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	355103	A. BUILDING _____ B. WING _____	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

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F 000	INITIAL COMMENTS The Centers for Medicare and Medicaid Services (CMS) conducted a comparative and extended Federal Monitoring Survey (FMS) on 11/27/23 through 12/4/23. Refer to State Survey Agency (SSA) Event ID YQD311. Deficiencies were cited. Census: 27	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform a resident's (R) representative of a change in status and treatment for 1 of 15 sampled residents (R14). Specifically, the facility failed to notify R14's	F 552		

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

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F 552	Continued From page 1	F 552		

representative about an acute change in condition. Failure to communicate to the representative can result in an incomplete assessment and treatment plan.

Findings include:

Review of facility policy, "FSHCC Notification of Changes Policy" last revised on 11/10/23, revealed in pertinent part:
- the facility "... promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification."
- "Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative, if known."

Review of R14's 2023 Progress Notes revealed in pertinent part:

- 10/18 the Director of Nursing (DON) documented R14 had wheezing noted in lungs, lower extremity edema (fluid in the tissue) and that R14 felt like he had a cold coming on. DuoNeb treatments to help with breathing and shortness of breath (SOB) were ordered.
- 10/20 Licensed Practical Nurse (LPN) 5 documented, "complaints of tight chest and phlegm. audible wheeze.
- 10/20 Resident out with family until Sunday afternoon.
- 10/22 Resident returned to the facility.
- 10/23 Registered Nurse (RN) 2 documented, "per request for SOB ... Resident requested O2 [oxygen] for one hour. he is now back on RA [room air]."

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F 552	Continued From page 2 - 10/25 the DON documented the attending physician called back wanting an update on the resident. "Resident has increased complaints of shortness of breath and not feeling quite right. Resident refuses to leave oxygen on or to finish a prn (as needed) nebulizer treatment." Day shift nurse reported abnormal lung sounds, edema, shortness of breath, and significant weight increase in last two days ... New orders received to start Lasix (diuretic to remove excess fluid) and potassium and to do daily weights and monitor blood pressures and oxygen saturations every shift while awake. "Repeat a BMP [basic metabolic panel] in a week. TED hose [anti-embolism stockings] to bilateral lower extremities for edema." - 10/27 the DON documented, the physician assistant called back because of weight gain, edema, chest congestion, SOB, wheezing and "oxygen use at 2L/NC [liters per nasal cannula]. Resident had nebulizer treatment, Lasix, and potassium added to his daily medications this week by [the attending physician]." Resident has audible expiratory wheezes, use of accessory muscles with breathing and oxygen 2L/NC. "Pulse and blood pressure elevated as he is talking about needing to get home. New orders to give an extra dose of Lasix today and for more lab work. "If resident does not improve with extra Lasix, use of oxygen, PRN nebulizer treatments nurse may send him to the ER [emergency room] for evaluation anytime this weekend." - 10/27 at 3:36 PM, LPN3 documented, "[First name], residents sister called saying the resident does not sound ok. She wondered whether he has a pneumonia. Resident experiencing SOB. Lasix increased. Will continue to monitor. On O2 2L."	F 552		

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F 552	Continued From page 3 - 10/27 at 7:18 PM, LPN3 documented, "Resident sent to the ER [emergency room] by Ambulance for SOB. Pitting edema. Resident did not respond to Lasix ... He continued to decline." - 11/2/23, RN1 documented resident returned from hospital. During an interview on 11/29/23 at 1:42 PM, Certified Medication Aide (CMA) 8 stated R14 went home prior to being sick but he came back from his family's with a cough and congestion. CMA8 stated R14's wife had been sick. The facility could provide no evidence R14's representative was notified of R14's change in condition, new medication or new treatment orders until the family member called on 10/27/23. During an interview on 12/4/23 at 10:41 AM, the DON stated the Charge Nurse was responsible for notifying the family and documenting in the progress notes.	F 552		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure self-administration of medications was assessed by the interdisciplinary team (IDT) as clinically appropriate for 1 of 12 residents (R) sampled for self-administration (R6). Specifically, the facility	F 554		

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failed to follow facility policy and physician orders for oxycodone administration and failed to ensure R6 was assessed to self-administer medications. This failure has the potential for drug diversion and overdose.

Findings include:

Review of professional reference from the Drug Enforcement Administration (DEA), retrieved on 12/5/23 from https://www.dea.gov/factsheets/oxycodone, revealed "Oxycodone is a semi-synthetic narcotic analgesic [controlled pain medication] and historically has been a popular drug of abuse among the narcotic abusing population."

Review of facility policy, "FSHCC Resident Self-Administration of Medication" revised 10/31/23, revealed in pertinent part,

"1. Each resident is offered the opportunity to self-administer mediations during the routine assessment by the facility's interdisciplinary team.
2. Resident's preference will be documented on the appropriate form and placed in the medical record.
3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at minimum consider the following:
a. The medications appropriate and safe for self-administration
b. The resident's physical capacity to swallow without difficulty, open medication bottles, administer injections.
c. The resident's cognitive status, including their

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ability to correctly name their medications and know what conditions they are taken for.
d. The resident's capability to follow directions and tell the time to know when medications need to be taken.
e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
f. The resident's ability to understand what refusal of medications is, and appropriate steps taken by staff to educate when this occurs.
g. The resident's ability to ensure that medication is stored safely and securely."

During an observation in R6's room on 11/29/23 at 3:39 PM, one oxycodone 5 mg tablet was left on the bedside table in front of R6 by Certified Medication Aide/Certified Nursing Assistant (CMA/CNA) 9. CMA9 left the room without watching R6 take the medication.

During an interview with CMA/CNA 9 on 11/29/23 at 3:45 PM, CMA/CNA 9 said that R6 can self-administer his medications and he usually takes them right away. CMA/CNA 9 said that she would go back in and give him his tray and would follow up with R6 to make sure he took the medication. CMA/CNA 9 said that there was a list in front of the narcotic binder if residents can self-administer medications.

During an observation of the medication cart on 11/29/23, there was a list of 12 residents typed on paper in the front cover of narcotic binder. The list was titled "May leave medications-Care Planned." R6's name was on list.

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Review of R6's Care Plan revealed R6 was admitted to the facility on 10/26/22. Diagnoses included osteoarthritis, anxiety disorder, chronic pain, major depressive disorder and patient's noncompliance with other medical treatment and regimen for other reasons. The Annual Minimum Data Set (MDS) assessment dated 10/26/23 revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15.

Further review of R6's Care Plan from 11/2/23 showed: "Staff will set up my pills and then bring them to my room with some pudding and then I am able to take them on my own. I do not want staff staying there and watching me."

Review of R6's Medication Administration Record (MAR) for November 2023 revealed Oxycodone was not ordered to be self-administered. However, there were two scheduled and two as needed medications that had physician orders that read, "supervised self-administration."

However, review of R6's Electronic Medical Record (EMR) revealed no evidence the interdisciplinary team, including the pharmacist and physician, had assessed R6 for appropriateness to self-administer any of his medications, specifically: physical capacity to swallow, cognitive status and ability to follow directions.

During an interview with CMA/CNA 8 on 11/30/23 at 9:18 AM, CMA/CNA 8 said R6 liked to take all of his pills with an entire container of pudding. R6 takes them very well by himself and takes a bite of pudding with his pills. CMA/CNA 8 stated she

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does watch him take his pills and would not leave medications and narcotics unattended without watching R6 take them as he can be clumsy. CNA/CMA 8 said that she would not leave any pills or narcotics unattended with any resident. If residents could self-administer, she still watched them to make sure medications were taken.

During an interview on 11/30/23 at 11:53 AM, the Director of Nursing (DON) stated that R6 can take medications on his own. R6 wants medications to be left in his room and that the medication administration record (MAR) could be referenced to see if medications could be self-administered. The DON stated she would review the MAR to see if Oxycodone could be self-administered.

During a follow up interview on 11/30/23 at 2:35 PM, the DON stated that the order note "supervised self-administration" meant that the resident could physically take the medication such as taking the pill out of the cup and putting it into their mouth. The DON stated she still expected staff to supervise the medication was taken. The DON said that there had not been an actual assessment completed to make sure that it was safe to self-administer medications. The DON stated that if narcotics were left unattended in residents' rooms that someone could come in and take the medication or the resident could overdose if staff is not watching. The DON said that nursing practice standards would not recommend leaving a narcotic at the bedside. The DON stated that R6's care plan did say that medications could be left with him. The DON stated that if medications were left with the resident that they should speak with the Medical

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F 554	Continued From page 8 Director (MD). During a telephone interview on 12/1/23 at 9:43 AM, the Pharmacist stated that R6 was on daily scheduled doses of Oxycodone. The Pharmacist said that there was nothing to say that controlled medications would be different in a self-medication policy versus another type of medication. The medication should be documented in the care plan and approved by the doctor for self-medication. The Pharmacist did not know what "supervised self-administration" meant in the physician order. During an interview on 12/1/23 at 9:52 AM, Pharmacist Consultant said that R6 should not be left alone to take controlled substances. The Pharmacist Consultant said she did not know what "supervised self-administration" meant and had not identified this note when conducting monthly medication reviews.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		

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F 561	Continued From page 9 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to facilitate resident (R) self-determination about aspects of life that were significant to the resident. Specifically, the facility failed to support a resident in developing a smokeless tobacco cessation plan per the facility Tobacco Policy for 1 of 15 sampled residents (R6). Findings include: Review of facility policy, "[facility name]- Resident Smokeless Tobacco" revised 10/2/23, revealed in pertinent part, "1. Smokeless tobacco is prohibited in all areas of [facility name]. 2. All residents and family members will be notified of this policy during the admission process, and as needed. 3. All residents will be asked about tobacco use during the admission process.	F 561		

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F 561	Continued From page 10 4. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smokeless tobacco use by: a. Including the resident, family, and/or resident representative in discussions regarding the risks associated with smokeless tobacco. b. Offering pharmacological and/or behavioral interventions to assist with tobacco cessation. c. Providing education materials regarding smokeless tobacco and cessation d. Developing a safe smokeless tobacco plan, or an individualized plan to quit smokeless tobacco. 5. Family members or visitors will be reminded to not bring in smokeless tobacco for the resident and abide by the care plan and facility policy. 6. Documentation to support decision making will be included in the medical record, including but not limited to: a. Resident's wishes, or those of the resident's representative. b. Assessment of relevant functional and cognitive factors affective ability to make the decision to stop use of smokeless tobacco on their own. c. Response to cessation interventions. d. Compliance with smokeless tobacco policy." Review of R6's Care Plan revealed R6 was admitted to the facility on 10/26/22. Diagnoses included obstructive sleep apnea and patient's noncompliance with other medical treatment and regimen for other reasons. The Annual Minimum Data Set (MDS) assessment dated 10/26/23 revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15.	F 561		

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F 561	Continued From page 11 During an interview on 11/28/23 at 9:41 AM, R6 stated that he would like to be able to chew tobacco, but he knows the facility is a smoke free facility. Review of physician progress note dated 7/23/23 revealed, "He is a former smoker and most recently has chewed tobacco. He has not chewed tobacco in some time." Review of a mental health visit note dated 11/22/23 revealed, "No changes made in psychiatric medications, continue with current medications. Addition of a new diagnosis of Nicotine Dependence as resident voiced, he was chewing tobacco in his room until he got caught but will do it again if he gets a chance. Resident reminded the facility is a tobacco free campus and no tobacco is allowed." Review of R6's care plan revealed no documentation of nicotine dependence history or cessation therapies offered. During an interview on 11/30/23 at 3:05 PM, the Director of Nursing (DON) stated R6 had been offered a medication patch and access to the hotline [smoking cessation] but R6 refused. The DON stated she would find documentation of where R6 was offered the patch and hotline information. The DON was unable to provide any information on tobacco cessation options that were offered to R6.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		

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F 578	Continued From page 12 §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 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	F 578		

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appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure residents (R) either had an advanced directive or to provide the resident/resident representatives written information of the right to formulate an advance directive for 2 of 2 residents (R11 and R25).

Findings include:

Review of facility policy, "Admission Agreement," reviewed/revised 10/20/23 read in pertinent part, "Advanced Directives
It is the policy of this facility to ensure that a resident's choice about advanced directives be respected.
Procedure
1. Prior to, or upon admission, the Social Service Designee will ask residents, and/or their family members, about the existence of any advance directives.
2. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, the facility will require that a copy of such directives be included in the medical record.
3. The facility has defined advanced directives as preferences regarding treatment options ..."

"Durable Power of Attorney for Healthcare
3. The Social Services Designee will review annually with the resident his or her advanced directives to ensure that they are still the wishes of the resident.
4. Changes or revocations of a directive must be submitted to the facility, in writing. The facility

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may require new documents if changes are extensive. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.
5. The facility will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical records and plan of care.
6. Inquiries concerning advance directives should be referred to social services, and/or to the director of nursing services.
7. If a resident wishes to write a Living Will or Durable Power of Attorney, the SSD can provide the necessary forms and assist them in filling them out.
8. Residents with Advanced Directives from other states will have them reviewed by SSD and new ND [North Dakota] ones will be written up if needed.
9. ND Department of Human Services has published forms for Living Wills and Durable Power of Attorney for Healthcare. These are the forms used by Four Seasons Social Services Department."

a. Review of R25's Care Plan revealed R25 was admitted to the facility on 9/1/2020 and readmission on 9/12/23. Diagnoses include type 2 diabetes, acute embolism and thrombosis of deep veins of lower extremity (DVT-Deep vein thrombosis), Alzheimer's disease, anxiety disorder, dementia with psychotic disturbance, delusional disorders, symptoms and signs involving cognitive functions and awareness, chronic kidney disease, hypertension, arthritis, anemia, and osteoporosis. The Quarterly review Minimum Data Set (MDS) assessment dated

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9/18/23 revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 11 out of 15.

Review of R25's electronic health record (EHR) revealed a Physician's Orders for Life Sustaining Treatment (POLST) form dated 2/24/23 signed by one of R25's family members. A second POLST dated 8/30/23 was signed by R25.

There was no evidence of the resident/resident representative being informed of an Advanced Directive or an Advanced Directive/Durable Power of Attorney (DPOA) for Health Care in the EHR.

During an interview on 11/30/23 at 9:05 AM with the Social Services representative, she revealed she has reminded the family numerous times that the DPOA is needed, and she said the family has only brought a Financial POA.

b. Review of R11's Care Plan revealed R11 was admitted to the facility on 5/17/23, diagnoses include Parkinson's disease, type 2 diabetes, heart disease, abnormalities of gait (walking) and mobility, muscle weakness, delusions, skin cancer, cancers spread to multiple organs, hallucinations, disorientation, hypertension, cataracts, mental disorders, altered mental status, and dystonia (abnormal muscle tone or spasms). The Annual MDS assessment dated 8/17/23 revealed the resident had intact cognition with a BIMS score of 15 out of 15.

Review of R11's EHR revealed an unsigned POLST form dated 9/30/23. A second POLST form dated 5/24/23 written in the signature area

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F 578	Continued From page 16 was, "[R11's spouse name] via phone." There was no evidence of the resident/resident representative being informed of an Advanced Directive or an Advanced Directive/DPOA for Health Care in the EHR. During an interview on 11/30/23 at 9:05 AM with the Social Services representative, she revealed she has tried multiple times and the family has not produced a DPOA. The Social Services representative stated that she never thought about the legal implications of a family member making a decision about withholding emergency life sustaining care or making medical decisions and not having the appropriate legal documents for them to make that decision.	F 578		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		

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F 585	Continued From page 17 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written	F 585		

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F 585	Continued From page 18 grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 585		

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Based on interview and record review, the facility failed to implement an effective Grievance system to ensure a resident's (R)/resident representative's right to file grievances included documentation, investigation and follow up with resident/resident representative's grievances regarding issues of resident care and life that were important to the resident/resident representatives. This failure had the potential to affect all 27 residents.

Specifically, the facility failed to ensure:
- the right to file a grievance, orally or in writing, the right to file grievances anonymously, the contact information of the grievance official with who a grievance can be filed, a reasonable expected time frame for completing the review of the grievance, and the right to obtain a written decision regarding his or her grievance
- residents were able to file an anonymous grievance and make information on how to file a grievance or complaint available to the resident
- the Grievance Official was clearly identified (the person who was responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, and issuing written grievance decisions to the resident)
- all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to

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whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued

Findings include:

Review of facility policy, "Admission Agreement," reviewed/revised 10/20/23 read in pertinent part,
"Grievance Procedure:
Each resident, family member and/or the resident's representative have the right to voice grievances or concerns with respect to treatment or care, without discrimination or reprisal. We ... strongly encourage the resident, family member or resident's representative to contact staff as soon as possible with any problems or concerns they are experiencing. Each concern will be dealt with promptly. At any time if you DO NOT feel that your concerns have been handled to your satisfaction, you may contact ..."

Review of facility policy, "Resident Grievance Process," reviewed/revised 7/11/19 read in pertinent part,
" ... Written grievances submitted by family, visitors and staff acting as advocates for residents will be handled with equal regard. These may include, but are not limited to, issues involving care and treatment, management of funds, lost items, and problems with respect to the behavior of other residents. The facility will thoroughly investigate all written grievances, and take appropriate corrective action in a fair and timely manner."

"Procedure:
1. The individual with the concern or problem

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discusses it with the Charge Nurse. The Charge Nurse completes the "Incident Report Form" ... The Incident Report Form is then electronically forwarded to the D.O.N., SSD and the MDS coordinator, who then review the "Incident Report Form." **Note: If the problem is a lost, misplaced, or damaged item, the facility 's Lost, Misplaced, or Damaged Item's policy protocol will be followed. If the D.O.N., Social Service Designee or the MDS coordinator is unable to resolve the problem or reach a settlement during the initial meeting, further investigation occurs. Within three (3) working days the D.O.N. or Social Service Designee will meet with the resident, their representative and or their family, with the proposed solution for the grievance. If a solution cannot be reached, the resident, their representative and/or family may proceed to STEP 2."

