STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	1966 HILL DRIVE GRENADA, MS 38901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 4/30/2023 to 5/15/2023. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F550, F578, F604, F655, F656, F657, F658, F679, F684, F758, F759, F761, F812, and F880 during the annual survey. The SA re-entered the facility on 5/15/23 for a Complaint Investigation (CI MS # 21504) related to neglect, pressure sores and staffing and determined the facility was in compliance with Medicare and Medicaid requirements of participation related to CI MS # 21504. The census at the time of the survey was 84 and the facility is licensed for 95 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		6/15/23

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

Electronically Signed | 05/26/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review the facility failed to respect the right of a resident as evidenced by the facility applying a lap tray to a cognitively intact resident against her wishes for one (1) of 29 residents sampled. Resident # 45. Findings Include Record review of the facility policy titled, "Resident's Rights " with no revision date revealed under " #3. Is assured of adequate and appropriate medical care is fully informed by a physician, of his medical condition unless	F 550	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely pursuant to the requirements under state and federal laws. F 550 Resident Rights/Exercise of Rights 1. Root Cause Analysis was conducted	

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F 550	Continued From page 2 medically contraindicated (as documentation by a physician, in his medical record) is afforded the opportunity to participate in the planning of his medical treatment to refuse to participate in experiment research and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions". An observation on 4/30/23 at 4:08 PM revealed Resident #45 was self-propelling her wheelchair down the hall with a lap tray attached. An observation and interview on 5/1/23 at 9:15 AM revealed that Resident #45 was self-propelling in her wheelchair with a lap tray attached. An interview at this time with the resident revealed she did not like the lap tray, did not want it and cannot remove it herself. Record review of Resident #45 Minimum Data Set with an Assessment Reference Date of 2/6/23 revealed in Section C a Brief Interview for Mental Status of 14, which indicates the resident is cognitively intact. An interview on 5/2/23 at 2:36 PM with the Corporate Clinical Nurse revealed she realized that the resident did not like the lap tray and did not want it. She confirmed that putting the lap tray on the resident's wheelchair was going against her wishes. She revealed that they did not mean to infringe on her rights. An interview on 5/2/23 at 4:21 PM with Resident #45's representative revealed he was aware that his sister had a lap tray on her wheelchair now and he knew she did not like it. He revealed the facility did not ask for his consent prior to applying	F 550	by the Interdisciplinary Team and based on findings Resident #45 received gradual reduction of restraint on 5-3-2023 and 5-10-2023 the gradual reduction was successful and new physician's orders discontinuing resident's lap tray was obtained. 2. Quality reviews of current Residents' care plans and physicians' orders were conducted on 5-10-2023, by the Director of Nursing (DON), Minimum Data Set Nurse (MDS), and Regional Director of Clinical Services (RDCS) to ensure compliance with protecting and promoting the rights of the residents regarding restraint physicians' orders. One resident out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated in-service for the following Departments: Administration, Nursing, Therapy, Social Services, Activities, Maintenance, Dietary and Environmental Services on Resident's Rights/Exercise of Rights and Restraints policy and procedures. New hires' training and education will be conducted in orientation. 4. Restraint Physician Orders will be monitored starting 5-15-2023 by the Minimum Data Set Nurse (MDS), Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with protecting and promoting the rights of the residents	

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F 550	Continued From page 3 the lap tray, he was notified by the facility after the lap tray was applied, he did not get educated on the risk of the lap tray and he did not have to sign anything giving consent. Observation and interview on 5/15/23 at 11:30 AM with Resident #45 revealed she was up in a wheelchair with a high back in her room. Resident has a soft pink helmet on her head. She does not have a lap tray or seat belt on. Her speech can be difficult to understand but she is able to say "yeah", "no" and complete simple sentences. When asked if she knew there would be a lap tray used before the staff used one on her wheelchair, she stated "yeah". When asked why she didn't want the lap tray on her wheelchair, she stated "couldn't move like I wanted". State Agency (SA) asked if the facility staff had explained to her that she could be harmed/hurt if she falls out of the wheelchair, she stated "yes". It is noted that she does display the jerking, sudden movements from her extremities that accompany Huntington's disease. Interview with the Director of Nurses on 5/15/23 at 11:45 AM revealed that the consent for the lap tray was verbally over the phone due to the Resident Representative (RR) living 3.5 hours away. She stated that Resident #45 had a fall this morning, but had no injuries from this fall. She said that Resident #45 is glad she doesn't have to use the lap tray anymore. The RR is aware the lap tray has been discontinued (dc'd). Care plan meeting with the RR are done over the phone due to the distance of his home to the facility. The DON explained the risks of falls and possible injury have been explained to both the RP and resident by the DON and the clinical nurse consultant. The DON confirmed the lap tray was	F 550	regarding restraints physicians' orders. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 550	Continued From page 4 dc'd 5/11/23. Record review of Resident #45's physician's orders revealed an order dated 4/10/23- Apply lap tray when up in wheelchair, check every 30 minutes and release every 2 hours for toileting and repositioning every shift for involuntary movement of trunk and extremities related to Huntington's Disease. Record review of Resident #45's Admission Record revealed the resident was admitted to the facility on 11/01/19 with medical diagnoses that included Huntington's Disease.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		6/15/23

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F 578	Continued From page 5 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review the facility failed to review and gain consent on a cognitively intact residents Advanced Directives (Resident # 52) and failed to obtain a physician's order and formulate a Do Not Resuscitate (DNR) status in the medical record (Resident #181) for two (2) of 29 resident's advance directives reviewed. Resident # 52 and #181 Findings Include: An interview on 5/1/23 at 3:15 PM, with the Administrator revealed the facility did not have a policy related to the process for ensuring the appropriate code status for DNR for residents. Resident # 52	F 578	F 578 Request/Refuse/Discontinue Treatment; Formulate Advanced Directives 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings; the Social Services Director met with Resident #52 on 5-3-2023 and reviewed his Advanced Directives with no negative findings nor updates, the Medical Records Nurse obtained the signed Advanced Directive physician order for Resident# 181 on 5-1-2023 and uploaded it into the Electric Health Record. 2. Quality reviews of current Residents' Advanced Directives were conducted on 5 -11-2023 by the Medical Records Nurse to ensure compliance with	

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F 578	Continued From page 6 An interview on 5/1/23 at 4:10 PM, with Resident #52 revealed no one from the facility had talked to him about his wishes regarding wanting CPR (cardio pulmonary resuscitation) or not. An interview on 5/1/23 at 4:20 PM, with the Corporate Clinical Nurse revealed that if a resident is admitted and is not cognitively able to sign their own admission paperwork and then becomes cognitive at a later date, they do not redo or go over the resident's advance directive. An interview on 5/1/23 at 4:30 PM, with Social Services revealed she was unaware that if a resident was not cognitive on admission but became cognitive during their stay at the facility then the resident's advance directive needed to be reviewed and resigned. An interview on 5/3/23 at 09:30 AM, with Social Services revealed that Resident #52 could understand you when you spoke with him and make his wishes known. She confirmed that the resident had never attended a care plan meeting and no follow up was documented regarding speaking with the resident to verify he agreed with the plan of care that was decided upon. Record review revealed Resident #52 had an Advance Directive signed by the resident's representative on admission 08/27/20 and a code status change on 01/28/21. Record review of Resident #52's history of Minimum Data Sets with Brief Interviews for Mental Status (BIMS) scores revealed a BIMS score on the Admission MDS dated 9/3/20 of 7 which indicated severely impaired cognitive	F 578	request/refuse/discontinue treatment; formulate Advanced Directives. Two residents out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing in-service on request/refuse/discontinue treatment; formulate Advanced Directives policy and procedures. New hires' training and education will be conducted in orientation. 4. Advanced Directives will be monitored starting 5-15-2023 by the Medical Records Nurse, Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 578	Continued From page 7	F 578		

status. The MDS dated 11/30/20 revealed a BIMS score of 11 which indicated that the resident had moderately impaired cognitive skills. The MDS dated 3/13/23 revealed a BIMS score of 11.

Record review of Resident #52's Admission Record revealed he was admitted to the facility on 08/28/20 with medical diagnoses that included Cerebral Infarction Unspecified.
Resident #181

Record review of "CONSENT FOR CARDIOPULMONARY RESUSCITATION (CPR) form, for Resident #181, signed by her Resident Representative on 4/20/23, revealed " ... This statement will remain in effect as long as the resident remain a resident of this facility ... 'x' Decline CPR' I understand that CPR constitutes an extraordinary measure and SHOULD NOT be performed. ... Date 4/20/23."

