STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	725 BUCHANAN ST., NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Long Term Care Survey Recertification Survey was conducted at Ascension Living Carroll Manor from July 19, 2021, through July 28, 2021. Survey activities consisted of a review of 60 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 173. The following complaints and facility reported incidences were investigated: DC00010112 DC00010117 DC00010118 DC00010120 DC00010149 DC00010159 DC00010169 DC00010173 The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations	F 000	Carroll Manor Nursing & Rehabilitation Center makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	9/17/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ED	8-27-2021

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

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F 000	Continued From page 1	F 000		

CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological

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F 000	Continued From page 2 NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		

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	095034	A. BUILDING _____ B. WING _____ OMB NO. 0938-0391	07/28/2021

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F 584	Continued From page 3 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by a dome cover that was missing from one (1) of 10 ceiling lights in the fifth floor dining room, dome covers that were missing from two (2) of nine (9) ceiling lights in the second floor dining room, a dome cover that was missing from one (1) of 10 ceiling lights in	F 584	F584 1.Environmental Services Director or Designee reviewed and addressed the following items: **a.** The ceiling light dome covers in the dining rooms (1st, 2nd, and 5th floor) were replaced on 7/22/2021. **b.** The ceiling tiles in the 5th floor Activity's Room were replaced on 7/22/2021. **c.** The dresser knob in room 254 was replaced on 7/22/2021. **d.** The water temperatures in rooms: 114, 135, 205, 230, 235, 313, 315, 414,431, and 433 were retested on 7/22/2021 and were within acceptable range. **e**.2nd floor dining room missing electrical outlet outside cover on 7/22/2021 **2**.The Environmental Services Director or Designee made rounds to ensure that the ceiling lights on each of the units have covers; that there are no stained ceiling tiles; that dressers have knobs; water temperatures are within acceptable ranges and outlets have covers. No new findings observed. **3.**The Environmental Services Director or Designee will re-educate the maintenance associates on ensuring that the ceiling lights on each of the units have dome covers; stained ceiling tiles are replaced; dressers have knobs; water temperatures are within acceptable ranges; and electrical outlets have covers. The facilities maintenance associates will randomly observe: two units of ceiling lights to ensure that they have covers; two units of ceiling tiles to ensure that stained tiles are replaced; two units of resident rooms to ensure that electrical outlets have covers; and two units of dresser knobs. The observations will be conducted on a monthly basis for 3 months	9/17/2021 9/17/2021 9/17/2021

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F 584	Continued From page 4 the first floor dining room, two (2) stained ceiling tiles in the Activity's room on the fifth floor, one (1) of eight (8) electrical outlets in the second floor dining room that lacked an outside cover, low water temperatures in 10 of 47 resident's rooms, and missing dresser knobs from one (1) of 47 resident's rooms. The findings included: During an environmental walkthrough of the facility on 07/21/2021 and 07/22/2021, the following was observed: 1. One (1) of 10 ceiling light dome cover located in the dining room on the fifth floor was missing. 2. Two (2) of nine (9) ceiling light dome covers located in the dining room on the second floor was missing. 3. One (1) of ten (10) ceiling light dome cover located in the dining room on the first floor was missing. 4. Two (2) ceiling tiles in the Activity's room on the fifth floor were stained. 5. One (1) of eight (8) electrical outlets in the dining room on the second floor did not have an outside cover. 6. Water temperatures were tested at less than 95 degrees Fahrenheit in 10 of 47 resident's rooms, including rooms #114, #135, #205, #230, #235, #313, #315, #414, #431, #433. 7. Knobs were missing off a dresser in resident room #254	F 584	F584 (continued) The facilities maintenance associates will also randomly test the water temperature of 4 rooms per resident wing per week. **4**.The results from the observations will be reviewed during the monthly QAPI meeting times 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021

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F 584	Continued From page 5 During a face-to-face interview conducted on 07/22/2021, at approximately 12:30 AM, Employee #7 acknowledged the findings.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the	F 622	F622 **1.**Resident #1 returned from the hospital on 5/24/2021. Resident #92, returned from the hospital on 8/6/2021. Resident #145 returned from the hospital on 8/3/2021. **2**.The unit manager or designee reviewed the documentation of current hospitalized residents on 8-24-2021 to ensure that the receiving hospital has the resident care plan goals. **3**.The nurse educator or designee will re-educate the licensed nurses on ensuring that the resident care plan is a part of the transfer documents. The unit manager or designee will review resident hospital discharges 5 days per week for 3 months to ensure that the receiving hospital has the resident care plan goals. **4.**The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 622	Continued From page 6	F 622		

resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:

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F 622	Continued From page 7	F 622		

(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews, facility staff failed to ensure all required documents were conveyed to the receiving health care provider for three (3) of 60 sampled residents that were transferred from the facility to the hospital. Residents' #1, #92 and #145.

The findings included:

1. Resident #1 was admitted to the facility on 10/13/2016, with diagnoses of Peripheral Vascular Disease Unspecified, Vitamin D Deficiency, Muscle Weakness, and Hypertension.

Review of the physician's order dated 05/23/2021, directed, "Send Resident to ER (emergency room) for s/p (status post) fall and fracture"

Review of Resident #1's transfer documents dated 05/23/2021, lacked evidence that the facility staff included the care plan goals with the transfer documents.

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F 622	Continued From page 8	F 622		

During a face-to-face interview conducted on 07/28/2021, at 4:21 PM, Employee #28, acknowledged the finding and stated, "The care plan is separate, we did not send it with them."

2. Resident #92 was readmitted to the facility on 06/01/2021, with diagnoses that included: Cancer, Hypertension, Diabetes Mellitus, Dementia, Dysphagia, and Gastrostomy Status.

Review of the medical record revealed:

A nursing progress note dated 3/16/2021, documented, "....NP (Nurse Practitioner) order given to transfer resident via 911 to the nearest ER (emergency room) for further evaluation of unresponsiveness..."

Review of the physician's orders showed the following:

05/11/2021 at 15:50 [3:50 PM], "Transfer resident to [Name of Hospital] on 5-12-21 to treat her [unable to read] Limbic Encephalitis, direct admission"

06/02/2021 at 20:00 [8:00 PM] "Transfer resident via 911 due to G-Tube (gastrostomy tube) malfunction, patient has a history of seizure and has not taken her medication."

A review of the documents [transfer packet] sent to the emergency room with Resident #92 on 05/11/2021 and 06/02/2021, lacked documented evidence that the resident's comprehensive care plan goals were included in the documents sent to the hospital (receiving provider).

During a face-to-face interview with Employee

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F 622	Continued From page 9 #28 (2nd floor Unit Manager) on 06/22/2021, at approximately 10:50 AM, she acknowledged that the comprehensive care plans goals were not sent to the hospital with the resident. 3. Resident #145 was admitted to the facility on 07/05/2009, with multiple diagnoses including Heart Failure, Respiratory Distress, Acute Kidney Failure, and Obesity. Review of the document entitled, "Transfer Sheet", dated 07/22/2021, revealed, "...Nurse reason for discharge/transfer ...for evaluation due to respiratory distress... MD (medical doctor) called order given to send resident emergency department (room) for further evaluation. 911 called ..." Review of the physician's order [telephone order] revealed: 07/22/2021 "transfer resident out to the nearest ER (emergency room) for evaluation and treatment of respiratory distress." Review of the transfer documents lacked evidence that the facility staff included the resident's comprehensive care plan goals. During a face-to-face interview on 07/22/2021 at approximately 1:00 PM, Employee #17 (Medical Records) stated that the resident's care plan goals are not included in the transfer documents sent to the hospital (emergency room) when residents are transferred.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 10 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 60 sampled residents, facility staff failed to accurately code a resident's assessment on the Minimum Data Set (MDS). Resident #152. The findings included: Resident #152 was admitted to the facility on 03/25/2021, with multiple diagnoses that included: Parkinson's Disease, Malnutrition, Adult Failure to Thrive and Dehydration. Review of the Quarterly MDS dated 06/29/2021, revealed in Section P (Restraints) that facility staff coded Resident #152 as, "Physical Restraints- Bed rail- used less than daily", indicating that the bedrail was being used as a restraint. During a face-to-face interview conducted on 07/28/2021, at 1:30 PM, Employee #11 (MDS Coordinator) acknowledged the finding and stated, "That assessment [MDS dated 06/29/2021] was coded in error. We don't use restraints in this facility. It needs to be modified."	F 641	F641 1. Resident #152's MDS was corrected by the MDS coordinator on 7/28/2021. 2. The MDS coordinators will review section P of current residents before Sep 17, 2021 to ensure correct coding. 3. The MDS Manager or designee re-educated the MDS associates on accurate coding of section P. The MDS coordinator will review completed MDS' on a monthly basis for 3 months to ensure that section P is coded accurately. 4. The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		

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F 655	Continued From page 11 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for	F 655	**F655** **1**.Resident #87's care plan was reviewed and completed on 8-27-2021 by the licensed nurse to address indwelling catheter Resident #372 was discharged on 8/8/2021. **2**.A Review of current residents' Care plans admitted during August 2021 were completed on 8-27-2021 to ensure that residents' Baseline care plans/ care plans were completed **3.**Facility staff was educated on completing the baseline care plans within 48 hours of admission. The Unit Manager or Designee will audit all new admissions baseline care plans for 3 months to ensure completion of baseline care plans within 48 hours of admission. **4**.The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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two (2) of 60 sampled residents, facility staff failed to develop and implement a baseline care plan within 48 hours of two (2) residents' admission. Residents' #87 and #367.

The findings included:

1. Resident #87 was admitted to the facility on 03/15/2021, with multiple diagnoses that included: Renal Insufficiency, Urinary Retention, Benign Prostatic Hypertrophy (BPH), and Non-Alzheimer's Dementia.

Review of the Significant Change Minimum Data Set (MDS) dated 05/25/2021, revealed the following:

In Section H (Bowel & Bladder), "... Appliances-Indwelling catheter"

Review of the physician's orders revealed:

05/19/2021 "Foley: Change Foley Catheter- 16 Fr (French) 10 ml (milliliters) every month..."

