rooms and wandered the hallways on the unit. The SRNA stated Resident #325 had torn down the plastic covering on his/her room doorway wanting to get out of the room.

Continued interview with RN #9, on 08/09/2021 at 10:55 PM, revealed Resident #325 roamed the halls, and residents were not staying in their rooms and fire doors were not closed to isolate positive residents to one end of the unit.

Interview with Physician #1, who is also the Medical Director, on 08/04/2021 at 1:05 PM, revealed he expected the facility to isolate residents on the COVID Unit and monitor them for decompensation and signs and symptoms of COVID-19. He stated he was aware there were difficulties isolating residents due to cognitive dysfunction, lack of following directions and lack of wearing masks. He further stated he did not recall when he was made aware COVID-19 was back in the facility, but those residents who were

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F 880	Continued From page 393 positive were expected to be isolated in an area away from non-positive residents on the floor. The physician stated he was not aware residents who were positive for COVID-19 were not isolated to one area of the unit. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed staff had not received new or recent training or education on PPE or COVID-19 since the outbreak began in the facility. She stated staff were evaluated on donning and doffing PPE by supervisory and visual observation of their competency. She stated she was not aware staff were doffing PPE in the hallway in the red biohazard containers. She stated staff should be doffing inside the resident's room. She further stated she had not been up on the 5th floor much since the COVID-19 outbreak began. The ADON stated residents who wandered in the hall could touch contaminated PPE containers and spread COVID-19. She further stated she was aware plastic zip barriers were not on COVID-19 positive residents' rooms until 08/05/2021. The Infection Control/ADON/DON stated the facility had initially attempted to isolate the positive residents in their rooms. Observations of residents, who were positive for COVID, wandering on the fifth floor and not isolated in one area, were discussed with the Infection Control Nurse/ADON/DON. She stated the facility tried to keep COVID positive residents in one area on the floor. However, the Infection Control Nurse/ADON/DON stated the COVID virus could spread if positive residents were not in a closed off unit and she stated a closed off area of the floor/unit could prevent the spread of COVID-19. Per the Infection Control Nurse/ADON/DON, she expected nursing staff to redirect residents to the closed off area on the	F 880		

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unit if they were wandering and to ask them to wear a facemask if they were not wearing one. However, she mentioned no further actions for nursing staff to utilize if redirection was not effective.

Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed the facility ensured staff were competent in utilizing PPE through observation and trained using CDC guidelines. She stated she was unsure if any retraining had been conducted with staff since this COVID-19 outbreak began. When asked how many residents were currently hospitalized with COVID-19, she responded there were initially four (4) residents hospitalized with COVID-19, but two (2) of those residents were back in the facility. She stated COVID positive residents were kept on one end of the 5th floor in the red zone and the Infection Control/ADON/ Interim DON was responsible for monitoring to ensure infection control practices were in place. The Administrator stated she was unaware that all COVID 19 positive residents were not on one end of the 5th floor. Per the Administrator, she was also unaware staff were doffing contaminated PPE in red biohazard containers in the hallway where other residents were wandering. She stated there should be containers in COVID rooms to doff PPE. She further stated there was no specific auditing or documentation the facility was using to monitor infection control other than observation monitoring.

7. Review of Resident #317's record revealed the facility admitted the resident on 07/23/2020 with diagnoses, which included Dementia and Hypertension. According to his/her Annual Minimum Data Set Assessment (MDS) dated 07/27/2021, revealed the resident was not

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F 880	Continued From page 395 interviewable and had a Brief Interview for Mental Status (BIMS) score of four (4). Per the MDS assessment, the resident required assistance of one staff member with transfers and toileting. Continued review of Resident #317's record revealed on 07/27/2021 at 9:35 AM, the resident was noted to require more assistance than normal, had wheezes in his/her lung fields and had a non-productive cough. Review of his/her record revealed the physician was notified of the change in his/her condition and directed staff to test the resident daily for COVID-19; administer nebulizer treatments twice a day for seven (7) days; obtain his/her vital signs every four (4) hours for three (3) days; and, isolate the resident to his/her room for "now". Resident #317's vital signs were noted to be 97.7 F (normal 98.6 F) temperature, heart rate was 86 (normal range 60-100), respirations were 20 (normal 12-20) and blood pressure was 150/77 (normal range 120/80). Observations conducted on 07/27/2021 on the 5th floor, at 11:25 AM and 3:50 PM revealed the resident was ambulating in the hallway, passing by other residents with no mask in use or noted on his/her person. Staff were close by; however, staff were not observed to offer Resident #317 a mask and no staff were observed to attempt to isolate him/her to his/her room as ordered by the physician. Further observations conducted on 07/28/2021 at 11:20 AM revealed Resident #317 was ambulating around the nurse's station, conversing with staff, with no mask on his/her person. Staff was not observed to offer/encourage him/her to wear a mask and no attempts to isolate him/her to his/her room for isolation due to a potential COVID-19 infection	F 880		