"2. The grievance is to be reviewed with the appropriate Department Head. The Social Service Designee, or D.O.N. will make the "Incident Report Form" available to the Department Head and assist in helping the parties come to a solution. If the Department Head has not satisfactorily offered a solution within three (3) working days following receipt of the written complaint, the resident, their representative and/or their family member may proceed to STEP 3."

"3. The problem, with the suggested remedy, will be brought to the Administrator. The Social Service Designee or D.O.N. will make the "Incident Report Form" available to the Administrator, if this has not already been done. The Administrator may investigate further and will

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offer a solution within five (5) working days, after the receipt of the written complaint. If the Administrator's solution does not resolve the grievance to the satisfaction of the resident, family, and or resident's representative, it may be referred to STEP 4."

"4. The problem may be referred to the Four Seasons Board of Directors President, who will render a decision within ten (10) working days following receipt of the written complaint. ***NOTE: The resident, family, and/or resident's representative may request that the grievance be brought before the Resident Council for input and resolution. If this is the case, the Resident Council protocol for problem solving will be followed. This may be an appropriate choice in matters that concern the entire resident population. ***NOTE: At any time during this process the resident, family and/or resident's representative may contact the State Long Term Care Ombudsman (SLTCO) at ..."

"Residents/Resident Representatives can file a grievance with the Grievance officer at any time orally or in writing ... may also be filed anonymously ... Grievances will be reviewed within 48 hours of the Grievance Officer receiving the grievance ..."

Review of facility policy, "Lost, Misplaced, Damaged Items Policy," revised 7/5/18 revealed in pertinent part,
"Charge Nurse or SSD will notify the resident's responsible party of the loss within twenty-four (24) hours."
"If item is NOT located within three (3) to five (5) days. The resident, resident's responsible

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representative, SSD and/or Administrator will meet and come to an agreement regarding replacement of the item. This outcome will be noted on Lost, Misplaced, Damaged Items Log ... If, after the investigation, it is determined that facility staff was the cause of lost/damaged item or if we are unable to determine who was responsible, the facility will have an action plan to replace the item within ten (10) days."

During a facility tour on 11/27/23 at 4:00 PM, informational postings regarding Resident Rights, the State Long Term Care Ombudsman, and the State Survey Agency were observed posted but no information regarding Grievance Official, Grievance forms, or a Grievance form drop off location.

During an interview on 11/27/23 at 4:18 PM, the Cook1 stated there is a Dietary Communication Book where information is kept about resident complaints and preferences. He said that complaints are usually handled on the spot because most residents have no problem voicing their concerns about the food and the dietary staff attempt to correct to the problem to the resident's satisfaction. Cook1 said that he was not aware of the concerns brought to the dietary staff during meal service needed to go to the Grievance Official because the dietary staff feel they have addressed the residents' concerns.

During an interview on 11/27/23 at 4:47 PM, R19 stated she had been missing pants for over 1 month. She stated that the laundry staff have been looking for them but have not found them and nobody has come to talk to her about replacing them.

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During an interview on 11/28/23 at 8:45 AM, R10 stated that she likes playing bingo, but they cancel it often because they don't have enough activity staff to call numbers. She said there have been times that she's missed it because she has family visiting.

During an interview on 11/28/23 at 10:15 AM, R5 stated she doesn't like the food, hot foods are not hot, but at least they are warm. She said her biggest complaint is there are lots of foods she doesn't like to eat, like burgers, pot roast, meat loaf, meat balls, and has voiced concerns at resident council, but there have been no changes. R5 said there are alternate meal options, but she can't live off the alternate menu, she feels they should just have a better menu as well as better optional menu. R5 said that she does not remember being asked what kinds of foods she likes or dislikes. She also said there sometimes is long wait times for meals. She said there is no use in complaining about it because it doesn't speed up the meal and it doesn't stop other meals from being served late.

During an interview on 11/28/23 at 1:31 PM, R12 stated that the Activities Department doesn't ask what interests them. She said she likes cards and crafts but they don't do either activity. R12 said there are no field trips and no activities if the activities person isn't there. She also said, "they don't stick to activity schedule, don't take you to grocery store or anywhere, you're on your own, so if you don't have family, you have to rely on someone else to do your shopping. But I'd like to go out every once in a while."

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During an interview on 11/29/23 at 9:05 AM, Housekeeping/laundry1 stated that the responsibility to label resident clothing is the family's but if they don't or another family member not familiar with the process doesn't label the clothing it will be done by the facility if they know about the new item. She said there is no specified requirement of how resident clothing is labeled, but the families will label clothing with either indelible marker or laundry marking label with the resident's name. She also added that sometimes initials are placed on clothing tags, so it can be a challenge to locate names or initials due to the varied locations they are placed in the clothing.

During the same interview, Housekeeping/laundry1 stated that laundry is delivered daily. She said she looks for residents' names or initials in clothing, put it on a hanger and places the item on the clothing rack which is separated with shower hooks with resident name tags; occasionally if she's moving too fast the coat hangers will jump the shower curtain hooks and clothing will be put on the wrong side of the shower hook and delivered to the wrong resident. There is a second clothing rack with clothing items that are unlabeled or that the labels/initials are faded and can't be read. She said this is usually the first place they will look for missing clothing. Housekeeping/laundry1 said initials sometimes will be read upside down or mistaken as another residents and clothing will be delivered to the wrong resident. She revealed that when clothing is reported as missing to the housekeeping/laundry staff, the staff will look in the laundry room as well as other residents' rooms for the clothing; most things are found in

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less than a week, but usually the label is hard to read and is kept in the laundry room because they don't know who it belongs to versus the clothing being delivered to wrong room. Housekeeping/laundry1 said that clothing that isn't found, maybe missing a week or so, before the facility will offer to replace the item, and that is after an extensive search. She said the process starts when the resident complains of a missing item. The Social Services Designee (SSD) will complete a Grievance form to start the process. Housekeeping/laundry1 said that after the search and nothing is found, she doesn't really hear anything until it's found or replaced. She also said that if money is found in the laundry, it is given to the SSD, so she can find the owner.

Review of the Laundry Communication Binder revealed communications about clothing donations, laundry procedural problems and note stating not to use red marker to mark resident initials because the red ink bleeds.

During an interview on 11/29/23 at 10:14 AM, the Cook2 stated complaints from residents are handled on the spot during meal service and are not documented. She said Resident Council complaints are entered into the dietary communication book, so all dietary staff know what the concerns are. Cook2 said menus are set by the dietician and previous dietary manager. They are a 10 day stretch and 4 cycles totaling 40 days. In addition, there is a meal of the month which is chosen by resident council. She said the residents get a say in the meals and those who complain usually are those who the staff expects complaints from.

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Review of the Dietary Communication Book revealed previous resident council concerns and resident preferences.

During an interview on 11/30/23 at 9:21 AM, the SSD revealed that missing laundry doesn't get brought to her attention a lot, and it should. She said that it is usually brought up in Resident Council and this is where she first hears of things and will fill out the form. Residents usually go to Laundry to complain instead of the SSD and the Laundry department doesn't often fill out the Lost/Misplaced/Damaged Items Form. The SSD said that things need to be missing 1-2 or 2-3 weeks before being replaced, but she was not certain of the time frame.

During the same interview, the SSD said most food complaints go directly to the kitchen and other food complaints are brought up at the care conference. She also said sometimes food complaints are brought to the resident council.

The SSD revealed Lost/Misplaced/Damaged Items Forms and Grievance Report Forms are only located at the nurses' station and at the SSD office and residents/representatives must ask staff for one. She said that she would always maintain confidentiality but had no idea how a complaint/grievance could be anonymous because they have never done that. The SSD revealed that these types of complaints are not often brought up to her and are not on the Grievance Log.

Review of the Grievance Log revealed 12 state reportable items which were investigated, none

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	355103	A. BUILDING _____ B. WING _____	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

(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 585	Continued From page 28 of which involved missing/damaged laundry, food complaints, activity complaints or other items regarding issues of resident life that were important to the residents/resident representatives. Review of the Resident Council Minutes revealed, 16 November 2023: (noted next to these complaints "complaint filled out and given to dept head") - Night shift doesn't answer lights - Housekeeping needs improvement - Laundry gets mixed - Food is cold and not prepared well - Activities are ...[statement not finished] --Response to November Resident Council Meeting Concerns from Nursing dated 11/16/23 revealed, 1. Call lights are not being answered in a timely manner. (No specific shift was singled out on this concern) -Nursing staff will be re-educated on the amount of time that is allowed to answer a call light. (5-10 minutes) -Call light audits will be conducted on all shifts for a week to time how long call lights are taken to be answered. -Shift staffing will be taken into consideration, along with time of day as during the day all departments can answer a call light. -A final report will be given for the resident council to review next month. This will also include the education as what is the appropriate amount of time to answer a call light in a timely manner. 2. Staff are too noisy in the hall in the middle of	F 585		

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the night. (This complaint was about 2 staff at 5 AM being too loud outside resident's doorway and woke her up, could not pinpoint date)
-Education to staff on voice level while in the hallway at night and during the day for those who nap.
-Education on keeping the movement of carts to a minimum at night to reduce noise in hallways when residents are sleeping.
-Keeping the conversations to a minimum in hallways, if needed take to a place where it can be conducted without waking anyone up.
-If it is a resident who is loud, redirect back to their room where they will not wake up other residents.

-- No response from Dietary, Housekeeping, Laundry or Activity department managers received/attached to Resident Council Meeting Minutes.

30 October 2023:
- Rooms not cleaned
-- No response from department management.

27 September 2023:
Old Business
- Residents didn't bring up any Issues/Concerns/Suggestions this meeting. Reminded them if they do not feel comfortable speaking up during this group-style meeting, they can visit one to one with _____(name) who is our Grievance Counselor or with a staff member they feel comfortable with. Also, told the Residents the sooner the issues are brought up the sooner we can try to resolve them.

New Business

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F 585	Continued From page 30 - A few residents are concerned about Housekeeping and how rooms are not being cleaned that well or cleaned often enough. -- Response to September Resident Council Meeting Minutes dated 10/3/23 Housekeeping Manager response read in pertinent part, "Will talk with my staff and see if on weekends we can spend just a little more time and during the week we well [sic] do some deep cleans to get them cleaner and if they see us in the rooms more hopefully that will fix the problem. If it doesn't [sic] fix next there will be check list to be completed for every room or actually [sic] room checks. Thanks [unreadable signature]" 23 August 2023: Old Business - A few Residents are having issues with laundry mixing up clothing and putting it in the wrong rooms. One issue is with Resident that have the same first name. -- Response to August Resident Council Meeting Minutes, undated Housekeeping Manager response read in pertinent part, "We are trying to rectify this, [sic] I do know some articles are mislabeled or are hard to read clearly. We are trying to keep up on relabeling. New Business: - Residents didn't bring up any Issues/Concerns/Suggestions this meeting. Reminded them if they do not feel comfortable speaking up during this group-style meeting, they can visit one to one with _____(name) who is our Grievance Counselor or with a staff member they feel comfortable with. Also, told the Residents the sooner the issues are brought up the sooner we can try to resolve them.	F 585		

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During an interview on 11/30/23 at 10:55 AM, the Activities Coordinator (AC) revealed she is new to the position in October 2023 and was previously a certified nursing assistant (CNA). She said that it's been a big learning curve doing the documentation. She revealed that the previous AC completed a Resident Interview Form to determine resident interests upon admission, usually the day of admission or the next day. The AC said that although there are interests on the form that residents may have indicated, that doesn't mean those interest would be offered. She said there just isn't the staff or the budget to do what residents are interested in. She said she tries to follow the activity calendar but it's just her, there is no other staff, and she must rely on someone volunteering to help. The AC said that activities can get canceled with little notice.

During an interview on 12/4/23 at 10:37 AM, the Administrator stated there really is not a good process and there isn't a log that tracks all grievances. He said the SSD cannot be held responsible to document all and right now everybody assumes she can do it all. The Administrator said that 90% of all complaints/concerns/grievances are verbal. He said, "this is the beauty of a small facility." The Administrator stressed that it is the staff responsibility to document resident/resident representative concerns on the appropriate forms. He said that the only way to make an anonymous grievance, is to slip a note under his office door, but plans to put up a box in the future since it has been brought to his attention that there is no way for residents/resident

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F 585	Continued From page 32 representatives to file an anonymous grievance. The Administrator stated that Resident Council concerns are written up and that he responds through Resident Council but those concerns are not documented on the Grievance Log or tracked and trended through the Quality Assurance and Performance Improvement (QAPI) process. During the same interview, the Administrator stated that missing or damaged laundry replacement occurs "maybe in 1-2 wks, doesn't really know, the policy is not really specific." He said he recognizes that it must be documented in the Grievance process to be able to do this. The Administrator was told of some of the complaints discovered during the survey process and that none were on the Grievance Log. The Administrator said that he plans to improve the Grievance Process now that it has been brought to his attention.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		

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F 623	Continued From page 33 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 34 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623		

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F 623	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident (R) and/or resident representative was notified in writing of the reason for a transfer from the facility to an acute care setting and failed to notify the Ombudsman for 3 of 3 residents reviewed for transfer/discharge (R12, R14, and R28). Findings include: Review of facility policy, "[Facility Name] Transfer and Discharge (including AMA [Against Medical Advice])," implemented on 1/11/23 revealed in pertinent part, "Transfer" refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility." "Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). ... e. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand. g. Provide a notice of transfer and the facility 's bed hold policy to the resident and representative as indicated ... h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all	F 623		

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requirements for content of such notices.
i. The resident will be permitted to return to the facility upon discharge from the acute care setting.
J. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility ..."

A. During a record review on 11/29/23 multiple nursing notes revealed R28 was transferred to the hospital on 8/14/23.

Review of a nursing note dated 8/18/23 at 1:05 PM revealed that R28's son came to the facility to pick up R28's belongings.

No evidence of Transfer Notice or Bed Hold found in electronic health record.

During a concurrent interview and record review on 11/30/23 at 4:06 PM, the Social Services Designee (SSD) produced her Transfer/Bed hold binder; no documents found for either the resident's Transfer to the hospital or Bed Hold. The SSD said R28's transfer to the hospital was emergent and there was no way of preparing the resident or getting R28's signature on Transfer/Bed Hold documents.

During the same interview, SSD said that R28's son was angry and refused to sign the forms when he came to the facility. She also said that she did not document the declination to sign the forms or get a witness to document the declination. The SSD said she did not notify the Ombudsman of the transfer.

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B. During an interview on 11/28/23 1:28 PM, R12 stated she was hospitalized in September and spent a few days in the hospital but returned to the hospital for additional care. She said that she was hospitalized two times in one month, but returned to the facility and was able to return to her room.

Review of R12's Hospital Discharge, revealed R12 was admitted to the hospital on 9/6/23 and discharged back to the facility on 9/12/23. She was then readmitted to the hospital on 9/16/23 and discharged and returned to the facility on 9/22/23.

During a concurrent interview and record review on 11/30/23 at 4:06 PM, the SSD produced her Transfer/Bed hold binder. She said R12's Transfer form not signed by R12 or R12's representative nor did she have a bed hold form. The SSD said R12's transfer to the hospital was emergent and there was no way of preparing the resident. The SSD said that she was not able to get the forms signed.

During the same interview, the SSD said she faxed the Transfer/Hospitalization information to the Ombudsman but she was not able to provide evidence that the Ombudsman was notified or a produce a fax confirmation.

C. During an interview on 11/28/23 at 1:55 PM, R14 stated he had a hospitalization a couple weeks ago and that they kept him for four days.

Review of R14's Hospital Discharge, revealed R14 was admitted to the hospital on 10/27/23

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F 623	Continued From page 38 and discharged back to the facility on 11/2/23. Review of R14's Electronic Health Record (EMR), revealed no evidence R14 or his representative, had been provided a copy of the transfer notice before, during or after his hospitalization. There was also no evidence the Ombudsmen was provided a copy of the transfer notice. During an interview on 11/30/23 at 12:18 PM, in the conference room the DON stated the family was notified about the transfer to the hospital, but it was not documented. During a concurrent interview and record review on 11/30/23 at 4:58 PM, the Social Services Designee stated she charted the bed hold for R14 but must have forgotten to finish the transfer notice. I can't find either form. During an interview on 11/30/23 at 4:17 PM, the Ombudsman stated there is no process for when he gets notifications for Transfers or Hospitalizations. He also said that his notifications from this facility have been sparse; only 8 singular notifications so far this year. He said he had received singular notifications not monthly faxes. The Ombudsman stated he feels that it is unusually low. He said he was not notified of R28's resident's transfer or hospitalization, and does not recall being notified of R12, or R14's hospitalizations.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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F 625	Continued From page 39 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written notice of the bed-hold policy before transfer to the hospital and subsequent return to the facility for 3 of 3 residents (R) reviewed for hospitalizations (R11, R12 and R28). Findings include: Review of facility policy, "Bed-Hold Policy,"	F 625		

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review/revised 7/9/2018 revealed in pertinent part,
"It is the policy of Four Seasons Health Care Center to provide information concerning bed-holds to our residents and/or their representatives. This requires two notices. The first is provided at the time of admission. The second notice is given when the resident transfers to the hospital or goes on therapeutic leave."

A. During a record review on 11/29/23 multiple nursing notes revealed R28 was transferred to the hospital on 8/14/23.

Review of R28's EHR revealed no evidence R28 or her representative, had been provided a written bed hold notice before, during, or after her hospitalization.

Review of a nursing note dated 8/18/23 at 1:05 PM revealed that R28's son came to the facility to pick up R28's belongings.

During a concurrent interview and record review on 11/30/23 at 4:06 PM, the Social Services Designee (SSD) produced her Transfer/Bed hold binder; no documents found for either the resident's Transfer to the hospital or Bed Hold. The SSD said R28's transfer to the hospital was emergent and there was no way of preparing the resident or getting R28's signature on Transfer/Bed Hold documents.