05/19/2021 "Indwelling catheter every shift due to urinary retention/BPH ..."

Review of the progress notes revealed:

05/19/2021 at 1:53 PM (nursing note) "[Resident #87] ... readmitted on 5/18/21 ... Foley catheter 16 F (French) in place secondary to prostate CA (cancer) and urinary retention..."

During a review of Resident #87's medical record to include the care plan section of the record, there was no documented evidence that facility staff developed a baseline care plan [within 48

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hours of admission] to address his use of an indwelling catheter.

During a face-to-face interview conducted on 07/28/2021, at approximately 1:00 PM, Employee #5 (4th floor Nurse Manager) acknowledged the finding and stated, "The admitting nurse doing the admissions assessment should have initiated that care plan [indwelling catheter]."

2. Resident #372 was admitted to the facility on 07/15/2021, with multiple diagnoses that included: History of Falling, Chronic Kidney Disease, Hypertension and Type 2 Diabetes Mellitus.

Review the facility's document entitled, "Falls Risk Assessment" dated 07/15/2021 revealed that Resident #372 had a documented score of "22... a resident whose score is over 9 is at risk for falls ..."

Review of the progress notes revealed the following:

07/15/2021 at 8:07 PM (nursing note) "Resident... admitted from [hospital name]... where she was treated for left side pain post fall from her bed..."

07/18/2021 at 2:22 PM (nursing note) " ... the resident was observed sitting on the floor on her buttocks besides her bed facing the wall... Resident is s/p (status post) new admission day 3 who presented to the ED (emergency department) after a fall at home ..."

Review of Resident #372's medical record to include the care plan section, lacked documented evidence that facility staff developed a baseline care plan [within 48 hours of admission] to

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F 655	Continued From page 14 address falls. During a face-to-face interview conducted on 07/26/2021, at approximately 11:30 AM, Employee #6 (Registered Nurse) acknowledged the finding and stated that either the nurse managers or the admitting nurse on the unit develops the baseline care plans.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

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F 656	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 60 sampled residents, facility staff failed to develop and implement a comprehensive person-centered care plan. Resident #87. The findings included: Resident #87 was admitted to the facility on 03/15/2021, with diagnoses that included: Renal Insufficiency, Urinary Retention, Benign Prostatic Hypertrophy (BPH), and Non-Alzheimer's Dementia. Review of the Significant Change Minimum Data Set (MDS) dated 05/25/2021, revealed in Section H (Bowel & Bladder), "... Appliances- Indwelling catheter". Review of the physician's orders revealed: 05/19/2021 "Foley: Change Foley Catheter- 16 Fr (French) 10 ml (milliliters) every month..." 05/19/2021 "Indwelling catheter every shift due to	F 656	F656 1.Resident # 87's care plan was reviewed and updated with person-centered approaches to include a foley catheter by the licensed nurse 8-27-2021. 2.A review of current residents care plans was completed by the licensed staff on or before September 17, 2021 to ensure that residents care plans included person-centered approaches. 3.Staff was re-educated on providing person-centered approaches to care plans. The Unit Manager or Designee will review resident care plans during the care plan meeting on a weekly basis for 3 months to ensure that care plans include person-centered approaches. 4. The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is Indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 656	Continued From page 16 urinary retention/BPH ..." Review of the progress notes revealed: 05/19/2021 at 1:53 PM (nursing note) "[Resident #87] ... readmitted on 5/18/21 ... Foley catheter 16 F (French) in place secondary to prostate CA (cancer) and urinary retention..." During a review of Resident #87's care plan on the 07/28/2021, there was no documented evidence that facility staff developed a person-centered care plan to address his use of an indwelling catheter. During a face-to-face interview conducted on 07/28/2021, at approximately 1:00 PM, Employee #5 (4th floor Nurse Manager) acknowledged the finding and stated, "The admitting nurse doing the admissions assessment should have initiated that care plan [indwelling catheter]."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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F 657	Continued From page 17 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 60 sampled residents, the facility staff failed to update/revise the resident's care plan to include person-centered aspects of care. Residents' #2, #51 and #92. The findings included: 1. Facility staff failed to update/revise the resident's care plan to include person-centered aspects of care for the resident's ileostomy. Resident #2 was admitted to the facility on 05/19/2009, with diagnoses that include: Ileostomy, Renal Insufficiency and Gastroesophageal Reflux Disease. The Annual Minimum Data Set completed on 07/06/2021, showed the resident was coded as having an ostomy (ileostomy) under Section H (Bladder and Bowel); and Section I (Active Diagnoses) was coded encounter for attention ileostomy.	F 657	F657 1.Resident #2 Care plan was reviewed and updated with person-centered approaches by the licensed nurse on 7/26/2021 to include ileostomy site treatment, Resident #51 Care plan was reviewed and updated with person-centered approaches by the licensed nurse on 7/27/2021 to include falls interventions. Resident # 92 Care plan was updated with person-centered approaches to include removal of remeron by the licensed nurse on 7/29/2021. 2.A Review of current residents care plans will be completed by the license staff to ensure that residents care plans include person-centered approaches on or before September 17, 2021. 3.Staff was re-educated on providing person-centered approaches to the resident care plans. The Unit Manager or Designee will resident care plans during the weekly care plan meetings for 3 months to ensure that care plans include person-centered approaches. 4.The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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Review of the physician's orders dated and signed on 06/02/2021, directed the following:

"Ostomy site ...cleanse stoma site with water and pat dry and apply powder

Cleanse stoma site with skin prep with each ileostomy bag change as needed nurses to supervise ...use no sting barrier film."

Review of the care plan in the category titled, "Bowel and Bladder" last updated 07/06/2021, showed approaches were not updated to include the aforementioned physician ' s orders in place to treat Resident #2 ' s ileostomy site.

During a face-to-face interview with Employee #28 conducted on 07/26/2021 at 5:34 PM, she reviewed the care plan and the orders and acknowledged the findings.

2. Facility staff failed to revise Resident #51's Fall Care Plan with new and adequate interventions.

Resident #51 was admitted to the facility on 08/26/2016. The medical record revealed the resident had multiple diagnoses including Dementia, Generalized Muscle Weakness, Wandering, History of Falling, Left Artificial Hip Joint, and Fracture of Neck of Left Femur.

Review of the medical record revealed the following:

09/19/2020 at 11:00 AM - [Nursing Note] - " ...she [Resident #51] states while going back and forth to use the bathroom she fell, got up without assistance and that alleged fall occurred this

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F 657	Continued From page 19 morning ...has some soreness in right knee ..." 04/15/2021 at 2:37 AM [Nursing Supervisor Note] - " ...I saw the resident sitting on the floor in front of her room ...Resident complained of sever pain in her left hip ...The resident is alert to herself but confused ...We did not move or turn the resident from the floor ...MD (medical doctor) said to send resident ot (sp) hospital for evaluation and treatment ...911 crew arrived ... left facility at 1:14AM ..." 04/23/2021 [Physician Progress Note] MD (medical doctor) readmission ...patient was sent to [hospital name] s/p (status post) fall sustained left hip fracture s/p (status post) left hemiarthroplasty ..." 07/27/2021 at 7:50 AM [Physician Geriatric Progress Note] - "Pt (patient) c/o (complained of) severe pain rt (right) hip ... she said [that she]fell down while trying to go to bathroom and got back to bed herself ... transfer to ER (emergency room) acute severe pain ..." 07/27/2021 at 8:00 AM [telephone - physician order] - "Transfer resident via 911 to ER (emergency room) for acute severe right hip pain". 07/27/2021 at 9:45 AM [Nursing Note] - "Writer's attention was called to the resident's room secondary to complaining of pain in her right hip during care... that won't go away ... Resident ... remained alert, oriented to her name only and able to verbally make her needs which is her baseline secondary to diagnosis of Dementia ...Resident confirmed that she did not tell anyone that she fell ... prior to now... 911 called ...first	F 657		

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responder in house ... left with resident via stretcher to [hospital name] ..."

Review of the Significant Change Minimum Data Set (MDS) dated 04/29/2021 revealed the following:

In section A (Assessment Reference Date) - 04/29/2021

In section G (Toileting Use) - the resident was coded as total dependence and requiring one-person physical assist.

In section G (Mobility Device) - the resident was coded as using a wheelchair.

In section I (Active/Other Diagnoses) - the resident was coded as history of falling, generalized muscle weakness and presence of left artificial hip joint.

In section J (Health Condition - Fall History/ Recent Surgery)- the resident was coded as having fracture related to fall and having major surgery.

In section O (Special Treatments, Procedures, and Programs) - the resident was coded as receiving speech, physical and occupational therapy services.

In section V (Care Area Assessment Summary) - indicated that the resident triggered for falls, which were addressed in the resident ' s care plan.

Review of Resident #51's Fall Risk Assessments revealed the following:

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F 657	Continued From page 21 On 04/15/2021 - the resident had a score of 14. On 04/22/2021 - the resident had a score of 24. On 06/04/2021 - the resident had a score of 20. According to the fall risk assessment, "A resident whose score is over 9 is at risk for falls." Review of the Fall care plan with a start date of 10/23/2018 lacked documented evidence that the Inter-Disciplinary Team revised it from 04/15/2021 to 07/27/2021 with new and adequate interventions to mitigate or prevent falls. During a face-to-face interview on 07/27/2021 at approximately 11:00 AM, Employee #5 (Unit Manager) acknowledged that no additional interventions for the fall care plan were "put in place" after 04/15/2021. Facility staff failed to update/revise the resident ' s care plan to reflect the appropriate disciplines to implement the approaches to the resident ' s care and failed to update the resident no longer receiving Remeron as an appetite stimulant. 3. Resident #92 was readmitted to the facility on 06/01/2021 with diagnoses that included: Cancer, Hypertension, Diabetes Mellitus, Dementia, Dysphagia, and Gastrostomy Status. According to the Minimum Data Set completed on 06/08/2021, the resident was coded for having a feeding tube under Section K (Swallowing/Nutritional Status). Review of the physician's order dated 06/02/2021	F 657		

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directed, "Glucerna 1.2 at 75 ml (milliliters)/hr (hour) times 18 hours"

Review of the care plans revealed the following:

"Category ' Feeding Tubes' last updated 06/01/2021

Approach- "administer water flushes as ordered; disciplines: Certified Nursing Assistant, Nursing, Physician

Assess for placement/patency of gastrostomy site; disciplines: Certified Nursing Assistant, Nursing, Physician

Assess GI (gastrostomy) function and tolerance to feedings; disciplines: Certified Nursing Assistant, Nursing, Physician

Flush tube with 30 ml (milliliters) of water before and after medication administration; disciplines: Certified Nursing Assistant, Nursing, Physician ..."