Record review of the "Order Summary Report," for Resident #181, revealed she did not have a Do Not Resuscitate (DNR) order in the Electronic Health Record (EHR).

Record review of the "Admission Record" for Resident #181 revealed an admission date of 04/24/2023.

An interview on 5/1/23 at 02:45 PM, with Medical Records confirmed there was not a DNR order in the EHR for Resident #181. She noted old DNR orders are used for residents who readmit to the nursing facility in less than 30 days of discharge and a new order for DNR did not have to be obtained from the physician. She confirmed that Resident #181 was discharged from the nursing facility and readmitted on 04/24/2023 and

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confirmed that the physician's order for DNR from the previous admission, for Resident #181, was being used for the readmission.

An observation and interview on 5/1/23 at 03:00 PM, with the Director of Nursing (DON), confirmed Resident #181 was recently readmitted to the nursing facility. After being completely discharged from the nursing facility, there was a new "Consent For Cardiopulmonary Resuscitation" form for the code status request of DNR signed by the Resident Representative. There was not a new code status order obtained related to the new admission to the nursing facility. She revealed she was not aware she needed to have a new physician's order for DNR upon readmission if the resident was not out of the nursing facility for more than 30 days and confirmed that the resident/family choice for plan of care related to Advance Directives was not being honored. She revealed Resident #181 needed to have a signed physician's order in the Electronic Health Record for DNR to ensure Resident #181's choice was honored for her Advanced Directive and to ensure the appropriate level of care was rendered in case of a medical emergency for Resident #181.

An interview on 5/1/23 at 03:15 PM, with the Administrator, revealed the nursing facility did not have a policy related to the process of ensuring the appropriate code status of DNR, for residents, was completed in the EHR. He confirmed the nursing staff should have obtained a signed DNR order for Resident #181 from her admitting physician and confirmed the nursing facility was not honoring the choice of DNR for Resident #181.

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F 604	Continued From page 9	F 604		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident interview and resident representative interview, record review and facility policy review the facility failed to ensure a resident was assessed for the need	F 604	F 604 Right to be Free from Physical Restraints 1. Root Cause Analysis was conducted	6/15/23

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F 604	Continued From page 10 of physical restraint as evidenced by no restraint assessment completed prior to applying a lap tray for one (1) of 18 residents reviewed. Resident #45 Findings Include Record review of the facility policy titled, "Physical Restraints and Involuntary Seclusion" with a revision date of 10/08/20 revealed under "Policy ...#1. Restraints will not be used unless the facility's Interdisciplinary Team has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). #3 The patient/resident will have the right to refuse or accept the use of restraints. In order for the patient/resident to make an informed choice about the use of restraints, the potential outcomes of restraint use will be explained to the patient/resident. This includes but is not limited to: A. Potential negative outcomes of incontinence, B. Decreased ROM, and ability to ambulate, C. Reduced social contact and D. Possible symptoms of depression. An observation on 4/30/23 at 4:08 PM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An observation and interview on 5/1/23 at 9:15 AM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An interview at this time with the resident revealed she did not like the lap tray, did not want it and cannot remove it herself. An interview on 5/1/23 at 3:00 PM with the Director of Nurses (DON) revealed that Resident	F 604	by the Interdisciplinary Team and based on findings Resident #45 received gradual reduction of restraint on 5-3-2023 and 5-10-2023 the gradual reduction was successful and new physician's orders discontinuing resident's lap tray was obtained. 2. Quality reviews of current Residents' care plans and physicians' orders were conducted on 5-10-2023, by the Director of Nursing (DON), Minimum Data Set Nurse (MDS), and Regional Director of Clinical Services (RDCS) to ensure compliance with protecting and promoting the rights of the residents regarding restraint physicians' orders. One resident out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all staff in-service on Resident's Rights/Exercise of Rights and Restraints policy and procedures. New hires' training and education will be conducted in orientation. 4. Comprehensive Care Plans/Restraint Physician Orders will be monitored starting 5-15-2023 by the Minimum Data Set (MDS) Nurse, Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with protecting and promoting the rights of the residents regarding restraints physicians' orders. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI)	

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F 604	Continued From page 11 #45 had several falls, and one was with a major injury, so they had a meeting with corporate and therapy and decided that a lap tray was the next step in keeping her in her wheelchair. She revealed the resident should have had an assessment regarding the restraint, but she could not find it or the consent form. An interview on 5/1/23 at 3:15 PM with the Corporate Clinical Nurse confirmed they had a meeting with therapy and decided that Resident #45 needed a lap tray to keep her from falling, because she had fallen so much and had some injuries. She revealed the facility did not have an assessment form that would have been completed for the restraint. She revealed the resident should have had a consent form on her record, but we cannot find it. An interview 5/1/23 at 3:38 PM with the Assistant Director of Nurses (ADON) revealed she went to medical records and found Resident #45's consent for the restraint that was signed by the resident's representative on 4/10/23. An interview on 5/2/23 at 12:15 PM with the Corporate Clinical Nurse confirmed that the facility policy read that an assessment was needed for a restraint but revealed she is unaware of an assessment form. She confirmed that Resident #45 did not have a restraint assessment completed prior to the lap tray being attached to the resident's wheelchair as a restraint. An interview on 5/2/23 at 4:21 PM with Resident #45's representative revealed he was aware that his sister had a lap tray on her wheelchair now and he knew she did not like it. He revealed the	F 604	Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 604	Continued From page 12	F 604		

facility did not ask for his consent prior to applying the lap tray, he was notified by the facility after the lap tray was applied, he did not get educated on the risk of the lap tray and he did not have to sign anything giving consent.

An interview on 5/3/23 at 9:50 AM with the ADON revealed that Resident #45's representative had given consent for the lap tray verbally over the phone but admitted that consent was not obtained prior to applying the lap tray. She revealed the consent for the resident's lap tray should have been obtained prior to applying it because it was not an emergency.

Observation and interview on 5/15/23 at 11:30 AM with Resident #45 revealed she was up in a wheelchair with a high back in her room. Resident has a soft pink helmet on her head. She does not have a lap tray or seat belt on. Her speech can be difficult to understand but she is able to say "yeah", "no" and complete simple sentences. When asked if she knew there would be a lap tray used before the staff used one on her wheelchair, she stated "yeah". When asked why she didn't want the lap tray on her wheelchair, she stated "couldn't move like I wanted". State Agency (SA) asked if the facility staff had explained to her that she could be harmed/hurt if she falls out of the wheelchair, she stated "yes". It is noted that she does display the jerking, sudden movements from her extremities that accompany Huntington's disease.

Interview with the Director of Nurses on 5/15/23 at 11:45 AM revealed that the consent for the lap tray was verbally over the phone due to the RP living 3.5 hours away. She stated that Resident #45 had a fall this morning, but had no injuries

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from this fall. She said that Resident #45 is glad she doesn't have to use the lap tray anymore. The Resident Representative (RR) is aware the lap tray has been discontinued (dc'd). Care plan meeting with the RR are done over the phone due to the distance of his home to the facility. The DON explained the risks of falls and possible injury have been explained to both the RR and resident by the DON and the clinical nurse consultant. The DON confirmed the lap tray was discontinued on 5/11/23.

Record review of Resident #45's physician's orders revealed an order dated 4/10/23- Apply lap tray when up in wheelchair, check every 30 minutes and release every 2 hours for toileting and repositioning every shift for involuntary movement of trunk and extremities related to Huntington's Disease.

Record review of Resident #45's care plans revealed the resident had a care plan created on 4/22/20 and revised on 4/11/23 that read; I am going to fall; I prefer to keep my independence with making coffee from sink. I do not want to have a special cup to prevent spills. She is at high risk for falls with a goal of; I will be free of major injury related to falls through the review date and interventions that include 4/10/23 Restraint would be appropriate at this time due to continuous decline in condition resulting in involuntary movement of trunk and extremities. (Resident #45's proper name) is no longer able to safely maintain position in wheelchair, lap tray applied to wheelchair, staff to check restraint placement every 30 minutes and remove for repositioning and toileting every 2 hours.