During the same interview, the SSD said when R28's son came to the facility to pick up R28's belongings, he was angry and refused to sign the Bed hold and Transfer forms. She said that she

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did not document his declination to sign the forms or get a witness to document the declination.

B. During an interview on 11/28/23 1:28 PM, R12 stated she was hospitalized in September and spent a few days in the hospital but returned to the hospital for additional care. She said that she was hospitalized two times in one month, but returned to the facility and was able to return to her room.

Review of R12's Hospital Discharge revealed R12 was admitted to the hospital on 9/6/23 and discharged back to the facility on 9/12/23. She was then readmitted to the hospital on 9/16/23 and discharged and returned to the facility on 9/22/23.

Review of R12's EHR revealed no evidence R12 or her representative, had been provided a written bed hold notice before, during, or after her hospitalization.

During a concurrent interview and record review on 11/30/23 at 4:06 PM, the SSD produced her Transfer/Bed hold binder. She said R12's Transfer form was not signed by R12 or R12's representative nor did she have a bed hold form.

C. During an interview on 11/28/23 at 1:55 PM, R14 stated he had a hospitalization a couple weeks ago and that they kept him for four days.

Review of R14's Hospital Discharge, revealed R14 was admitted to the hospital on 10/27/23 and discharged back to the facility on 11/2/23.

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F 625	Continued From page 42 Review of R14's Progress Notes revealed on 11/1/23, "Verbal bed hold per wife ..." Review of R14's EHR revealed no evidence R14 or his representative, had been provided a written bed hold notice before, during, or after his hospitalization. During a concurrent interview and record review on 11/30/23 at 4:58 PM, the SSD stated she charted the bed hold for R14. "I can't find the form." In addition, Progress Notes revealed that R14 went on a therapeutic leave from 10/20/23 through 10/22/23. There was no evidence a written bed hold notice was provided to the resident or his representative for the leave.	F 625		
F 656 SS=E	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	F 656		

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provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the 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 observation, interview, and record review, the facility failed to develop and/or implement a comprehensive person-centered care plan for 4 of 15 sampled residents (R) (R11, R13, R14, and R15).

Specifically, the facility failed to:
1. Care Plan for non-pharmacologic [type of health intervention which is not primarily based

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F 656	Continued From page 44 on medication] treatment options for R13's jaw pain 2. Care Plan a new diagnosis of CHF (congestive heart failure) for R14 3. Update the current skin Care Plan for R15 4. Update the fall Care Plan with interventions after each fall evaluation for R11. These failures could limit coordination to meet resident goals and safely meet a resident's medical, physical, and psychosocial needs. Findings include: Review of facility policy, "[Facility Name] Comprehensive Care Plans" implemented 1/11/23, revealed in pertinent part: - "It is the policy of [Facility Name] to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." - "The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." - "The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment."	F 656		

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F 656	Continued From page 45 - "The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed." 1. Review of R13's Care Plan revealed R13 was admitted to the facility on 5/17/21. Diagnoses include Parkinson's disease, dementia, chronic obstructive pulmonary disease, and Bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment dated 9/30/23 revealed the resident had moderate cognition impairment with a brief interview for mental status (BIMS) score of 9 out of 15. During an interview on 11/28/23 at 2:56 PM, R13 stated that he has pain in his jaw. Sometimes the pain really bothers him and sometimes it does not hurt. R13 stated he told staff about his pain in his jaw and the nurse had given him a "nerve pill" for his pain. R13 states this pain has been going on for a couple of years on and off and he saw a dentist within the last year. When asked if he was offered a heating pad or other things, he said, "Yes, sure." Review of Physician order dated 12/15/21, revealed, "Apply warm pack to left jaw pain as needed." Further review of the Care Plan revealed the Intervention, "I do have complaints of jaw pain due to my triggering neuralgia [a sharp, shocking pain that follows the path of a nerve and is due to irritation or damage to the nerve]. I have PRN [as needed] Gabapentin [nerve pain medication] for	F 656		

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this as needed and staff will give per my request." Date initiated 5/17/21. There was no mention of using a heat pack for jaw pain in R13's Care Plan.

During an interview on 12/1/23 at 8:00 AM, the MDS Coordinator stated she could add the ordered warm pack treatment option for R13's jaw pain to the Care Plan.

2. Review of R14's Care Plan revealed R14 was admitted to the facility on 7/20/23. Diagnoses included CHF, lung cancer, and pneumonia. Review of the 5-day PPS (prospective payment system) assessment, dated 11/9/23, revealed R14 had moderate cognition with a brief interview for mental status (BIMS) score of 9 out of 15.

During an observation in R14's room on 11/29/23 at 10:34 AM, TED Hose [anti-embolism stockings] were seen on R14's lower extremities.

Review of R14's physician orders revealed TED hose were ordered on 10/25/23, "every day and evening shift for Edema On in AM and Off at HS [night]."

Review of R14's medical diagnoses revealed congestive heart failure with a date of 11/2/23 after a four-day hospital stay.

However, review of R14's Care Plan revealed no evidence for the management of R14's CHF, specifically the use of TED hose and edema.

During an interview on 12/1/23 at 8:00 AM, MDS Coordinator stated there was not a Care Plan for R14's CHF, edema [swelling caused by too much

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fluid trapped in the body's tissues] or TED hose. MDS Coordinator stated she could add it to R14's Care Plan.

3. Review of R15's Care Plan revealed R15 was admitted to the facility on 6/8/22. Diagnosis included sleep apnea. The Quarterly MDS assessment dated 9/5/23 revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of 7 out of 15.

Review of Progress notes revealed on:
- 9/13/23, the Attending Physician saw the resident and "discussed and that wound on back is healed."
- 10/9/23, "Skin warm & dry, skin color WNL [within normal limits], mucous membranes moist, turgor [skin's elasticity] normal. No current skin issues noted at this time. Resident has no new skin issues at this time."
- 11/20/23, "Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. No current skin issues noted at this time. No skin concerns at this time. Resident skin is intact. No areas of redness, bruising, or increased warmth. Capillary refill WNL."

Review of R15's Care Plan revealed, "Staff will do my dressing change as ordered to my area on my back that had a boil that opened up. Staff monitors for signs of infection and will report ... wound specialist will check as needed." Date initiated 8/28/23.

During an interview on 12/1/23 at 8:00AM, the MDS Coordinator stated she could change the Care Plan since the boil had cleared up and R15

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was no longer being treated.
4. Review of R11's Care Plan revealed R11 was admitted to the facility on 8/17/21. Diagnosis include Parkinson disease, abnormalities of movement and gait (walking), muscle weakness, delusional disorders, hallucinations, disorientation, and altered mental status. The Annual MDS assessment dated 8/17/23 revealed the resident had normal cognition with a brief interview for mental status (BIMS) score of 15 out of 15.

Review of R11's falls revealed,
Unwitnessed fall on 9/20/23.
Witnessed falls on 4/25, 6/7, 6/8, 7/4, 7/5, 7/22, 7/29, and 9/20/23.

Further review of R11's care plan revealed,
"I am at risk for falling due to Parkinson's. I would like to have no fall [sic] or Disease [sic], medication use [sic], and some an injury [sic] from a fall on a daily [sic] cognitive loss[sic]. Date Initiated: 8/17/2021"
"I have been doing a lot of self transfers [sic] and walking on my own even though staff reminds me frequently I really should call for assist. Staff has reminded me that there is a chance for me to fall. Date Initiated: 3/23/2022"

Care plan revealed R11 Care Plan was initiated on 3/23/23 but does not show evidence of updates or interventions after R11's falls.

During an interview on 12/1/23 at 8:00 AM, MDS Coordinator stated she reviews nursing and physician notes or what she is told in morning huddle to update residents care plans. She said unless someone tells her something specific

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F 656	Continued From page 49 needs to be in the Care Plan she has to guess what is needed and most of what she puts in the care plan is general. The MDS Coordinator also stated that the nurses and other members of the Interdisciplinary Team can update the care plan, but they leave it up to her even though she may not have all the information.	F 656		
F 680 SS=D	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered with the State.	F 680		

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F 680	Continued From page 50 Specifically, the facility failed to ensure the current activities coordinator was either a qualified therapeutic recreation specialist or an activities professional recognized by an accrediting body necessary to care for residents' needs as identified through resident assessments, and described in the plan of care. The lack of a qualified professional had the potential to affect the independence, community interactions, and well-being of all residents. Findings include: Review of professional reference from the National Certification Council of Activity Professionals (NCCAP), retrieved on 12/4/23 from www.nccap.org, revealed in pertinent part, "The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is: - Licensed or registered, if applicable, by the State in which practicing ... - Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body... - Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or - Is a qualified occupational therapist or occupational therapy assistant; or - Has completed a training course approved by the State." Review of facility Job Descriptions for the Activities Department, provided by the Director of Nursing on 12/6/23. Activities Director and	F 680		

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F 680	Continued From page 51 Activities Coordinator both undated, revealed in pertinent part, "Activities Director [*Old - written at top of document] Required Qualifications The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: - Is licensed or registered, if applicable, by the state in which practicing and - Is: -- Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or -- Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full/time in a therapeutic activities program: or -- Is a qualified occupational therapist or occupational therapy assistant: or -- Has completed a training course approved by the State." "Activity Coordinator [*New - written at top of document] Required Qualifications The Activities Assistant must possess: - A minimum of a high school diploma or Its equivalent, - A valid CNA [certified nurse aid] license/certification." During an interview on 11/28/23 at 8:45 AM, R10 stated that she likes playing bingo, but they cancel it often because they don't have enough	F 680		

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activity staff to call numbers. She said they don't always follow the calendar and the calendar doesn't have things that interest all residents.

During an interview on 11/28/23 at 1:31 PM R12 stated that the Activities Department doesn't ask what interest them. She said she likes cards and crafts but they don't do either activity. R12 said there are no field trips and no activities if the activities person isn't there. She also said, "they don't stick to activity schedule, don't take you to grocery store or anywhere, you're on your own, so if you don't have family, you have to rely on someone else to do your shopping. But I'd like to go out every once in a while."

During an interview on 11/30/23 at 10:55, AM the Activities Coordinator (AC) revealed that the previous AC completed a Resident Interview Form to determine resident interests upon admission, usually the day of admission or the next day. The AC said that although there are interests on the form that residents may have indicated, that doesn't mean those interest would be offered. She said there just isn't the staff or the budget to do what residents are interested in. She said she tries to follow the activity calendar but it's just her, and she must rely on someone volunteering to help. The AC said that activities can get cancelled with little notice.

Review of R12's Resident Interview Form indicates the facility's previous and new Activities Coordinator has known R12's interests since her admission on 12/28/17, including all the activities she mentioned in the interview and more.

During the same interview, the AC said she is

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F 680	Continued From page 53 new to the position and was previously a CNA. She said that it's been a big learning curve learning the documentation. The AC revealed she had been a CNA for 13 years, but at the facility 8 years, she also revealed she is new to the AC position and started in October, after the previous AC left in August or September. When asked when she finished her training, she said she is not trained; that she recently signed up for online courses and will start soon. She said she is not a certified Activities Coordinator or Activities Program Director. Review of the new Activity Coordinator Job Description document revealed that it was signed by the new AC on 11/7/23 and the Administrator on 11/8/23. The DON also supplied the AC's Modular Education Program for Activity Professionals Registration paperwork and Application for National Certification Council for Activity Professionals dated 11/15/23.	F 680		
F 684 SS=G	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 interview and record review, the facility failed to ensure resident (R) received treatment and care in accordance with	F 684		

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professional standards of practice for 1 of 3 hospitalizations reviewed (R14). Specifically, the facility failed to assess and monitor R14's acute change in condition, resulting in a delay of treatment that resulted in a 4-day hospitalization.

Findings include:

Review of facility policy, "FSHCC Notification of Changes Policy" last revised on 11/10/23, revealed in pertinent part:
- the facility "... promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification."
- "Circumstances requiring notification include ... significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status."

During an interview on 11/28/23 at 1:55 PM, R14 stated he had a hospitalization a couple weeks ago and that they kept him for four days.

Review of the 5-day PPS (prospective payment system) assessment, dated 11/9/23, revealed R14 had moderate cognition with a brief interview for mental status (BIMS) score of 9 out of 15.

Review of R14's Hospital Discharge, dated 11/2/23, revealed R14 was admitted to the hospital on 10/27/23. A chest CT (computed tomography x-ray images) scan showed "Findings are most consistent with infectious process" and was signed by Physician 49 on 10/31/23. Further review revealed an order from

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Physician 48 for physical and occupational therapy to evaluate and treat related to diagnosis of acute respiratory failure. Patient specific instructions included "Lasix [diuretic medication to remove excess fluid accumulation related to congestive heart failure (CHF) or renal failure (CKD)] 80mg [milligrams] po [by mouth] daily and PRN [as needed] 3-5lbs [pounds] weight gain ... Start Cefdinir [antibiotic] 300mg PO Daily x [times] 5 days ... weigh patient three times a week."

Review of R14's Medical Diagnoses record revealed R14 was admitted on 7/20/23 with sepsis (major infection) and a urinary tract infection that both resolved on 8/16/23; acute kidney failure that resolved on 9/29/23; lung cancer that resolved on 11/2/23.

Additional admission diagnoses included atrial fibrillation, atherosclerotic heart disease, prostate cancer, CKD stage 4, type 2 diabetes mellitus and hypertension.

Diagnoses added on 11/4, 11/5 and 11/15/23, after the hospitalization, included a primary diagnosis of CHF, pneumonia and dementia with psychotic disturbance.

Review of R14's 2023 Progress Notes revealed in pertinent part:
- 10/18 at 6:16 PM, the Director of Nursing (DON) documented the Attending Physician (AP) saw R14. The DON documented, "Lungs, heart, bilateral lower extremities assessed with wheezing noted in lungs and 2-3 plus edema [excess fluid in the tissue] in BLE [bilateral lower extremities]. Resident did voice that he felt like he

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had a cold coming on ... Start PRN [as needed] DuoNeb treatments [Ipratropium-Albuterol inhalation to help relax and open the airway] for wheezing/SOB [shortness of breath], monitor oxygen saturations when SOB."

Edema is measured by gently pressing a finger into the tissue to measure the indent or 'pit' left behind and then to see how quickly the indent disappears. For plus 1 or (1+) edema, there is a small pit (in millimeters) that immediately rebounds back. For plus 2, there is a deeper pit that takes up to 15 seconds to rebound. For plus 3, the pit is deeper and can take up to a minute to rebound.

Review of the Attending Physician visit on 10/18/23 revealed R14 was seen by the doctor for recertification and that "Per nursing staff, patient has edema." Vital signs were documented within normal limits. Further documentation showed, "Lungs: clear with no rales/rhonchi or wheezes ... Extremities: 2+ pedal [foot] edema."

When there is swelling, fluid or blockages in the airway, it can produce abnormal lung sounds such as rales, rhonchi, wheezing or crackles.

Continued review of R14's 2023 Progress Notes revealed in pertinent part:
- 10/20/23 at 4:41 AM, Licensed Practical Nurse (LPN) 5 documented, "complaints of tight chest and phlegm. audible wheeze." LPN5 administered DuoNeb treatment. At 5:00 AM, LPN5 documented, "Effective resident feels like this may have helped with some of the tightness in chest."
- 10/20/23 at 12:17 PM, Resident out with family

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until Sunday afternoon.
- 10/22/23 at 5:31 PM, Resident returned to the facility.
- 10/23/23 at 1:33 PM, Registered Nurse (RN) 2 documented, "per request for SOB. O2 [oxygen] is at 93% [percent] RA [room air]. Resident requested O2 for one hour. He is now back on RA." Oxygen order read, "Apply Oxygen at 2 liters [2L] per nasal cannula or mask as needed for oxygen saturations below 90%. Notify MD" However, there was no evidence the physician was notified or that R14's oxygen saturations were below 90%. RN2 further documented the treatment was effective.
- 10/23/23 at 12:05 PM, R14 declined influenza, RSV (respiratory syncytial virus) and COVID-19 immunizations.
- 10/25/23 at 5:59 AM, LPN3 documented, "complained of shortness of breath." LPN3 administered DuoNeb treatment. At 6:21 AM, LPN3 documented it was effective.
- 10/25/23 at 8:46 AM, RN1 documented, "Resident complain of shortness of breath, a 2L of oxygen and a nebulizer was administered. The resident pull[ed] out the nebulizer and the oxygen tubing indicating they are not helping him breath. His 02 [oxygen saturation] reading was 88. The head of his bed was elevated and he later put back his oxygen tubing. Crackles was noted while he breath in and out. He is being monitor[ed]."
- 10/25/23 at 1:15 PM, RN1 documented, "Resident was assess and I notice a[n] increase in his weight, and also discover a 1-2+ edema. He is still complaining of shortness of breath. A 2L of oxygen has been administered."
- 10/25/23 at 3:20 PM, the DON documented, "[The attending physician] called back to be

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updated on resident after message left by nursing ... Resident has increased complaints of shortness of breath and not feeling quite right. Resident refuses to leave oxygen on or to finish a prn nebulizer treatment ...Day shift nurse assessed resident and reported the following abnormal lung sounds throughout all fields, bilateral lower extremity pitting edema of 2-3 plus, shortness of breath, weight is up significantly in the last 2 days ... New orders received to start Lasix 40mg [milligram] orally daily, K+ [potassium] 20 meq [milliequivalents] orally daily, Daily weights in am [morning], monitor blood pressures and oxygen saturations every shift while awake. Repeat a BMP [basic metabolic panel] in a week. TED hose [anti-embolism stockings] to bilateral lower extremities for edema."
- 10/25/23 at 4:14 PM, the DON documented, "Resident notified of new orders from [the attending physician] to help with his shortness of breath, bilateral pitting edema in lower extremities, and weight gain. Resident is not really happy about having to take more medications, but if it makes him feel better, he will try it. Resident encouraged to elevate his feet in between meals to help reduce edema. Resident voiced understanding, but then will in another sentence say he isn't going to lay down today as it is hard to breath. Residents head of his bed is elevated to assist to breathe easier, oxygen is available, but is not wanting to use it."
- 10/25/23 at 4:28 PM, LPN4 documented, "Resident removed oxygen at 1450 [2:50 PM]. This writer went to check on the status of interventions per PCP [primary care provider]. At 1455 [2:55 PM] this writer went back to see the resident to let the resident know PCP was aware

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F 684	Continued From page 59 and would be giving new orders. This writer encouraged the resident to put oxygen back on, resident stated "That thing doesn't work" referring to the oxygen concentrator. Oxygen is able to be felt through nasal cannula by this writer. Resident also states "That damn thing gets turned off and on all day and it doesn't work either". Encouraged resident to elevate legs instead of sitting at the edge of bed with legs hanging down. Resident refused at this time to elevate legs." - 10/25/23 at 5:08 PM, LPN4 documented, "Check Full set of Vitals every shift while awake. every shift for Edema, Abnormal lung sounds ... Resident refuses to allow oxygen at this time." - 10/25/23 at 8:26 PM, LPN4 documented, "Resident refused to allow oxygen to be put on. Resident refused neb treatment. Resident refused to elevate legs ... Resident is now in bed and legs are elevated ... Denies SOB. 1st dose of lasix was administered this evening. Residents cough is wet, productive." - 10/26/23 at 6:27 AM, Certified Medication Aide (CMA) 8 documented she administered a DuoNeb treatment but did not document what symptoms R14 was having. At 7:38 AM, CMA8 documented the treatment was effective. - 10/26/23 at 5:12 PM, CMA10 documented, resident SOB. CMA10 administered DuoNeb treatment. At 5:51 PM, CMA10 documented the treatment was effective. - 10/26/23 at 7:12 PM, LPN3 documented, "Visual hallucination as evidenced by resident talking of people in his room." Between 10/25/23 8:26 PM and 10/27/23 1:52 PM, there was no documented nursing assessment related to R14's edema, weight, lung sounds or respiratory status.	F 684		

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Review of the Physician Review Consult regarding R14, faxed on 10/26/23 at 1:24 PM, revealed, "OT [occupational therapy] request resident order for ADL [activities of daily living] Resident said he wants to go home." Physician response was, "Patient admitted to hospital at this time" and signed 10/30/23. There was no evidence the nursing staff communicated R14's vitals and condition on 10/26/23.