The aforementioned approaches list "certified nursing assistants" as a interdisciplinary team member identified to implement approaches.

According to "District of Columbia Register Vol. 66 - No. 35, August 23, 2019 Chapter 96, Certified Nursing Assistants" the aforementioned approaches are not within the scope of practice for a Certified Nursing Assistant.

Review of the physician's orders dated 07/01/2021 directed, "D/c (discontinue) Remeron.

Review of the care are plan last updated 03/26/2021 showed, "Psychotropic Drug Use...

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F 657	Continued From page 23 [Resident #92] is taking Remeron 7.5 mg (milligram) for appetite stimulator ..." Review of the care plan lacked documented evidence that facility staff updated the resident's care plan to show that the resident was no longer receiving Remeron. During a face-to-face interview conducted on 07/28/2021 at 4:22 PM, Employee #28 (Unit Manager) acknowledged the finding and stated, "I will check it (care plan discipline and discontinued Remeron)" and acknowledged the findings.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		

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ASCENSION LIVING CARROLL MANOR	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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F 676	Continued From page 24 grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, for one (1) of 60 sampled residents, facility staff failed to demonstrate evidence that Resident #1 received assistance with meals as directed by the care plan and physician ' s orders to maintain the resident ' s ability to carry out ADLs (activities of daily living). The findings included: Resident #1 was admitted to the facility on 10/13/2016, with the following diagnoses of Anemia, Vitamin D Deficiency, Chronic Kidney Disease Stage 3 Moderate and Hypertension. During an observation on 7/19/2021, at 1:05 PM, the writer observed Resident #1 in her room, the head of the bed was raised and the resident was asleep. Her lunchtime meal tray was on the over-the-bed table that was placed to the right side of the resident ' s bed. A lid was covering the plate of food, a roll/bread was wrapped in plastic and two beverages were unopened and	F 676	F676 1. Resident #1 food was offered to her by the assigned associate. 2. The Executive Director and Assistant Executive Director made rounds on 7/28/2021 to ensure that residents, who needed assistance with food received assistance during the evening meal service. 3. The Staff educator or designee re-educated nursing staff on ensuring that residents, who need assistance with set up, receive assistance with their food as needed. 4. The Unit Manager or designee will randomly make observations during meal service 3 days per week for 3 months to ensure that residents, who need assistance with set up are assisted. The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 676	Continued From page 25	F 676		

lying flat on the tray.

At 1:17 PM, the writer observed the staff remove the tray from Resident #1 ' s room and place it on the food cart with other soiled food trays (from other resident rooms) to be returned to the kitchen. Upon further review of the resident ' s tray, the lid was still on the plate, the food had been untouched/uneaten, the roll/bread was still wrapped in plastic and the beverages were unopened and lying flat on the tray.

According to the Annual Minimum Data Set dated 07/14/2021, in Section C (Cognitive Pattern), Resident #1 had a Brief Interview for Mental Status score of "00" indicating the resident had severe cognitive impairment. Under Section G (Functional Status) the resident was coded as requiring supervision and one person physical assistance for eating.

According to the ADL (Activities of Daily Living) care plan last update 05/24/2021, shows, "...Requires assistance with ADLS...Approach: ...requires one assist with ADLS setup help with meals."

According to the Physician ' s orders dated 5/24/2021, "[Resident #1] requires 1 assist with ADL ' s. Set up help with meals..."

There was no evidence that facility staff assisted Resident #1 with her meal set up and encouraged or cued the resident to eat her lunch meal.

During a face-to-face interview conducted on 7/19/2021, at 1:17 PM, Employee #29 acknowledged the finding and stated, "She does not want to eat. The resident asked for her

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F 676	Continued From page 26 dentures and I gave them to her."	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for six (6) of 60 sampled residents, facility staff failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and/or personal hygiene. Residents' #61, #109, #116, #123, #127, and #144. The findings included: 1. Resident #61 was admitted to the facility on 11/15/2017, with multiple diagnoses that included: Dementia, Anxiety Disorder, Tinea Unguium, Unspecified Mood Disorder and Restlessness and Agitation. During a tour of unit 5 north on 07/26/2021, at 2:57 PM, Resident #61 was observed in bed with her heels offloaded on pillows. A head-to-toe skin assessment of the resident was conducted with Employee #19 (Licensed Practical Nurse). The resident ' s fingernails were observed to be long. Toenails on bilateral feet were noted to be very long, thick and yellow. Review of the Quarterly Minimum Date Set (MDS) dated 05/18/2021, revealed the following:	F 677	F677 1.Residents #61, 109, 116,127 nail care was provided on July 26, 2021 by the licensed nurse. Resident #123 was given a shower on July 23, 2021 by the nursing staff. Resident #144 was fed by the nurse assistant on 7/19/2021. 2.The Nursing Administration team made rounds to assess the nail care needs of the current residents. The unit manager or designee reviewed the resident shower schedules to determine that current residents are offered showers per schedule and as needed. The unit manager or designee made rounds to ensure that residents, who need assistance with feeding received assistance as needed. 3.,The Staff educator or designee re-educated nursing staff on ensuring residents, who need assistance with bathing, grooming or meals get the assistance they need. The unit manager or designee will randomly make observations 3 days per week, for 3 months to ensure residents who need assistance are assisted. 4.The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 677	Continued From page 27 In Section C (Cognitive Patterns) - "Brief Interview for Mental Status (BIMS) score of 0" indicating severe cognitive impairment. In Section G (Functional Status) - "... Personal Hygiene- extensive assistance, two + (or more) persons physical assist." Review of the care plan revealed the following: "11/15/2017 Category ADL (activities of daily living), "[Resident #61] requires assistance with ADL (activities of daily living) secondary to: history of falls/muscle weakness. Approach: assist with bathing, dressing, toileting and personal hygiene as needed" "03/25/2019 Category Mycotic Toenails. "[Resident #61] has mycotic toenails. Approach: Podiatry consult as ordered. Wash and dry feet and between toes with scheduled bath." 07/16/2021 Category Behavior "[Resident #61] resisting care: Fingernail care. Approach: Offer assistance with fingernail care, notify MD (medical doctor)/ RR (resident representative) if resident refuses" Review of the physician ' s orders revealed the following: 04/16/2021 "Weekly skin check document findings in progress note on shower days..." 07/19/2021 "Podiatry consult... podiatry consult for nail care when available..." Review of Nurses ' Notes revealed the following:	F 677		

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07/20/2021 at 9:45 PM " ... [Resident #61] was assisted with foot care, toenails are thick, podiatry consults was placed. Resident assisted with fingernail care..."

07/26/2021 at 3:26 PM "... Resident [has] a podiatrist consult for foot and nail care on 07/28/2021, head to toe skin assessment done, right second toe corn slightly tender to touch, medicated for pain x1, R/R (resident representative) aware..."

During a face-to-face interview conducted on 07/26/2021, at approximately 3:15 PM, Employee #8 (5th floor Nurse Manager) acknowledged the finding and stated, "The podiatrist had not been coming in due to COVID but the staff should have been doing nail care with bathing. The resident is on the list to see the podiatrist on 7/28/2021."

2. Resident #109 was admitted to the facility on 02/12/2021, with multiple diagnoses that included: Anemia, Heart Failure, Hypertension, Renal Insufficiency, Alzheimer' s Disease/Non-Alzheimer ' s Dementia and Depression.

On 07/20/2021 at 04:45 PM Resident #109 was observed wearing blue socks size large. The resident was able to ambulate from the day room to her room. The unit manger removed the resident ' s blue socks and the Resident #109 was observed to have long toe nails.

Review of Resident #109 ' s Quarterly Minimum Data Set (MDS) dated 06/08/2021, under Section

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G0110 Activities of Daily Living Assistance showed the resident required extensive assistance for personal hygiene.

Review of Resident #109 ' s care plan identified mycotic toenails as a medical problem and noted the following goal for resident: "Resident #109 will receive routine footcare to prevent complications. Goal date 6/20/2021 to 9/8/2021. Approach: Podiatry consult as ordered ..."

Review of the nurses progress note dated 7/19/2021 at 23:03 [11:03 PM] revealed, "... Resident toenails assessment done, needs podiatry care."

During a-face-to-face interview conducted at the time of the observation, Employee #12 acknowledged the findings and stated, "We have called the podiatrist. She [Resident #109] has not seen the podiatrist."

3. Resident #116 was admitted to the facility on 05/13/2019, with diagnoses that included: Non-Alzheimer's Dementia, Arthritis, Muscle Weakness and Gastroesophageal Reflux Disease.

During a tour of unit 1 west on 07/19/2021, at 3:51 PM, Resident #116 was observed sitting in a Geri-chair, outside her room, in the hallway. Her fingernails were noted to be long and toe nails were thick, yellow, long, curving to the left on the left foot and curving to the right on the right foot.

Review of the Quarterly MDS dated 06/15/2021, revealed the following:

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F 677	Continued From page 30	F 677		

In Section G (Functional Status), the resident is coded as "Activities of Daily Living (ADL) assistance... personal hygiene- ' 4 ' - total dependence, one person physical assist"

In Section I (Active Diagnoses) , "Need for assistance with personal care"

Review of the Activities of Daily Living care plan dated 05/14/2019 revealed:

"[Resident #116] requires assistance with ADL secondary to dementia. Approach: Assist with bathing, dressing, toileting. oral hygiene, and personal hygiene as needed..."

During a face-to-face interview conducted on 07/19/2021, at approximately 4:00 PM, Employee #12 (1st floor Unit Manager) acknowledged the finding and stated that podiatry had not been in to see the residents during the pandemic and that the nursing staff should have been doing nail care for the residents who are not diabetics.