Record review of Resident #45's record revealed

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F 604	Continued From page 14 there was no documentation of an assessment for the use of the lap tray or whether the resident could release the lap tray. Record review of Resident #45's Face Sheet revealed the resident was admitted to the facility on 11/01/19 with medical diagnoses that included Huntington's Disease. Record review of Resident #45 Minimum Data Set (MDS) an Assessment Reference Date (ARD) of 2/6/23 revealed in Section C a Brief Interview for Mental Status (BIMS) of 14, which indicates the resident is cognitively intact.	F 604		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §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.	F 655		6/15/23

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F 655	Continued From page 15 §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. (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 record review, staff interviews, and facility policy review the facility failed to complete a baseline care plan, within 48 hours, for new admits to the nursing facility as evidenced by observation of incomplete baseline care plans for one (1) of eight (8) resident investigations. Resident #178 Findings include: Review of the facility policy titled "Care Plans - Baseline," with a revised date of March 2022, revealed "Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission; Policy	F 655	F 655 Baseline Care Plan 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings, Resident #178 Baseline Care Plan sections; Social Services provided, Mental health needs, Behavioral concerns, Preadmission Screening and Resident Review Level II, Social Services goals, and Depression screening were completed and updated by the Social Services Director on 5-4-2023. 2. Quality reviews of current Residents' Baseline care plans were conducted on 5-10-2023, by the Director of Nursing (DON)	

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F 655	Continued From page 16 Interpretation and Implementation: 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: ... e. Social Services." Record review of the Baseline Care Plan dated 4/28/23 for Resident #178 revealed the Social Services section of the Baseline Care Plan was not completed. The record review revealed the questions in the Social Services section of the form " ... 1. Social Services provided; 2. Mental health needs; 3. Behavioral concerns; 4. PASARR (Preadmission Screening and Resident Review) Level II recommendations; 5. Social Services goals; 6. Depression screening." were not answered. An observation and interview on 5/3/23 at 09:15 AM, with the Care Plan Nurse related to the Baseline Care Plan for Resident #178 confirmed the Social Services section of the Baseline Care Plan was not completed. She revealed that a Baseline Care Plan should be developed and discussed with the residents/Resident Representatives within 48 hours of admission. She revealed the Baseline Care Plan for Resident #178 was not developed within 48 hours. An observation and interview on 5/3/23 at 9:30 AM, with Social Services, confirmed the Social Services section of the Baseline Care Plan was not completed. She revealed she was not aware of what a Baseline Care Plan was. An interview on 5/3/23 at 9:45 AM, with the	F 655	and Minimum Data Set Nurse (MDS), to ensure Baseline care plans were in compliance with each section being completed within 48 hours. One resident out of eighty-four had the potential to be affected. 3. On 5-5-2023 the Regional Case Mix RN (RCM) in-services the Minimum Data Set Nurse (MDS) on Baseline Care Plans policy and procedures and on 5-15-2023 Minimum Data Set Nurse (MDS) in-serviced the Interdisciplinary Care Plan Team on Baseline Care Plans policy and procedures. New hires' training and education will be conducted in orientation. 4. Baseline Care Plans/physicians' orders will be monitored for protecting and promoting the rights of the residents regarding restraints starting 5-15-2023 by the Minimum Data Set (MDS) Nurse, Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 655	Continued From page 17 Administrator revealed he was not aware that the Baseline Care Plans were not being completed for all new admits to the nursing facility within 48 hours. He was not aware that Social Services had no knowledge of a Baseline Care Plan and confirmed that Resident #178 did not have an adequate plan of care in place. He confirmed that a Baseline Care plan should have been completed for Resident #178 within 48 hours of admission. Record review of the Admission Record revealed Resident #178 was admitted to the facility on 04/28/2023.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		6/15/23

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F 656	Continued From page 18 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 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and policy review the facility failed to develop a care plan for the application of an Aspen collar, splint, and a Wrist-Hand-Finger Orthosis (WHFO) for Resident # 17 and implement a care plan for monitoring of side effects and behaviors for psychotropic medication (Resident # 229) for two (2) of 20 residents care plans reviewed. Findings include: A review of the facility policy titled, "Care Plans, Comprehensive Person-Centered", dated 10-2022; Reviewed Jan 2023 Policy Statement: A	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #17 physician orders and care plans were clarified and updated by the Director of Nursing on 5-2-2023 and 5-3-2023. Resident #229 physician orders and care plans were clarified and updated by the Director of Nursing on 5-1-2023. Resident #17 and Resident #229 were assessed by the Director of Nursing of 5-3-2023 with no negative findings.	

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F 656	Continued From page 19 comprehensive, person-centered care plan ... is developed and implemented for each resident. Policy Interpretation and Implementation, 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Resident #17 Record review of the care plans, for Resident #17, revealed he did not have a comprehensive person-centered care plan developed to ensure proper implementation of care for his Aspen Collar, proper implementation of care for his right-hand Wrist-Hand-Finger Orthosis (WHFO), and proper implementation of care for his left knee extension splint. An observation and interview on 5/3/23 at 9:15 AM, with the Care Plan Nurse confirmed the Aspen Collar, the right-hand WHFO and the left knee extension splints were not care planned for Resident #17 and confirmed there should have been a care plan developed for these areas. She revealed she was aware that a comprehensive person-centered care plan was to be developed for residents from physician's orders with goals and interventions related to care needed to carry out that plan of care for the residents. An interview on 5/3/23 at 11:00 AM, with the Administrator, confirmed Resident #17 did not have a comprehensive person-centered care plan developed for the Aspen Collar, for the right-hand WHFO, and for the left knee extension splint. He confirmed Resident #17 could possibly have a	F 656	2. Quality reviews of current Residents' care plans were conducted on 5-10-2023, by the Director of Nursing (DON) and Minimum Data Set Nurse (MDS) to ensure comprehensive care plan interventions were in compliance for residents with splints/mobility/positioning devices and monitoring for adverse reactions to psychotropic medications side effects and behaviors. Two residents out of eighty-four had the potential to be affected. 3. On 5-5-2023 the Regional Case Mix RN (RCM) in-services the Minimum Data Set Nurse (MDS) on Comprehensive Care Plans policy and procedures and on 5-15-2023 Minimum Data Set Nurse (MDS) in-serviced the Interdisciplinary Care Plan Team on Comprehensive Care Plans with splints, Aspen collar, right hand wrist-hand finger orthosis splints, knee extension splints, and adverse reactions to psychotropic medications side effects and behaviors policy and procedures. New hires' training and education will be conducted in orientation. 4. Comprehensive Care Plans will be monitored for residents with splints, Aspen collar, right hand wrist-hand finger orthosis splints, and knee extension splints, knee extension splints, and for adverse reactions to psychotropic medications side effects and behaviors starting 5-15-2023 by the Minimum Data Set (MDS) Nurse or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x	

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F 656	Continued From page 20 decline in positioning due staff being unaware of the full plan of care, for Resident #17, related to a care plan was not developed for implementation of care. Record review of the active physician's orders on the "Order Summary Report," for Resident #17, revealed Order Date: 03/10/2023; Start Date: 03/10/2023 ... Pt to have Aspen Collar to neck at all times until follow up with Neurosurgeon. Every shift related to SUBLUXATION OF C1/C2 CERVICAL VERTEBRAE, SUBSEQUENT ENCOUNTER ... Order Date: 03/08/2023 ... Pt to have L knee extension splint for contracture management. Splint to be worn up to 6 hours/day per pt tolerance and applied by therapy ... Order Date: 03/08/2023 ... Pt to have R WHFO to be worn up to 6 hrs/day per patient tolerance to be applied by nsg to manage contractures." Record review of the Admission Record revealed Resident #17 was admitted to the facility on 2/10/2023 with diagnoses that included SUBLAXATION OF C1/C2 CERVICAL VERTEBRAE, SUBSEQUENT ENCOUNTER, UNSPECIFIED FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING, AND ENCOUNTER FOR OTHER ORTHOPEDIC AFTERCARE." Record review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/20/23, for Resident #17, revealed a Brief Interview for Mental Status (BIMS) score of 03, indicating Resident #17 is severely cognitively impaired. Resident #229	F 656	weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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A record review of Resident # 229's care plan, date initiated 4/21/23 revealed, "Focus The resident uses antidepressant medication (Mirtazapine) r/t (related to) Depression ...Goal The resident will be free from discomfort or adverse reactions related to antidepressant therapy...Interventions, Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT THERAPY ..."

Record review of Resident #229's care plan, date initiated 4/20/23, revealed, "Focus The resident uses anti-anxiety medications (Lorazepam) r/t Anxiety disorder. ...Goal The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy...Interventions Monitor/document/report PRN adverse reactions to ANTI-ANXIETY THERAPY ...

Record review of the care plan dated 4/24/23 revealed, "Focus The resident has a behavior problem ... Goal The resident will have fewer episodes of behavior ...Interventions ...Monitor behavior episodes and attempt to determine underlying cause ..."

Record review the Medication Administration Record dated 4/1/23 through 4/30/23 revealed no documentation of behavior monitoring.

An interview with the DON on 05/01/13 at 3:00 PM, revealed that Resident # 229 had a care plan for monitoring for side effects and behavior monitoring for psychotropic drugs and confirmed the care plans were not being followed. Concerns related to failure to follow the care plan were over sedation, falls, and drowsiness.