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F 880	Continued From page 396 was observed. Observations of Resident #317's room on 07/27/2021 and 07/28/2021 revealed no signage had been placed on his/her door to indicate he/she should have been isolated due to a potential COVID-19 infection. Interview with Registered Nurse (RN) #1, on 07/30/2021 at 9:50 AM, revealed she contacted Resident #317's physician on 07/27/2021 at 9:35 AM due to the resident's change in condition and a potential COVID-19 infection. According to the RN, the physician ordered medications/treatments for the resident, COVID testing and ordered he/she be isolated to his/her room. The RN stated she tested him/her and he/she was negative. However, she acknowledged she failed to place signage on his/her door, and failed to take actions in attempts to isolate him/her to his/her room as ordered by the physician, but stated she should have. RN #1 also stated she had not provided the resident with a mask, because she did not think he/she would wear it. RN #1 stated she informed the ADON of the Physician's Orders to isolate the resident and the ADON just stated, "OK". She stated the ADON never directed any further testing of other residents to occur, and she gave the RN no further actions to take to protect the other residents. Interview with Physician #1, on 08/04/2021 at 1:00 PM, confirmed he was Resident #317's physician and was notified of the resident's change in condition. Physician #1 had given orders for staff to test and isolate the resident for a potential COVID-19 infection. He stated he was informed of staff's difficulty in isolating residents, especially those with dementia. However, he stated he expected staff to isolate sick residents	F 880		

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away from the other residents to decrease the likelihood of the virus spreading in the facility and should follow their policy.

8. Observations conducted in the dietary department on 08/05/2021 at approximately 4:00 PM revealed Dietary Aide (DA) #1 was observed to retrieve a food tray cart from the 5th floor where COVID-19 positive residents resided. Further observations revealed no one cleaned/sanitized the cart before the cart was taken from the 5th floor, onto the elevator and back to the kitchen soiled dish area, where other tray carts were observed. Continued observations revealed the DA utilized a surgical mask and had no other PPE in use while cleaning the cart, which had been on the COVID-19 Unit in the facility. Observations also indicated the DA used "Silver Power" to clean/sanitize the carts.

Interview with DA #1, on 08/05/2021 at 4:15 PM, revealed he was informed that facility residents had tested positive for COVID-19 on the fifth floor. However, he had not been directed to do anything different when carts were retrieved from the COVID-19 unit in the facility. He stated he always utilized the "Silver Power" degreaser to clean the food carts in the facility, and had not been directed to change any dietary processes.

Review of the Safety Data Sheet for Silver Power indicated the agent was utilized as a "presoak" and further review of the sheet provided no evidence it was an effective disinfectant for the COVID-19 virus.

Interview with the Registered Dietician (RD), on 08/18/2021 10:30 AM, revealed she would have expected dietary staff to sanitize the food carts,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256	A. BUILDING _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

POC NOT FINAL

(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 880	Continued From page 398 with an effective agent for COVID-19 before the carts were brought back into the kitchen to prevent the potential spread of COVID-19. She stated she had not conducted training with staff related to COVID-19 infection control processes and had not been directed to do so. Interview with the Infection Control Nurse/ADON/Interim DON, on 08/18/2021 at 9:50 PM, revealed she was not aware dietary staff had not disinfected food carts with an effective agent for COVID-19, before they were brought back in the kitchen, after being on the COVID-19. However, she stated she would have expected them to do so. She acknowledged reeducation was required to be conducted in the facility, when new cases of the virus were identified for residents/staff as outlined in the facility's policy. However, she stated she had not conducted facility wide training because she had been working the floor as a staff nurse.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policy for pest control, it was determined the facility failed to have an effective pest control program to ensure the facility was free of pest. Gnats were observed during the survey on 06/15/2021 and 06/16/2021 in resident hallways, and in residents' rooms. The findings include:	F 925		

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F 925	Continued From page 399 Review of the facility's pest control policy titled, "Pest Control" with a revision date of May 2008, revealed the facility shall maintain an effective pest control program and maintain an on-going pest control program to ensure that the building was kept free of pest. Further review of the policy revealed pest control services were provided by an outside company and that maintenance services assisted in providing pest control services. Observation during the initial tour on 06/15/2021 at 2:24 PM revealed multiple gnats observed in resident room 414. Observation of the fourth floor hallway on 06/16/2021 at 9:18 AM revealed a gnat near resident room 406. Observation of room 414 on 06/16/2021 at 1:06 PM revealed a gnat observed in the room of Resident #92, who was eating lunch. Observation on 06/16/2021 at 1:07 PM, revealed a gnat was observed in room 416 near Resident #74, who was eating lunch. Observation of Resident #339's room, on 08/05/2021 at 2:08 PM, revealed gnats and flies around the resident's bed and the over bed table. An interview was attempted with Resident #339; however, the resident declined. Interview with Registered Nurse (RN) #8, on 08/05/2021 at 2:08 PM, revealed Resident #339's room always had gnats and flies. A group interview conducted on 06/16/2021 at	F 925		

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F 925	Continued From page 400 10:13 AM with five (5) alert and oriented residents who resided on the third, fourth, and fifth floors revealed the residents had complained that the facility had a problem with gnats. Interview with the Maintenance Director, on 06/19/2021 at 10:22 AM, revealed the lab treated the facility monthly for pest control. Review of the Invoices revealed the lab had treated the facility for gnats on 06/17/2021, 05/27/2021, and 04/30/2021. Further interview with the Maintenance Director revealed if he observed gnats he would try to get rid of the gnats by treating the drains. According to the Maintenance Director, if the gnats were in a resident's room "real bad" he would place traps in the room to control the gnats. Further interview with the Maintenance Director revealed if the pest control was ineffective, gnats could get on residents' food or wounds and cause illness or infection. Interview with Administrator, on 06/19/21 at 1:30 PM, revealed she had started employment at the facility the first of June 2021. She stated she had a discussion with housekeeping staff related to gnats and a potential problem of insects in the building/facility. The Administrator stated the exterminator had been in the facility yesterday.	F 925		