4. Resident #123 was admitted to the facility on 07/29/2017, with multiple diagnoses including Hemiplegia, Acquired Absence Right Leg Above Knee, Morbid Severe Obesity and Generalized Muscle Weakness.

During a face-to-face interview on 07/23/2021 at approximately 3:30 PM, Resident #123 stated that she had not had a bed bath or shower since 07/01/2021. The resident said that because her motorized wheelchair doesn ' t fit in the tub area on her floor (5th), she would usually go to the 3rd floor shower room. Continued interview revealed that she was unable to go to the 3rd floor for a few months due the facility ' s COVID-19

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F 677	Continued From page 31	F 677		

Precautions.

Review of the Annual Minimum Data Set dated 06/15/2021, revealed the following:

In section C (Brief Interview for Mental Status), the resident had a summary score of "14", indicating the resident was intact cognitively.

In section E (Rejection of Care) - resident was coded as behavior not exhibited.

In section G (Functional Status), the resident was coded as needing supervision and the physical assistance of one person for personal hygiene.

In section I (Active/Other Diagnoses), the resident was coded for hemiplegia, acquired absence right leg above knee and morbid obesity ...

Review of the Activities of Daily Living care plan dated 07/29/2017, outlined multiple interventions including assist with bathing ...and personal hygiene as needed ...

Review of the Shower Schedule revealed Resident #123 ' s shower days were every Wednesday and Saturday on day shift.

The record lacked documented evidence that the facility ' s staff made arrangements or offered the resident another floor to take a shower.

During a face-to-face interview on 07/23/2021 at approximately 4:00 PM, Employee #18 (Certified Nursing Aide) stated that residents are provided showers twice a week on the days and shifts indicated on the shower schedule.

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During a face-to face interview on 07/23/2021 at approximately 5:00 PM, Employee #16 (Unit Manager) stated that she would give the resident a bath that evening.

5. On 07/19/2021, at approximately 11:45 AM, an observation of Resident #127 ' s room noted that the resident was lying in bed. The resident was observed to have long, thick, and discolored bilateral toenails.

During a face-to-face interview on 07/19/2021, at approximately 11:45 AM, Resident #127 stated that his toenails had not been trimmed in "6-7 months".

Resident #127 was admitted to the facility on 08/01/2019. The medical record revealed the resident had multiple diagnoses including Type 2 Diabetes Mellitus without complications, Pain in Right Foot, Pain in Left Foot, Atherosclerosis Heart Disease, Chronic Peripheral Venous Insufficiency, and Generalized Muscle Weakness.

Review of the Annual Minimum Data Set dated 06/22/2021, revealed the following:

In Section C (Brief Interview for Mental Status), the resident had a summary score of "15", indicating the resident was intact cognitively.

In Section G (Functional Status), the resident was coded as needing supervision and the physical assistance of one person for personal hygiene.

In Section M (Foot Problems), nothing was coded in this section.

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F 677	Continued From page 33	F 677		

Review of the Mycotic toenail care plan listed multiple interventions including podiatry consult as ordered, with start date of 05/10/2021.

Review of the progress notes and consults revealed the last podiatry consulted 01/27/2020.

During a face-to-face interview conducted on 07/19/2021, at approximately 4:30 PM, Employee #16 (Unit Manager) stated that she would ensure a podiatrist saw the resident today or as soon as possible.

6. Resident #144 was admitted to the facility on 10/01/2014 with multiple diagnoses that included: Hypertension, Alzheimer's Disease and Non-Alzheimer's Dementia.

During a tour of unit 1 on 07/19/2021 at 10:53 AM, Resident #144 was observed in her room, in bed, with her breakfast tray at her bedside. The food on the tray was noted to be cold and untouched, indicating no attempts had been made to feed the resident.

Review of the Annual MDS dated 06/29/2021, revealed the following:

In Section G (Physical Function), the resident was coded as "Activities of Daily Living (ADL) - Eating "total dependence" "One person physical assist".

Review of the care plan revealed:

07/21/2020 "[Resident] requires total assistance with ADL due to decreased cognition..." Goal: [Resident] will be provided total assist with... feeding... Approach: Total assist with ... feeding ... daily q (every) shift ..."

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F 677	Continued From page 34 Review of the physician ' s orders revealed the following: 02/23/2021 "Feeding assistance, total care ... everyday..." During a face-to-face interview conducted on 07/19/2021, at approximately 11:00 AM, Employee #12 (1st floor Unit Manager) she stated, "Breakfast trays were delivered between 8:00 AM and 8:15 AM today." During a face-to-face interview conducted on 07/19/2021, at approximately 11:05 AM, Employee #13 (Certified Nurses Aide) acknowledged the finding and stated, "I thought my coworker was going to feed her since I have three other feeders on my assignment."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for three (3) of 60 sampled residents, facility staff failed to ensure that residents received treatment and care in accordance with the professional standards of practice, the	F 684		

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F 684	Continued From page 35 comprehensive person-centered care plan, as evidenced by: failure to ensure one (1) resident ' s blood sugar was obtained in accordance with the professional standards of practice and the physician ' s order; failed to administer hydrocortisone (used to treat redness, swelling, itching, and discomfort of various skin conditions) as ordered by the physician for one (1) resident; and failed to follow the physician ' s orders and care plan approaches for bowel regimen for one (1) resident. Residents' #67, #106, and #369. The findings included: 1. Facility staff failed to ensure Resident #67 ' s blood sugar was obtained in accordance with the professional standards of practice and the physician ' s order. Resident #67 was admitted to the facility on 7/9/2021, with multiple diagnoses which include: Hypertension, Renal Insufficiency, Acute Cholecystitis, Diabetes Mellitus, Hyperlipidemia, Seizure disorder, and Hemiplegia or Hemiparesis. Review of physician ' s orders dated 5/14/2021, revealed, "Blood glucose check TID (3 times per day) before meals at 07:30; 11:30, 16:30..." On 07/12/2021 at 10:30 AM, Employee #22 was observed checking the resident ' s blood sugar and administering his AM medication. The resident ' s breakfast tray was placed in front of him on the over-the-bed table. Resident #67 stated he had just finished eating his breakfast. Employee #22 performed the resident ' s blood sugar check, and the reading was 169 mg/dl (milligrams/deciliter).	F 684	F684 1.Resident #67 blood sugar was obtained in accordance with the professional standards of practice and the physician's order on 7/13/2021 by the licensed nurse. The hydrocortisone for resident #106 was applied as ordered on 7/28/2021 by the clinical nurse. 2.The unit manager or designee observed the following: process for collecting blood sugars for current residents to ensure that blood sugars were obtained in accordance with professional standards and the physician's order and the medication and treatment administration for hydrocortisone and laxatives on or before September 10, 2021. 3.The Staff educator or designee will re-educate the licensed nurses on obtaining blood sugars in accordance with the professional standards of practice and the physician's order and following physician's orders. The unit manager or designee will randomly review 10 percent of residents on a weekly basis for 3 months to ensure that blood sugars are obtained in accordance with the professional standards of practice and the physician's order and physician orders are followed. 4.The results from the reviews will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 684	Continued From page 36	F 684		

Facility staff failed to follow the physician ' s orders for checking the resident ' s blood sugar.

During a face-to-face interview conducted at the time of the observation, Employee #22 stated that she was giving the medication late.

2. Facility staff failed to administer hydrocortisone as ordered by the physician for Resident #106.

Resident #106 was admitted to the facility on 05/10/2018, with multiple diagnoses that included: Dermatitis, Localized Edema, Shortness of Breath and Asthma.

Review of the physician ' s orders revealed:

06/04/2021 "Hydrocortisone cream 2.5% apply to b/l (bilateral lower) extremities twice a day for severe dry skin X 7 days ..."

06/08/2021 "Hydrocortisone cream 2.5% topically apply to b/l low extremity 3 times a week after 06/12/2021 for venous stasis dermatitis ..."

Review of the Electronic Medication Administration Record for June 2021 revealed that Resident #106 did not receive the Hydrocortisone cream on 06/11/2021 as ordered by the physician.

A face-to-face interview with Employee #28 (Unit Manager) was conducted on 07/28/2021, at 4:21 PM. At this time, she reviewed the document and acknowledged the finding.

3. Facility staff failed to follow the physician ' s orders and care plan approaches for Resident #369.

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F 684	Continued From page 37	F 684		

Resident #369 was admitted to the facility on 07/13/2021, with diagnoses that included: Stroke, Hemiplegia Following Cerebral Infarct, Hypertension and Hyperlipidemia.

Review of the Physician ' s orders revealed:

07/13/2021 "Polyethylene Glycol (osmotic laxatives) 3350, powder 17gram/dose ... Give by mouth one time a day as needed for constipation"

07/13/2021 "Bisacodyl suppository (stimulant laxative), 10mg (milligram): administer 1 suppository rectally one time a day as needed for constipation"

07/13/2021 "Senna (laxative)-S tablet, 8.6-50mg; administer 1 tablet by mouth one time a day as needed for constipation"

Review of the Bowel and Bladder care plan revealed the following:

07/14/2021 "[Resident #369] is at risk for constipation r/t (related to) decreased mobility and medication regimen. Goal- [Resident #369] will have regular formed BM (bowel movement) at least once every 3 days over the next 30 days. Approach- Medicate a/o (as ordered); monitor BM and record; offer assistance to toilet ..."