An interview and record review with LPN # 4 on

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F 656	Continued From page 22 05/01/23 at 3:35 PM, she confirmed they were not following the plan of care. Record review of the Admission Record revealed Resident # 229 was admitted to the facility on 4/19/2023 with diagnoses which included Anxiety, Alcohol Abuse, and Major Depressive Disorder. Record Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/27/2023 revealed a Brief Interview for Mental Status (BIMS) score of eight (8) indicating Resident #229 had moderate cognitive impairment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		6/15/23

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F 657	Continued From page 23 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 staff and resident interview, record review and facility policy review the facility failed to include a resident in the development of their plan of care for one (1) of 18 resident care plans reviewed. Resident # 52. Findings Include Record review of the facility policy titled, " Care Plans, Comprehensive Person Centered " with a revision date of January 2023 revealed "Policy Interpretation and Implementation...#1. The Interdisciplinary Team (IDT) , in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident". An interview on 5/1/23 at 4:10 PM, with Resident #52 revealed no one from the facility had asked him to attend a care plan meeting. An interview on 5/3/23 at 09:30 AM, with Social Services revealed that Resident #52 could understand you when you spoke with him and make his wishes known. She confirmed that the resident had never attended a care plan meeting and no follow up was documented regarding speaking with the resident to verify he agrees with the plan of care that was decided upon.	F 657	F 657 Care Plan Timing and Revision 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings the Social Services Director met with Resident #52 on 5-3-2023 and reviewed his Advanced Directives and the resident agreed with his current Advanced Directives and did not wish to make any changes. 2. Quality reviews of current Residents' care plans were conducted on 5-10-2023, by the Director of Nursing (DON) and Minimum Data Set Nurse (MDS) to ensure comprehensive care plan interventions were in compliance for attempting to include residents in their development of the plan of care. One resident out of eighty-four had the potential to be affected. 3. On 5-5-2023 the Regional Case Mix RN (RCM) in-services the Minimum Data Set Nurse (MDS) on Care Plan Timing and Revision policy and procedures and on 5-15-2023 Minimum Data Set Nurse (MDS) in-serviced the Interdisciplinary Care Plan Team on Care Plan Timing and Revision policy and procedures. New hires' training and education will be	

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F 657	Continued From page 24 Record review of Resident #52's Progress Notes revealed the following care plan meetings documentation. 3/7/23 was not attended by either the resident or the resident representative. There was no documentation that Resident #52 attended care plan meetings on 12/13/22, 09/20/22, 06/23/22, or 03/24/22. The documentation indicated the facility had care plan conferences with Resident #52's Resident Representative by phone. Documentation did not include that Resident #52 had attended the phone conference or had attend in person. Record review of Resident #52's history of Minimum Data Sets with Brief Interviews for Mental Status (BIMS) scores revealed Resident #52 had BIMS scores on 1/2/22 of 14 indicating Resident #52 was cognitively intact and on 3/13/23 a score of 11 indicating Resident #52 had moderate cognitive impairment. Record review of Resident #52's Admission Record revealed he was admitted to the facility on 08/28/20 with medical diagnoses that included Cerebral Infarction Unspecified.	F 657	conducted in orientation. 4. Comprehensive Care Plans will be monitored for attempting to include residents in their development of the pan of care starting 5-15-2023 by the Minimum Data Set (MDS) Nurse or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and	F 658	F 658 Services Provided Meet	6/15/23

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F 658	Continued From page 25 facility policy review the facility failed to assure that services being provided meet professional standards of quality as evidenced by staff failed to sign off medications as administered for one (1) of four (4) residents reviewed(Resident #60) and failed to check the 5 rights of medication prior to the administration for one (1) of four (4) residents reviewed. (Resident #181) Findings include: Review of the facility's policy titled, "Administering Medications," Revised April 2019 revealed, Policy heading: Medications are to be administered in a safe and timely manner, and as prescribed ...Interpretation and Implementation: 4.) Medications are to be administered in accordance with prescribed orders ...10.) The individual administering the medication checks the label three times to verify the right resident, right medication, right dose, right time, and right route of administration before giving the medication ...22.) The individual administering the medication initials the resident's MAR (Medication Record) after giving each medication and before administering the next ones ... Resident #60 An observation of medication administration with Licensed Practical Nurse (LPN) #2 on 5/2/23 at 8:00 AM, revealed LPN #2 set up and administered medication to Resident # 60. LPN #2 returned to her cart and began to set up another resident's medications with no observation by the State Agency (SA) of LPN #2 signing off medications as administered. During an interview on 5/2/23 at 8:20 AM, with	F 658	Professional Standards 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #60 and Resident #181 were assessed by the Director of Nursing with no negative finding on 5-2-2023. On 5-3-2023 Licensed Practical Nurse #2 was in-serviced by the Director of Nursing on signing off Medications after they are administered. On 5-3-2023 the Assistant Director of Nursing was in-serviced by the Director of Nursing on checking the 5 rights of medication prior to administering medications. 2. Eighty-four residents have the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing Staff in-service on signing off medications after they are administered, Medication Administration, and 5 Rights of Med Administration policy and procedures. New hires' training and education will be conducted in orientation. 4. Nursing Medication Pass will be monitored for signing off medications after they are administered, Medication Administration, and 5 Rights of Med Administration starting 5-15-2023 by the Infection Preventionist Nurse (IPN), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure	

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F 658	Continued From page 26 LPN #2, confirmed she was finished giving medication to Resident #60. LPN #2 confirmed she did not sign off the medications as given after administration, but she should have done so and would correct that now. A review of the Medication Administration Audit Report for Resident #60 dated 5/2/23 revealed administration time of 8:20 AM and documented time of 8:21 AM. Record review of the Admission Record revealed that the facility admitted Resident # 60 to the facility on 1/17/22 with diagnoses of Myotonic Muscular Dystrophy and Unspecified protein calorie malnutrition. Resident # 181 An observation of a room called the Charge Nurse/Storage Office with the Assistant Director of Nursing (ADON) on 5/2/23 at 8:50 AM, revealed the Assistant Director of Nursing (ADON) pick up a small bag of intravenous fluids (IV) off a shelf with multiple other bags of IV fluids. She verbalized she was ready to hang Resident #181's antibiotics. The ADON administered Vancomycin HCl in NaCl (Sodium Chloride) Intravenous Solution 1.25-0.9 GM/250ML% (grams/milliliter)to Resident #181. The ADON failed to review the E-MAR (Electronic Medication Administration Record) with the medication label and check the five (5) rights of medication before administering the intravenous medication. The SA asked the ADON about how she knew she had the correct medication for Resident #181. The ADON revealed she had reviewed the order early in the morning and knew the resident got the medication. The SA asked	F 658	compliance with services meeting professional standards. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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the ADON about possible concerns of not checking the five rights of medication and the ADON remained silent.

A review of the Medication Administration Audit Report for Resident #181 dated 5/2/23 revealed administration time of 8:57 AM and documented time of 8:57 AM.

An interview with Registered Nurse (RN) #1 on 5/2/23 at 9:40 AM, revealed that not checking the 5 rights of medications when preparing a medication using E-MAR /medication label could possibly result in the wrong medication being given because there may have been a new change to the order, or discontinued. RN #1 confirmed a number of concerns could be possible from failing to check the 5 rights like adverse reactions and possibly death.

An interview with the Infection Control (IC) nurse on 5/2/23 at 1:00 PM, revealed all nurses have been educated on medication administration and know they must check the medication label with the E-MAR prior to administering medications because a medication may have been changed or discontinued. The IC nurse confirmed medications should be signed immediately after administration to the resident.

An interview with the Director of Nursing (DON) on 5/03/23 at 8:10 AM, she confirmed the nursing staff should use the medication record with the medication label and check the five (5) rights to ensure they give the correct medication to a resident. She confirmed the nurses should sign off the medications after every resident.