Continued review of R14's 2023 Progress Notes revealed in pertinent part:
- 10/27/23 at 1:17 PM, LPN4 documented she administered a DuoNeb treatment but did not document what symptoms R14 was having. At 6:20 PM, CMA9 documented it was effective, in contrast to LPN4 documentation at 1:52 PM.
- 10/27/23 at 1:52 PM, LPN4 documented, " Resident using accessory muscles and having SOB. Crackles to upper lobes bilateral [both upper lungs]. Lower lobes diminished, poor air exchange. Resident did allow neb treatment at 1330 [1:30 PM], resident reports ineffective. Resident did allow oxygen to be placed via nasal cannula at 3-4 lpm [Liters pr minute]. Oxygen 87% RA. Oxygen after O2 90%. Elevated BP 160/106. Elevated pulse 118. PCP notified at this time. Will await interventions. Resident is resting well in bed. Legs elevated."
- 10/27/23 at 2:40 PM, the DON documented, "[Physician Assistant (PA)] called back on fax received from day shift charge nurse. Background: Weight increase from BLE, chest congestion, SOB, wheezing, oxygen use at 2L/NC [liters per nasal cannula]. Resident had nebulizer treatment, Lasix, and potassium added to his daily medications this week by [the

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F 684	Continued From page 61 attending physician] ... Resident assessed with audible expiratory wheezes noted upper lobes, use of accessory muscles with breathing, oxygen per nasal canula at 2L/NC. Pulse and blood pressure elevated as he is talking about needing to get home but is slid down in bed with chin tucked against his chest. Repositioned and started to breathe easier. Assessment of resident given to [PA] at this time ... New orders receive to give him an extra dose of Lasix 40mg orally today at 4pm. Check a BNP [B-Type Natriuretic Peptide], CBC [complete blood count], along with the BMP that was ordered for next Tuesday. If resident does not improve with extra Lasix, use of oxygen, PRN nebulizer treatments nurse may send him to the ER for evaluation anytime this weekend." - 10/27/23 at 3:36 PM, LPN3 documented, "[First name], residents sister called saying the resident does not sound ok. She wondered whether he has a pneumonia. Resident experiencing SOB. Lasix increased. Will continue to monitor. On O2 2L." - 10/27/23 at 4:20 PM, LPN3 documented, "Provider order one time Lasix 40 mg for SOB. Resident out of room wheeling self in the hallway. Order to send to the emergency room [ER] given if not improving. Will continue to monitor. Resident said he is improving." A nursing assessment was not documented. - 10/27/23 at 7:29 PM, LPN3 documented, "1915 [7:15 PM]: Resident sent to the ER by Ambulance for SOB. Pitting edema. Resident did not respond to Lasix 40 mg one time order. He continued to decline." - 11/2/23, RN1 documented resident returned from hospital.	F 684		

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Review of the Huddle Binder at the nursing station between 10/18/23 and 10/27/23, revealed on 10/20/23 (Friday) R14 was out (with family) until Sunday afternoon. There was no evidence of R14's change in condition.

Review of the Nurse Communication Binder and the Communication Book (binder) also at the nursing station, revealed no evidence of R14's change in condition.

Review of a COVID-19 Rapid Test, dated 10/27/23 revealed negative results.

Review of R14's October 2023 Medication Administration Record (MAR) revealed in pertinent part, R14 was administered:
- Lasix 40 mg (milligram) on 10/25/23 for bilateral lower extremity pitting edema.
- Lasix 40 mg on 10/26/23 and 10/27/23 for bilateral pitting lower extremity edema and abnormal lung sounds.
- Lasix 40 mg, one time on 10/27/23 at 5:59 PM for increased shortness of breath with congestion and edema.
- 20 MEQ (milliequivalent) of potassium chloride extended release daily, starting 10/25/23, 10/26/23 and 10/27/23.
- Ipratropium-Albuterol inhalation via nebulizer, as needed three times a day, for wheezing, shortness of breath related to lung cancer. This was administered on 10/20/23 at 4:41 AM, 10/23/23 at 6:49 AM, 10/24/23at 6:28 AM and 2:26 PM, 10/25/23 at 5:59 AM, 10/26/23at 6:27 AM, 5:12 PM, and 10/27/23 at 1:17 PM.

Review of R14's October 2023 Treatment Administration Record (TAR) revealed in

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pertinent part, R14 was weighed prior to breakfast on Oct 26 and Oct 27 without the weights documented.

Review of R14's weights in 2023 revealed in pertinent part:
- 8/1/23 140 lbs
- 10/17/23 158.5 lbs
- 10/23/23 164.5 lbs
- 10/24/23 through 10/27/23, nothing documented.

The TAR also showed an order to check full set of vitals every shift for edema, abnormal lung sounds. Pertinent findings documented included:
- 10/25/23Day shift: blood pressure (BP) was 178/80, pulse was 114, respirations were 22 and oxygen saturations were 90%;
- 10/25/23 PM shift the vitals were not documented
- 10/26/23 Early AM: BP was 155/102, pulse was 115
- 10/26/23 Day shift: BP was 146/88, oxygen saturations were 91%
- 10/26/23 PM shift: BP was 168/83, pulse was 100
- 10/27/23 Early AM shift: BP was 160/106, pulse was 118, respirations were 22 and oxygen saturation were 91%
- 10/27/23 Day shift: BP was 170/100, pulse was 116 and oxygen saturations were 91%

Review of R14's BP in 2023 revealed since R14's admission, it was abnormal for his systolic BP to be as high as 146 and his diastolic level to be above100.

Review of R14's heart rate in 2023 revealed

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since R14's admission, he had had elevated heart rate results on 9/25/23 116 and 114 and 9/26/23 110.

Review of R14's respirations in 2023 revealed since R14's admission, it was abnormal for his respirations to be about 20.

The TAR, in contrast to the progress notes, showed the order to apply oxygen at 2 liters per nasal cannula or mask as needed for oxygen saturations below 90, was only applied on 10/23/23 at 1:33 AM. The oxygen saturations were documented as 93.

Review of R14's oxygen saturation levels in 2023 revealed in pertinent part:
- 9/24 through 9/27 ranged from 99% to 93% on room air
- 9/27 through 10/19, nothing documented
- 10/20 through 10/27, ranged from 80% to 99% on room air and with oxygen; pertinent findings revealed on 10/25 at 5:59 AM 80% room air, at 8:50 AM 88% oxygen cannula, 5:08 PM 90% room air.

During an interview on 11/29/23 at 10:34 AM, LPN3 stated he was working the day that R14 was sent to the hospital. LPN3 stated R14 went downhill very fast and that he had been getting worse. LPN3 stated the symptoms he had required emergency treatment and described his worsening edema. LPN3 stated R14 also refused medications, oxygen and nebulizer treatments.

During a continued interview at 5:55 PM, LPN3 stated he remembered that R14's sister had called and said her brother sounded sick. LPN3

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looked at his phone and said he worked on Oct 18th, 20th, 24th, 26th and 27th on night shift when R14 was usually sleeping. LPN3 stated he spoke to the DON on 10/25 because R14's legs were "so swollen." LPN3 stated he thought the DON called the doctor. LPN3 stated R14 sometimes has hallucinations and that the hallucination on the 26th was not a new thing but LPN3 said not getting enough oxygen to the brain can be delirium. LPN3 stated LPN4 had assessed R14's lungs. When asked about what nursing assessments he documented, LPN3 stated, "We always assess."

During an interview on 11/29/23 at 1:42 PM, CMA8 stated R14 went home prior to being sick but he came back from his family's with a cough and congestion. CMA8 stated R14's wife had been sick. CMA8 stated R14 was different. CMA8 stated, R14 could usually get out of bed and move around but then for three or four days, his edema got bad. "I mentioned to the nurse that he sounds sick and we started nebulizer treatments. He got really rough and went to the hospital. I think he should have gone sooner." CMA8 stated when R14 wasn't feeling well, she tried to get him to move around and push water but by day six he was not getting out of bed or eating much. He was on oxygen and any movement drained him. CMA8 stated she did not remember what nurses she worked with but LPN4 and RN1 "rang a bell."

During an interview on 11/29/23 at 2:45 PM, CMA9 stated she remembered that R14 had not looked good at all and that he had gained weight. CMA9 stated her role was to report to the nurse whenever a resident was different than normal.

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F 684	Continued From page 66 During an interview on 11/30/23 at 12:18 PM, in the conference room with the DON, the Medical Director (MA), the Attending Physician (AP) and the PA (via phone), the AP stated she saw R14 on Oct 18th on rounds. At the time, the focus was on R14's edema which he had when he was admitted and it was being followed up in [close city in a neighboring state]. The AP stated she was advised of abnormal lung sounds but her assessment was clear. To address the edema, the AP stated she ordered DuoNebs and Oxygen and that his edema was getting worse and it was probably fluid overload and was not thinking COVID-19, flu or other respiratory illness because there were no other respiratory symptoms. Vitals signs were also within normal limits (WNL). When discussing the nursing documentation between Oct 22 and Oct 25, the AP and PA stated the DON and nursing staff at the facility are very good at communicating with them about the residents' health status and are notified via fax or phone. The PA stated, "They are very detailed and accurate when they communicate with providers." The AP stated on 10/25 she remembered that R14 was not happy to have to take additional medications (speaking about the additional Lasix order). The PA stated that she provided orders on 10/27 for lab work already scheduled to be completed sooner and that R14 could be sent to the ER but "If I recall correctly, he did not initially want to go." When asked about COVID-19 testing, the AP stated the presentation was more like CHF but she cannot answer if a respiratory panel should have been done. The PA stated, "In retrospect, a face to face evaluation would have been optimal [Oct 27]." The MA stated she had reviewed the medical record and that the final discharge was	F 684		

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heart failure and that they put R14 on empiric antibiotics but that it was nowhere close to a primary diagnosis.

During continued interview, the DON stated she also identified that there was no documentation in R14's chart on 10/26/23 but that RN1 was in her office discussing R14's situation that day. The DON stated the family was notified about the transfer to the hospital, but it was not documented.

On 11/30/23 at 2:45 PM, the DON stated she saw the effusion (too much fluid) on the CT scan and that it was infectious. The DON stated she will make sure that only nursing staff complete nebulizer treatments so that they can do a lung assessment prior to and after the treatment. The DON stated they should always be thinking about COVID-19 as a possible reason for respiratory changes.

During an interview on 12/4/23 at 10:41 AM, the DON stated the nursing staff were communicating about R14's condition during the whole thing. The DON stated that LPNs can assess but are supervised by Registered Nurses. The DON stated on Oct 25th, RN1 worked days and RN7 worked nights; on Oct 26th, RN1 worked days and LPN3 worked nights; on Oct 27th, LPN4 worked days and LPN3 worked evenings and RN7 worked nights. We had conversations between day and night shifts and checked lung sounds, edema and weights. We talked about whether he was using oxygen or refusing. The DON stated that based on the documented vitals, he was getting worse, and I would have expected more documentation by the

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F 684	Continued From page 68 nurses. The DON stated she worked on Oct 25, 26 and 27 and that she did assess R14 with RN1 on the 25th. "I did not document my chest assessment on Oct 25 because I did it in collaboration with RN1 who documented the assessment." The DON could not remember if she assessed R14 on Oct 26th. The DON stated the Huddle Binder, and the Nurse Communication Binder should have had documentation about R14's change in condition and weights. The DON stated she would also look at the Report Sheets and any Faxes to physician. One fax was provided that did not include information related to R14's change in condition.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's (R) fall risk was assessed, and care planned accurately to receive the appropriate transfer support to minimize the likelihood of falls for 1 of 5 residents reviewed for falls (R4); and failed to ensure manufacturer instructions were followed for 1 of 1 observed transfer with a mechanical sit to stand lift (R8). These failures create the potential for a fall with injury to staff or residents.	F 689		

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F 689	Continued From page 69 A Sit to Stand lift is a mechanical lift with an upper body sling that supports a resident, who has some mobility and strength, to participate in a transfer from one surface to another. Findings include: Review of facility policy, "Fall Prevention Program" last reviewed on 4/10/23 revealed in pertinent part, "Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls." The policy stated a fall risk assessment would be completed every 90 days and as indicated and the resident's care plan would include risk factors and environmental hazards that would be monitored and revised as needed. With every fall, the resident will be assessed, and the care plan reviewed and updated as needed. Review of facility policy, "Policy and Procedure on Using Sit to Stand Lift" updated on 4/1/23 revealed in pertinent part, - "The Sit to Stand Lift is used on residents who are able to use their hands to hand [sic] onto the handles and who are able to stand on their legs." - "Hand/feet placement will be checked during transfers to ensure proper placement." - "[Therapy] to evaluate for any concerns on Sit to Stand Lift transfers." - "If a resident can no longer stand using their legs ... the Hoyer lift may need to be used ... This change will be determined by the Charge Nurse, Director of Nursing [DON], or [Therapy]. - "The Sit to Stand Lift may be utilized by one caregiver unless otherwise care planned."	F 689		

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F 689	Continued From page 70 1. Review of R4's Care Plan revealed R4 was admitted to the facility on 2/8/17. Diagnoses include hemiplegia and hemiparesis (paralysis and weakness) following a stroke on the left non-dominant side, cellulitis of left lower limb, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment dated 9/4/23 revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. During an interview on 11/28/23 at 10:03AM, R4 stated that he has had no falls recently, but he fell once trying to get up on his own. Review of R4's 2023 Progress Notes, revealed: - Post Fall Note, dated 3/12/23 that the resident had a prior fall with no injury. - Post Fall Note, dated 4/29/23, "Resident found on floor leaning against his scooter." - Post Fall Note, dated 8/9/23 at 5:59 PM, "Witnessed fall. Resident fell down during transfer. Sit to stand lift strap came off, left side. Resident's top half was off the floor as he was holding on to the right trap which was intact. Resident denied injury, pain and hitting head. Resident was in the process of utilizing the bathroom with the assist of one staff member using sit to stand lift. Resident helped off the floor after completing assessment. Resident later assisted to the bathroom with assist of two staff members." Review of R4's Post Fall Assessments revealed the last post fall assessment was conducted on 5/1/23 by Licensed Practical Nurse (LPN) 3.	F 689		

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Review of R4's Quarterly MDS assessment, dated 6/4/23 revealed R4 was assessed for extensive assistance with two persons providing physical assistance for transfers.

Review of the Incident Report, dated 8/9/23 and prepared by LPN3 revealed,
- "Nursing Description: Two staff called for help in the resident's room. One side of the sit to stand strap came off during the transfer. Resident's lower half of the body on the floor while supporting self by holding on to the remaining strap."
- "Resident Description: "I did not hit my head, it was not my fault this time"
- "Vitals obtained: Assessment completed. Resident assisted off the floor using Hoyer [full body mechanical lift] with the assistance of 3 staff. Resident assisted to the bathroom. Staff educated on the proper use of the lift." "No injuries observed post incident."

Review of the Fall/Incident/Unknown Injury Quality Assurance Form, dated 8/9/23 revealed a fall that was a near miss, lowered to floor. "Going from his scooter into the bathroom via sit to stand lift with assist of one CNA [Certified Nurse Aide]." Witness statement information revealed the CNA [CNA16] stated all straps were attached but it came loose going through the bathroom doorway. The corrections included maintenance to check the lift for safety to use, care plan reviewed and R4 was transferred according to care plan and therapy to evaluate the transfer to ensure safest transfer for R4. CNA16 documented the weak side of the R4's sling came off the hook. "I called for assistance over walkie and the nurse and another CNA came into

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assist to lower him to the floor. Then the [Hoyer] was used to assist him to his bed."

Review of Huddle Safety Concern Notes, dated 8/10/23 revealed "The charge nurse did education with the CNAs on proper use of placement of sling and safety when using a sit to stand lift."