Review of the facility ' s document entitled, "Bowel and Bladder Summary ... For recordings from 07/13/2021 to 07/21/2021" ... revealed that on the dates: 07/14/2021, 07/15/2021, 07/16/2021, 07/17/2021 and 07/18/2021 (5 days) facility staff documented "0" under the section "Bowel Movement", indicating Resident #369 had

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F 684	Continued From page 38 no bowel movements'. Review of the electronic medication administration record (EMAR) from dates 07/15/2021 through 07/21/2021 revealed that facility staff failed to follow the physician ' s orders to administer Resident #369 ' s medications for constipation. During a face-to-face interview conducted on 07/26/2021, at 3:27 PM, Employee #6 (Registered Nurse) acknowledged the finding and stated, "The resident does go on her own sometimes and that is not being recorded. I will educate the CNAs (Certified Nurse ' s Aide) to always ask the resident and document when she reports having a bowel movement."	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		

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F 688	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 60 sampled residents, the facility staff failed to ensure that a resident with limited range of motion received appropriate treatment and services to increase their range of motion. Resident #92. The findings included: Resident #92 was readmitted to the facility on 06/01/2021, with multiple diagnoses that included: Cancer, Hypertension, Diabetes Mellitus, Dementia, Dysphagia and Gastrostomy status. According to the Minimum Data Set completed on 06/08/2021, Resident #92 ' s Brief Interview for Mental Status (BIMS) score was coded as "99", indicating the resident was unable to complete the interview. The resident was coded as having "impairment to one side of her upper extremity (shoulder, elbow, wrist, hand)" under Section G0400 Functional Limitation in Range of Motion. On 07/19/2021, at approximately 3:50 PM and on 07/21/2021, at 12:07 PM, Resident #92 was observed lying in bed with her left hand in a closed position. Review of the physician ' s orders and the resident ' s care plan lacked documented evidence of specific interventions to maintain or improve Resident #92 ' s range of motion. During a face-to-face interview conducted on 07/28/2021, at approximately 1:50 PM, with Employee #26 (Director of Rehabilitation), she stated, "The resident ' s four fingers on the left	F 688	F688 1. Resident # 92 was discharged to the hospital on 7/28/2021. 2. The unit manager or designee observed current residents on or before September 17, 2021 to determine if there was additional need for intervention due to debility. 3. The Staff educator or designee will re-educate nursing staff on the process for making rehab referrals for treatment and services related to resident mobility and debility. The unit manager or designee will make random observations on a weekly basis times 3 months to determine if there is need for rehab intervention. 4. The results from the observations will be reviewed during the monthly QAPI meeting times 3 months and then re-evaluated to determine if further monitoring is indicated	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 688	Continued From page 40 hand have passive range of motion (movement of a joint with no effort from the patient/resident). We will address it, she will be screened." Employee #26 also verified that the resident had no positioning device such as a splint in place. During a face-to-face interview on 07/28/2021 at 4:25 PM, Employee #28 (3rd floor Unit Manager) was made aware of the finding.	F 688		
F 689 SS=G	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 record review and staff interview, for one (1) of 60 sampled residents, facility staff failed to provide supervision, monitoring and modification of the residents plan of care to decrease the resident ' s risk for falls. Resident #51, who had a history of falls with injury, sustained another subsequent fall with injury. The findings included: Resident #51 was admitted to the facility on 08/26/2016. The medical record revealed the resident had multiple diagnoses including Dementia, Generalized Muscle Weakness, Wandering, History of Falling, Left Artificial Hip Joint, Fracture of Neck of Left Femur and	F 689		

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F 689	Continued From page 41 Age-Related Physical Debility. Review of the medical record revealed the following: 04/15/2021 at 2:37 AM [Nursing Supervisor Note] " ...I saw the resident sitting on the floor in front of her room ...Resident complained of severe pain in her left hip ...The resident is alert to herself but confused ...We did not move or turn the resident from the floor ...MD (medical doctor) said to send resident ot [to] hospital for evaluation and treatment ...911 crew arrived ... [Resident #51] left facility at 1:14AM ..." Resident #51 was readmitted to the facility on 04/22/2021 with a diagnoses of Left Hemiarthroplasty (a surgical procedure that involves replacing half of the hip joint). 04/23/2021 [Physician ' s Progress Note] MD (medical doctor) readmission ...patient was sent to [hospital name] s/p (status post) fall sustained left hip fracture s/p (status post) left hemiarthroplasty ..." .Review of Resident #51 ' s Fall Risk Assessments revealed the following: On 04/15/2021 - the resident had a score of 14. On 04/22/2021 - the resident had a score of 24. On 06/04/2021 - the resident had a score of 20. According to the fall risk assessment, "A resident whose score is over 9 is at risk for falls." Review of the Significant Change Minimum Data	F 689	F689 1.Resident #51's fall risk assessment was reviewed and the plan of care was updated to reflect the risk of falls on 7/30/2021 by the nurse manager 2.Current residents were assessed by the unit manager or designee to determine their risk for fall on or before 9/17/2021 and their plan of care was reviewed and updated when appropriate on or before 9/17/2021 3.Associates were re-educated on fall prevention management protocol by the Staff Development Nurse or designee. The unit manager or designee will review new admissions and new falls during the weekday clinical huddle times 3 months to ensure that residents are assessed for falls, with appropriate interventions in place. 4. The results from the observations will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 689	Continued From page 42	F 689		

Set (MDS) dated 04/29/2021, revealed the following:

In section C (Brief Interview for Mental Status - Summary Score) - the resident was coded as a "3" indicating that the resident was "severely impacted cognitively". In Section E (Rejection of Care) -the resident was coded as behavior not exhibited. In Section G (Toileting Use) - the resident was coded as total dependence and requiring one-person physical assist. In section G (Mobility Device) - the resident was coded as using a wheelchair. In Section J (Health Condition - Fall History/ Recent Surgery)- the resident was coded as having fracture related to fall and having major surgery. In Section M (Other Ulcers, Wounds and Skin Problems) - the resident was coded as having a surgical wound. In Section O (Special Treatments, Procedures, and Programs) - the resident was coded as receiving speech, physical and occupational therapy services. In Section V (Care Area Assessment Summary) - indicated that the resident triggered for falls, which were addressed in the resident ' s care plan.

Review of the Fall Care Plan with a start date of 10/23/2018 outlined multiple intervention including:

Initial interventions:

Complete Fall Risk Assessment quarterly.

Encourage resident to request assistance, as needed.

Encourage resident to rise slowly and sit in upright position before attempting to transfer.

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Keep frequently used items in easy reach.

Revised interventions after fall on 04/15/2021:

PT/OT (physical therapy/occupational therapy) Screen.

Transferred to ER (emergency room)

Left hip hemiarthroplasty

It should be noted that the 10/23/2018 interventions were still being implemented.

There was no evidence that facility staff revised the plan of care and or facility practice with goals and approaches to reduce the likelihood of another fall for Resident #51 who has a history of a fall with injury and is cognitively impaired.

Review of therapy documents revealed the following:

Physical Therapy Plan of Care" with a start care date of 04/23/2021 and end date of 06/02/2021 revealed, "... Treatment diagnosis - aftercare following joint replacement surgery... Frequency/duration of services were four (4) times a week for 60 days"

"Resident #51 required skilled services to focused on ... therapeutic exercise, neuromuscular re-education, gait training, manual therapy, physical therapy evaluation moderate complexity, and therapeutic activity."

The "Physical Therapy Progress & Discharge Summary" dated 06/02/2021 documented,

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"Patient has achieved 100% of rehab goal at this time and to be d/c (discharged) to LTC (long term care) with assistance from nursing staff as needed ...Pt (patient) educated in order to improve functional mobility ...Pt (patient) educated on safety precautions in order to decrease ...falls ...Pt. requires *CGA (contact guard assist- the assisting person has one or two hands on your body but provides no other assistance to perform the functional mobility task) -*SBA (stand by assist- the assisting person does not touch you or provide any assistance, but needs to be close by for safety in case you lose your balance or need help to maintain safety during the task being performed.) for safety mobility ..."

The therapy discharge summary indicates that Resident #51 (who was assessed as cognitively impaired) was educated. However, there was no evidence in the discharge summary that the resident verbalized understanding or was able to return demonstration of the material she was taught.

On 07/27/2021 at 7:50 AM [Physician Geriatric Progress Note] - "Pt (patient) c/o (complained of) severe pain rt (right) hip ... she said [that she] fell down while trying to go to bathroom and got back to bed herself ... transfer to ER (emergency room) acute severe pain ..."

07/27/2021 at 8:00 AM [Telephone - physician order] - "Transfer resident via 911 to ER (emergency room) for acute severe right hip pain".

07/27/2021 at 9:45 AM [Nursing Note] - "Writer ' s attention was called to the resident ' s room

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F 689	Continued From page 45 secondary to complaining of pain in her right hip during care ... that won ' t go away ... Resident ... remained alert, oriented to her name only and able to verbally make her needs which is her baseline secondary to diagnosis of Dementia ...Resident confirmed that she did not tell anyone that she fell ... prior to now ... 911 called ...first responder in house ... left with resident via stretcher to [hospital name] ..." During a face-to-face interview conducted on 07/28/2021, at approximately 10:30 AM, Employee #26 (Director of Rehabilitation) stated that the resident required moderate assistance with transfers. She then said she did not see any evidence that therapy staff provided nursing staff education on safety issues including contact guard assist and stand-by assist to reduce falls and improve functional mobility for Resident #51. During a face-to-face interview conducted on 07/28/2021, at approximately 11:00 AM, Employee #5 (4th floor Unit Manager) acknowledged the findings.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		

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F 695	Continued From page 46 Based on observation and staff interview, for one (1) of 60 sampled residents, facility staff failed to ensure that a resident ' s respiratory care was consistent with professional standards of practice. Resident #8. The findings included: Review of the facility ' s policy entitled, "Respiratory Care - Prevention of Infection," documented, " ... Change the oxygen cannula and tubing every seven (7) days, or per state regulations (whichever is more strict), or as needed..." On 07/20/2021, at approximately 11:30 AM, Resident #8 was observed lying down in her bed and wearing a nasal cannula. There was no labeling noted on the resident ' s nasal cannula tubing to indicate the last date and time that either was changed. Resident #8 was admitted to the facility on 06/23/2021, with multiple diagnoses that included: Shortness of Breath, Heart Failure, Gastroesophageal Reflux Disease and Non-Alzheimer's Dementia. During a face-to-face interview conducted at the time of the observation, Employee #28 (2nd floor Unit Manager), she acknowledged the finding.	F 695	F695 1.Resident #8 02 tubing was changed and dated on 7/20/2021 by the licensed nurse. 2.No other residents were found to have oxygen without dates. 3.The nurse educator or designee will re-educate licensed nursing staff on ensuring that oxygen tubing is dated and changed per policy. The unit manager or designee will observe residents on oxygen on a weekly basis for 3 months to ensure that oxygen is changed and dated per policy. 4.The results from the observations will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		

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F 755	Continued From page 47 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, facility staff failed to: (1) administer medications in accordance with professional standards of practice, (2) dispose of medications in a timely manner and (3) accurately reconcile narcotics. Residents ' #67 and #123. The findings included: 1. Facility staff failed to ensure medication was	F 755	F 755 1. Employees #22, 14, 20, 21, 23, 27 were re-educated on the reconciliation of narcotics,disposing medications in a timely manner and administering medications in accordance with professional standards of practice.. 2. The medication of the discharged resident was discarded by the licensed nurse on 7/21/2021 3. Licensed nursing staff were re-educated on administering medications in accordance with professional standards of practice, the reconciliation of narcotics and discarding medications of discharged residents in a timely manner. The unit manager or designee will randomly observe two nurses during narcotic reconciliation per week times 3 months to ensure that professional standards are practiced. The unit manager or designee will also randomly observe one medication med room per week to ensure that the medication of discharged residents is discarded. 4. The results of the rounds will also be reported at the monthly QAPI committee for 3 months for review.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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administered in accordance with professional standards of practice.