A record review of in-services titled Safe Handling

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F 658	Continued From page 28 of Drugs /Administration dated 1/12/23, revealed in-service topics: Documentation of Medication Administration and Administering Medications with signatures for LPN #2 and the ADON as attended. Record review of the Admission Record revealed that the facility admitted Resident # 181 to the facility on 4/21/23 with diagnoses of Infection following a procedure, superficial incision surgical site and Methicillin Resistant Staphylococcus Aureus infection.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record review, and facility policy review the facility failed to provide activities on the weekends, as evidenced by, independent activities only listed on the activity calendar for Saturday's and no scheduled activities on Sunday's for three (3) of 29 sampled residents. Resident #26, Resident #67, Resident #178. Findings include:	F 679	F 679 Activities Meet Interest/Needs Each Resident 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #26, Resident #67, and Resident 178 were assessed by the Activities Director with no negative finding on 5-15-2023.	6/15/23

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F 679	Continued From page 29 Review of the facility policy titled, "Activity Program," dated 2001, with no review/revised date, revealed "Policy Statement: An ongoing program of activities is designed to meet the needs of residents. Policy Interpretation and Implementation: 1. Our activity program is designed to encourage restoration to self care and maintenance of normal activity which is geared to the individual resident's needs. 2. Activities are scheduled daily...3. Our activity program consist of individual, and small and large group activities...6. Individualized and group activities are provided that...b. Are offered...including weekends..." Record review of the activities calendar from February 2023 - April 2023 revealed independent activities for residents on Saturday "Saturday 10:30 Independent Activities: Coloring Sheets, Board Games, Puzzles, and Table Games in South Dining Room." The record review revealed there were no activities scheduled on the activities calendar for Sundays. Resident #26 An interview on 5/1/23 at 03:50 PM, with Resident #26 during the Resident Council Meeting, revealed she wanted guided activities on the weekends. She revealed that no staff helped the residents with activities on the weekends. She noted she would like staff to be there to assist with organizing the activities and have group activities. Record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of	F 679	2. Quality reviews of current Residents' Activity care plans were conducted on 5-10-2023, by the Director of Nursing (DON), Minimum Data Set Nurse (MDS) to ensure compliance with directed/lead Group Activities on the Weekends. Forty-seven out of eighty-four residents had the potential to be affected. 3. On 5-10-2023 the Administrator (NHA) initiated an all Activities Department in-service on directed/lead Group Activities on the Weekends and procedures. On 5-10-2023, the Activities Director modified the current Monthly Activities calendar to include additional staff led (Transportation Certified Nursing Aide Activities Assistant/Activities Director/Activities Assistant Director) Group Activities on Saturdays and Sundays. New hires' training and education will be conducted in orientation. 4. The activity participation logs will be monitored for weekend group led Activities starting 5-15-2023 by the Administrator (NHA) or Activities Director (AD); 2 x weekly for 4 weeks, then 1 x weekly for 8 weeks to ensure compliance with Activities meeting interest and needs of each resident. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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03/01/2023, for Resident #26, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #26 is cognitively intact.

Resident #67

An interview on 5/1/23 at 03:50 PM, with Resident #67, during the Resident Council Meeting, revealed there were no activities on the weekends and the Activities Coordinator had set up a room to have residents go to for independent activities on their own. She noted no staff assisted with activities on the weekend. She also noted she attempted to go and tell other residents to come to the weekend activities room and could only ask those residents that are able to get to the room on their own.

Record review of Section C of the Quarterly MDS Assessment, with an ARD of 02/23/2023, for Resident #67, revealed a BIMS score of 14, indicating Resident #67 is cognitively intact.

Resident #178

An interview on 05/01/23 at 08:15 AM, Resident #178 revealed there were no activities on the weekend. He revealed he was admitted to the nursing facility on Friday, 4/28/23 and there was nothing offered to him to occupy his time over the weekend. He revealed there was nothing going on in the building and he was bored just sitting in his room. He noted he would like kind of activity on the weekend to help him stay busy and he suffers from total blindness.

Record review of Section C of the MDS dated 5/2/23 revealed a BIMS score of 13 indicating Resident #178 was cognitively intact.

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F 679	Continued From page 31 An interview on 5/1/23 at 03:00 PM, with the Activities Director revealed she nor the Assistant Activities Director worked the weekends. She confirmed there were no staff assigned to the weekends to assist with activities. She stated that there was an activities room set up for the residents attend on their own on Saturday and Sunday. She stated she would remind residents about the activities room on Fridays. An interview on 5/2/23 at 04:30 PM, with the Administrator confirmed he did not have staff scheduled to assist the residents with activities on the weekends.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to provide professional standards of practice to a resident related to application and documentation for an Aspen Collar, for a right-hand Wrist-Hand-Finger Orthosis (WHFO) splint, and for a left knee extension splint, for one (1) of four (4) residents reviewed for Position and Mobility. Resident #17	F 684	F 684 Quality of Care 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #17 physician's orders/care plan were updated and clarified on 5-3-2023 by the Director of Nursing for Therapy to apply right hand WHFO splint and left knee extension	6/15/23

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F 684	Continued From page 32 Findings include: Review of the facility policy titled, "Contracture Management Program," with a reviewed date of 10/8/2020, revealed "Intent: To have a program within the facility geared toward the prevention of new contractures and maintenance or improvement of Range of Motion. ... Residents identified as at risk: should progress through the following continuum of care: ... 2. Possible treatments may include but not limited to splinting, ROM and Pain Management ... Rehabilitation Responsibilities: 1] Splinting order must be written correctly." An observation on 4/30/23 at 04:40 PM, revealed Resident #17 was not wearing the Aspen Collar. An observation on 05/01/23 at 09:00 AM, revealed Resident #17 was not wearing the Aspen Collar, was not wearing his right Wrist-Hand-Finger Orthosis (WHFO) splint and left knee extension splint. Resident pulled his cover back to reveal his left leg. An observation on 5/2/23 at 08:42 AM, revealed Resident #17 was not wearing his Aspen Collar, his right WHFO and was not wearing his left knee extension splint. An observation and interview on 05/02/23 at 08:45 AM, with Licensed Practical Nurse (LPN)#3, revealed Resident #17 did not have to wear the Aspen Collar around his neck anymore. She observed the current physician's orders and confirmed an order for Resident #17 to wear the Aspen Collar and only to be removed for eating, skin checks, and for Resident #17's neck to be	F 684	splint as tolerated up to 6 hours per day during days shift and the Aspen Collar to worn at all times with exceptions for cleaning and skin checks until Neurosurgeon follow up. On 5-3-2023 Resident #17 was assessed by the Director of Nursing with no negative finding. 2. Quality reviews of current Residents' care plans were conducted on 5-3-2023, by the Director of Nursing (DON) and Minimum Data Set Nurse (MDS) to ensure care plan interventions for residents with splints, Aspen collar, wrist-hand finger orthosis splints, and knee extension splints are in compliance with providing quality care standards. Six residents out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing and Therapy Staff in-service on care plan interventions for residents with splints, Aspen collar, wrist-hand finger orthosis splints, and knee extension splints policy and procedures. New hires' training and education will be conducted in orientation. 4. Care Plans reviews and resident observations of residents with splints, Aspen collar, wrist-hand finger orthosis splints, and knee extension splints starting 5-15-2023 by the Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with	

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F 684	Continued From page 33 cleaned. LPN #3 and the Director of Nursing (DON) entered Resident #17's room with the State Agency (SA) at 08:50 AM and confirmed that Resident #17 was not wearing his Aspen Collar. LPN #3 noted Resident #17 often took the Aspen Collar off himself. LPN #3 was observed to find the Aspen Collar, that was located under another item in the top drawer of Resident #17's bedside dresser and confirmed that Resident #17 was not able to physically place the Aspen Collar in the dresser drawer himself. LPN #3 confirmed that she had not assessed Resident #17 this AM to see if he was wearing the Aspen Collar and confirmed that she did not place the Aspen Collar on Resident #17 when she was assigned to him yesterday. She noted she was not aware of the right WHFO and the left knee extension splints being placed on Resident #17. She noted she had not seen either of the splints on Resident #17 lately, but those splints were applied and removed by the therapy department. The DON confirmed Resident #17 did not have his Aspen Collar on, revealed she was not aware the nursing staff was not applying the Aspen Collar to his neck, and revealed the Aspen Collar not being placed on Resident #17 could possibly cause problems with his positioning and could possibly cause a decline in the range of motion of his neck. An interview on 5/2/23 at 08:55 AM, with Certified Nurse Aide (CNA) #1, confirmed she observed Resident #17 was not wearing the Aspen Collar yesterday and today. She revealed she had not seen a splint on Resident #17's right hand or left leg on 5/1/23 during her 7-3 shift. An observation and interview on 5/2/23 at 09:20 AM with the Occupational Therapist (OT)	F 684	quality of care standards. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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confirmed the therapist did not document application of a splint to the resident. She revealed there was no area in their documentation to check a box to indicate a splint was applied, that she did not type it in manually. She did not verify it was being documented by the Certified Occupational Therapy Aide (COTA) when she verified and signed off on his notes. She revealed OT was responsible for applying Resident #17's right WHFO splint three (3) times a week and no splint placement was done on the weekend. She shared that she could not remember specific dates and times of application and removal of the right WHFO splint for Resident #17, because therapy would apply the splint when they had the time available during the day. She revealed the order indicated the WHFO splint to be applied daily, up to six (6) hours, because that is the goal for Resident #17 with the right WHFO splint. She revealed she entered the physician's order for nursing to apply the right WHFO by mistake and revealed the order should have indicated OT was to apply the WHFO to Resident #17. She noted therapy had been working with Resident #17 with splinting since the order was provided on March 8, 2023.