Review of Huddle Safety Concern Notes dated 8/24/23 revealed "Implemented that 2 staff assist resident with the sit to stand lift with all transfers for safety until a PT [Physical Therapy] order could be obtained to evaluate was started immediately after the fall. Further documentation showed R4 was upset having 2 assist him when 1 staff was able to do it before and that the Attending Physician was made aware of R4 unstrapping the lower belt on the sit to stand while transferring so the AP spoke with R4 about the risks and provided education. "Staff educated that if resident removes the Velcro legs strap, they can switch to use the lift that has the buckle strap to ensure safety."

Review of the Care Plan revealed a focus area for Falls that revealed, "[R4] was at risk for falls due to my body control problems, and I have medications that may cause falls" dated 11/27/2020. Interventions included:
- "Staff now transfers me with the sit to stand lift and one to two assist to the bathroom due to a history of falls" dated 8/14/23
"I have been educated on not unhooking the strap on the sit to stand lift because it may result in a fall but I continue to do it at times" dated 8/15/23
- "I can be very uncooperative when staff is

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transferring me with the sit to stand lift, not trying to stand well for staff, unhooking straps, resulting in the risk of me falling. Staff reminds me not to unhook things and to stand but I do what I want" dated 8/25/23
- "I did have a PT evaluation for transfer and did well for him so he did let me remain CNA in the sit to stand lift with two assist for transfers. Staff will continue to remind me that I need to cooperate, not unhook straps, stand as well as I can so that I can be safe" dated 8/30/23.

Further review of the Care Plan, revealed a focus area for Activities of Daily Living (ADL) deficit due to body control problems, dated 2/4/21. Interventions included:
- "I need the sit to stand lift and two assist for transfer, reminders to cooperate with CNA standing better and not unhooking safety straps etc." dated 8/25/23

Review of Physical Therapy (PT) note, dated 8/24/23, revealed PT30 documented, "Facility asked that PT observe the sit to stand lift with Res. [R4] to determine if that lift is safe for him. In chart review and interview there have been problems with Res. taking off the bottom strap of the lift and left leg sliding out laterally of the anterior brace. In transfer today. Res. stated you do not need the bottom strap however kept it in place when asked. CNA made sure left knee was properly positioned before and during lift. When Res. had some weight on left l/e [lower extremity], his leg was easily held in position in the lift. While standing he denied any pain with the transfer. It was observed that he had a significant amount of weight being taken by shoulder straps. Res. denied that was a problem

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and was able to take full weight on his l/e when asked. With proper use of lift Res. is safe in this lift and it is the best transfer that can be accomplished with him. No changes [recommended]."

Review of R4's Quarterly MDS assessment, dated 9/4/23 revealed R4 was assessed for extensive assistance with two persons providing physical assistance for transfers.

Review of R4's fall assessments showed the two most recent fall assessments were completed by the MDS Coordinator on 12/5/22 (score of 15 - At risk) and nine months later on 9/5/23 (score of 12 - At Risk).

Review of R4's Care Conference note, dated 9/13/23 revealed "Need two people during transfer because he has a tendency to unhook straps on lift."

Further review or R4's electronic medical record revealed no evidence R4 has been changed to a one person assist after 9/13/23.

During an interview on 11/29/23 at 2:16 PM, R4 stated he had never fallen and that he did not use a lift to transfer. "The girls just get me up and put me in the scooter."

During an interview on 11/29/23 at 2:42 PM, Certified Medication Aide (CMA) 9/CNA stated R4 was a sit to stand transfer with one assist. "He uses the blue sit to stand with the strap on the bottom that buckles."

During an interview on 11/29/23 at 2:54 PM,

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F 689	Continued From page 75 CNA16 stated R4 uses a sit to stand with a leg strap to transfer. CNA16 stated she prefers to use the lift that has a strap that clicks. "You must use the leg strap." CNA16 stated R4 can be a one person assist but you can always get a second person to help. During an interview on 11/30/23 at 2:57 PM the DON stated R4 was a 1 or 2 person assist because some CNAs were not as comfortable transferring R4. The DON stated the nursing staff had the authority to assess what the safest transfer was for a resident and care plan accordingly as per facility policy. The DON stated fall risk assessments should be done quarterly and post fall assessments would now be completed in the nurses' progress notes. During a telephone interview on 11/30/23 at 4:19 PM, PT30 stated therapy should be involved when a resident transfer would be downgraded (requiring less assistance). PT30 stated he did not have the medical record in front of him so he was not sure if R4 should have one- or two-person assistance with the sit to stand transfer. PT30 stated he has trained CNAs on how to work with R4 and that he has had to reiterate that the manufacturer instructions had to be followed, even if it seemed there was a better way to transfer R4. During a concurrent interview and record review on 12/1/23, starting at 8:00 AM, the MDS Coordinator stated R4 was a one- or two-person transfer depending on his mood. The MDS Coordinator reviewed the Care Plan and MDS assessments and stated she would make sure it was clear if one or two staff were to assist R4	F 689		

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with his transfers using a sit to stand lift. The MDS Coordinator stated the CNAs will tell the nursing staff if they have difficulty with a resident transfer so that a nursing or therapy assessment could be done to ensure the resident's current care plan was safe. The MDS Coordinator stated they no longer used the Post Fall Assessment which was why the last one was in May. The MDS Coordinator stated she was completing Fall Risk Assessments every quarter so she did not know why there was a nine-month gap for R4. "They should have been completed."

2. During a concurrent observation and interview on 11/29/23 at 10:40 AM, CNA18 was observed transferring R8 from a recliner to the toilet using a sit to stand mechanical lift. During the transfer, CNA18 did not encourage R8 to place her knees against the knee pads. R8 was observed with her legs approximately 4 inches away from the knee pads. CNA18 stated this sit to stand did not have a leg strap but the other sit to stand lifts they used for R4 did have a leg strap. CNA18 stated R8 was the only resident who could use the sit to stand without the leg strap.

Review of the laminated sit to stand manufacturer instructions attached to the lift was titled "Pal Lift!" and revealed in pertinent part, "7. Before the patient's body is lifted from the bed, stop and make sure the sling is secured and patient's knees are against the knee pad."

During an interview on 11/29/23 at 2:54 PM, CNA16 stated every sit to stand lift required the resident to lean their knees against cushion. CNA16 stated there was a sit to stand lift they used with R8 that did not have a strap but R8

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F 689	Continued From page 77 was still supposed to put her knees against the cushion. During an interview on 11/30/23 at 10:42 AM, the observation of the transfer was discussed with CNA18 who stated, yes, the legs should be pressed against the knee pad. CNA18 stated she was trained by the Restorative CNA15 on how to use the sit to stand lift with R8. CNA18 stated that if the proper technique was not used, the resident could slide out of the upper body sling and fall. During an interview on 11/30/23 at 2:28 PM, the DON stated CNA18 told her about the sit to stand observation with R8. The DON stated they have already determined that if R8 can no longer support her lower body then she would no longer be safe to transfer with the sit to stand. The DON stated that the sit to stand instructions must be followed for a safe transfer.	F 689		
F 700 SS=F	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700		

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F 700	Continued From page 78 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to use a person-centered approach when determining the use of bed rails for 25 of 25 residents that slept in a bed. The facility census was 27. Note: bed rails and side rails are used interchangeably throughout the document. Specifically, the facility failed to attempt alternatives, failed to assess/re-assess the bed rail use, including entrapment, and failed to check bed rails regularly. In addition, the facility failed to obtain informed consent for 5 of 14 residents reviewed for bed rails (R9, R12, R13, R24 and R25) and failed to care plan bed rails for 13 of 14 residents reviewed for bed rails (R5, R6, R9, R11, R12, R14, R15, R16, R17, R20, R24, R25 and R180). Failures to attempt to use alternatives to bed rails, assess/re-assess bed rail use, obtain informed consent, care plan, and regularly inspect/maintain installed bed rails have the potential for entrapment and/or injury. Findings include:	F 700		

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F 700	Continued From page 79 Review of facility policy, "Policy and Procedure on Bed Rails, last reviewed on 10/31/23 revealed in full: - "Policy: to help maintain residents highest level of function, bedrails are used to help with repositioning, boundaries, getting in and out of bed safely, and a place to keep bed and tv controls." - "Procedures: Bed rails comes standard on all of our beds and there are risks of injuries, strangulation, suffocation and possible death so the following will be done: A) On admission resident and/or their representative will be given the Bed Rails information Sheet and sign the Bed Rail Informed Consent Form." - "All bed rails are checked for rips, tears, and if bed rails are secure, at least monthly by housekeeping. Any concerns are given to maintenance to fix." - "Residents have the option for one or both side rails to be up and as they chose." - "The need for bed rails will be evaluated at least every three months or before if any concerns arise." - "Bedrails will be care planned prn." During a concurrent interview and record review on 11/30/23 at 11:39 AM, the Director of Nursing (DON) stated the Policy and Procedure on Bed Rails, last reviewed 10/31/23 was used by the previous DON. Review of facility policy, "Proper Use of Side Rails" last reviewed on 10/31/23, revealed in pertinent part:	F 700		

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F 700	Continued From page 80 - the facility would "utilize a person-centered approach when determining the use of side rails. Alternative approaches are attempted prior to installing a side or bed rail. If used, the facility ensures correct installation, use, and maintenance of the rails." - "Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ... one-half, one-quarter, or one-eighth lengths ... Examples of bed rails include ... side rails, bed side rails, safety rails, grab bars and assist bars." - Bed rails will be considered as part of the resident's comprehensive assessment completed "not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail." The assessment will include such things as medical diagnosis, medications, cognition, risk of falling, entrapment, accident hazards, restraint and decline with activities of daily living. "The interdisciplinary team will make decisions regarding when the side/bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the rail." - Informed consent will be obtained prior to installation. Physician orders will be obtained for the use of bed rails. - "Inspecting and regularly checking the mattress and bed rails for gaps and areas of possible entrapment ... Checking rails regularly to make sure they are still installed correctly and have not shifted or loosened over time."	F 700		

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- "The use of side rails will be specified in the resident's plan of care."

During a concurrent interview and record review on 11/30/23 at 11:39 AM, the DON stated the facility will be using the Proper Use of Side Rails policy, last reviewed on 10/31/23.

During the initial facility tour on 11/27/23, starting at 4:00 PM, R1, R7, R16, R18, R19, R21, R23, R26 and R27 were observed in their rooms either in bed or in a chair/recliner/wheelchair. R1, R16, R18, R21, R23, R26 and R27's right and left top side rails were in the up position. R1 and R27 stated they used the rails for bed mobility. R19 stated she did not sleep in a bed but in a recliner.

1. During an observation on 11/28/23 at 8:40 AM, R15 was observed sitting in his wheelchair in his room. There was a bed in the room. Both the right and left top side rails were in the up position and secured to the bed frame.

Review of R15's Care Plan revealed R15 was admitted to the facility on 6/8/22. Diagnosis included dementia, Parkinson's disease, diabetes, and sleep apnea. The Quarterly Minimum Data Set (MDS) assessment dated 9/5/23 revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of 7 out of 15.

Review of R15's untitled Bed Rail Consent verbally provided by R15's representative by phone on 3/8/23 revealed:
- A section titled Bed rails with an area to indicate Yes or No. This section was not completed.
- The next area of the form had areas to indicate

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if the Left, Right and Both rails where used. This section was not completed.
- The next area of the form had Reason for use: (circle all that apply): Repositioning, Transfers, Call light placement, Feeling of safety and Other: Explain. Nothing was circled but there was handwritten documentation that showed, "small rails on both sides he can grab to assist with position. These do not keep him from getting out of bed."
- The form then showed, "Risks of using side rails in bed include: Accident hazard (falls, entrapment, injuries); Barrier from safely getting out of bed; Physical restraint (hinders independence getting out of bed); Decline in function, such as muscle functioning/balance; Skin integrity issues; Decline in other areas of daily living, such as using the bathroom, continence, eating, hydration, walking, and mobility; Negative psychosocial outcomes, such as altered self-esteem, feelings of isolation, or agitation/anxiety."

Review of R15's untitled Bed Rail Consent form signed by R15's representative on 6/7/22 revealed the same omissions as the consent from 3/8/23 with handwritten documentation that showed, "small rails he can grab to assist with position and transfer. Do not keep him from getting out of bed."

Review of R15's untitled Bed Rail Consent verbally provided by R15's representative by phone on 12/14/22 revealed the same omissions as the consent from 3/8/23 with handwritten documentation that showed, "small rails in bed he can use to grab to assist with position and transfer. Do not keep him from getting out of

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F 700	Continued From page 83 bed." Review of R15's Care Plan and Physician Orders revealed no evidence of bed rails. Review of R15's Electronic Health record (EHR) revealed no evidence R15 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail installation. 2. During an observation on 11/28/23 at 8:52 AM, R6 was observed lying in bed. Both the right and left top side rails were in the up position in a bariatric bed. The rails were secure to the bed with no gap between the frame and the mattress. Review of R6's Care Plan revealed R6 was admitted to the facility on 10/26/22. Diagnoses included obstructive sleep apnea and patient's noncompliance with other medical treatment and regimen for other reasons. The MDS assessment dated 10/26/23 revealed the resident had intact cognition with a BIMS score of 15 out of 15. Review of R6's untitled Bed Rail Consent signed by R6 on 11/2/23 revealed the same omissions as R15's consent forms. The handwritten documentation showed, "small rails he can grab to assist with position. Do not keep him from getting up." Review of R6's Care Plan revealed no evidence of bed rails. Review of R6's Electronic Health record (EHR) revealed no evidence R6 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail installation.	F 700		

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3. During a concurrent observation and interview on 11/28/23 at 9:51 AM, R4 was observed in his bed. Both the right and left top side rails were in the up position. R4 stated he only used the right rail and said the facility had told him about the risks of using bed rails. R4 said he used the rail for stability with transfers. The right-side rail was secure to the bed with no gap between the frame and the mattress.

Review of R4's Care Plan revealed R4 was admitted to the facility on 2/8/17. Diagnoses include a stroke on the left non-dominant side, cellulitis of left lower limb, and vascular dementia. The Quarterly MDS assessment dated 9/4/23 revealed the resident had intact cognition with a BIMS score of 15 out of 15.

Review of R4's Care Plan revealed, "I have small rails on my bed that I can use to grab for assist with position and CNA transfer. These do not keep me from getting out of bed." Date Initiated: 6/7/2022.

Review of R4's untitled Bed Rail Consent verbally consented to by R4 on 12/7/22 revealed the same omissions as R15's consent forms. The handwritten documentation showed, "small rails he can use to grab for assist with position transfer."

Review of R4's Physician Orders revealed no evidence of bed rails.

Review of R4's Electronic Health record (EHR) revealed no evidence R4 had been assessed for bed rail use or that alternatives had been

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F 700	Continued From page 85 attempted prior to bed rail installation. 4. During a concurrent observation and interview on 11/28/23 at 10:18 AM, R24 was observed laying in his recliner listening to the television. There was a bed in the room that had both the right and left top side rails were in the up position. R24 stated he had very poor vision and required staff assistance for using his television remote and for walking. R24 stated he used one bed rail so he could use the call light. Review of R24's admission date revealed R24 was admitted to the facility on 1/11/23. Diagnoses include atrial fibrillation, diabetes, and vision impairment. The Quarterly MDS assessment dated 10/11/23 revealed the resident had intact cognition with a BIMS score of 15 out of 15. Review of R24's untitled Bed Rail Consent signed by R24 on 4/19/23 revealed a section titled Bed rails. "No" was checked. Review of R24's untitled Bed Rail Consent signed by R24 on 7/19/23 revealed the same omissions as R15's consent forms. The handwritten documentation showed, "He leaves small rails down." Review of R24's Care Plan revealed no evidence of bed rails. Review of R24's Care Conference Note, dated 10/18/23, revealed, "Devices Used: Bed Rails: small rails on bed he can use to grab to assist with position. These do not keep him from getting out of bed."	F 700		

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Review of R24's EHR revealed no evidence R24 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail installation.

5. During a concurrent observation and interview on 11/28/23 at 1:06 PM, R180 was observed sitting in her recliner listening to the television. There was a bed in the room that had both the right and left top side rails were in the up position. R180 stated she used the rails for bed mobility. The rails were secure to the bed with no gap between the frame and the mattress.

Review of R180's Care Plan revealed R180 was admitted to the facility on 11/9/23. Diagnoses include a fall with fracture, atrial fibrillation, diabetes, peripheral vascular disease, and femur fracture.

Review of R180's untitled Bed Rail Consent signed by R180 on 11/22/23 revealed the same omissions as R15's consent forms. The handwritten documentation showed, "small rails she can use to grab to assist with position and transfer these do not keep her from getting up unattended if she would want."

Review of R180's baseline Care Plan reveals that she was an assist of one with transfers and bed mobility but revealed no evidence of bed rail use. Review of R180's comprehensive Care Plan and Physician Orders revealed no evidence of bed rails.

Review of R180's EHR revealed no evidence R180 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail

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installation.

6. During a concurrent observation and interview on 11/28/23 at 1:39 PM, R14 was observed lying in his bed. Both the right and left top side rails were in the up position. The rails were secure to the bed with no gap between the frame and the mattress.

Review of R14's Care Plan revealed R14 was admitted to the facility on 7/20/23. Diagnoses included Congestive Heart Failure (CHF), lung cancer, and pneumonia. Review of the 5-day PPS (prospective payment system) assessment, dated 11/9/23, revealed R14 had moderate cognition with a BIMS score of 9 out of 15.

Review of R14's untitled Bed Rail Consent signed by R14 on 11/15/23 revealed the same omissions as R15's consent forms. The handwritten documentation showed, "small rails he can use to grab to assist with position and transfer these do not keep him from getting up."

Review of R14's Care Plan and Physician Orders revealed no evidence of bed rails.

Review of R14's EHR revealed no evidence R14 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail installation.