Review of the facility ' s policy entitled, "Medication Administration Policy 5.2 PAXIT MED-Pass Procedure" revealed, " ...Explain to the resident the type of medication to be administered. The resident has the right to be informed of all medications that are administered."

1a. Resident #67 was admitted to the facility on 07/09/2021, with multiple diagnoses which included: Hypertension, Renal Insufficiency, Acute Cholecystitis, Diabetes Mellitus, Hyperlipidemia, Seizure disorder, and Hemiplegia or Hemiparesis.

On 7/20/2021, at 10:30 AM, during a medication administration observation, Employee #22 (Licensed Practical Nurse) was administering medications to Resident #67. Employee #22 placed the clear 30 cc medication cup containing four pills, up to the resident ' s lips for him to take the medication. Prior to administering the medication to Resident #67, the nurse did not properly inform the resident of the medications being administered.

During a face-to-face interview conducted at the time of the observation, Employee #22 acknowledged the finding.

1b.During an observation of medication administration on 07/21/2021 at 8:49 AM, Employee #14 (Licensed Practical Nurse) poured nine (9) tablets into a 30cc (cubic centimeters) plastic cup, introduced herself to Resident #123,

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and administered the medications. Employee #14 failed to inform the resident of the names of the medications she was administering and the reasons why she was giving the pills(tablets).

Resident #123 was admitted to the facility on 07/29/2017 with multiple diagnoses including Hypertension, Major Depression, Anemia, and Hyperlipidemia.

Review of the Annual Minimum Data Set dated 06/15/2021 revealed in Section C (Brief Interview for Mental Status), the resident had a summary score of "14", indicating the resident was intact cognitively.

Review of the Care plan category "9 or more medications" revealed multiple interventions including "medication teaching as appropriate ..."

During a face-to-face interview conducted on 07/21/2021 at approximately 9:15 AM, Employee #14 stated that she should have told the resident the names of the medications and the reasons for them.

2. The facility ' s staff failed to discard a residents medications in a timely manner.

During an observation of unit 4 ' s medication room on 07/21/2021 at approximately 3:30 PM, a resident ' s medications and supplements (14 in total) were noted in a plastic bag in an upper cabinet.

Review of the nurse ' s progress notes revealed the following:

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03/08/21 at 20:25 - "At 16:06 (4:06 PM), a 70-year-old AA (African American) female admitted to facility room 321 on 3rd floor from [hospital ' s name] on stretcher via ambulance ..."

03/28/21 at 20:10 (8:10 PM) - "About 7PM assigned charge [nurse] reported a changes in a resident mental status, on arrival resident observed ...non verbally responsive and difficult to arose with sternum rub ...911 called and the EM (emergency med team arrived at 7:30 PM and transferred resident to [hospital ' s name]".

Review of physician orders revealed a telephone order dated 03/28/2021 that ordered, "Transfer resident out via 911 to ER (emergency room) for change in mental status."

During a face-to-face interview conducted on 07/21/2021 at 3:35 PM, Employee #5 (Unit Manager) stated that the resident came to the facility with the medications and when she reached out to the resident ' s family, they did not want resident ' s medications. The employee said that the resident was sent to hospital on 03/28/2021 and discharged home from there. Employee #5 stated that she would discard the medications on 07/21/2021.

3. Facility staff failed to ensure accurate reconciliation of narcotics.

Review of the "Controlled Substances" policy with a revision date of 06/2020, instructed "associates (staff) to count controlled medications at the end of each shift. The associates coming on duty and the associate going off duty are to make count

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together."

3a. During a tour of the 1st floor medication storage room on 07/21/2021 at 03:51 PM, it was observed in the "Ascension Living shift to shift controlled medication count log" that there was no narcotic reconciliation (counting of the number of medications) nor any staff signatures documented at 3:00 PM for the evening shift.

During a face-to-face interview conducted on 07/21/2021 at approximately 3:55 PM, Employee #20 (Licensed Practical Nurse), the medication nurse stated, "My shift starts at 3. She [day shift medication nurse] gave me the keys and left to get report upstairs. She said she would come down after getting report for us to do the narcotic count."

During a face-to-face interview conducted on 07/21/2021 at approximately 4:00 PM, Employee #21 (Licensed Practical Nurse), acknowledged that she did not do a narcotic count and stated, "I just went up to get report quickly and was going to come back to count."

During a face-to-face interview conducted on 07/27/2021 at 2:38 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "They [nurses] are required to count at the change of shift and if giving the key to someone else taking over the assignment."

3b. During an observation of 2 west, medication cart #3, on 07/27/2021 at 1:36 PM, it showed in the "Ascension Living shift to shift controlled medication count log" that two nurses signed off. However, the form lacked documented evidence that the two nurses counted the narcotics as the

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section labeled, "Total RX (prescription)" was left blank for the 7:00 AM change of shift.

During a face-to-face interview conducted on 07/27/2021 at approximately 1:40 PM, Employee #22 (Licensed Practical Nurse) acknowledged the findings.

3c. During an observation of the 3rd floor, medication cart #3, on 07/27/2021 at 2:12 PM, it was noted in the document entitled, "Ascension Living shift to shift controlled medication count log", one facility staff signed off in the section "off going" and "on coming" signature line, indicating reconciling the narcotic count with herself.

During a face-to-face interview conducted on 07/27/2021 at approximately 2:15 PM, Employee #23 (Licensed Practical Nurse) acknowledged the finding and stated, "That's how we have been doing it, if you stay over for a double shift, you sign off with yourself."

3d. During an observation of 5 west, medication cart 3, on 07/27/2021 at 2:29 PM, it was noted in the document entitled, "Ascension Living shift to shift controlled medication count log", one facility staff signed off in both "off going" and "on coming" signature line, indicating reconciling the narcotic count with herself.

During a face-to-face interview conducted on 07/27/2021 at 2:38 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "It ' s our process that two nurses must count at the end or change of shift. If a nurse is staying over or working a double, they count when someone is relieving them."

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F 755	Continued From page 53 3e. During an observation of 5 west medication cart on 07/21/2021 at approximately 3:30 PM revealed the narcotic count sheet with Employee #27 ' s signature for the following times: 07/20/2021 [11:00 PM] - On-coming 07/21/2021 [7:00 AM] - Off-going 07/21/2021 [7:00 AM] - On-coming This indicated that Employee #27 (Registered Nurse) signed off with herself for doing the narcotic reconciliation count. During a face-to-face interview on 07/21/2021 at approximately 3:35 PM, Employee #27 was asked how does she ensure the narcotic count is accurate if there is not a second nurse to count with her? The employee stated that she was unaware she could not sign for off-going and on-coming when working a double shift on the same team.	F 755		
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	F 758		

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F 758	Continued From page 54 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be 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 observation, record review and staff interview, for one (1) of 60 sampled residents, the facility staff failed to attempt a gradual dose	F 758	F758 1. Resident # 123' s Bupropion was reviewed by the physician and a GDR was initiated on July 31, 2021. 2. Residents on Antidepressant medications were reviewed for possible GDR on or before 9/17/2021 by the licensed nurse to determine if the physician had reviewed the residents medical care. 3. The Pharmacy provider educated the pharmacist on GDRs for antidepressant medications. The pharmacist will review residents on antidepressant medication during the monthly review for 3 months to determine GDR need. 4. The results from the observations will be reviewed during the monthly QAPI meeting times 3 months and then re-evaluated to determine if further monitoring is indicated.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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reduction for a resident who used Bupropion (antidepressant) HCL (hydrochloride) SR (sustain released tablet) daily for depression. Resident #123.

The findings included:

During observations from 07/19/2021 to 07/29/2021, Resident #123 was observed in her room, alert, oriented to name, place, time, very pleasant watching movies and interacting with staff.

Resident #123 was admitted to the facility on 07/29/2017. The medical record revealed the resident had multiple diagnoses including Major Depression.

Review of the physician ' s order dated 02/12/2021, ordered, "Bupropion HCL SR 150 milligrams by mouth one time a day for depression.

Review of the psychotherapy progress notes from 02/16/2021 to 07/20/2021, lacked documented evidence that Resident #123 was observed or verbalized she had any signs/symptoms of depression.