An interview on 5/2/23 at 09:30 AM, with the Physical Therapist confirmed there was no documentation that reflected each time and date of application of the left knee extension splint for Resident #17. She shared that it was understood in therapy treatment that splint application took place after exercise and stretching was completed for the affected limb.

An observation and interview on 5/2/23 at 03:30 PM, with the Director of Nursing (DON) revealed she was not aware if Resident #17 was wearing

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the right WHFO and the left leg splints, because nursing was not responsible for application of the right WHFO. She confirmed that the physician's order for the right WHFO splint revealed the nurse was to apply the splint daily, assess skin every two (2) hours, swelling, and skin breakdown and confirmed it triggered as a daily task for nursing on the MAR (Medication Administration Record) She revealed she was not aware the order indicated nursing was responsible for application of the WHFO splint for Resident #17. She confirmed the physician's order should have indicated that the OT was responsible to apply the right WHFO for Resident #17. She stated she did not know therapy only applied the two (2) splints on Resident #17 three (3) times a week. She revealed the care Resident #17 was receiving related to the Aspen Collar, the right WHFO splint, and the left leg splint were not provided according to professional standards of practice.

An interview on 5/3/23 at 11:00 AM, with the Administrator confirmed Resident #17 had not received professional standards of practice related to care regarding his Aspen Collar not being applied as ordered by nursing, related to his physician's orders being incorrect for the designated discipline who was to apply his right-hand WHFO splint, and the frequency the right-hand WHFO splint and the left knee extension splint were to be applied. He also confirmed Resident #17 had not received professional standards of practice related to the Physical and Occupational Therapists not adequately documenting the application of the right-hand WHFO splint and the left knee extension splint.

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Record review of the active physician's orders on the "Order Summary Report," for Resident #17, revealed "Order Date: 04/12/2023 ... OT to eval (evaluate) and treat as indicated. OT extension: Pt (Patient) to continue to be seen 3/wk x 8 weeks and treatment may consist of ... splinting PRN (as needed) ... Order Date: 04/14/2023 ... PT to veal and treat as indicated. PT extension (effective 4-14-23): Pt to be seen 3/wk x 8 wks (weeks) and treatment may include ... modalities PRN ... Order Date: 03/10/2023; Start Date: 03/10/2023 ... Pt to have Aspen Collar to neck at all times until follow up with Neurosurgeon. Every shift related to SUBLUXATION OF C1/C2 CERVICAL VERTEBRAE, SUBSEQUENT ENCOUNTER ... Order Date: 03/08/2023 ... Pt to have L knee extension splint for contracture management. Splint to be worn up to 6 hours/day per pt tolerance and applied by therapy. Nsg (Nursing) to assess skin q (every) 2 hours when splint is on for redness, swelling, and skin breakdown. ... Order Date: 03/08/2023 ... Pt to have R WHFO to be worn up to 6 hrs/day per patient tolerance to be applied by nsg to manage contractures. NSG to assess skin q 2 hours while splint applied for redness, swelling, decreased circulation."

Record review of the Medication Administration Record (MAR), for Resident #17, revealed "... Pt to have R (right) WHFO to be worn up to 6 hrs/day per patient tolerance to be applied by nsg to manage contractures. NSG to assess skin q 2 hours while splint applied for redness, swelling, decreased circulation.

Record review of the "Admission Record" for Resident #17, revealed an admission date of 2/10/2023 and diagnoses of , SUBLAXATION OF

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F 684	Continued From page 37 C1/C2 CERVICAL VERTEBRAE, SUBSEQUENT ENCOUNTER, UNSPECIFIED FRACTURE OF UNSPECIFIED THORACIC VERTEBRA, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING, AND ENCOUNTER FOR OTHER ORTHOPEDIC AFTERCARE." Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02-23-2023, for Resident #17, revealed a Brief Interview for Mental Status (BIMS) score of 03, indicating Resident #17 is severely cognitively impaired.	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		6/15/23

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F 758	Continued From page 38 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record and policy review the facility failed to ensure residents were free from unnecessary medications as evidenced by no monitoring for side effects of psychotropic medications or the presence of behaviors for one (1) of six (6) residents reviewed for unnecessary medications. Resident # 229. Findings include: Review of the facility's policy tiled, "Psychotropic/Psychoactive Medication Policy"	F 758	F 758 Free from Unnecessary Psychotropic Medications/PRN Use 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #229 physician orders and care plans were clarified and updated to include psychotropic medication monitoring for adverse side effects and behaviors by the Director of Nursing on 5-1-2023. Resident #229 was assessed by the Director of Nursing of 5-3 -2023 with no negative findings.	

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F 758	Continued From page 39 revised 01/2023 revealed, "...Policy Implementation...7. Residents will be monitored for behaviors to include behavior changes and for side effects and complications related to psychoactive medications ..." A record review of the Electronic Medication Record (E-MAR) for Resident #229 revealed that there was no monitoring for the side effects of psychotropic medications or for resident behavior. During an interview with the Director of Nursing (DON) on 5/01/23 at 3:00 PM, she revealed monitoring for side effects of psychotropic medications and resident specific targeted behaviors should be on the E-MAR. The DON verified there was no monitoring for side effects or resident behavior on the E-MAR for Resident #229. The DON then revealed that concerns related to failing to monitor for side effects which could include over sedation, falls, drowsiness and behaviors. During an interview with Licensed Practical Nurse (LPN) #1 on 5/01/23 at 3:30 PM, she revealed monitoring for side effects and behaviors should be on the E-MAR. LPN #1 went on to reveal failing to monitor for side effects or for behaviors could lead to over sedation, drowsiness, changes in appetite or mood and behaviors. During an interview with LPN #4 on 5/1/23 at 3:35 PM, she confirmed, after review of Resident #229's E-MAR with the State Agency (SA), that there was no monitoring for side effects or specific resident behaviors for psychotropic medications. Record review of Resident # 229's Admission	F 758	2. Quality reviews of current Residents with Psychotropic physicians' orders were conducted on 5-12-2023, by the Director of Nursing (DON) and Minimum Data Set Nurse (MDS) to ensure comprehensive care plan interventions were in compliance for monitoring for adverse side effects and behaviors to psychotropic medications. Eleven residents out of eighty-four had the potential to be affected. 3. On 5-5-2023, monitors were added to the Electronic Medication Administration Record for residents with Psychotropic physicians' orders and the Regional Case Mix RN (RCM) in-serviced the Minimum Data Set Nurse (MDS) on Comprehensive Care Plans policy and procedures. On 5-15-2023 Minimum Data Set Nurse (MDS) in-serviced the Interdisciplinary Care Plan Team on Comprehensive Care Plans with monitoring for adverse side effects and behaviors to psychotropic medications policy and procedures. New hires' training and education will be conducted in orientation. 4. The Electronic Medication Administration Record will be monitored for residents with Psychotropic physicians' orders to include monitoring for adverse side effects and behaviors to psychotropic medications 5-15-2023 by the Assistant Director of Nursing (ADON), Minimum Data Set Nurse (MDS), or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a	

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F 758	Continued From page 40 Record revealed that the facility admitted him on 4/19/2023 with diagnosis which include Anxiety, Alcohol Abuse, and Major Depressive Disorder. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/27/2023, revealed a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated moderately impaired cognitive.	F 758	week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure that the medication error rate was no greater than 5% during a medication administration observation, for Resident #282. The medication error rate was calculated at 6.9%. Findings include: Review of the facility's policy titled, "Administering Medications," Revised April 2019 revealed, Policy Statement: Medications are to be administered in a safe and timely manner, and as prescribed ... Policy Interpretation and Implementation... 4. Medications are to be administered in accordance with prescribed orders ...10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dose, right time, and right route	F 759	F 759 Free of Medication Error Rate 5% or More 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #282 was assessed by the Director of Nursing with no negative finding on 5-2-2023. On 5-2-2023 Licensed Practical Nurse #3 was in-serviced by the Director of Nursing on verifying medication orders prior to administering medications. 2. Eighty-four residents have the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing Staff in-service on verifying medication orders	6/15/23