7. During a concurrent observation and interview on 11/28/23 at 2:38 PM, R13 was observed sitting in a recliner in his room. R7 was also sitting in a chair in the room. There was no bed in the room. R13 and R7 stated they slept together in R7's room. After the interview, R7's room was

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observed with two beds pushed together. The right top side rail of one bed, and the left top side rail of the other bed were in the up position.

Review of R13's Care Plan revealed R13 was admitted to the facility on 5/17/21. Diagnoses include Parkinson's disease, dementia, chronic obstructive pulmonary disease, and Bipolar disorder. The Quarterly MDS assessment dated 9/30/23 revealed the resident had moderate cognition impairment with a BIMS score of 9 out of 15.

Review of R13's Care Plan and Physician Orders revealed no evidence of bed rails.

Review of R13's EHR revealed no evidence of an informed consent or that R13 had been assessed for bed rail use or that alternatives had been attempted prior to bed rail installation.

Review of R13's Care Conference Note, dated 10/18/23, revealed, "Devices Used: Bed Rails: small rail on the side of the bed he can use to grab on to assist with position."

8. Similar findings were identified for the following sampled residents:
- R9, R12 and R25 did not have evidence of the alternatives attempted prior to bed rail installation, informed consent, bed rail assessment, physician orders or care plan documentation.
- R5, R11, R20, R17 R25 did not have evidence of the alternatives attempted prior to bed rail installation, bed rail assessment, physician orders or care plan documentation.

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During a facility tour on 11/30/23, starting at 9:24 AM, 22 of 24 occupied resident rooms had beds with beds rails in the up position. One of the 22 beds only had 1 bed rail up, while 21 beds had both bed rails up. One room did not have a bed in the room. One room had both bed rails down.

During an interview on 11/28/23 at 2:32 PM, Maintenance stated there were three different beds the facility used. There were two standard bed frames that residents used and one bariatric bed frame for R6. Maintenance stated he used the manufacturer's instructions for installation and maintenance. Maintenance said he did not routinely check the bed rails to ensure they were securely on the bed but if the nursing staff or the residents told him a bed rail was loose, he would tighten them.

During an interview on 11/29/23 at 1:43 PM, Certified Medication Aide (CMA) 8/CNA stated only the residents that are care planned to have a bed rail use them for safety or repositioning. CMA8 stated all the bed rails can be put in the down position.

During an interview on 11/29/23 at 2:42 PM, CMA9 stated most of the residents like to use the bed rails. CMA9 stated all the bed rails can be put down and maintenance could take them off the bed. CMA9 said all staff could check the bed rails and that she checked them anytime she was with a resident who was using the rail to position or transfer. CMA9 stated there was not a routine bed rail safety check.

During a concurrent interview and record review on 11/30/23 at 11:39 AM, the DON stated small

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F 700	Continued From page 90 rails on resident beds were not evaluated. The main reason for the rails to be in the up position was for re-positioning at the resident's request or through an evaluation by occupational therapy (OT). The OT evaluation and informed consents would be scanned into the resident's electronic health record (EHR). The DON stated that sometimes the facility will try alternatives to bed rails, but that therapy recommends bed rails because it would make the resident more independent for repositioning. The DON stated that residents who have dementia and bed rails were at greater risk for injury, such as suffocation from getting stuck between the bed rail and mattress. The DON stated that if a bed rail was loose, there also could be injuries from a fall. Cross reference F867.	F 700		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident (R) who displayed or was diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for 2 sampled residents (R12 & R13). Findings include:	F 744		

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Based on facility policy, "Dementia Care" implemented on 1/11/23, revealed in pertinent part that the facility would assess, develop, implement, and monitor care plans. The care plans would include achievable goals and interventions related to the individual symptomology and rate of dementia progression. The care plans would be developed through an interdisciplinary team (IDT) approach that included the resident and their representatives.

1. Review of R12's Care Plan revealed R12 was admitted on 1/5/23 and most recently readmitted on 9/18/23. Diagnoses included Alzheimer's disease, general anxiety disorder, dementia with psychotic disturbance delusional disorders, major depressive disorder, psychotic disorder with delusions, depression, specified anxiety disorder, and dysthymic disorder (persistent depressive disorder).

Review of the Quarterly Minimum Data Set (MDS) dated 9/18/23, revealed R12 had moderate cognition impairment with a BIMS score of 11 out of 15.

Review of the Behavior Progress Notes reveal decrease in frequency of noted behaviors of delusions requiring intervention. Notes dated 3/5, 3/15, 3/18, 3/19 two notes, 4/9 three notes, 4/28, 5/1, 5/7, 6/30, 8/15, 9/4, 9/21, 9/23, and 11/5/23. It can be noted that R12 was hospitalized due to illness, 9/21 & 9/23 notes related to behaviors refusing to leave room to eat can be attributed to that illness.

Review of R12's Psychiatry Provider Notes dated 3/29/23, 7/21/23, 9/14/23, and 11/22/23

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Physician 50 documented Chief Complaint(s) & Current Diagnosis/Problem List: major depressive disorder, recurrent, moderate; generalized anxiety disorder; Psychotic disorder with delusions due to known physiological condition; dysthymic disorder (persistent depressive disorder); dementia in other diseases classified elsewhere, moderate, with psychotic disturbance; and Alzheimer's disease.

On 3/29/23 Physician 50 documented "staff report that [R12] "has a BIMS of 13. It was 11 when tested previously. Her PHQ-9 is two. She has a history of depression and psychosis. She's had hallucinations. She continues to have some delusions." We discussed her clinical history, diagnoses, and psychotropic medications. We agree to adjust her psychotropic medications today ... Dementia/ Cognitive Impairment: Reports ... Reported: hallucinations and delusions; persistent depressive disorder."

"Problem(s) Addressed: Chronic illness with exacerbation, progression or side effects of treatment."

On 7/21/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 14 and PHQ-9 of one. She's doing better with the increase in her Abilify. She is less delusional and yelling less. She is eating better." Today, when I asked [R12] how she was feeling, she said "Okay; board." When asked if there was anything new, she said "No, other than they had water on my knee and they removed it yesterday." She was sitting on her bed and had good eye contact. Her affect was flat. She seemed dysphoric. At the and, she said "thank you. Bye now" ... Psychiatric review

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of Systems: Dementia/Cognitive Impairment: Reports ... Other Reported: hallucinations and delusions; persistent depressive disorder."

"Previously noted: [R12] is improved on her psychotropic medications and not having side effects ... Her psychiatric condition is chronic and progressive."

On 9/14/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 11 and PHQ-9 of zero. She was in the hospital ... She stays in bed all the time. She doesn't want to do anything. She has lost 10 pounds over the last month or so. Her weight is 128.5." We discussed her clinical situation and agreed to start her on mirtazapine for depression. Today, when I asked [R12] how she was feeling, she said "not so great this morning. There is nothing to do here." When asked if there was anything new, she said "I think that was under of what I told you." She seemed irritable and angry. She was sitting in her wheelchair and had fair I contact. Her affect was flat. At the end, she said "thank you." ... Psychiatric review of Systems: Dementia/Cognitive Impairment: Reports ... Other Reported: hallucinations and delusions; persistent depressive disorder, depression."

"[R12] appears depressed... She will be started on mirtazapine for depression today. Her psychiatric condition is chronic and progressive with acute exacerbation."

On 11/22/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 11 and PHQ-9 of zero. she is doing so much better. She is sleeping better. Her hallucinations and

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depression have decreased." Today, when I asked [R12] how she was feeling, she said "oh, I'm doing pretty good today; full of oatmeal. I'm doing much better than I was." When asked if there was anything new, she said "not much is new. The [team] one [sic] last weekend. She was lying in bed and had good eye contact. At the end, she said "thank you very much." ... Other Reported: hallucinations and delusions; persistent depressive disorder, depression."

"[R12] is improved on her psychotropic medications and not having side effects ... Her psychiatric condition is chronic and progressive."

Review of R12's Care Plan on 11/29/23 revealed, "I have depression, anxiety, and a delusional disorder ... I will see the psychiatrist when he does rounds and he will assess my condition and adjust my medications as needed ... Staff will be available for me to talk to if I need but during some of my delusions ect. I am not easily redirected, staff will assist me to call my family if needed ... Staff will give me my medications as directed. Staff will monitor for side effects of these medications and the doctor will review."

During an interview on 12/1/23 at 8:00 AM, MDS Coordinator stated she reviews nursing and physician notes or what she is told in morning huddle to update residents care plans. She said unless someone tells her something specific needs to be in the Care Plan she has to guess what is needed and most of what she puts in the care plan is general. The MDS Coordinator also stated that the nurses and other members of the Interdisciplinary Team can update the care plan,

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F 744	Continued From page 95 but they don't. During an interview on 12/1/23 at 9:00 AM, the Director of Nursing stated that Care Plans should be individualized for the resident and have measurable and realistic goals to help the resident as their disease progresses. She also said that it is important that the Interdisciplinary Team participates in Care Planning, but she does not believe that happens. 2. Review of R13's Medical Diagnoses on 11/1/23 revealed R13 was admitted to the facility on 5/17/21. Diagnoses included Parkinsons's disease, bipolar disorder, major depressive disorder, primary insomnia, dementia without disturbance, and other symptoms and signs involving cognitive functions and awareness. Further review showed R13's dementia diagnoses was added on 1/23/23, 9 months prior. Review of R13's Psychiatry Provider Note, dated 1/23/23, Physician 50 documented one of the chief complaints and current diagnosis/problem list was dementia. Documentation showed "Patient presents with a history of memory impairment, moderate in intensity, with additional impairments in executive functioning, learning, language, social cognition, as well as having visual perception problems, impacting the patient in all contexts of life and requiring structured living with nursing support. Meets criteria for a DSM [Diagnostic and Statistical Manual of Mental Disorders] diagnosis of Major Neurocognitive disorder/dementia." "[R13] also meets criteria for Parkinson's-related dementia and will be given that diagnosis today." "Consider adding rivastigmine [cognition-enhancing medication] for Parkinson's dementia."	F 744		

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Review of R13's Psychiatry Provider Note, dated 7/21/23, Physician 50 documented, "staff report that [R13] "Has a BIMS [Brief Interview for Mental Status] of 10 [moderate cognition] and a PHQ-9 [Patient Health Questionnaire] of one [minimal depression]. He's doing good." We agreed to start him on rivastigmine for Parkinson's related dementia. Today, when I asked [R13] how he was feeling, he said "I'm all right. Getting by." when I asked him if there was anything new, he said "Nothing that I know of." He was sitting in a recliner and had good eye contact. He had little to say. He was calm and in no distress."

Review of the Quarterly MDS dated 9/30/23, revealed R13 had moderate cognition impairment with a BIMS score of 9 out of 15. Further review revealed R13 did not display inattention, disorganized thinking or altered level of consciousness; nor did he display any moods or behavior.

Review of R13's 2023 Progress Notes revealed on 1/23/23, a note to begin discussing Rivastigmine and a note on 7/21/23 that R13 would begin Rivastigmine for his Parkinsons dementia. There was no evidence of any dementia assessment to identify and address R13's dementia care.

Review of R13's Care Plan revealed a focus area for depression, activities, Parkinson's, insomnia. The care plan also revealed R13 would like to be at home and "would like to be as calm and comfortable as possible on a daily basis" with interventions for staff to be available to talk, antidepressant therapy, social service visits

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biweekly. Pharmacological approaches include antidepressant and antipsychotic therapy for depression. However, there was no plan of care for R13's dementia, specifically the goals and treatment (Rivastigmine) for R13's memory impairment, executive functioning, social cognition, and visual perception as noted in Physician 50's assessment on 1/23/23 and 7/21/23.

During an interview on 12/2/23, starting at 8:00 AM, the MDS Coordinator/Registered Nurse (RN) stated she was responsible for resident assessments and care planning. The MDS Coordinator stated she reviewed all the information in the chart and included discussions from nursing meetings and huddles. The MDS Coordinator stated she did not know why R13 had a new diagnosis of dementia in January because they hadn't noticed any confusion or changes. The MDS Coordinator stated they could add a dementia care plan and add some interventions. She also stated the care plan should include non-pharmacological approaches to care and not just a medication. The MDS Coordinator said that having a goal would help to measure any decline.

During an interview on 12/1/23 at 11:20 AM, Licensed Practical Nurse (LPN) 3 stated the types of non-pharmacological interventions you should see in a care plan for residents with dementia include redirecting and reorienting to realty. LPN3 said other types of things we should expect in the care plan were decreased noise, lighting, and less stimulating environments. LPN3 stated R13 was hard of hearing and wore a hearing aide. "You need to be aware of your tone

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F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		

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limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure the drug regimen of each resident (R) was reviewed at least once a month by a licensed pharmacist for 3 of 5 residents reviewed for unnecessary medications (R1, R5 and R12).

Findings include:

A. During a record review on 11/28/23 revealed R5 was admitted to the facility on 1/25/23.

Review of R5's Electronic Health Record (EHR) revealed no evidence of Monthly Medication Reviews.

B. During a record review on 11/28/23 revealed R12 was admitted to the facility on 1/11/23 and most recently readmitted on 9/12/23.

Review of R12's EHR revealed no evidence of Monthly Medication Reviews.

C. During a record review on 11/28/23 revealed R1 was admitted to the facility on 1/13/23.

Review of R1's EHR revealed no evidence of Monthly Medication Reviews.

During an interview on 11/28/23 at approximately 2:30 PM, the Director of Nursing (DON) stated that Monthly Medication Reviews (MRR) can be

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found in the EHR's Miscellaneous section where scanned documents are uploaded. She also said, "have you looked in Progress Notes?"

During a later interview on 11/30/23 at 4:09 PM, the DON was given a list of residents and was asked for assistance getting R1, R5, and R12's MRR and GDR's as the information could not be located in each residents EHR. The DON was also asked to provide Medication Regimen Review and Gradual Dose Reduction Policies.

On 12/2/23 the DON provided documents. Review of documents revealed,
GDR policy was provided, but not the MMR policy.
R12:
-- R12 had a MMR dated/signed by the Consultant Pharmacist on 1/26/23.
-- No evidence provided for MMR's February - November 2023.
R5:
-- No evidence provided for MMR's January - November 2023.
R1:
-- No evidence provided for MMR's January - November 2023.

During an interview on 12/04/23 at 1:06 PM, the DON provided printed copies of MMR's and GDR's and stated, the MRR's provided was all that she has found and for the GDR's, she could not find evidence of any GDR's for last 18mo's for the residents requested.

During the same interview, the DON stated that the Pharmacist keeps their own record, and she may be able to get copies of the MMR's and

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F 756	Continued From page 101 GDR's. On 12/8/23 no further evidence was supplied by the DON.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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F 758	Continued From page 102 §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 record review and interviews, the facility failed to ensure a resident (R) was free from unnecessary psychotropic medications for 3 of 5 residents (R1, R12 and R13) reviewed for unnecessary psychotropic medications. Specifically, the facility failed to attempt a gradual dose reduction (GDR) of an antipsychotic medication for a resident on psychotropic medications. Findings Include: Review of facility policy, "Gradual Dose Reduction of Psychotropic Drugs," reviewed on 11/1/23 revealed in pertinent part, "Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." "Within the first year in which a resident is admitted on a psychotropic medication or after	F 758		

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the
prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated ...
3. After the first year, a GDR will be attempted annually, unless clinically contraindicated.
4. The timeframes and duration of attempts to taper any medication shall depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and
pharmacologic characteristics of the medications.
a. Tapering shall be consistent with accepted standards of practice.
b. Some medications (e.g., antidepressants, sedative/hypnotics, opioids) require more gradual tapering so as to minimize or prevent withdrawal symptoms or other adverse consequences.
c. Opportunities during the care process to consider whether the medications should be continued,
reduced, discontinued, or otherwise modified include:
i. During the monthly medication regimen review by the pharmacist.
ii. When the physician or prescribing practitioner evaluates the resident's progress.
iii. During the quarterly MDS review by the interdisciplinary team."

Review of facility policy, "Psychotropic Medication use in Residents with a Diagnosis of Dementia," reviewed and updated 10/11/22 revealed in pertinent part,
"It is the policy of [facility] to ensure that residents with a diagnosis of any form of Dementia and are

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F 758	Continued From page 104 on an antipsychotic medication receive the appropriate treatment and medication to ensure quality of life." "When a resident is on an antipsychotic medication and has a diagnosis of some for of Dementia, the following will be implemented: 1. AIMS [abnormal involuntary movement scale] test to be completed every 6 months. 2. BIMS [Brief Interview for Mental Status] to be done correlating with their MDS schedule, generally quarterly. 3. A current diagnosis to support the reason for the antipsychotic. 4. Pharmacy medication reviews with annual GDR (gradual dose reduction) suggestion made to Provider or Psychiatrist. 5. Resident to be seen by Provider and/or Psychiatrist according to policy and prn [as needed]. 6. Updates are made to care plans a medications and diagnosis changes are made by the Provider and/or Psychiatrist." A. Review of R12's Care Plan revealed R12 was admitted on 1/5/23 and most recently readmitted on 9/18/23. Diagnoses included Alzheimer's disease, general anxiety disorder, dementia with psychotic disturbance delusional disorders, major depressive disorder, psychotic disorder with delusions, depression, specified anxiety disorder, and dysthymic disorder (persistent depressive disorder). Review of the Quarterly Minimum Data Set (MDS) dated 9/18/23, revealed R12 had moderate cognition impairment with a BIMS score of 11 out of 15.	F 758		

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Review of R12's Physician Orders revealed the following psychotropic medications:
- Abilify 10 mg (antipsychotic) one time a day related to delusional disorders, start date 5/13/23.
- Donepezil 10 mg (cognition enhancing medication used to treat dementia and Alzheimer's disease) at bedtime for Alzheimer's disease with late onset, start date 3/29/23.
- Remeron 15 mg (antidepressant) at bedtime for major depressive disorder, start date 9/14/23.