Review of the Annual Minimum Data Set dated 06/15/2021 revealed the following:

In Section C (Brief Interview for Mental Status) the resident had a summary score of "14", indicating that the she was cognitively intact. In section D (Feeling Down, Depressed, or Hopeless) - the resident was coded "0", indicating that the resident did not have any symptoms of feeling down, depressed or hopelessness. In

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F 758	Continued From page 56 Section N (Medication received) - the resident was coded as receiving anti-depressants (psychotropic drug). In Section N (Date of last attempted Gradual Dose Reduction (GDR)) - nothing was coded in this section. In section N (Antipsychotic- Physician documented GDR is clinically contradicted) - nothing was coded in the section. The record lacked documented evidence that facility staff attempted a GDR for Bupropion HCL SR from 02/12/2021 to 07/23/2021 for Resident #123. During a face-to-face interview conducted on 07/23/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) stated that a GDR was not attempted, but she would ensure that Resident #123 was seen by a psychiatrist to evaluate for a possible GDR of the Bupropion HCL SR.	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.	F 812		

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F 812	Continued From page 57 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by 10 of 11 steam pans that were stacked wet, two (2) of two (2) convection ovens that were soiled throughout, 14 of 42 plastic dinner plates that were soiled, seven (7) of seven (7) food tray transport carts that were marred, two (2) of two food tray transport carts plastic coverings that were torn and soiled, and one (1) of 14 baffle filters from the kitchen range hood that was damaged. The findings included: 1. 10 of 11 full steam pans were stored wet, on a shelf, ready for use. 2. Two (2) of two (2) convection ovens were soiled throughout with leftover burnt food deposits. 3. 14 of 42 dinner plates were soiled throughout. 4. Seven (7) of seven (7) enclosed food tray transport carts located on the second (2), third (1), fourth (2), and fifth floor (2), were soiled on the outside 5. Two (2) of two plastic covers to open food tray transport carts on the first-floor unit were torn and soiled. 6. Stainless-steel/aluminum panels to one (1) of	F 812	F812 1.2 Soiled convection ovens were immediately cleaned and the leftover burnt food deposits were removed by the dining services associate on 7/21/2021 14 dinner plates that were soiled were immediately cleaned by the dining services associate on 7/21/2021. **2** plastic covers to open food plates that were torn on the first floor unit were replaced on 7/21/2021 by the dining services associate. Wet steam pans stored wet were immediately dried by the dining services associate on 7/21/2021 7 enclosed food tray transport carts on the 2nd, third and fifth floor were immediately cleaned from soiling on the outside by the dining services associate on 7/21/2021. Stainless steel/aluminum panels to kitchen range hood were inspected and fastened/straightened on 7/21/2021 by the dining services associate., **2**.Kitchen staff was re-educated on proper storage of steam pans, cleaning convection ovens, cleaning soiled plates, cleaning the outside of enclosed food tray transport carts, inspecting and replacing torn plastic food tray covers, and ensuring no loose or bent baffle filters from the Kitchen range. **3.**The Dining Services Manager or designee will make rounds 3 times per week to ensure proper procedures were followed times 3 months **4**.The results of the rounds will also be reported at the monthly QAPI committee meeting for review	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 812	Continued From page 58 14 baffle filters from the kitchen range hood, were loose and bent. Employee #9 acknowledged the findings during a face-to-face interview on 07/21/2021, at approximately 10:00 AM.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842	F842 1. Resident #3 wander assessment was completed by the licensed nurse on or before September 17, 2021 2. Wander assessments were completed by the unit manager or designee for current residents, who wander on or before September 17, 2021 3. The Nurse educator or designee re-educated the licensed nurses on elopement risk assessments. The unit manager or designee will randomly review new admission elopement risk assessments on a monthly basis for 3 months to ensure that the assessments reflect the residents. 4. The results of the reviews will also be reported at the monthly QAPI committee meeting for review	9/17/2021 9/17/2021 9/17/2021 9/17/2021

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F 842	Continued From page 59 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 60 sampled residents, facility staff failed to accurately document resident	F 842		

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assessments in the medical record in accordance with professional standards and practice. Resident #3.

The findings included:

Resident #3 was admitted to the facility on 12/11/2014, with diagnoses that included: Non-Alzheimer's Dementia, Psychotic Disorder, Muscle Weakness and Chronic Kidney Disease.

Review of the Quarterly Minimum Data Set (MDS) dated 04/06/2021 revealed the following:

In Section E (Behavior) - "... Wandering- Presence and Frequency- Has the resident wandered?" the resident was coded "2" indicating, "Behavior of this type occurred 4 to 6 days, but less than daily". In Section I (Active Diagnoses) - "Hypertension, Insomnia Unspecified".

Review of the physician ' s orders revealed:

04/12/2018 "Check wander guard (roam alert) for safety risk placement q (every) shift..."

Review of the care plan revealed the following problem areas:

12/17/2014 "[Resident #3] wanders r/t (related to) dementia"

10/15/2017 "[Resident #3] will not leave unit/facility without notification of

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F 842	Continued From page 61 staff/management via alarm system Watchmate" Review of the progress notes revealed: 07/08/2021 at 11:09 AM (nursing note) "... redirection and reminders provided as needed. Resident continues wandering out ..." 07/15/2021 at 10:26 AM (social services note) ... "[Resident #3] was found wandering on a few occasions but is easily redirected back to her room or unit ..." Review of the facility ' s document entitled "Elopement Risk Assessment" dated 7/20/2021 revealed that facility staff failed to document in the following areas: "wanders aimlessly", "physical changes in the brain (e.g., Dementia process)", "respiratory/cardiac disorders" and "sleep disturbances", all which applied to Resident #3. The document also revealed that facility staff scored the resident as "Not at risk to wander ..." During a face-to-face interview conducted on 07/28/2021 at 12:21 PM, Employee #5 (5th floor Unit Manager) acknowledged the finding and stated that the form was filled out incorrectly.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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F 880	Continued From page 62 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	F880 1.Resident # 61 and #67 were assessed by licensed nurse on 7/21/2021and had no negative outcome from receiving medications that were not handled following infection prevention and control standard practices Resident # 64 and #168 were assessed by a Licensed nurse on 7/21/22 and had no negative outcome related to not using infection prevention and control practices. Resident #370 was assessed and had no negative outcome due to a CNA sitting at his bedside without eye protection. Employees #19, 22, 10, 14 were re-educated on infection prevention and control practices when providing medication and treatment, CNA was re-educated on COVID-19 to include precautions to include wearing eye protection on or before September 17, 2021 by the staff educator or designee 2.Unit Manager or Designee will ensure all residents on droplet precautions have signage on their door to indicate precautions status. 3.Licensed nursing staff were re-educated on infection prevention and control practices when providing medication and treatment and Staff was re-educated on COVID-19 to include precautions on or before 9/10/2021 by the staff educator or designee. The unit manager or designee will randomly observe one 1 nurse during med pass and treatment administration per week for 3 months to ensure that infection prevention policies are in place. The unit manager or designee will also randomly observe staff in resident care areas to ensure that staff is following COVID-19 precautions.	9/17/2021 9/17/2021 9/17/2021

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F 880	Continued From page 63 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, for five (5) of 60 sampled residents, facility staff failed to maintain infection prevention and control practices to minimize the potential spread of infections during medication administration, while providing wound care and not continuing transmission-based precautions. Residents' #61, #64, #67, #168, and #370. The findings included: 1. Facility staff failed to maintain infection prevention and control practices during medication administration for Residents' #61 and #67. Review of the facility ' s policy and entitled,	F 880	4.The results of the rounds will also be reported during the monthly QAPI committee meeting for 3 months for review.	9/17/2021

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"Medication Administration Policy..." documented, " ... never touch any of the medication with fingers ..."

1a. During an observation of medication administration on 07/21/2021 at 8:15 AM, Employee #19 (Licensed Practical Nurse) performed hand hygiene, poured five (5) tablets into a 30cc (cubic centimeters) plastic cup, introduced herself to Resident #61. As the employee was administering the pill, two (2) pills fell on to the resident ' s gown. The employee failed to maintain infection control practices when she scooped the two (2) pills up from the resident ' s gown using the plastic 30cc cup and administer them to the resident.

Resident #61 was admitted to the facility on 11/15/2017. The medical record revealed the resident had multiple diagnoses including Unspecified Pain, Constipation, Iron Deficiency Anemia and Agitation.

Review of the sixty-day (05/01/2021 to 07/31/2021) Physician Order Sheet Medication Administration Record, showed the following:

Employee #19, initialed on 07/21/2021 at 9:00 AM that she administered (by mouth) the following medication orders:

-Acetaminophen (pain reliever) 500 mg (milligrams) by mouth for pain.

-Docusate Sodium (laxative) 100mg by mouth for constipation

-Ferrous Sulfate (iron supplement) 325mg by mouth for anemia.

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F 880	Continued From page 65 -Seroquel (antipsychotic) 25mg by mouth for agitation. During a face-to-face interview on 07/21/2021 at 8:20 AM, Employee #19 stated that she should have discarded and not administered the pills that fell on the resident ' s gown. 1b. During an observation on 07/20/2021, at 10:30 AM, Employee #22 (Licensed Practical Nurse) was observed administering medications to Resident #67. Employee #22 placed the clear 30 cc medication cup containing four pills up to the resident ' s lips for him to take the medication. At this time, one pill fell out of the cup and onto the unclean bed linen. Employee #22 then scooped the medication back into the cup with her bare hands and administered the pill to the resident. Resident #67 was admitted to the facility on 07/09/2021, with diagnoses that included: Hypertension, Renal Insufficiency, Diabetes Mellitus and Hyperlipidemia. During a face-to-face interview conducted at the time of the observation, Employee #22 acknowledged the findings and stated, "I should have discarded the medication." 2. Facility staff failed to maintain infection prevention and control practices during wound care for Residents ' #64 and #168. Review of the facility ' s "Wound Care/Dressing Policy" with a review date of 12/2021	F 880		

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instructed staff to, "...place a disposable cloth ...under the wound to serve as a barrier to protect ...other body sites". The procedure also instructed staff to [after removing the old dressing] "pull glove over dressing and discard into appropriate receptacles ...wash and dry hands thoroughly ...apply clean gloves ...then proceed with wound care."

2a. During an observation on 07/21/2021 at 10:58 AM, Employee #10 (Registered Nurse) was providing wound care to Resident #64 ' s Stage 4 sacral wound. The employee failed to maintain infection control practices by not placing a barrier under the resident while providing wound care. Instead, Employee #10 opened the resident ' s incontinent brief (which was blood tinged due to the resident ' s wound not being covered with a gauze) and provided wound care.

Resident #64 was admitted to the facility on 09/24/2019 with multiple diagnoses including Generalized Muscle Weakness, Mild Cognitive Impairment, and Acute Kidney Failure.