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F 759	Continued From page 41 of administration before giving the medication ..." An observation of medication administration with Licensed Practical Nurse (LPN) #3 on 5/2/23, at 8:30 AM, revealed LPN #3 set up and administered medications for Resident #282 as the State Agency (SA) wrote down each medication prepared using the Electronic Medication Record (E-MAR)/medication label. Following the administration of Resident #282's medication LPN #3 returned to the cart and signed off each medication given on the E-MAR and confirmed she was finished with Resident #282 . A review of the E-MAR for Resident #282 with LPN #3 revealed Aspirin (ASA) 81 milligrams (mg) oral tablet chewable give one tablet by mouth one time a day and Glycolax Powder give 17 grams by mouth two times a day signed as administered. The SA asked LPN #3 to verify that she administered those two medications. LPN #3 confirmed she administered Aspirin 81 mg enteric coated which she verified was the wrong form of the medication and confirmed she should have given Aspirin 81 mg chewable tablet. LPN #3 then revealed she had not given the Glycolax at all. LPN #3 verified she did sign both the ASA 81 mg chewable tablet and the Glycolax as administered. LPN #3 then went on to say a possible concern from failing to administer the laxative would increase the risk for constipation, and giving the wrong form of a medication was not following the physician's orders and confirmed both were medication errors. An interview with the Infection Control (IC) nurse on 5/2/23 at 1:00 PM, she revealed all nurses have been educated on Medication Administration and know they must check the medication label with the E-MAR prior to	F 759	prior to administering medication and Medication Administration policy and procedures. New hires' training and education will be conducted in orientation. 4. Nursing Medication Pass will be monitored for verifying medication orders prior to administering medication and Medication Administration starting 5-15-2023 by the Infection Preventionist Nurse (IPN), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with services meeting professional standards. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 759	Continued From page 42 administering medications because a medication may have been changed or discontinued and would be a medication error if given. An interview with the Director of Nursing (DON) on 05/03/23 at 8:10 AM, she confirmed the nursing staff should use the medication record with the medication label and check the five rights to ensure they give the correct medication and dose to the correct resident. A review of the Order Summary Report, active orders as of 5/2/23, for Resident #282 revealed Aspirin 81 oral tablet chewable give one tablet by mouth one time a day related to Atherosclerotic Heart disease and Glycolax Powder give 17 grams by mouth two times a day related to constipation. A record review of in-services titled Safe Handling of Drugs /Administration dated 1/12/23, revealed in-service topics: Documentation of Medication administration and Administering Medications with a signature for LPN #3 as attended. An observation by the SA of 29 medication error opportunities on 5/2/23 revealed two medication errors with a total facility medication error rate of 6.9%. Record review of Resident # 282's Admission Record revealed that the facility admitted him on 4/03/2023 with diagnosis which include Atherosclerotic heart disease, Paroxysmal Atrial Fibrillation and constipation.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/15/23

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F 761	Continued From page 43 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure Drugs and biological's used in the facility were stored in accordance with currently accepted professional principles as evidenced by a medication storage room left open and left unattended for one (1) of four (4) medication rooms reviewed. Findings include: Review of the facility's policy titled, "Storage of	F 761	F 761 Label/Store Drugs and Biologicals 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings the Charge Nurse/Storage room was locked and closed on 5-2-2023. On 5-3-2023, the Maintenance Director installed an automatic door closing latch and keypad lock to the Charge Nurse/Storage room. 2. Eighty-four residents have the	

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F 761	Continued From page 44 Medications," revised April 2019, revealed, "Policy statement: The facility stores all drugs and biological's in a safe secure, and orderly manner ...Interpretation and Implementation: 1. Drugs and biological's used in the facility are stored in locked compartments ...3. The nursing staff is responsible for maintain medication storage areas in a safe manner ...5. Discontinued, outdated, or deteriorated drugs or biological's are returned to the pharmacy or destroyed ...8. Compartments (including, but not limited to drawer's, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's are locked when not in use ...12. Only persons authorized to prepare and administer medications have access to locked medications ..." An observation of a room called the Charge Nurse/storage office with the Assistant Director of Nursing (ADON) on 5/2/23 at 8:50 AM, revealed the office door to be open with a gentleman the ADON referred to as the Transporter in the room on his cell phone. The State Agency (SA) observed the ADON pick up a small bag of intravenous fluids (IV), tubing, and flushes. During the observation, the SA observed multiple bags of fluids, tubing, IV start kits, laboratory supplies, and syringes with needle intact. The ADON revealed the door should have been locked. An interview with the Director of Nursing (DON) on 5/2/23 at 9:50 AM, she revealed the door to the Charge Nurse/storage room should have been locked due to there being medications and IV supplies in the room and confirmed anyone including a cognitively impaired resident could get the medication.	F 761	potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing Staff in-service closing and locking the Charge Nurse/Storage room when left unattended. New hires' training and education will be conducted in orientation. 4. The Charge Nurse/Storage Room will be monitored to verify that is closed and locked when left unattended by Nursing staff starting 5-15-2023 by the Infection Preventionist Nurse (IPN), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with Labeling/Storing Drugs and Biologicals. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 761	Continued From page 45 A further observation of the Charge Nurse room on 5/2/23 at 10:00 AM, with the Nurse Consultant revealed a box of medications on a shelf in easy reach of anyone entering the office including someone in a wheelchair. The box included a card of Levetiracetam 75 mg (milligrams) for seizures 48 pills, Aptiom 600 mg for seizures 12 pills, Seroquel 25 mg antipsychotic 12 pills, Xarelto 20 mg a blood thinner seven (7) pills, Hydralazine 100 mg for high blood pressure 10 pills, Naloxone 4 mg used to reverse opioid overdose, and Atorvastatin 40 mg for hyperlipidemia 12 pills. An interview with the Infection Control (IC) nurse on 5/2/23 at 1:00 PM, she revealed medications must be kept always locked in a secure area and if not a resident or staff could possibly take a medication that could cause an adverse reaction. An interview with the DON on 05/03/23 at 8:10 AM, she revealed the medications discovered by the SA in the Charge Nurse office/storage room were considered hazardous medications and revealed the facility's practice is the charge nurse on the weekends are to destroy the discontinued medications, but she has been off. An interview with the Transporter on 5/03/23 at 8:58 AM, confirmed he was in the Charge Nurse/storage office on 5/2/23 when he received a phone call and the door was open and he didn't want to be on his phone in the hallway. The Transporter confirmed the door to the room is often open and he was unaware there was medication in the room, and it needed to be locked.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/15/23

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F 812	Continued From page 46 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review, the facility failed to properly label and store food items in a cooler in the kitchen according to professional standards for food service safety, failed to properly label food items stored in the resident nourishment refrigerators, failed to maintain a temperature log for the resident nourishment refrigerators, and failed to maintain a cleaning schedule for the resident nourishment refrigerators located on A-Hall and C-Hall nursing units of the nursing facility for one (1) of two (2) tours. Findings include: Review of the facility policy titled, "Receiving,"	F 812	F 812 Food Procurement/Store/Prepare/Serve Sanitary 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings on 4-30-2023, the Dietary Director disposed of all expired food items including brown gravy, beef base, ham, egg salad, V8 juice, tomato soup, and sliced bologna. On 5-3-2023 the Maintenance Director removed the nourishment refrigerators from A, B, and C Hall Nursing units. Residents' nourishment items will now be stored in Dietary and available upon request. On 5-	

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F 812	Continued From page 47 with a revised date of 9/2017, revealed "Policy Statement: Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. Procedures ... 6. All food items will be stored in a manner hat ensure appropriate and timely utilization based on the principles of "first in - first out" (FIFO) inventory management." Review attempted for facility policy for resident nourishment refrigerators revealed the nursing facility did not have a policy. The Administrator provided a letter on the nursing facility's letterhead that revealed "The facility does not have a policy on Resident Nourishment Refrigerators in regard to cleaning schedules and general maintenance." An observation during the initial kitchen tour on 4/30/23 at 03:47 PM, revealed a cooler with food items stored that were not disposed of by the date indicated on the containers. The observation revealed an opened and partially used white plastic container of pimento cheese with a Date Prepared/Opened of 4/19/23 and no Use By Date was indicated; revealed a clear plastic storage container of leftover brown gravy with a Shelf Life date of 4/22/23; revealed an unopened white plastic container of beef base with a Shelf Life date of 2/26/23, revealed an opened and partially used white plastic container of beef base with a Shelf Life date of 2/26/23; revealed a clear plastic zip lock bag that contained a leftover portion of a ham with a date of 4/16/23; revealed a clear plastic storage container of leftover egg salad with a Shelf Life date of 4/21/23; revealed a clear plastic pitcher of V8 vegetable juice drink with a Date Prepared/Opened of 4/20/23; revealed a	F 812	3-2022, quality review observations were conducted by the Administrator to ensure Nourishment Refrigerators and expired food were disposed of and the facility was in compliance. No deficient areas were noted. 2. Eighty-four residents have the potential to be affected. 3. On 4-30-2023, the Dietary Director initiated an all Dietary staff in-service on labeling/dating food items and disposing of expired food policy and procedures. New hires' training and education will be conducted in orientation. 4. On 5-15-2023, the Administrator and or Dietary Director will conduct Quality Review Observations ensuring that food items are properly dated/labeled and expired foods are disposed 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks to ensure compliance with food procurement, storing, and serving sanitary. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion Date 6-15-2023.	