Review of R12's Psychiatry Provider Notes dated 3/29/23, 7/21/23, 9/14/23, and 11/22/23 Physician 50 documented Chief Complaint(s) and Current Diagnosis/Problem List: major depressive disorder, recurrent, moderate; generalized anxiety disorder; Psychotic disorder with delusions due to known physiological condition; dysthymic disorder; dementia in other diseases classified elsewhere, moderate, with psychotic disturbance; and revealed decrease in frequency of noted behaviors of delusions requiring intervention. Notes dated Alzheimer's disease.

On 3/29/23 Physician 50 documented "staff report that [R12] "has a BIMS of 13. It was 11 when tested previously. Her PHQ-9 is two. She has a history of depression and psychosis. She's had hallucinations. She continues to have some delusions." We discussed her clinical history, diagnoses, and psychotropic medications. We agree to adjust her psychotropic medications today ... Dementia/ Cognitive Impairment: Reports ... Reported: hallucinations and delusions; persistent depressive disorder."

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"Problem(s) Addressed: Chronic illness with exacerbation, progression or side effects of treatment."

On 7/21/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 14 and PHQ-9 of one. She's doing better with the increase in her Abilify. She is less delusional and yelling less. She is eating better." Today, when I asked [R12] how she was feeling, she said "Okay; board." When asked if there was anything new, she said "No, other than they had water on my knee and they removed it yesterday." She was sitting on her bed and had good eye contact. Her affect was flat. She seemed dysphoric. At the and, she said "thank you. Bye now" ... Psychiatric review of Systems: Dementia/Cognitive Impairment: Reports ... Other Reported: hallucinations and delusions; persistent depressive disorder."

"Previously noted: [R12] is improved on her psychotropic medications and not having side effects ... Her psychiatric condition is chronic and progressive."

On 9/14/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 11 and PHQ-9 of zero. She was in the hospital ... She stays in bed all the time. She doesn't want to do anything. She has lost 10 pounds over the last month or so. Her weight is 128.5." We discussed her clinical situation and agreed to start her on mirtazapine for depression. Today, when I asked [R12] how she was feeling, she said "not so great this morning. There is nothing to do here." When asked if there was anything new, she said "I think that was under of what I told you." She seemed irritable and angry. She was sitting in her

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wheelchair and had fair I contact. Her affect was flat. At the end, she said "thank you." ... Psychiatric review of Systems: Dementia/Cognitive Impairment: Reports ... Other Reported: hallucinations and delusions; persistent depressive disorder, depression." "[R12] appears depressed... She will be started on mirtazapine for depression today. Her psychiatric condition is chronic and progressive with acute exacerbation."

On 11/22/23 Physician 50 documented "Staff report that [R12] "Has a BIMS of 11 and PHQ-9 of zero. she is doing so much better. She is sleeping better. Her hallucinations and depression
have decreased." Today, when I asked [R12] how she was feeling, she said "oh, I'm doing pretty good today; full of oatmeal. I'm doing much better than I was." When asked if there was anything new, she said "not much is new. The [team] one [sic] last weekend. She was lying in bed and had good eye contact. At the end, she said "thank you very much." ... Other Reported: hallucinations and delusions; persistent depressive disorder, depression." "[R12] is improved on her psychotropic medications and not having side effects ... Her psychiatric condition is chronic and progressive."

Review of the facility's AIMS Binder revealed, R12 is scheduled to have AIMS testing on 1/23/23 and 7/24/23. The AIMS binder had documentation that the testing occurred on 1/24/23 and 7/24/23. R12's AIMS scores for both exams were zero.

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F 758	Continued From page 108 R12 was on the following medication: Abilify - antipsychotic Buspirone - antianxiety Remeron - antidepressant Aricept - Dementia Review of R12's Care Plan on 11/29/23 revealed, "I have depression, anxiety, and a delusional disorder ... I will see the psychiatrist when he does rounds and he will assess my condition and adjust my medications as needed ... Staff will be available for me to talk to if I need but during some of my delusions ect. I am not easily redirected, staff will assist me to call my family if needed ... Staff will give me my medications as directed. Staff will monitor for side effects of these medications and the doctor will review." Review of the Tasks section of the EHR revealed, no behavior monitoring or medication side effect monitoring. Review of R12's EHR revealed no evidence of MMR's or GDR's. B. During a record review on 11/28/23 revealed R1 was admitted to the facility on 3/10/1999. Diagnoses include type 2 diabetes, schizoaffective disorder bipolar type, specific personality disorders, major depressive disorder, dementia with agitation, Alzheimer's disease, restlessness and agitation. Review of the Quarterly Minimum Data Set (MDS) dated 10/13/23, revealed R1 had normal cognition with a BIMS score of 15 out of 15. Review of R1's Physician Orders revealed the following psychotropic medications:	F 758		

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F 758	Continued From page 109 - Risperdal 0.5 mg (antipsychotic) at bedtime for Psychosis related to schizoaffective disorder, bipolar type, start date 3/10/22. - Latuda Tablet 80 mg (antipsychotic) in the evening for schizoaffective disorder, start date 5/13/2020. - Namenda XR 28 mg (cognition enhancing medication) at bedtime for Alzheimer's disease, start date 6/22/23. - Aricept Oral Tablet 10 mg (Dementia) in the evening for Dementia, start date 10/18/23. - Gabapentin 100 mg (for nerve pain and off label for anxiety and other conditions) 2 capsule by mouth three times a day for Diabetic Neuropathy, start date 10/3/2020. Review of R1's Psychiatry Provider Notes dated 5/12/23, 7/21/23, 9/14/23, and 11/22/23 Physician 50 documented Chief Complaint(s) and Current Diagnosis/Problem List: excortication disorder (Obsessive compulsive disorder - skin picking disorder), mild intellectual disabilities, other specific personality disorder with Cluster B features, dementia in other diseases classified elsewhere, moderate, with agitation, Alzheimer's disease, restlessness and agitation, patient's noncompliance with other medical treatment and regimen for other reason. On 5/12/23 Physician 50 documented "Staff report that [R1] "Is doing well. Her dementia is progressing. She's not talking as much. Her BIMS is 15 and her PHQ-9 is zero." We agreed to start her on memantine today for Alzheimer's dementia ... Today, when I asked [R1] how she was doing she said, "Oh, not too bad." When I asked her if there was anything new, she said	F 758		

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"Nothing new. I got a new wheelchair." She was sitting in her wheelchair. She had good eye contact. She had little to say. She offered no mental health complaints or concerns ... Dementia/ Cognitive Impairment: Reports ... Other Reported: mild intellectual disability."

"Medication Recommendations:
Continue current psychotropic medications with modification:
risperidone 0.5 mg at HS for SAD [seasonal affective disorder - type of depression]
Lurasidone 80 mg for SAD
donepezil 10 mg at HS for Alzheimer's dementia.
Begin memantine XR 7 mg for one week, then 14 mg for one week, then 21 mg for one week, then 28 mg at HS for Alzheimer's dementia."

On 7/21/23 Physician 50 documented "Staff report that [R1] "Is doing good. Her BIMS is 15 and her PHQ-9 is zero." Today, when I asked P[R1] how she was doing she said, "I'm still in her." When I asked her if there was anything new, she said "Oh, nothing new. Same old thing." She was sitting in her wheelchair. She had good eye contact. She had little to say. She offered no mental health complaints or concerns ... Psychiatric review of systems: Dementia/ Cognitive Impairment: Reports Other Reported: mild intellectual disability."

"Medication Recommendations:
Continue current psychotropic medications:
risperidone 0.5 mg at HS for SAD
Lurasidone 80 mg for SAD
donepezil 10 mg at HS for Alzheimer's dementia.
memantine XR 28 mg at HS for Alzheimer's dementia."

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F 758	Continued From page 111 On 9/14/23 Physician 50 documented "Staff report that [R1] "is great. Her BIMS is 15 and her PHQ-9 is zero." Today, when I asked [R1] how she was doing she said, "I'm okay." When I asked her if there was anything new, she said "oh, nothing new." She was lying in bed and have good eye contact. She had little to say. She offered no complaints or concerns ... Psychiatric review of systems: Dementia/ Cognitive Impairment: Reports, Other Reported: mild intellectual disability." Medication Recommendations: "Continue current psychotropic medications: risperidone 0.5 mg at HS for SAD Lurasidone 80 mg for SAD donepezil 10 mg at HS for Alzheimer's dementia. memantine XR 28 mg at HS for Alzheimer's dementia Switch to Namzaric for Alzheimer's dementia and discontinuing donepezil and memantine for medication simplification." On 11/22/23 Physician 50 documented "Staff report that [R1] "is doing fine. Her BIMS is 15 and her PHQ-9 is zero." Today, when I asked [R1] how she was doing she said, "pretty good." When I asked her if there was anything new, she said "oh, nothing new." She was lying in bed and have good eye contact. She had little to say. She offered no complaints or concerns. This apparently is her typical presentation ... Psychiatric review of systems: Dementia/ Cognitive Impairment: Reports - dementia; mild intellectual disability." Medication Recommendations:	F 758		

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"Continue current psychotropic medications:
risperidone 0.5 mg at HS for SAD
Lurasidone 80 mg for SAD
donepezil 10 mg at HS for Alzheimer's dementia.
memantine XR 28 mg at HS for Alzheimer's dementia.
NOTE: Insurance won't cover Namzaric for Alzheimer's dementia and discontinuing donepezil and memantine for medication simplification."

Review of the facility's AIMS Binder revealed, R1 is scheduled to have AIMS testing 5/12/23 and 11/[left blank].
The AIMS binder had documentation verifying that the testing occurred on 5/12/23. R12's AIMS score for the exam was one.

R1 was on the following medication:
Latuda - antipsychotic
Aricept - Dementia
Namenda - Dementia
Gabapentin - for nerve pain but used off label for anxiety and other conditions.

Review of the Behavior Progress Notes revealed isolated incident of noted behaviors of requiring intervention. One note dated 4/3/23.

Review of the Care Plan revealed,
"I have schizophrenic affective disorder and am on psychoactive medications.
Dr. [Name] (psychiatrist) did review my condition and medications and did not do a dose reduction on my Risperdal because he feels it would make my behaviors worse again and I am stable with where my dose is at. [sic] ... I am on Latuda and Risperdal for my schizophrenia. The psychiatrist

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adjusts dosages as needed ... I have no family or friends to talk to and assist me to make my decisions. I am able to make my own decisions ... Staff is available for me to talk to if I have any concerns or am feeling down ... Staff will monitor me for mood changes and side effects of my psychoactive medications such as changes in appetite, or any areas of concern. At certain times of the year I have a history of cutting up magazines, books, or other people's things and may steal pictures from a photo album or pieces of a puzzle or game. I will get a look in my eye that only staff will recognize. I will see Dr. [Name] (psychiatrist) as directed."

Review of the Tasks section of the EHR revealed, no behavior monitoring or medication side effect monitoring.
Review of R1's EHR revealed no evidence of MRR's or GDR's.

During an interview on 11/28/23 at approximately 2:30 PM, the Director of Nursing (DON) stated that Monthly Medication Reviews (MRR) can be found in the EHR's Miscellaneous section where scanned documents are uploaded. She also said, "have you looked in Progress Notes?"

During a later interview on 11/30/23 at 4:09 PM, the DON was was asked to assist getting R1, and R12's GDR's as the information could not be located in each residents EHR. The DON was also asked to provide Gradual Dose Reduction Policy.

On 12/2/23 the DON provided documents.
Review of documents revealed,
- GDR policy was provided.

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R12:
- No evidence provided for GDR's January - November 2023.
R1:
- No evidence provided for GDR's January - November 2023.

During an interview on 12/04/23 at 1:06 PM, the DON stated she could not find evidence of GDR's for last 18mo's for R1 and R12.

During the same interview, the DON stated that the Pharmacist keeps their own record, and she may be able to get copies of the GDR's.

On 12/8/23 no further evidence was supplied by the DON.
C. Review of R13's Medical Diagnoses on 11/1/23 revealed R13 was admitted to the facility on 5/17/21. Diagnoses included Parkinsons's disease, bipolar disorder, major depressive disorder, primary insomnia, dementia without disturbance, and other symptoms and signs involving cognitive functions and awareness.

Review of R13's Physician Orders revealed the following psychotropic medications:
- Trazodone (antidepressant/sedative) 25 milligrams (mg) daily for insomnia, start date 7/2/21
- Zyprexa (antipsychotic) 5 mg twice daily for bipolar disorder, start date 7/10/21
- Prozac (antidepressant) 20 mg daily for bipolar disorder and major depressive disorder, start date 1/24/23

Review of the Medication Binder provided by the Director of Nursing (DON) revealed no evidence

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of gradual dose reduction (GDR)s for R13's psychotropic medications.

Review of R13's Progress notes in 2023, revealed five Mental Health Visit entries by the DON on 1/23, 3/29, 7/21, 9/14 and 11/22. There was no evidence of a GDR.
During an interview on 11/30/23 at 11:35 AM, the DON stated that Physician 50 was aware of the regulations for GDRs and there should be documentation in Physician 50's documentation.

Review of R13's Psychiatry Provider Note, dated 1/23/23, Physician 50 documented "His psychotropic medications will be adjusted today." The documented Medication Recommendations included: discontinue Sertraline and begin Prozac 20mg; continue Trazodone 25mg and Zyprexa 5mg.

Review of R13's Psychiatry Provider Note, dated 7/21/23, Physician 50 documented, "His family said that he did poorly when he was not on Zyprexa ... We discussed his clinical situation and psychotropic medications in detail. We agreed to make some adjustments today." Further review showed, "[R13] is improved on his psychotropic medications and not having side effects." The documented Medication Recommendations included: continue Trazodone 25mg, Zyprexa 5mg, Prozac 20mg; and begin Rivastigmine.

During an interview on 11/30/23 at 11:35 AM, the DON stated for GDRs, either Physician 50 or the Pharmacist Consultant should identify and document when a GDR was needed, and the physician would have to document whether the

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GDR would be contra-indicated.
Review of the Pharmacy Consult notes revealed monthly medication reviews from January through October 2023. There was no evidence the pharmacy recommended or documented a GDR for R13's three psychotropic medications.

During an interview on 12/1/23 at 9:43 AM, the Pharmacist stated he was not responsible for the GDRs.

During an interview on 12/1/23 at 9:52 AM, the Pharmacist Consultant stated she completed the monthly medication reviews and would look in her notes find R13's GDRs for Trazodone, Zyprexa and Prozac. The Pharmacist Consultant stated R13 just started the Prozac this year but knew that a GDR should be attempted twice in the first year, separated by two quarters. "I try to do one at least annually for residents who are stable on their medication." The Pharmacist Consultant stated that before they switched to the current electronic medical record, they did a better job documenting pharmacy reviews and GDRs. The Pharmacist Consultant stated she had a binder at the Pharmacy she would review it to see if there were paper consultation notes that might not be getting into R13's medical record. The Pharmacist Consultant stated, either way, the formal process for GDRs must be followed. The recommendations must be documented, and the DON and Attending Physician have to be notified and the Attending Physician has to document the clinical rationale. The Pharmacist Consultant stated Physician 50 does his GDRs in his notes.

During a follow-up interview on 12/1/23 at 10:24

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F 758	Continued From page 117 AM, the Pharmacist Consultant stated Physician 50 documented the family said R13 did poorly without his Zyprexa. "I guess that is not really a GDR." The Pharmacist Consultant stated a GDR had not been done for the Trazadone since June 2022 and that a GDR was not done for the Paxil, though it was due.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food to residents and staff in accordance with professional standards for food service safety.	F 812		

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F 812	Continued From page 118 Specifically, the facility failed to: - ensure dishwasher temperatures (temps) were consistently logged on the correct form with appropriate temperature ranges for the low temp/chemical dishwasher to ensure the appropriate temperature and chemical concentration was being maintained throughout the day; and - ensure refrigerator, ice cream freezer, reach-in, and storage room temps were consistently logged on the temp logs; and - ensure the sanitation bucket log was consistently being completed to ensure the appropriate chemical concentration was being maintained throughout the day. These failures had the potential to cause foodborne illness among residents and staff who consume food and beverages prepared and served by the facility's kitchen. Findings include: Review of facility policy, "Cleaning Dishes/Dish Machine," dated 2019, revealed in pertinent part, "The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing." "Low Temperature Dishwasher Spray Type Dish Machines Using Chemicals to Sanitize - Wash Temperature 120° F, Final Rinse Temperature or Sanitization 50 PPM Hypochlorite" "Mechanical Dish Machine Using Hot Water to Sanitize - Hot water sanitizing rinse as it enters the manifold may not be more than or less than -	F 812		

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F 812	Continued From page 119 Final Rinse Temperature or Sanitization 194° F ..." Review of facility policy, "Dish Machine Temperature Log," dated 2019, revealed in pertinent part, "Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. Procedure: The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures. (See Sample Dish Machine Temperature and Sanitizer Log Form on the next page.) 1. Staff will monitor dish machine temperatures throughout the dishwashing process. 2. Staff will record dish machine temperatures for the wash and rinse cycles at each meal. a. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures. 3. Staff will be trained to report any problems with the dish machine to the director of food and nutrition services as soon as they occur. 4. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes." During an interview and concurrent observation on 11/27/23 at 4:18 PM, Cook1 was preparing the Supper meal he explained that there had been a problem with ordering food, and he had discussed with residents a meal substitution. He explained that meal substitutions can be pulled	F 812		

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from the dietician approved menus to ensure they meet nutritional requirements. Cook1 also revealed the plate warmer does not work. He further explained that the facility was going to get a new one but one of the refrigerators stopped functioning properly, so the facility needed to purchase a new refrigerator first. He said that a new plate warmer purchase was still pending.

During the same kitchen observation and record review on 11/27/23 at 4:29 PM revealed,
- "Record of Ice Cream Freezer Temperatures Nov 23"
-- No recorded temperatures for 10th, 13th, 18 & 19th, 24th, and 27th.
-- All other dates had temperatures recorded within the range of "Zero or less" listed on the log.