A review of the medical record showed the following physician ' s order dated 05/19/2021 that directed staff to "Cleanse sacrum wound Stage 4 [wound] with normal saline, pat dry, pack with calcium alginate ribbon 2 times a day ...for sacrum wound stage 4 ...".

Review of the Skin Condition Report dated 07/21/2021, documented, " ... Coccyx is a deep tissue injury ... Stage 4, length in cm (centimeter) = 5, width in cm = 3.5, depth in cm = 2.2, skin is not blanchable, no odor is apparent, moderate drainage is present, color is serosanguineous ... wound base is visible, pink wound base = 100%,

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F 880	Continued From page 67 granulation tissue type = 100%..." A review of the Alteration in Skin Integrity care plan outlined multiple interventions including "Cleanse [wound] W (with) NS (normal saline), pat dry, apply calcium alginate ribbon, cover with gauze and Alleyvn Life dressing BID (twice a day) and prn (as needed)" with a start date of 07/21/2021. During a face-to-face interview on 07/21/2021 at 11:15 AM, Employee #10 stated that she should have placed a barrier under the resident before providing wound care. 2b. During an observation on 07/21/2021 at 10:00 AM, Employee #14 (Licensed Practical Nurse) provided wound care for Resident #168 ' s unstageable sacral pressure ulcer, left buttocks blister, lower back blister, and left heel deep tissue injury. While providing wound care, Employee #14 failed to maintain infection control practices by not placing a barrier under the resident. Instead, the employee provided wound care on top of the draw sheet Resident #168 was lying on prior to the wound care services. Additionally, Employee #14 failed to perform hand hygiene after providing wound care for each wound including the unstageable sacral pressure ulcer, left buttocks blister, lower back blister, and left heel deep tissue injury wounds. However, the employee was observed wearing two pairs of gloves during each wound change. Employee #14 removed the top pair of gloves after each wound change, but she did not remove the bottom pair of gloves until she completed all the wound care.	F 880		

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F 880	Continued From page 68	F 880		

Resident #168 was admitted to the facility on 06/30/2021 with multiple diagnoses including Venous Insufficient, Muscle Weakness, and Essential Hypertension.

A review of the medical record revealed the following: 07/20/21:

07/20/2021 [Physician order] - Sacral and left buttocks: clean with NS (normal saline), apply Santly (debridement ointment) BID (two times a day) and prn (as needed) , cover with moist gauze and apply Alleyvn Life (dressing).

07/20/2021 [Physician order] - Lower back open blister: clean with NS (normal saline) apply Santyl daily and prn (as needed), cover with moist gauze and Alleyvn Life.

07/20/2021 [Physician order] - DTI (Deep Tissue Injury) left heel: apply betadine daily and prn (as needed).

Review of the Skin Condition Report dated 07/22/2021 documented the following:

Sacrum Pressure Ulcer/Injury - " ... Unable to accurately stage - suspected deep tissue injury ... length =8.5 cm (centimeters), width = 7.5 cm ... wound base is visible, pink wound base = 60 %, other color in wound base +40 %, granulation tissue type = 60%, slough tissue type = 40% ... wound noted with mild drainage of serosanguinous, with no cellulitis and no odor noted ...this wound present on admission."

Left lower buttocks - "open blister, length = 1 cm, width = 2 cm, skin is not blanchable, no odor is apparent, no drainage apparent ... wound base is

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visible = 100 %, granulation tissue type = 100% ... this wound was not present on admission .... "

Left heel Pressure Ulcer/Injury - " ... length in cm = 3, width in cm = 3, skin is not blanchable, no odor is apparent, no drainage is apparent ... This wound was not present on admission ..."

A review of the Alteration in Skin Integrity care plan outlined multiple interventions including: Clean [sacral and left buttocks clean with NS (normal saline), apply Santly (debridement ointment) BID (two times a day) and prn (as needed), cover with moist gauze and apply Alleyvn Life (dressing) with a start date of 07/20/2021.

During a face-to-face interview on 07/21/2021 at 10:30 AM, Employee #14 stated that she should have placed a barrier under the resident ' s wounds, removed her gloves, and used hand sanitizer (hand hygiene) after providing wound care for each wound.

3. Facility staff failed to maintain infection prevention and control practices by not providing Droplet Precautions as ordered for Resident #370.

During a unit tour of the 1st floor on 07/21/2021 at 10:20 AM, Resident #370 was observed in bed, with the door open, with a CNA (Certified Nurse ' s Aide) sitting at his bedside (less than six feet apart). It should be noted that the CNA was wearing only a surgical face mask. Also, there was no signage observed on the door to indicate the resident was on Droplet Precautions.

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F 880	Continued From page 70	F 880		

Resident #370 was admitted to the facility on 07/13/2021, with diagnoses that included: Unspecified Dementia without Behavioral Disturbance and Altered Mental Status.

Review of the physician ' s orders revealed the following:

07/14/2021 "COVID-19 Precautions: droplet precautions (gloves, gown, mask, eye protection) every shift for 14 days... Finish date 7/27/2021"

07/15/2021 "Re-locate resident to room 128 for safety and continue COVID observations precautions"

Review of the care plan revealed the following:

07/14/2021 "Resident is high risk for infection; developing signs and symptoms of COVID-19 related to presence of underlying health ... Approach: Follow [facility name] protocol for COVID-19 Screening/precautions ..."

Review of the progress notes revealed the following:

07/15/2021 5:44 PM (nursing note) " ... received call from infection control nurse that the resident should be moved to room 128 for safety and continued COVID-19 observation... Upon his transfer to room 128 all precautions are to be continued."

During a face-to-face interview conducted on 07/21/2021 at 10:44 AM, when asked about Resident #370 ' s transmission-based precautions, Employee #12 (Unit Manager) stated, "The infection control nurse said it was

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F 880	Continued From page 71 OK. He was only on COVID-19 observation because he has not received his vaccine yet; he's scheduled to get it later this week." During a face-to-face interview conducted on 07/27/2021, at 3:42 PM, Employee #15 (Infection Control Preventionist) acknowledged the finding and stated Resident #370 was moved to that room [128] where he was the only resident on that wing since he wanders. COVID-19 precautions should have been maintained for the full 14 days.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility staff failed to maintain a low air loss mattress (for pressure redistribution) in a safe operating condition for one (1) of 60 sampled resident ' s using a low air loss mattress, Resident #64; and failed to maintain essential equipment in safe condition as evidenced by one (1) of 14 baffle filters from the kitchen range hood that was damaged. The findings included: 1. Facility staff failed to maintain a low air loss mattress in a safe operating condition for Resident #64. During observations on 07/23/2021 at 8:30 AM, 10:30 AM and 12:23 PM, Resident #64 ' s low	F 908		

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F 908	Continued From page 72 air loss mattress was inflated, but the mattress pump ' s operating light was off. Resident #64 ' s medical record revealed the resident was admitted to the facility on 09/24/2019 with multiple diagnoses including Generalized Muscle Weakness, Mild Cognitive Impairment, and Acute Kidney Failure. A review of the current physician ' s orders showed the following: 10/21/2020 "Low air mattress 3 times a day ...for sacral wound Stage 4" Review of the Skin Condition Report dated 07/21/2021, documented, " ... Coccyx is a deep tissue injury ... Stage 4, length in cm (centimeter) = 5, width in cm = 3.5, depth in cm = 2.2, skin is not blanchable, no odor is apparent, moderate drainage is present, color is serosanguineous ... wound base is visible, pink wound base = 100%, granulation tissue type = 100%..." A review of the Alteration in Skin Integrity care plan with a start date of 09/26/2019 listed multiple interventions including low air loss mattress to bed for pressure redistribution. During a face-to-face interview on 07/23/2021 at approximately 12:25 PM, Employee #5 (Director of Facility Management) stated that the pump for the mattress was not working. The employee then stated he would replace the resident ' s pump and [low air loss] mattress. 2. Facility staff failed to maintain essential equipment in safe condition as evidenced by one	F 908	1. Resident #64 low air loss mattress was replaced on 7/23/2021 by the housekeeping associate. The baffle filter from the kitchen range was replaced on 7/19/2021 by dining services associate. 2. There were no other low air mattresses identified to have issues. There were no other baffle filters identified to have issues. 3. The Staff Education nurse or designee re-educated staff on the process of reporting items in need of repair. 4. The Dining Services Manager or designee will make rounds 3 days per week, times 3 months to ensure that the baffle filters are not broken or in need of repair. The unit manager or designee will make rounds on a weekly basis to ensure that air mattress pumps are functioning. The results of the rounds will also be reported at the monthly QAPI committee meeting for review.	9/17/2021 9/17/2021 9/17/2021 9/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING CARROLL MANOR	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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F 908	Continued From page 73 (1) of 14 baffle filters from the kitchen range hood that was damaged. During a tour of dietary services on 07/19/2021, at approximately1000 AM, the stainless-steel/aluminum panels to one (1) of 14 baffle filters from the kitchen range hood, were loose and damaged. Employee #9 acknowledged the findings during a face-to-face interview on 07/21/2021, at approximately 10:00 AM.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by call bells in three (3) of 43 resident's rooms that failed to alarm when tested. The findings included: During an environmental tour of the facility on 07/21/2021, at approximately 3:00 PM, and on 0722/2021, at approximately 11:00 AM, call bells in three (3) of 47 resident ' s rooms (#215, #455, #555) failed to initiate an alarm when tested.	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095034	A. BUILDING _____ B. WING _____	07/28/2021

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F 919	Continued From page 74 These breakdowns could prevent or delay staff from responding to resident ' s needs in a timely manner. During a face-to-face interview on 07/22/2021, at approximately 12:30 AM, Employee #7 acknowledged the findings.	F 919	F919 1. The call bells for room #'s 215, 455, 555 were reset by the Maintenance Director reset on Jul 23, 2021 and they alarmed when tested. 2. No other call bells were identified to be in need of reset. 3. The Maintenance Staff was re-educated on maintaining the call bell system in good working condition at all times. 4. The Facilities Maintenance Associate or Designee will randomly test the call bells for 4 rooms per resident wing/ per week. The results of the call bell tests will also be reported at the monthly QAPI committee meeting for review.	9/17/2021 9/17/2021 9/17/2021 9/17/2021