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F 812	Continued From page 48	F 812		

clear plastic storage container of leftover tomato soup with a Date Prepared/Opened date of 4/18/23; and revealed a clear plastic zip lock bag that contained sliced bologna with a Date Prepared/Opened of 4/19/23.

An observation and interview on 4/30/23 at 03:52 PM, with the Dietary Aide was observed to remove the items from the cooler, revealed the stored food items were expired, and should be thrown away after being in the cooler for six (6) days. She noted she was responsible to store leftovers and unused portions of food items in the cooler on her shift and was supposed to watch the dates to throw the leftovers and unused food items away by the expiration dates. She noted if any of the food items had been fed to a resident, the resident could have possibly gotten sick.

An interview on 5/2/23 at 11:30 AM with the Dietary Manager revealed all other food items listed should have been discarded after 7 days of the date on the containers. She revealed she usually checked the coolers for expired food each week but did not check this cooler before she left on Friday, 4/28/23. She confirmed that if a resident had been served the expired food items there was the possibility of them getting a food borne illness.

An interview on 5/2/23 at 12:00 PM with the Administrator, he confirmed the items should have been labeled properly for storage and to enable the dietary staff to discard the food items by the expiration date of 7 days. He also confirmed that if a resident had been served the expired food items there was the possibility of them getting a food borne illness.

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F 812	Continued From page 49	F 812		

An observation and interview with the Director of Nursing (DON), on 5/3/23 at 10:30 AM, confirmed the resident nourishment refrigerators' freezers on the A Hall and the B Hall nursing units had a thick layer of ice. The buildup of ice in the freezer protruded outward causing the A-Hall refrigerator's door not to close and seal. The DON observed and revealed that the thermometer in the refrigerator on the A Hall nursing unit registered 60 degrees for the internal temperature. The A Hall refrigerator was observed to have two (2) unlabeled clear plastic zip lock bags of cut up cantaloupe, a small bottle of milk, and a clear plastic storage container, of outside food, that was not properly labeled. The B Hall Refrigerator was observed to have a thick layer of ice in the freezer section of the resident nourishment refrigerator and had 1 quarter sized and 2 nickel sized brown spots of a thick appearing liquid substance on the bottom floor of the refrigerator. DON confirmed there was a temperature log that indicated the refrigerator was last inspected and cleaned on 11/5/22 and had been inspected and cleaned 9/1-6/2022. She confirmed the resident nourishment refrigerators had not been inspected and cleaned regularly on the A-Hall and B-Hall nursing units. She confirmed that both resident nourishment refrigerators needed to be cleaned, should have been kept clean, and the temperatures should have been monitored on a regular schedule, and confirmed the food items in the refrigerator should have been labeled properly to avoid the possibility of food borne illnesses for residents and to allow food items to be discarded in a timely manner. She revealed the unlabeled food items in the refrigerator and the refrigerators not being cleaned regularly have the possibility to cause a resident the possibility of food borne

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F 812	Continued From page 50 illnesses. Record review of the nursing facility's dietary manager and the dietary department staff in-services revealed "Associate In-Service Record ... (Dietary Manager's Name Removed) ... 4/24/23 ... Topic: Labeling, Dating, and Expired Foods Procedures: Once a product is opened, it must be dated, and if necessary, labeled. ... There cannot be any expired food in the kitchen. As an Account Manager, it is your responsibility that all food items are in date. All food items must be checked during your daily morning walk through. If a food item has expired, throw it away. Every food item, in your kitchen must be seen and touched daily to ensure it has not expired/fallen out of date." Associate In-Service Record ... 4/19/23 ... Topic: Labeling and Dating Procedures and Expired Food Items: Once a product is opened, it must be dated, and if necessary, labeled. " Record review of the log for the B-Hall resident nourishment refrigerator revealed "REFRIGERATOR-NON-Medication TEMPERATURE no greater than 38 degrees; Monitored for temperature and appropriate contents. The refrigerator should be clean. ... MONTH Nov 22; DAILY INSPECTION 11/5/22; DAILY TEMP 36 degrees; REFRIGERATOR CLEANED? (check mark) ... MONTH 09/22; DAILY INSPECTION 9/1, 9/2, 9/3, 9/4, 9/5, 9/6; REFRIGERATOR CLEANED? (check mark for all dates noted)."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		6/15/23

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F 880	Continued From page 51 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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	F 880		

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F 880	Continued From page 52 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review the facility failed to prevent the possible spread of infection as evidenced by staff failed to remove gloves and perform hand hygiene after administering eye drops and prior to administering oral medication, and failed to sanitize an eye drop box before placing it in the medication cart that was sitting on a residents bedside table without a barrier for one (1) of four (4) residents reviewed during medication and treatment administration. Resident #62.	F 880	F 880 Infection Prevention and Control 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #62 was assessed by the Director of Nursing with no negative finding on 5-2-2023. On 5-2-2023 License Practical Nurse #2 was in-serviced by the Director of Nursing on medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and	

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F 880	Continued From page 53 Findings include: Review of the facility's policy titled, "Instillation of Eye Drops," Revised January 2014, revealed, "... Equipment and supplies... 1. Eye dropper... 4. Personal protective equipment ...Steps in the Procedure... 13. After instillation remove gloves and discard ... Wash and dry your hands thoroughly 14. Clean equipment and return to designated storage area ...." Review of the facility's policy titled, "Administering Medications," Revised April 2019 revealed, Policy Statement: Medications are to be administered in a safe and timely manner, and as prescribed...Policy Interpretation and Implementation... 25. Staff follows established facility infection control procedures (e.g., (example) handwashing, aseptic technique, gloves) for the administration of medications as applicable ..." Review of the facility's policy titled, "Cleaning and Disinfection of Resident -Care Items and Equipment," reviewed 3/2023, revealed "Policy Statement: Resident -care equipment, including reusable items... will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen Standard ..." An observation of medication administration with Licensed Practical Nurse (LPN) #2 on 5/2/23 at 8:15 AM, revealed LPN #2 set up and administer medications for Resident #62. LPN #2 administered Refresh Tears solution one (1) drop to both eyes, placed the eye drops back in the	F 880	barrier usage. 2. Eighty-four residents have the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing Staff in-service on medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and barrier usage. New hires training and education will be conducted in orientation. 4. Nursing Medication Pass will be monitored for medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and barrier usage starting 5-15-2023 by the Infection Preventionist Nurse (IPN), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance Infection Control standards. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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F 880	Continued From page 54	F 880		

box on the resident's bedside table without a barrier, then went on to administer oral medications to Resident #62. LPN #2 administered the oral medications with the same gloves she was wearing to administer the eye drops. LPN #2 then returned to her medication cart, put her dirty gloves in the trash and sanitized her hands. She placed the eye drop box that had been sitting on the residents bedside table with no barrier back into the medication cart without sanitizing the box.

An interview on 5/2/23 at 8:20 AM, LPN #2 confirmed she did not take her gloves off or sanitize her hands after instilling the eye drops and picking up the medication cup and handing it to Resident #62. LPN #2 also confirmed she did not sanitize the eye drop box that was sitting on the resident's table before putting it back in the medication cart. She confirmed she should have done so and revealed possible concerns of not performing hand hygiene would be risk of transferring bacteria causing infections.

An interview with the Infection Control (IC) nurse on 5/2/23 at 1:00 PM, she revealed staff nurses should perform hand hygiene after administering eye drops to reduce the spread of bacteria from one site to another and should sanitize any item that was placed on a dirty area before placing them back in the medication cart.

A record review of in-services titled Safe Handling of drugs /Administration dated 1/12/23, revealed in-service topics: Administering Medications and Instillation of Eye drops with a signature for LPN #2 as attended.

Record review of Resident # 62's Admission

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F 880	Continued From page 55 Record revealed that the facility admitted him on 2/02/22 with diagnosis which include Dry eye Syndrome, Schizophrenia and Bipolar disorder.	F 880		