- "Record of Store Room Temperatures Nov 23"
-- No recorded temperatures for 10th, 18 & 19th, 24th, and 27th.
-- The 1st - 5th have recorded temperatures of 68 degrees with no corrective actions indicated
-- All other dates had temperatures recorded within the range of "70 - 80 degrees" listed on the log.

- "Record of Walk-in Cooler and Freezer Temperatures Nov 23"
-- No recorded temperatures for 10th, 13th, 18 & 19th, 24th, and 27th.
-- All other dates had temperatures recorded within the ranges for "Refrigerator (less than 41 degrees)" and "Freezer (Zero or less)" as listed on the log.

- "Record of Reach-In Cooler Temperatures Nov

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F 812	Continued From page 121 23" -- No recorded temperatures for 9th, 13th, 19th, 24th, and 27th. -- All other dates had temperatures recorded within the logs required ranges for "Refrigerator (less than 41 degrees)" as listed on the log. - "Dishwasher Temperature Chart Nov 23" -- No recorded temperatures, chemical levels or initials for any shifts (Morning, Noon, Evening) for 9th, 12th, 13th, 18th, 19th - 21st, 24th, or 27th. -- No recorded temperatures, chemical levels or initials for Evening shift for 6th - 8th and 11th - 27th. -- No recorded temperatures, chemical levels or initials for Noon shift for 9th, 12th, 13th, 17th, 18th, 19th - 21st, 24th, or 27th. -- All dates/shifts that had recorded chemical levels fell within the range of "Sani 50-100" as listed on the log. -- All dates/shifts that had recorded temperatures consistently fell between 120 - 150 and the section "If Temp < 180 or > 194 Corrective Action Taken" section was consistently left blank. -- At the bottom of the log there was "Note: Corrective action must be taken if final temperature does not reach 180 degrees, or exceeds 194 degrees." Review of Dishwasher Chlorine Test papers revealed expiration of 7/24. - "PH Tester/Sanitizer Checklist Nov 23" (Sanitizer bucket) -- No recorded chemical levels or initials for any shifts (Breakfast, Dinner, Supper) for 10th or 19th . -- No recorded chemical levels or initials for	F 812		

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F 812	Continued From page 122 Supper shift for 7th, 8th, 14th - 18th, 20th, 23rd, 25th - 27th. -- No recorded temperatures, chemical levels or initials for Dinner shift for 24th. Review of Sanitizer bucket ECOLAB Sink and Surface Cleaner Sanitizer Test Strips revealed expiration of June 2024. During an interview and concurrent observation on 11/29/23 10:14 AM, Cook2 revealed there has been no Dietary Manager since approximately September 2023. She stated the Administrator, and the Dietician are overall in charge of the kitchen. Cook2 said there is a core of 3 staff members with the most experience and who have been at the facility the longest, 1 traveler who has kitchen experience, who is learning the facility's processes and 2 new staff who are very new to kitchen with no experience. She said there are Production Sheets, which are for everyone to get tasks completed on their shift as well as the temperature and sanitation logs. During an interview and concurrent record review on 11/29/23 at 12:20 PM, the Administrator was asked about the Dietary Manager vacancy, and he revealed that he had the education to fulfil the requirement and would provide proof. During the same interview, the Administrator was asked to provide information about the Policy and Procedures for Kitchen Sanitation, Dishwasher Policy, and other policies that would encompass temperature and chemical logs for the kitchen. The Administrator was also shown a picture of the "Dishwasher Temperature Chart Nov 23,"	F 812		

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F 812	Continued From page 123 specifically the "If Temp < 180 or > 194 Corrective Action Taken" section was consistently left blank; and "Note: Corrective action must be taken if final temperature does not reach 180 degrees, or exceeds 194 degrees." The Administrator stated this was an old log that they [kitchen staff] used and he was not sure where they got it, because "the dishwasher the facility uses is a low temperature/chemical dishwasher." He further explained, "the dishwasher uses a chemical process and can't get too hot or the chemical will be rendered ineffective." The Administrator stated he recognized there were holes in all of their logs (temp & chemical). He was shown the logs and acknowledged the holes are random so there is no way of identifying individuals for retraining, that it is everyone working in the kitchen. During a record review on 11/30/23 at 1:29 PM, the Administrator provided evidence of credentials to fulfil requirements for Dietary Manager position. On 11/30/23 at 9:43 AM, the Administrator provided the following; - Cleaning Dishes/Dish Machine Policy dated 2019; and - Policy & Procedural Manual Dish Machine Temperature Log, dated 2019 with attached Sample Dish Machine Temperature and Sanitizer Log Form - not used in the facility; and - a copy of the PH Tester/Sanitizer Checklist Nov 23 - with current information. --The Kitchen Sanitation Policy was not provided. Review of the current "PH Tester/Sanitizer Checklist Nov 23" revealed,	F 812		

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F 812	Continued From page 124 - Addition of chemical level documentation for 27th Supper shift, after meal service had already been observed being prepared and served - documented after dinner preparation observation. - No recorded chemical level documentation for Supper shift 28th and 29th, or Dinner shift 29th, or Breakfast shift 30th. On 12/8/23 an email was sent to the Administrator and DON requesting the Kitchen Sanitation Policy as a second request. The DON returned the email stating that she would ask someone and "send what they [kitchen] has." On 12/12/23 no response from the Administrator or DON has been received.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		

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F 867	Continued From page 125 information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness	F 867		

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F 867	Continued From page 126 of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's	F 867		

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governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility's Quality Assurance and Performance Improvement/Quality Assessment and Assurance (QAPI/QAA) program, failed to self-identify and take action to address a high-risk, high-volume area that had the potential to cause an adverse event and affect resident safety. Specifically, the facility failed to implement a policy for bed rail use. This failure resulted in a substandard quality of care citation at F700 Bedrails.

Findings include:

Review of facility policy, "QAPI Plan" last updated 11/6/23, revealed in pertinent part:

- "The Purpose of QAPI is to monitor and investigate current practices to prevent adverse events and increase use of evidence-based practices. QAPI helps us to continually improve the way we care for and interact with our residents, caregivers, families, and others."

- "Each department will identify any problems in

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F 867	Continued From page 128 their area, perform a root cause analysis, offer solutions to what is being done to ensure this problem does not happen again, and give a time frame of how long you are monitoring the problem." On 12/1/23, review of the QAPI/QAA program binder and committee meeting minutes. provided by the Administrator and Director of Nursing (DON), revealed no evidence the facility had identified bed rails as an issue that required corrective action. During an interview on 12/1/23 at 11:37 AM, the Administrator stated he has been the Administrator at this facility for since July (five months) and should have noticed the bed rails. The Administrator stated he has been an Administrator for 22 years and was very aware of the importance of bed rail safety. "I've taken them off at another facility." He stated he has been down this road before but "It didn't click" at this facility. The Administrator stated the QAPI program had been focusing on other priorities such as mechanical lift safety and one other high risk complaint investigation. The Administrator stated the QAA committee met today to discuss bed rails and already had a plan in place. The Administrator said he has called around to see about buying different beds that do not have the controls built into the bed frame and they would also be assessing residents to ensure bed rails were used appropriately. Cross reference F700.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 129 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 130 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to 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. This failure had the potential to affect all residents (R).	F 880		

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F 880	Continued From page 131 Specifically, the facility failed to: A. Assess, measure and monitor the facility for opportunistic waterborne infections and Legionella and develop a facility water management plan; and B. Ensure residents respiratory equipment (Oxygen (O2) tubing, Nebulizer, and Continuous Positive Airway Pressure (CPAP) mask) are cleaned and stored in a sanitary manner, failing to follow facility policy and physician orders to ensure maintaenance of clean equipment for respiratory care (R14 & R15). Findings include: A. Review of professional reference from the Center for Disease Control and Prevention (CDC), recommendations for Legionella, last reviewed on 3/25/21, was retrieved on 12/5/23 at https://www.cdc.gov/legionella/wmp/healthcare-facilities/healthcare-wmp-faq.html read in pertinent part, "Healthcare facilities, such as hospitals and nursing homes, usually serve the populations at highest risk for Legionnaires' disease. These include older people and those who have certain risk factors, such as being a current or former smoker, having a chronic disease, or having a weakened immune system. Also, healthcare facilities can have large complex water systems that promote Legionella (the bacterium that causes legionnaires' disease) growth if not properly maintained. For these reasons, the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) consider it essential that hospitals and nursing homes have a water management program that is effective in limiting legionella and other opportunistic pathogens of	F 880		

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premise plumbing (waterborne pathogens, for short) from growing and spreading in their facility."

"Water management programs identify hazardous conditions and take steps to minimize the growth and spread of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key activities are routinely performed in a Legionella water management program: Establish a water management program team; describe the building water systems using flow diagrams and a written description; identify areas where Legionella could grow and spread; decide where control measures should be applied and how to monitor them; establish ways to intervene when control limits are not met; make sure the program is running as designed (verification) and is effective (validation); document and communicate all the activities."

"Members of a building water management program team work together to: Identify ways to minimize growth and spread of legionella and other waterborne pathogens, conduct routine checks of control measures to monitor areas at risk, and take corrective action if a problem is found."

"Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions. Programs should include predetermined responses to correct hazardous conditions if the team detects them."

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F 880	Continued From page 133 Review of facility policy, "[Facility Name] Legionella Surveillance," implemented 5/20/22, reviewed/revised 9/26/23 read in pertinent part, "Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems ... Legionella has to grow in numbers and be aerosolized so people can breathe in small, contaminated water droplets." "Legionella grows best in water temperatures of 77°F [degrees Fahrenheit] - l08°F, particularly in water that is not moving or that does not have enough disinfectant (i.e. pH 6.5-8.5) to kill germs." "Legionella can make people sick when the germs spread in droplets small enough for people to breathe in. Medical devices, cooling towers, showers, hot tubs, and fountains create aerosols." "Primary prevention strategies: ... Investigation for a facility source of Legionella, which may include culturing of facility water for Legionella ..." "Physical controls: i. Cooling towers and potable water systems shall be routinely maintained. ii. At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. iii. Non-potable water systems shall be routinely cleaned and disinfected. iv. Nebulization devices shall be filled only with sterile fluid (e.g., sterile water or aerosol medication)." "Temperature controls:	F 880		

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F 880	Continued From page 134 i. Cold water shall be stored and distributed below 68°F. ii. Hot water shall be stored above l 40°F and circulated at a minimum return temperature of 124°F." "Secondary prevention strategies: ... Full-scale environmental investigation to identify environmental sources ...Performing an environmental assessment ... Performing environmental sampling, as indicated by the environmental assessment ..." During an interview and concurrent record review on 11/29/23 at 9:39 AM, the facility's Maintenance staff revealed that there is "no water program per se [sic]." He further clarified that he checks water temperatures in resident rooms and other areas throughout the facility. The Maintenance staff produced a binder with 12 months of facility water temperatures, 6 months of water temperatures were reviewed. The Maintenance staff stated that he randomly checks resident rooms and tries to not check the same room from month to month. Temperatures in resident rooms were stable at 114°F -118°F. He further revealed that he was not sure if he checked vacant rooms and there was no indication on the temperature log if the room was a vacant room. The Maintenance staff revealed that there was no water testing other than testing temperatures. He said he thinks [Company] Water comes in and tests the water, but he would follow up with the Administrator. During an interview on 11/29/23 at 9:50 AM, the Administrator said that he would look for the [Company] Water test results.	F 880		

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	355103	A. BUILDING _____ B. WING _____	12/04/2023

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F 880	Continued From page 135 During an interview on 11/29/23 12:21 PM, the Administrator said that the Maintenance staff was looking for the water results in the Maintenance room. During an interview on 11/29/23 1:00 PM, the Maintenance staff said that he doesn't have water results. He was asked to coordinate with the Administrator to find the facility Water Program with the assessment, monitoring and surveillance information. During an interview on 11/29/23 1:10 PM, the Director of Nursing/Infection Preventionist (DON/IP) stated she had Legionella program documentation and would provide. During an interview and concurrent record review on 11/29/23 2:13 PM, the DON/IP provided the facility Legionella policy, City Water Results, and a CDC information sheet on Legionella. She revealed that she did not know where [Company] Water test results would be located, that it wasn't something she kept as part of the Legionella Program. During an interview on 11/29/23 at 4:45 PM, the DON/IP and NHA were told that parts of the Legionella Program had been received, but there hasn't been any evidence of a water flow diagram, facility/water assessment, monitoring and surveillance information. During a continuing interview on 11/29/23 at 4:50 PM, the DON/IP acknowledged that the City Water Results demonstrated that water coming into the facility was not contaminated, but the	F 880		

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F 880	Continued From page 136 facility had not demonstrated that their water program had assessed or tested for waterborne illness or Legionella and asked for the requirement reference. During an interview on 11/30/23 at 12:10 PM, the DON/IP was shown the federal requirement to assess, measure and monitor the facility for Opportunistic Waterborne Infections and Legionella. The DON/IP stated that facility did not have a facility Water assessment, ongoing measurements or monitoring, only monitoring resident health/illness conditions. During an interview on 12/1/23 at 10:21 AM, the Adminstrator stated that there is no building water assessment or vulnerability assessment. He plans to set up water testing and work with Maintainance staff to set up a program and keep a log of results. The Administrator also stated that he understands that building maintainenance and building walktroughs for safety will need to occur by leadership staff and that he will work closely with the DON/IP to make sure they met the requirement. B. Review of facility policy, "[Facility Name] Policy and Procedure on Nebulizer Treatment" last reviewed 5/24/23, revealed in pertinent part, "Procedure: 7. Nebulizer treatment mask are to be cleaned daily and replaced weekly. 9. Document that cleaning and replacement has been completed in treatment section of MAR [medication administration record]." Review of facility policy, "[Facility Name] Storage of nebulizer equipment" last reviewed 10/31/23,	F 880		

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F 880	Continued From page 137	F 880		

revealed in pertinent part,
"Policy: To help stop the spread of infection, nebulizer tubing will be kept in a bag.
Procedure: When a resident has orders for nebulizer treatments the following will be done with the tubing
1. Put on treatment sheet to be changed every two weeks.
2. Date the tubing and the bag.
3. Be sure tubing is in bag whenever nebulizer treatment is done and each time you are in the room."

Review of facility policy, "[Facility Name] Nebulizer Therapy" last revised 11/6/23, revealed in pertinent part,
"Care of the Equipment
1. Clean after each use.
2. Wash hands before handling equipment.
3. Disassemble parts after every treatment.
4. Rinse the nebulizer cup and mouthpiece with tap water.
5. Shake off excess water.
6. Air dry on an absorbent towel.
7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag.
8. Change the nebulizer tubing every two weeks per facility policy.
9. Periodically disinfect per manufacturer's recommendations."
CPAP/BIPAP (continuous positive airway pressure/bilevel positive airway pressure) are machines to helps with breathing.

Review of facility policy, "[Facility Name] CPAP/BIPAP Cleaning" revised 10/31/23, revealed in pertinent part,
"Policy Explanation and Compliance Guidelines:

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F 880	Continued From page 138 2. Respiratory therapy equipment can become colonized with infectious organisms and serve as a source of respiratory infections. 6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. 7. Weekly cleaning activities (specify day of the week): a. Wash headgear/straps in warm, soapy water and air dry. b. Wash tubing with warm, soapy water and air dry. 8. Follow manufacturer instructions for the frequency of cleaning/replacing filters and servicing the machine. Only the supplier may service the machine." 1. Review of R14's Care Plan revealed R14 was admitted to the facility on 7/20/23. Diagnoses included congestive heart failure (CHF), lung cancer, and pneumonia. The Annual Minimum Data Set (MDS) assessment dated 11/13/23 revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 9 out of 15. During an observation in R14's room on 11/28/23 at 1:51 PM revealed an oxygen concentrator (device that concentrates the oxygen from a gas supply) was in R14's room with a nasal cannula that was laying over it and was not in a bag. A Nebulizer (a device for producing a fine spray of liquid, used for example for inhaling a medicinal drug) was also in the room on a table and the nebulizer mask was laying on the table, not laying on a paper towel or in a bag.	F 880		

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2. Review of R15's Care Plan revealed R15 was admitted to the facility on 6/8/22. Diagnosis included sleep apnea. The Annual Minimum Data Set (MDS) assessment dated 9/5/23 revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of 7 out of 15.
Further review of R15's Care Plan revealed "Staff will apply my CPAP as directed. I will not always leave this on. Staff will clean CPAP machine as directed." This entry was entered on 8/28/23.

Review of R15's treatment administration record (TAR) revealed an order for the CPAP to be cleaned daily with vinegar water in the morning. Another order stated, "apply CPAP at night and remove in the morning. Clean CPAP daily with vinegar water every morning and at bedtime."

During an observation in R15's room on 11/28/23 at 8:42 AM revealed the CPAP mask and machine were on R15's bedside table. The mask was not on a paper towel or in a bag and was connected to tubing.

An observation in R15's room on 11/29/23 at 1:53 PM revealed that the CPAP mask was not on a paper towel or in a bag. There was a washcloth lying on top of the CPAP machine.

An observation in R15's room on 11/30/23 at 9:24 AM revealed the CPAP mask appeared rinsed and was laying on a cloth.

During an interview on 11/29/23 at 12:23 PM, the DON said nebulizers should be cleaned and rinsed out and put in plastic bags. The DON stated that oxygen tubing should be changed

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F 880	Continued From page 140 every two weeks. If a resident is no longer using equipment, the DON stated staff should have pulled out the oxygen tubing but kept the machines in the room in case they needed them later for a resident. The DON stated that nursing is responsible for the CPAP cleaning and medication aides are responsible for cleaning the nebulizer, but some residents can take nebulizers off themselves. The DON stated the MDS coordinator is responsible for care planning. During an interview on 11/29/23 at 1:49 PM, the Certified Medication Aide/Certified Nursing Assistant (CMA/CNA) 8 stated that after nebulizer treatments are given, CMA/CNA will rinse them out and leave them to dry on a paper towel.	F 880		